

Failed Back Surgery Syndrome (FBSS)

In a sense this diagnosis is self-explanatory. Patients have failed to have an adequate response to their back surgeries. In many cases these patients may have more pain than prior to intervention.

There are a number of reasons why back surgery may fail. In some cases the surgery may have been technically good but the wrong diagnosis was made, resulting in no benefit being attained. Alternatively, there may be complications from the surgery itself or worsening of the underlying pathology.

While discectomy for radicular pain has a very high rate of success (around 90%) other more complex surgeries for back pain do not achieve the same outcomes.

Spinal fusions in particular are more controversial. There is data from Rick Derby in California that demonstrates that there may be varied outcomes from different types of fusions relating to the sensitivity of the disc during provocative discography. Discs that are markedly painful at low pressure discography may have poorer surgical outcomes with posterior instrumentation (screws and plates) compared to disc removal and interbody fusion.

Often when one of the instrumentation procedures has failed there is consideration for removal of the metal apparatus, however, there is limited evidence to support better outcomes with removal of screws and rods in the failed back surgery patient.

Sometimes the body's reactions to surgery, including scar formation traversing the nerve roots, can cause persisting radicular or neuropathic type pain. Neuropathic pain may respond to some medications (especially anti-epileptics and tri-cyclic anti-depressants), radicular pain can be controlled occasionally by a series of transforaminal epidurals.

Perhaps an even more significant issue in the failed back surgery group is that of complex neuropathic pain and central sensitization, this is where the nervous system starts misinterpreting the information it receives; what otherwise might be felt as a light touch can become a burning sensation that persists long after the light touch has gone. The risk of this occurring increases with subsequent surgeries and intervention. These patients may have this burning pain spreading over the buttocks and into the lower limbs.

The management of failed back surgery syndrome is multimodal. These patients may be referred to a pain management center for a comprehensive program to

Remember:

- The primary goal is to help you find ways to manage your pain and return to your usual activities.
- It is important to work with your health practitioner to manage your pain and address your concerns.
- If pain persists it is important to follow up with your doctor or health practitioner as you may need further assessment.

help them cope with their pain and rule out other sources that may be contributing.

It may be appropriate to consider these patients for medial branch blocks to assess whether the pain could be arising from the facet (zygapophysial) joints above or below the spine surgery. Commonly, the patient may need sacroiliac joint blocks to assess the involvement of the sacroiliac joint as a cause of ongoing pain below the surgery. Provocative discography may be relevant to perform above and below the surgery to determine whether they have a new level of disc pain that could respond to one of the newer minimally invasive interventions.

Advanced neuromodulation using spinal cord stimulation has been used in recent decades to manage failed back surgery syndrome. With the improved technology and reliability of the better equipment good to excellent results are being achieved in this difficult patient group.

Longitudinal studies have demonstrated that FBSS patients with arachnoidal epidural fibrosis have better outcomes with spinal cord stimulation compared to repeated surgical interventions on the lumbar spine (for back and leg pain). In one case series of 114 patients with failed back surgery syndrome recorded over a 15 year experience, 80% of patients had satisfactory initial pain relief and therefore had these systems internalized. After an average of over five years follow-up, 60% continued to achieve satisfactory pain relief. Of that 60%, 40% reported it was excellent pain relief and the other 60% reported good pain relief. This fits with a larger patient cohort of complex neuropathic pain that on the whole achieve greater than 50% pain relief in greater than 50% of patients using spinal cord stimulation.¹ [See related information: **Spinal Cord Stimulation Patient Fact Sheet**]

References

1. Kumar K, Toth C, Nath RK, Laing P., Epidural spinal cord stimulation for treatment of chronic pain-some predictors of success. A 15-year experience. *Surg Neurol.* 1998 Aug;50(2):110-20; discussion 120-1.

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