Healing Centre

7 Reasons to Avoid Spinal Surgery

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Introduction

Lower back pain is a common medical problem in the United States. Most adult individuals will experience at least one episode of lower back pain in their lives. Many patients will have recurrent attacks of lower back pain and some will have chronic, persistent lower back pain. Back pain can, less commonly, be associated with pain down one or both legs.

There are many causes of pain in the lower back.. The most common cause is strain of the lower back muscles, of which there are many. The tissue covering the- se muscles, fascia, can also be strained as well, compounding the lower back pain. The tail bone (sacrum) is a common cause of many types of lower back pain.

Muscles in the buttocks and hip areas are also a common cause of back and/or leg pain, in particular, the piriformis muscle that attaches the tail-bone to the hip bone. If this muscle is sprained, it can cause severe back pain associated with sciatic (leg) pain. This is due to the fact that the sciatic nerve is either just under or runs through the lower portion of the piriformis muscle.

Much less commonly, herniated discs in the lumbar spine can cause back and leg pain. Disc bulges do not cause back or leg symptoms. Arthritic spinal changes are rarely symptomatic. Spinal stenosis, narrowing of the spinal canal, which may cause spinal cord or nerve root compression, is an uncommon cause of predominantly leg pain (claudication), but may also cause lower back pain. It is out of the scope of this report to discuss other secondary causes of back pain such as cancer, vertebral fractures, spinal cord or related tumors and vascular disease, such as aortic aneurysms.

"Back surgery is the most commonly over utilized surgery in the United States."

Back surgery is the most commonly over utilized surgery in the United States. By 2010 the number of spinal fusion surgeries at U.S. hospitals, just one of an assortment of back surgeries, had jumped to 453,000. The cost for 413,000 spinal fusions in 2008 amounted to $34 billion, resulting in spinal fusion doctors becoming the most highly paid doctors in the country, with average annual salaries of $806,000. The efficacy of spinal fusion surgery has been shown to be poor by numerous studies.

> **"It's amazing how much evidence there is that fusions don't work, yet surgeons do them anyway," said Sohail Mirza, a spine surgeon who chairs the Department of Orthopedics at Dartmouth Medical School in Hanover, New Hampshire. "The only one who isn't benefitting from the equation is the patient."[1]**

In this report, we will take a measured, conservative look at the seven most significant reasons not to have neck or back spinal surgery. However, if you want to get truly frightened, just click on the following link to Bloomberg News for a more alarming overview of the problem of unnecessary back surgeries:

http://www.bloomberg.com/news/2010-12-30/highest-paid-u-s-doctors-get-rich-with-fusion-surgery-debunked-by-studies.html

Reason #1:
Back Pain Will Clear On Its Own or Heal with Natural Methods

Most causes of back pain clear on their own or with conservative therapy. In many cases, taking an anti-inflammatory medication such as aspirin, ibuprofen or naproxen can provide relief. Using an ice pack wrapped in a light towel, applied to the back for 20 minutes 2-3 times daily, can relieve pain and reduce inflammation in the injured area. It is best to avoid heat in

[1] (http://www.bloomberg.com/news/2010-12-30/highest-paid-u-s-doctors-get-rich-with-fusion-surgery-debunked-by-studies.html)

situations of acute back or neck strain.

For cases of pain that last for more than a few days, getting acupuncture and/or massage therapy is frequently beneficial. If your pain continues, visit your physician and get a referral for acupuncture and/or physical therapy. The type of physical therapy that you get is important. Routine, "typical" physical therapy consisting of ultrasound, electrical stimulation and hot/cold packs is ineffective. Effective physical therapy consists of hands on manual physical therapy to help relax the muscles in painful spasm and correct any joint mobility problems. A knee, hip or tailbone joint problem can make back pain worse. It is absolutely necessary that your physical therapist address these areas to ensure proper joint mobility.

