



LETTER TO THE EDITOR

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Re: Back Pain and Needles in the Fall, 2007 JLGH;¹ Peul, et al., reported results in the New England Journal of Medicine of a controlled study of 283 patients with sciatica, comparing early surgery with conservative treatment, and based conclusions on carefully analyzed results.²

Dr. James Artuso advocated that “ESI should be part of a multimodal approach to reduce painful symptoms,” even though “controlled studies of outcomes have been—at best—limited . . .” He does not offer evidence to validate the “contemporary techniques” he recommends, techniques that “may rarely lead to . . . permanent neurological injury and death.”

Guidelines of the American Academy of Neurology³ state, in part:

“1) . . . epidural steroid injections may result in some improvement in radicular lumbosacral pain when assessed between 2 and 6 weeks following the injection, compared to control treatments. The average magnitude of effect is small and generalizability of the observation is limited . . . 2) in general, epidural steroid injection for radicular lumbosacral pain does not impact average impairment of function, need for surgery, or provide long-term pain relief beyond 3 months. Their routine use for these indications is not recommended . . .”(2)

Genuine evidence to support an update of these guidelines would be welcome.

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REFERENCES

1. Artuso, JD. Back Pain and Needles: Epidural Steroid Injections for Radicular Back Pain. *J Lanc Gen Hosp* 2007;2:95-100.
2. Peul WC, van Houwelingen HC, van den Hout WB, et al. Surgery versus Prolonged Conservative Treatment for Sciatica. *N Engl J Med* 2007;356:2245-56.

3. Armon C, Argoff CE, Samuels J, et al. Use of epidural steroid injections to treat radicular lumbosacral pain. *Neurology* 2007;68:723-729.

REPLY:

Dr. Ellenberger expresses concern that I advocated a dangerous procedure without supportive clinical evidence. To the contrary, my article carefully defined the benefits, limitations, indications, and risks of ESIs, and stressed that ESIs should be used for *acute* radicular back pain, and only with fluoroscopic guidance. As I acknowledged, it is well known that all treatments for low back and spinal pain, other than time and exercise, are weakly supported by controlled scientific studies, in large part because the spine is complex and most diagnostic studies have limited ability to identify the cause of symptoms.

Studies that did not monitor patients radiographically are outdated. In the familiar review article cited by Dr. Ellenberger, only one of six studies used image guidance, and it showed a statistically significant benefit. The other 5 studies used inaccurate non-image guided procedures, which are irrelevant to current practice. I agree that larger controlled trials are needed, but they

must use fluoroscopic guidance; consensus statements based on the old techniques are no substitute.

Finally, the goal in treating acute radicular pain secondary to disc herniation or stenosis is rapid relief of symptoms to initiate the phase of self healing and resolution of pain. Most studies, even older ones, showed at a least short term benefit from ESIs. As we know, most patients eventually recover from an acute bout of sciatica, but ESIs seem able to help speed many of them on their way. For those with acute back pain, this is not a trivial benefit.

Finally, it is unclear why Dr. Ellenberger cites the study by Peul in the NEJM. Peul found no significant difference in outcomes at one year when early surgery was compared with “conservative therapy” (rest and pain medication supervised by general practitioners). ESIs weren’t used or even mentioned in that report, which has no bearing on this discussion.

James D. Artuso, M.D.

REFERENCE

1. Armon, et al. *Neurology* 2007;68:723-729.