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Rapport : Douleurs lombaires postopératoires

Failed back surgery syndrome: Who has failed?

Lombo-radiculalgies postopératoires : d'où vient l'échec?

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ABSTRACT

Introduction. – Failed back surgery syndrome (FBSS) results from a cascade of medical and surgical events that lead to or leave the patient with chronic back and radicular pain. This concept is extremely difficult to understand, both for the patient and for the therapist. The difficulty is related to the connotations of failure and blame directly associated with this term. The perception of the medical situation varies enormously according to the background and medical education of the clinician who manages this type of patient. Eight health system experts (2 pain physicians, 1 orthopaedic spine surgeon, 1 neuro spine surgeon, 1 functional neurosurgeon, 1 physiatrist, 1 psychologist and one health-economic expert) were asked to define and share their specialist point of view concerning the management of postoperative back and radicular pain. Ideally, it could be proposed that the patient would derive optimal benefit from systematic confrontation of these various points of view in order to propose the best treatment option at a given point in time to achieve the best possible care pathway.
Conclusion. – The initial pejorative connotation of FBSS suggesting failure or blame must now be replaced to direct the patient and therapists towards a temporal concept focusing on the future rather than the past. In addition to the redefinition of an optimised care pathway, a consensus based on consultation would allow redefinition and renaming of this syndrome in order to ensure a more positive approach centered on the patient.

Mots clés :
Lombo-radiculalgies postopératoires
Stimulation médullaire épidurale
Rachis
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RÉSUMÉ

Introduction. – Les lombo-radiculalgies postopératoires (LRPO) résultent d'une cascade d'évènements médicaux et chirurgicaux, ayant conduit ou laissé le patient avec des douleurs persistantes chroniques du dos et des membres inférieurs. Ce concept est extrêmement difficile à saisir, tant pour le patient que son thérapeute. La principale difficulté est en relation avec les connotations d'échec et de blâme qui sont associées directement à ce terme. La perception de la situation médicale varie énormément en fonction de la culture et de l'éducation médicale du clinicien qui prend en charge ce type de patient. Huit experts du système de soins (deux médecins de la douleur, un chirurgien du rachis orthopédiste, un chirurgien du rachis neurochirurgien, un neurochirurgien fonctionnel, un médecin de rééducation, un psychologue et un expert médico-économique) ont été sollicités pour définir et partager leur point de vue de spécialiste concernant le management de la douleur postopératoire lombo-radiculaire. Dans l'idéal, il pourrait être proposé au patient une confrontation systématique de ces différents points de vue afin d'optimiser sa prise en charge et proposer les meilleures alternatives thérapeutiques possibles, à un moment donné, dans son parcours de soins.

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Conclusion. – La connotation initiale du FBSS est péjorative parce qu'elle suggère un échec ou un blâme. Elle doit maintenant être remplacée pour guider le patient et ses thérapeutes vers un concept temporel se focalisant sur l'avenir plutôt que sur le passé. La redéfinition d'un algorithme de prise en charge optimisé serait un bon début mais il faudra en plus un consensus basé sur l'échange de points de vue pour redéfinir et renommer ce syndrome afin qu'une approche plus positive s'en dégage et reste finalement centrée sur le patient.

1. Introduction

Failed back surgery syndrome (FBSS) is a diverse and complex array of symptoms involving persistent or recurrent, chronic pain after one or more surgical procedures on the spine. Commonly this results in functional failure of the spine, as opposed to failure of treatment or surgery, although these may also occur [1]. In the United States, where spine surgery exceeds 300,000 operations per year, 10–40% of lumbar spine operations result in FBSS [1]. Patients with FBSS are a heterogeneous group, with complex and varied aetiologies [2]. Patients typically present with chronic back or extremity pain, often both. Back pain is described as diffuse, dull, or aching; extremity pain as sharp, pricking, or stabbing. FBSS patients might also experience weakness and spasm in the limbs, numbness and, possibly, bladder and bowel difficulties [2]. Patients with FBSS have a low quality of life (QoL) and high psychological morbidity and are frequent users of health services [3–5]. The term "FBSS" does not identify a cause or provide guidance to appropriate management [6]. Further, such a term may leave the impression of a lack of precision in diagnosis and treatment [7].

1.1. FBSS: two-sided failure

The concept of failed back surgery syndrome is extremely difficult to understand, both for the patient and for the therapist and this difficulty is related to the connotations of failure and blame directly associated with this term.

Patient may find that it is difficult to accept upon agreeing to a proposed treatment, designed to treat and relieve pain, his or her life is transformed into a state of permanent, severe chronic pain after one or several surgical procedures.

The patient's personal perception and everyday experience may associate both technical failure and psychological failure related to impairment of quality of life as a result of the pain or the surgical procedure.

The therapist may consider that the situation corresponds to a technical failure or a poor indication [8], however, aggression to the nervous system by the underlying spinal disease can *per se* lead to postoperative persistence or recurrence of pain, despite a clearly defined indication or a technically satisfactory procedure.

1.2. The medical community's perception

The perception and assessment of the medical situation in this context of failure vary enormously according to the background and medical education of the clinician who manages this type of patient.

Spine surgeons tend to adopt an anatomical and biomechanical vision of pain. The advantage of this approach is that it might avoid missing indications for repeated surgery in this setting. However, a possible disadvantage of this approach might be a more singular focus of mechanistic aetiologies while ignoring the pathophysiology and the characteristics of the pain itself, as well as its neuropsychological impact. Without incorporating these various elements into the evaluation of the patient, failure may result despite a technically justified surgical indication.

Pain physicians tend to focus on symptom management based on a multidimensional approach. Ideally, the advantage of this management strategy is that it might limit the invasiveness and determine the order of priority of the techniques proposed; it takes into account the psychological dimension of the problem, related to the patient's perception and mental acceptance of pain, and finally, it allows a diversity of medical techniques to be proposed to the patient. The disadvantages of this approach are related to the limitations of some pain physician's in their degree of competence with relation to anatomical or radiological assessment of any mechanical conflicts that would partly account for the pain and that would be eligible for a more aggressive curative procedure or a singular focus on palliative or interventional procedures without the hope for resolution.

1.3. Health system constraints

The particularly difficult economic context in European countries is currently responsible for a paradox concerning the use of medical technologies: on the one hand, there is a rapid growth of the potential indications for new electronic medical devices, such as neurostimulation techniques, but, on the other hand, the inevitable restrictive policy related to excess costs induced by health systems for the community is designed to limit excessive diffusion of these expensive devices or erratic practices without any multidisciplinary consensus, and can therefore constitute a major obstacle to the potential benefit that patients could derive from these new technologies.

However, the health system is designed to avoid excessive use of technological equipment in all of these patients before the efficacy and cost-effectiveness ratio of these devices have been clearly demonstrated.

The purpose of this article is to compare the points of view of the various therapists involved in the care pathway of these patients.

2. Expert point of views

Eight health system experts were asked to define and share their specialist point of view concerning the management of postoperative back and radicular pain.

Doctor Al Kaisy is the Director of the Pain Management Department at St Thomas & Guy's Hospital, London, UK. As an anaesthetist, he is specialised in the non-invasive, medical management of chronic pain patients. However, his world-recognized experience in spinal cord stimulation and peripheral nerve stimulation has given him particular insight into what can be considered to be broad, global management of this disease.

Doctor Pang is a consultant in the same department and is particularly specialised in semi-invasive analgesic procedures, such as spinal infiltration, radiofrequency techniques, and autonomic nervous system blocks.

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