The sacrum (tailbone) is a common cause of back and even leg pain. The sacrum is at the end of the spine and connects the two halves of the hip bones together. The main movement of the sacrum is slight, but is basically forward or backward. When you bend or extend your back, the sacrum will normally move the opposite direction. To illustrate, bending forward will cause the sacrum to move backward. With turning or twisting the sacrum can rotate on the vertical axis to a small degree. Sometimes, the sacrum gets "stuck" in rotation - either on a vertical or horizontal axis, or both. When this happens, the normal motion of the sacrum, lower back and spine is restricted. This causes pain. In compensation for this, the back muscles tighten up and cause more pain. It is a vicious cycle that needs proper treatment to restore normal movement. This is where manual hands on physical therapy or acupuncture can help

In case of more persistent spasm or pain, acupuncture can also be of benefit in relieving pain. Topical analgesic creams such as Tiger Balm, Blue Emu Cream and many others - applied to sore muscles - can provide temporary benefit as well. Generally, with one or more of these combined

therapies, the vast majority (95 %+) of cases of lower back or neck pain can be treated successfully. No invasive procedure is needed. Also not needed: MRI or CT scanning of the neck or back.

The dangers associated with CT scans are not minimal and have long been known but are only now coming to the public's awareness. Dr. John Gofman, Ph.D (Nuclear Physics), M.D. clarified these dangers in his book **X-Rays, Health Effects of Common Exams**, published in 1985. He notes that the cancer risk from a 1-slice Bladder area scan for a 20 year old male non-smoker is 1 chance in 700. Consider that multiple slices are often taken when performing a CT exam; the risk is multiplied accordingly!

The fourteen (14) peer-reviewed research studies which follow affirm the efficacy of acupuncture in the treatment of lower back pain:

1. Weblink: http://www.nejm.org/toc/nejm/363/5
Journal: N Engl J Med 2010; 363:454-461July 29, 2010
Title: **Acupuncture for Chronic Low Back Pain**
Authors: B.M. Berman, H.M. Langevin, C.M. Witt, and R. Dubner
Conclusions: "Clinical trials of acupuncture for chronic low back pain have shown higher rates of symptom improvement with either acupuncture or sham acupuncture than with usual care."

2. Weblink: http://www.ncbi.nlm.nih.gov/pubmed/19433697
Journal: Arch Intern Med. 2009 May 11;169(9):858-66.
Title: **A randomized trial comparing acupuncture, simulated acupuncture- ture, and usual care for chronic low back pain**.
Authors: Cherkin DC, Sherman KJ, Avins AL, Erro JH, Ichikawa L, Barlow WE, Delaney K, Hawkes R, Hamilton L, Pressman A, Khalsa PS, Deyo RA.
Source: Center for Health Studies, 1730 Minor Avenue, Seattle, WA 98101, USA. cherkin.d@ghc.org
Results: "At 8 weeks, mean dysfunction scores for the individualized, standardized, and simulated acupuncture groups improved by 4.4, 4.5, and 4.4 points, respectively, compared with 2.1 points for those receiving usual care ($P < .001$). Participants receiving real or simulated acupuncture were more likely than those receiving usual care to experience clinically meaningful improvements on the dysfunction scale (60% vs. 39%; $P < .001$). Symptoms improved by 1.6 to 1.9 points in the treatment groups compared

with 0.7 points in the usual care group (P < .001). After 1 year, participants in the treatment groups were more likely than those receiving usual care to experience clinically meaningful improvements in dysfunction (59% to 65% vs. 50%, respectively; P = .02) but not in symptoms (P > .05)."

