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SCIATICA INFORMATION

You have been diagnosed with having a sciatica secondary to nerve pressure. This nerve pressure may be the result of a ruptured disc or osteophyte (bone spur) formation. Irregardless, the result is the same that of pain significant with associated on occasion numbness and weakness.

We know from experience that most patients with sciatica improve over a period of time. The accepted improvement interval is two to three months. That is not to say you will be totally pain free at that juncture but showing substantial improvement to the point where we would not have to concern ourselves with further aggressive treatment.

While waiting for the natural healing process to occur, we have found benefit in use of medications to help control symptoms. The primary medications are three types:

1. Anti inflammatories, stronger form of aspirin utilized to help control pain and diminish irritation around the nerve. Not one anti inflammatory pill works for all patients so there may be a period of trial to find what works most successfully for you. The most common side effect of anti inflammatories are GI upset associated nausea or diarrhea. If that would occur, that would require change in medication. What we need to find is the medicine best tolerated by you and does the best job controlling symptoms. We are not talking about long term use, only during the acute phase of the sciatica and as time progresses, we would work to wean you away from the medicine.

2. Muscle relaxants do serve a purpose, especially for patients whose pain is worse at night or have difficulty sleeping secondary to their sciatic type pain. There are several different muscle relaxants and we would need to find one to work most effectively for yourself as far as controlling spasms and one you would be able to tolerate. For patients with significant sciatica, we will often use muscle relaxants during the day as well, but this is only over short term.

3. Narcotic analgesics. There is indication for using this medication to help reduce the intense edge of sciatic pain. Sciatica or nerve pain is bad pain, and we should use whatever is available through us to help reduce the symptoms from that. The pain medication will not take all your pain away but will improve it. Again, not all people tolerate all pain medications so it may be a matter of one that works the most successful for you with the least side effects. There is a danger of addiction with use of narcotic medication, this is not present in short term use but becomes a greater concern in use over several months.

In addition to medications, my recommendation often will extend to a physical therapy program. This would consist of a back school or back education program designed to teach you how to use your back effectively and avoid recurrent injury. Physical therapy is also important to mobilize not only the injured segment but additional muscle tendon ligaments so secondary problems are not created. Therapy will consist of some modalities, i.e. heat stimulation, occasional TENS trial in attempt to help control symptoms as well as an exercise program and workout program. As symptoms diminish for you, physical activity will be increased. If you have to loose time from work secondary to your nerve pain, once symptoms diminish we would make arrangements to return you to work safely, possibly with restrictions.

If, over a six to eight week period of time symptoms fail to improve for you, consideration can be given for more aggressive treatment step that would be epidural cortisone injection. These are also known as nerve blocks. The advantage to this approach is direct delivery of anti inflammatory medicine to the source of the problem. It is also a relatively low risk procedure. The disadvantages to epidural injections are threefold: #1 although successful in a majority of patients , they do not work for everyone and it is possible to undergo injections and not derive any relief, #2 more than one injection may be required and the series will go up to three before decision is made if treatment was successful or not, multiple repetitive injections are discouraged, #3 although pain relief may be total, symptoms on occasion can return and if the return of symptoms is over several months period of time, consideration can be given for re-injection, however within a few weeks you wound not be re-injected. The epidural injections are administered at the hospital by a trained anesthesiologists. We will on occasion administer trigger point injections in the office in an attempt to diminish muscle pain for someone, however these are not the more involved epidurals.

In patients whom have waited a reasonable length of time, two to three months and are still left with significant residual pain, a decision must then be made how to further treat them. This is entirely an individual and patient based decision. It is not a physician made decision at all. If the patient perceives his pain level as too high for him to live with or the pain interfering too much with his activities of daily living or his work activities, then consideration may be given for surgical intervention. This is under the assumption that there is indeed a surgical lesions present. Not all back pain or back/leg pain is amenable to surgical correction. Utilizing studies such as MRI, CT, myelogram, and/or diskogram allows the surgeon to determine how appropriate you are as a surgical candidate.

By appropriate it is meant that how successful we expect the surgery to be in relieving or reducing your symptoms. There is no question that surgery is a very aggressive approach. The purpose is to reduce neural compression and allow the nerve roots to resolve their irritation and the sciatica to diminish. There are risks involved with surgery just as with anything in life. There is potential for cardiac or lung problems following administration of anesthesia. Occasionally, it will be necessary to obtain preoperative clearance from your medical doctor prior to proceeding with surgical planning. Infection rate for a disc procedure in a patient who has never been operate on before is less than 1%. Antibiotics are used before and after surgery to help diminish the risk of infection. If infection occurs, it can most often be successfully treated by continued antibiotic administration and not repeat operation. Loss of blood from a disc operation is a rare consideration, this is also included with decompressive type surgery, so concerns over transfusion including hepatitis and AIDS are minimized because sufficient blood is not lost. However, if someone is undergoing a long or involved reconstructive spinal procedure for fusion procedure, then arrangements would be made for setting aside their own blood in case transfusion is required.

Injury to nerve is a fourth potential risk, since the surgery is done in the area of the nerve and disc. Paralysis, requiring wheelchair mobility is fortunately a very, very rare and unusual event in low back surgery. Its incidence is well less than 1%. The sac enveloping the nerve roots known as the dura, may develop a hole during the process of surgery known as a dural leak. This would require repair at the time of surgery, would result in bedrest following your operation before immobilization. It should also be stated that there are no guarantees with an operation. Even in the best controlled studies in the United States and around the world, the success rate approach is 90 to 95%. That would indicate that 5 to 10 people out of 100 go through the surgery and are not relieved of their pain or in fact may complain worse. If you as a patient cannot accept this as a possibility, then it is not recommended that you undergo the surgical procedures. Results for failure of the procedure to relieve pain can sometimes be found on a mechanical anatomic basis but may be that the nerve just fails to recover as we would expect once the pressure has been taken from it. Although we cannot guarantee the result of surgery, we can guarantee that the best possible effort will be exerted in obtaining a satisfactory result. As indicated above, not everyone with back and leg pain is a candidate for surgery. You would need two matching x-ray studies agreeing with your complaints before you would be considered an appropriate surgical candidate.

Overall, the success rate of nonoperative care for sciatica ranges somewhere between 75 to 85%. The remainder of the patients would then undergo if they decide to, more aggressive treatments indicated above. It goes without saying that once someone develops a disc herniation, although the symptoms can be controlled, the disc is never "cured". The patients should be aware that if their sciatic type pain becomes too intense for them to manage at home in spite of the use of medications as noted above, then arrangements will be made for hospital admission to gain better pain control and consider nerve block at that time.