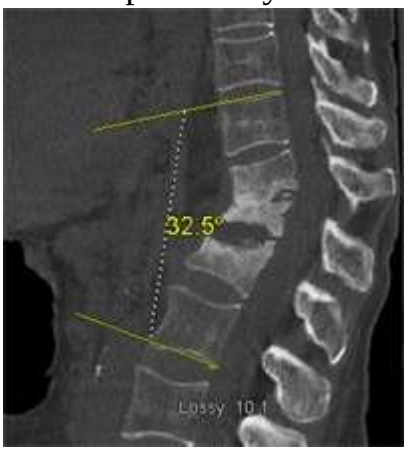
Non-Operative Interventions for Failed Back Surgery Syndrome

Written by Ralph F Rashbaum, MD

Ralph Rashbaum, MD, an orthopaedic spine surgeon answers questions posed by SpineUniverse about failed back surgery syndrome. In this segment, Dr. Rashbaum explains when surgery is not elective and important considerations for both patients and surgeons.

SpineUniverse: ***You're an orthopedic surgeon, yet a big proponent of non-surgical intervention. Can you explain why?***

Dr. Rashbaum:
One of the biggest problems I deal with in a patient population is the possibility of recurrence of the pain, for whatever reason. Our job as interventionists is to keep patients out of spine surgery if they don't absolutely need it.



There's only one reason to have spine surgery–and that is progressive neurologic deficit. In simple terms, that means that a patient's nerve, or their lower extremities are becoming progressively weaker. Or, they could be losing bowel or bladder function. Loss of bowel or bladder function is an absolute indication for emergency surgery. The statistical occurrence of that is about 0.4 of 1%, so 99.5% of what we do is elective surgery.

Another absolute indicator for surgery is progressive deformity. That's where the spine is angulating and creating potential problems. Ninety percent of what we do is treat benign back pain. *My back hurts, doctor, I don't want to feel this way.* Patients often think that surgery is the answer to a condition not caused by something serious like infection or a tumor. Obese patients want surgery, yet they don't want to make lifestyle changes and become an active participant in their care. They want an instant fix and I want nothing to do with this type of disengaged patient population.

Above image depicts an example of spinal deformity

SpineUniverse: ***Do you recommend that back pain patients see a specialist, even for elective surgery?***

Dr. Rashbaum:
Absolutely. Too many surgeries are being done by clinicians lacking expertise in a surgical specialty. Doctors become specialists in a particular field for a reason. A generalist can't even compete, in terms of knowledge or expertise.

Take the issue of family practice. What is a family practitioner? Frankly, today a family practitioner is a doctor that sees patients in his office and almost never goes to the hospital. Why? Because there are hospitalists. Do family practitioners do a good job? *No question about it.* Are they necessary? Absolutely. Family practice physicians are underserved, underpaid, under-represented–and it's getting worse and worse. But if you pay an internal medicine doctor the same as a family practitioner and you have a cardiac problem, why wouldn't you go to a cardiologist? This is exactly what's happening in surgery. Why go to a generalist when you can go to the specialist at the same cost basis.

SpineUniverse: ***How do you talk to a patient that comes to you with failed back surgery syndrome (FBSS)*****?**

Dr. Rashbaum:
To me, the most important thing is to identify the problem before you ascribe blame. This is what I think has happened over the last decade or so. I'll walk you through it and be as candid as possible.

The time has come where we as physicians have to "out," if you will, bad doctors. If a patient had surgery for something that was absolutely not indicated, I'll tell them that, in my opinion, this wasn't the right thing to do. I have no qualms about letting a patient know that the surgery might not have been necessary.

Does that heighten the likelihood of that doctor being sued? I suspect so. But I can't protect that doctor and let him or her wreak havoc on patients. If I see a pattern, I'm quick to tell the patient I think this was done wrong and for the wrong indication.

SpineUniverse: ***Do you consider yourself a Lone Ranger when it comes to pointing out what you consider poor standards of care?***

Dr. Rashbaum:
Are most surgeons as outspoken as I am? I doubt it. Does it get me into trouble? Sometimes. But to me, patients have to understand what happened. They deserve to know the truth. By the way, only a very small percentage of doctors operate outside of their realm, but unfortunately, you tend to see the same outcomes as a result of the same surgeon's intervention. If you're living in the community, you know the bad guys. You

know the good guys and you know the guys that tried and it just didn't work, and they're still good guys.

SpineUniverse: ***So you are a patient advocate. Would that be an apt description?***

Dr. Rashbaum:
I support the issue of a patient wanting to know whether or not he or she was done wrong. Most important, I need to allow them to feel comfortable when it was done right and bad things happened. That's why we have informed consent. If a patient is about to undergo a procedure, the state stipulates that there are certain things that may occur as a result of the surgery being done, with no implication of operating below the standard of care. When those things occur, it doesn't necessarily mean that things were done right, and it certainly doesn't imply that things were done wrong. It's up to me to tell the patient the truth, and then determine what needs to be done.

So, we see what happened, we know what's wrong, and now we have to move on. I think I can help you or I don't think you need any surgery. This is an important consideration when trying to figure out what to do next. If I have a great method from the standpoint of reconstructive spine surgery to allow them to benefit to some degree, then I tell them that's what's necessary, and we'll either move forward or not. At times, I'll simply say you are not a candidate for reconstructive surgery, but you are a candidate for a well-defined pain therapy; for example, the spinal cord stimulator or a narcotic pump if the stimulators don't work. You have to give patients hope because these are people who are profoundly depressed, and for the most part, on large doses of opioid medication that isn't working.

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