3. Weblink: http://www.ncbi.nlm.nih.gov/pubmed/17893311
Journal: Arch Intern Med. 2007 Sep 24;167(17):1892-8.
Title: **German Acupuncture Trials (GERAC) for chronic low back pain: randomized, multicenter, blinded, parallel-group trial with 3 groups**.
Authors: Haake M, Müller HH, Schade-Brittinger C, Basler HD, Schäfer H, Maier C, Endres HG, Trampisch HJ, Molsberger A.
Source: Orthopaedic Department, University of Regensburg, Bad Abbach, Germany.
Results: "At 6 months, response rate was 47.6% in the verum acupuncture group, 44.2% in the sham acupuncture group, and 27.4% in the conventional therapy group. Differences among groups were as follows: verum vs. sham, 3.4% (95% confidence interval, -3.7% to 10.3%; P = .39); verum vs. conventional therapy, 20.2% (95% confidence interval, 13.4% to 26.7%; P < .001); and sham vs. conventional therapy, 16.8% (95% confidence interval, 10.1% to 23.4%; P < .001."
Conclusions: "Low back pain improved after acupuncture treatment for at least 6 months. Effectiveness of acupuncture, either verum or sham, was almost twice that of conventional therapy."

4. Weblink: http://www.annals.org/content/142/8/651.reprint
Journal: Annals of Internal Medicine
Title: **Meta-Analysis: Acupuncture for Low Back Pain**
Authors: Manheimer, E., White, A., Berman, B. Forsys, K., Ernst, E.
Source: University of Maryland School of Medicine, Center for Integrative Medicine, Baltimore, Maryland, and Peninsula Medical School, Plymouth, United Kingdom.
Results: "For the primary outcome of short-term relief of chronic pain, the meta-analyses showed that acupuncture is significantly more effective than sham treatment (standardized mean difference, 0.54 [95% CI, 0.35 to 0.73]; 7 trials) and no additional treatment (standardized mean difference, 0.69 [CI, 0.40 to 0.98]; 8 trials). For patients with acute low back pain, data are sparse and inconclusive. Data are also insufficient for drawing conclusions about acupuncture's short-term effectiveness compared with most other therapies. Limitations: The quantity and quality of the included trials varied."

Conclusions: "Acupuncture effectively relieves chronic low back pain. No evidence suggests that acupuncture is more effective than other active therapies."

5. Weblink: http://www.medscape.com/viewarticle/583148
Journal: Spine [2008, 33(23):E887-900]
Title: **Effectiveness of Acupuncture for Low Back Pain: A Systematic Review**
Authors: Jing Yuan, PhD; Nithima Purepong, MSc; Daniel Paul Kerr, PhD; Jongbae Park, KMD, PhD; Ian Bradbury, PhD; Suzanne McDonough, PhD
Source: School of Health Sciences, University of Ulster, Co Antrim, Northern Ireland.
Results: "Twenty-three trials (n = 6359) were included and classified into 5 types of comparisons, 6 of which were of high quality. There is moderate evidence that acupuncture is more effective than no treatment, and strong evidence of no significant difference between acupuncture and sham acupuncture, for short-term pain relief. There is strong evidence that acupuncture can be a useful supplement to other forms of conventional therapy for nonspecific LBP, but the effectiveness of acupuncture compared with other forms of conventional therapies still requires further investigation."

Conclusions: "Acupuncture versus no treatment, and as an adjunct to conventional care, should be advocated in the European Guidelines for the treatment of chronic LBP."

6. Weblink: http://www.ncbi.nlm.nih.gov/pubmed/16980315
Journal: BMJ. 2006 Sep 23;333(7569):626. Epub 2006 Sep 15.
Title: **A randomized controlled trial of acupuncture care for persistent low back pain: cost effectiveness analysis**.
Authors: Ratcliffe J, Thomas KJ, MacPherson H, Brazier J.
Source: School of Health and Related Research, University of Sheffield. j.ratcliffe@sheffield.ac.uk
Results: "Total costs to the United Kingdom's health service during the two year study period were higher on average for the acupuncture group (460 pounds sterling; 673 euros; 859 dollars) than for the usual care group (345 pounds sterling) because of the costs associated with initial treatment. The mean incremental health gain from acupuncture at 12 months was 0.012 QALYs (95% confidence interval -0.033 to 0.058) and at 24 months was 0.027 QALYs (-0.056 to 0.110), leading to a base case estimate of 4241 pounds sterling per QALY gained. This result was robust to sensitivity analysis. The probabilistic sensitivity analysis showed acupuncture to have a

more than 90% chance of being cost effective at a pound20 000 cost per QALY threshold."
Conclusions: "A short course of traditional acupuncture for persistent non-specific low back pain in primary care confers a modest health benefit for minor extra cost to the NHS compared with usual care. Acupuncture care for low back pain seems to be cost effective in the longer term."

7. Weblink:
http://www.worldscinet.com/ajcm/08/0801n02/S0192415X80000141.html
Journal: The American Journal of Chinese Medicine (AJCM), Volume: 8, Issues: 1-2(1980) pp. 181-189 DOI: 10.1142/S0192415X80000141
Title: **The Acupuncture Treatment of Low Back Pain: A Randomized Controlled Study**
Authors: Ralph M. Coan, Grace Wong, Su Liang Ku, Yick Chong Chan, Lucy Wang, Faruk T. Ozer, Patricia L. Coan
Source: Acupuncture Center of Washington, 4400 East-West Highway, Bethesda, Maryland 20014, USA; Acupuncture Clinic of Maryland, 11125 Rockville Pike, Rockville, Maryland 20852, USA
Results: "After acupuncture, there was a 51% pain reduction in the average pain score in the Immediate Treatment Group. This short-term controls, the Delayed Treatment Group, had no reduction whatsoever in their pain scores at the comparable followup period. Later, the Delayed Treatment Group were also treated by acupuncturists, and reported 62% less pain.
When these two treatment groups were compared at 40 weeks with long-term controls (Inadequate Treatment Group), the Inadequate Treatment Group still had the same pain scores, on the average, as when they were enrolled in the study. Both treatment groups, on the average, had 30% lower pain scores. Furthermore, 58% of the treatment groups felt that they were definitely improved at 40 weeks, while only 11% of the Inadequate Treatment Group felt definitely improved at 40 weeks."
Conclusions: "The acupuncture treatment situation was beneficial to the majority of people with low back pain."

8. Weblink: http://www.ncbi.nlm.nih.gov/pubmed/16505266
Journal: Arch Intern Med. 2006 Feb 27;166(4):450-7.
Title: **Acupuncture in patients with chronic low back pain: a randomized controlled trial**.

Authors: Brinkhaus B, Witt CM, Jena S, Linde K, Streng A, Wagenpfeil S, Irnich D, Walther HU, Melchart D, Willich SN.
Source: Institute of Social Medicine, Epidemiology, and Health Economics, Charité, University Medical Center, Berlin, Germany. benno.brinkhaus@charite.de
Results: "A total of 298 patients (67.8% female; mean +/- SD age, 59 +/- 9 years) were included. Between baseline and week 8, pain intensity decreased by a mean +/- SD of 28.7 +/- 30.3 mm in the acupuncture group, 23.6 +/- 31.0 mm in the minimal acupuncture group, and 6.9 +/- 22.0 mm in the waiting list group. The difference for the acupuncture vs. minimal acupuncture group was 5.1 mm (95% confidence interval, -3.7 to 13.9 mm; P = .26), and the difference for the acupuncture vs. waiting list group was 21.7 mm (95% confidence interval, 13.9-30.0 mm; P<.001). Also, at 26 (P=.96) and 52 (P=.61) weeks, pain did not differ significantly between the acupuncture and the minimal acupuncture groups."
Conclusions: "Acupuncture was more effective in improving pain than no acupuncture treatment in patients with chronic low back pain, whereas there were no significant differences between acupuncture and minimal acupuncture."

9. Weblink: http://www.ncbi.nlm.nih.gov/pubmed/16798792
Journal: Am J Epidemiol. 2006 Sep 1;164(5):487-96. Epub 2006 Jun 23.
Title: **Pragmatic randomized trial evaluating the clinical and economic effectiveness of acupuncture for chronic low back pain**.
Authors: Witt CM, Jena S, Selim D, Brinkhaus B, Reinhold T, Wruck K, Liecker B, Linde K, Wegscheider K, Willich SN.
Source: Institute for Social Medicine, Epidemiology, and Health Economics, Charité University Medical Center, Berlin, Germany. claudia.witt@charite.de
Results: "At 3 months, back function improved by 12.1 (standard error (SE), 0.4) to 74.5 (SE, 0.4) points in the acupuncture group and by 2.7 (SE, 0.4) to 65.1 (SE, 0.4) points among controls (difference=9.4 points (95% confidence interval 8.3, 10.5); p<0.001). Nonrandomized patients had more severe symptoms at baseline and showed improvements in back function similar to those seen in randomized patients. The incremental cost-effectiveness ratio was euro 10,526 (euros) per quality-adjusted life year."
Conclusions: "Acupuncture plus routine care was associated with marked clinical improvements in these patients and was relatively cost-effective."

10. Weblink: http://www.ncbi.nlm.nih.gov/pubmed/17893311
Journal: Archives of Internal Medicine, Volume 167 No. 17, Sept. 24, 2007
Title: **German Acupuncture Trials (GERAC) for Chronic Low Back Pain Randomized, Multicenter, Blinded, Parallel-Group Trial With 3 Groups**
Authors: Michael Haake, PhD, MD; Hans-Helge Müller, PhD; Carmen Schade-Brittinger; Heinz D. Basler, PhD; Helmut Schäfer, PhD; Christoph Maier, PhD, MD; Heinz G. Endres, MD; Hans J. Trampisch, PhD; Albrecht Molsberger, PhD, MD
Source: Orthopaedic Department, University of Regensburg, Bad Abbach, Germany.
Results: "At 6 months, response rate was 47.6% in the verum acupuncture group, 44.2% in the sham acupuncture group, and 27.4% in the conventional therapy group. Differences among groups were as follows: verum vs. sham, 3.4% (95% confidence interval, –3.7% to 10.3%; P = .39); verum vs. conventional therapy, 20.2% (95% confidence interval, 13.4% to 26.7%; P < .001); and sham vs. conventional therapy, 16.8% (95% confidence interval, 10.1% to 23.4%; P < .001."
Conclusions: "Low back pain improved after acupuncture treatment for at least 6 months. Effectiveness of acupuncture, either verum or sham, was almost twice that of conventional therapy."

11. Weblink: http://www.ncbi.nlm.nih.gov/pubmed/12406534
Journal: Pain. 2002 Oct;99(3):579-87.
Title: **Does acupuncture improve the orthopedic management of chronic low back pain--a randomized, blinded, controlled trial with 3 months follow up**.
Authors: Molsberger AF, Mau J, Pawelec DB, Winkler J.
Source: Orthopedic Surgery and Research, Kasernenstr 1b, 40213, Düsseldorf, Germany. molsberger@t-online.de
Results: "In the whole sample a pain relief of >or=50% on VAS was reported directly after the end of treatment protocol: Verum+COT 65% (95%CI 51-77%), Sham+COT 34% (95%ci 22-49%), nil+COT 43% (95%ci 29-58%) - results are significant for Verum+COT over Sham+COT (P<or=0.02). The results after 3 months are: Verum+COT 77% (95%ci 62-88%), Sham+COT 29% (95%ci 16-46%), nil+Cot 14% (95%ci 4-30%) - effects are significant for Verum+COT over Sham+COT (P<or=0.001) and for Verum+COT over nil+COT (P<0.001). No difference was found in the mobility of the patients or in the intake of NSAID diclofenac. "

Conclusions: "Our conclusion is that acupuncture can be an important supplement of conservative orthopedic treatment in the management of chronic LBP."

12. Weblink: http://www.ncbi.nlm.nih.gov/pubmed/15838072
Journal: Ann Intern Med. 2005 Apr 19;142(8):651-63.
Title: **Meta-analysis: acupuncture for low back pain**.
Authors: Manheimer E, White A, Berman B, Forys K, Ernst E.
Source: University of Maryland School of Medicine, Center for Integrative Medicine, Baltimore, Maryland 21207, USA.
Results: The 33 randomized, controlled trials that met inclusion criteria were sub-grouped according to acute or chronic pain, style of acupuncture, and type of control group used. The principal [correction] measure of effect size was the standardized mean difference, since the trials assessed the same outcome but measured it in various ways. For the primary outcome of short-term relief of chronic pain, the meta-analyses showed that acupuncture is significantly more effective than sham treatment (standardized mean difference, 0.54 [95% CI, 0.35 to 0.73]; 7 trials) and no additional treatment (standardized mean difference, 0.69 [CI, 0.40 to 0.98]; 8 trials). For patients with acute low back pain, data are sparse and inconclusive. Data are also insufficient for drawing conclusions about acupuncture's short-term effectiveness compared with most other therapies.
Conclusions: Acupuncture effectively relieves chronic low back pain. No evidence suggests that acupuncture is more effective than other active therapies.

13. Weblink: http://www.ncbi.nlm.nih.gov/pubmed/15834340
Journal: Spine (Phila Pa 1976). 2005 Apr 15;30(8):944-63
Title: **Acupuncture and dry-needling for low back pain: an updated systematic review within the framework of the Cochrane collaboration**
Authors: Furlan AD, van Tulder M, Cherkin D, Tsukayama H, Lao L, Koes B, Berman B.
Source: Institute for Work & Health, Toronto, Ontario, Canada. afurlan@iwh.on.ca
Results: "Thirty-five randomized clinical trials were included: 20 were published in English, 7 in Japanese, 5 in Chinese, and 1 each in Norwegian, Polish, and German. There were only 3 trials of acupuncture for acute low back pain. These studies did not justify firm conclusions because of their small sample sizes and low methodology quality. For chronic low back

pain, there is evidence of pain relief and functional improvement for acupuncture compared to no treatment or sham therapy. These effects were only observed immediately after the end of the sessions and in short-term follow-up. There is also evidence that acupuncture, added to other conventional therapies, relieves pain and improves function better than the conventional therapies alone. However, the effects are only small. Dry-needling appears to be a useful adjunct to other therapies for chronic low back pain. No clear recommendations could be made about the most effective acupuncture technique."
Conclusions: "The data do not allow firm conclusions regarding the effectiveness of acupuncture for acute low back pain. For chronic low back pain, acupuncture is more effective for pain relief and functional improvement than no treatment or sham treatment immediately after treatment and in the short-term only. Acupuncture is not more effective than other conventional and "alternative" treatments. The data suggest that acupuncture and dry-needling may be useful adjuncts to other therapies for chronic low back pain. Because most of the studies were of lower methodologic quality, there is a clear need for higher quality trials in this area."

14. Weblink:
http://www.nice.org.uk/media/7D0/4D/2009031LowBackPainGuidelineRelease.pdf
Journal: Press Release from the National Health Service [UK] National Institute for Health and Excellence, www.nice.org.uk , Ref: 2009/031
Title: **New NICE guidelines to help millions of people with low back pain**
Authors: National Institute for Health and Clinical Excellence (NICE)
Source: National Health Service [UK] National Institute for Health and Excellence

ABSTRACT:

Conclusions: "Millions of people with low back pain will benefit from new guidance issued to the NHS on the most effective ways to treat this often painful and distressing condition.

"The National Institute for Health and Clinical Excellence (NICE) and the National Clinical Guideline Centre today (Wednesday 27 May) publish a guideline to improve the early management of persistent non-specific low back pain. This covers people who have been in pain longer than six weeks

but less than one year, where the pain may be linked to structures in the back such as the joints, muscles and ligaments. Setting out a range of effective mainstream and complementary treatments, the guideline recommends what care and advice the NHS should offer to people affected by low back pain.

"Affecting around 1 in 3 adults in the UK each year, low back pain is a very common disorder, with an estimated 2.5 million people seeking help from their GP about their condition. For many people the pain goes away in days or weeks. However for some, the pain can be distressing and persist for a long time. It is difficult to 'cure' low back pain, but the treatments recommended in this guideline can reduce its effect on people's lives.

"Professor Peter Littlejohns, NICE Clinical and Public Health Director, said:

"Most people will be affected by low back pain at some stage in their lives, so it's good news that the NHS now has evidence-based guidance on how to treat the condition effectively. There is variation in current clinical practice, so this new NICE guideline means that for the first time we now have the means for a consistent national approach to managing low back pain. Importantly patients whose pain is not improving should have access to a choice of different therapies including acupuncture, structured exercise and manual therapy. The recommendations will enable health professionals to provide the best care and advice for people seeking help for low back pain, which should reduce the impact of the condition on patients' day-to-day lives."

"***Recommendations from the guideline for health professionals include***:

• "Advise people with low back pain that staying physically active as much as possible is likely to help and provide people with advice and information to help them manage their low back pain
• "Offer one of the following treatment options, taking into account the patient's preference: an exercise program, a course of manual therapy including manipulation, or a course of acupuncture (more details on each below). Consider offering another of these options if the chosen treatment does not result in satisfactory improvement

• "Consider offering a structured exercise program tailored to the individual that may include exercises to strengthen muscles, improve posture and stretching
• "Consider offering a course of manual therapy, including spinal manipulation, spinal mobilization and massage. Treatment may be provided by a range of health professionals including chiropractors, osteopaths, manipulative physiotherapists or doctors who have had specialist training
• "Consider offering a course of acupuncture needling, up to a maximum of 10 sessions over a period of up to 12 weeks
• "Injections of therapeutic substances into the back for non-specific low back pain are not recommended
• "Offer a combined intensive exercise and psychological treatment program for people who have had at least one less intensive treatment already, but who still have disabling pain which causes significant distress or seriously impacts on daily life
• "Do not offer X-ray of the lumbar spine for the management of non-specific low back pain, and only offer an MRI scan within the context of a referral for an opinion on spinal fusion."

The five (5) peer-reviewed research studies which follow affirm the efficacy of massage in the treatment of lower back pain:

1. Web link**:** http://www.jpsmjournal.com/article/S0885-3924(98)00129-8/abstract
Journal: *Journal of Pain and Symptom Management*
Title: **Massage Therapy for Low Back Pain**
Authors: Edzard Ernst, MD, PhD, FRCP
Conclusions**:** 4 clinical trails were used and massage therapy was used as a monotherapy. One trial suggested massage was better than no treatment. Two trials suggested massage was no better than Spinal manipulation or Transcutaneous Electrical Stimulation. Finally one trial suggested it was not more effective than spinal manipulation. There are too few trials for massage therapy as a resolution to low back pain. Massage could be a good treatment for low back pain.

2. Web link: http://www6.miami.edu/touch-research/Massage.html
Journal: *CMAJ, 162, 1815-1820.*
Title: **Effectiveness of massage therapy for subacute low-back pain: a randomized controlled trial**.

Authors: Preyde, M. (2000).
Conclusions: People with subacute low back pain were put into 4 groups. The groups were comprehensive massage therapy, soft tissue manipulation only, exercise with posture education, and a placebo group with a sham laser therapy. After 1 month 63% of the comprehensive massage therapy group reported no pain compared to 27% of the soft tissue manipulation group, 14% of the exercise group and 0% of the placebo group.

3. Web link: http://www.ncbi.nlm.nih.gov/pubmed/11322842
Journal: *Arch Intern Med. 2001 Apr 23;161(8):1081-8.*
Title: **Randomized trial comparing traditional Chinese medical acupuncture, therapeutic massage, and self-care education for chronic low back pain**.
Authors: Cherkin DC, Eisenberg D, Sherman KJ, Barlow W, Kaptchuk TJ, Street J, Deyo RA.
Conclusions: 262 patients aged 20 to 70 years who had persistent back pain to receive Traditional Chinese Medical acupuncture, therapeutic massage , or self-care educational materials . Up to 10 massage or acupuncture visits were permitted over 10 weeks. At 10 weeks, massage was superior to self-care on the symptom scale. Massage was also superior to acupuncture. After 1 year, massage was not better than self-care but was better than acupuncture. The massage group used the least medications and had the lowest costs of subsequent care.

4. Web link: http://www.ncbi.nlm.nih.gov/pubmed/7855683
Journal: *Spine, 19*, 2571-2577.
Title: **A prospective randomized three-week trial of spinal manipulation, transcutaneous muscle stimulation, massage and corset in the treatment of subacute low back pain**.
Authors: Pope, M. H., Phillips, R. B., Haugh, L. D., Hsieh, C. Y., MacDonald, L., and Haldeman, S. (1994).
Conclusions: A randomized study of chiropractic, massage, corset and transcutaneous muscle stimulation (TMS) was conducted in patients with low back pain. Patients were enrolled for a period of 3 weeks and were evaluated once a week by questionnaires, visual analog scale, range of motion, maximum voluntary extension effort, straight leg raising and a fatigue test. After 3 weeks, the chiropractic group scored the greatest improvements in flexion and pain while the massage group had the best extension effort and fatigue time, and the TMS group the best extension.

5. Web link: http://nccam.nih.gov/research/results/spotlight/070411.htm
Journal: *Annals of Internal Medicine*. 2011;155(1):1–9.
Title: **Massage Therapy Holds Promise for Low Back Pain**
Authors: Cherkin DC, Sherman KJ, Kahn J, et al
Conclusions: 400 patients were randomly assigned to a structural massage group, relaxation massage group, or a usual care group. The usual care group included medications, physical therapy and back exercises. The structural massage group received neuromuscular and musculoskeletal massage and the relaxation massage was Swedish massage. Each massage participant received a 1 hour massage once a week for 10 weeks. The patients were measured by amount of medications, symptoms, and ability to perform activities at 10 weeks, 6 months, and 1 year. Both massage groups showed significant increases in reduction of symptoms and daily functions. At 6 months, the massage groups still showed some improvement, but at 1 year all three groups were the same. This study shows that massage can be helpful in reducing back pain.

In some instances, even with the most comprehensive conservative therapies, some patients may continue to experience some degree of variable back pain. Even then, back surgery is not indicated. There are many types of lower back (or neck) pain that do not have an identifiable cause. The mere persistence of pain and the fact that it has not fully responded to conservative therapy is not justification for back surgery. The simple fact is that spinal surgery will not work to "cure" this type of persistent back or neck pain.

Reason #2:
Back Surgery is Not Reversible

Back surgery makes changes to the spine and surrounding structures which are not reversible. Once a patient has committed to having spinal surgery on the neck or back, whether for the right or wrong reasons, it is a one way path. Once the spine has been operated on and the incision made in the back or neck, the skeletal and spinal anatomy is forever

"Once the spine has been operated on… the skeletal and spinal anatomy is forever changed."

changed. It will never be the same - even if the surgery is successful.

The spine is composed of many different structures that are changed with surgery. Of course, the spine is bone, held together by ligaments, with many muscles attaching to the bones by tendons. Nerves are coming in and going out of the spinal cord and can be injured during surgery for removing herniated disc fragments or spinal stenosis surgery. In many back surgeries, part of the bone in the spine is removed. This causes stress on the remaining spine. The remaining spine structures can become damaged due to this stress, resulting in a new source of pain and accelerated arthritis build up. In view of this, even with successful back surgery, the changes and new stresses put on the spine can result in the need for additional back surgeries at the levels above and below the original site of surgery, generally within 3-5 years. This problem is compounded by the age of the patient - the younger the patient is when they have their first spine surgery, the greater the need for additional surgery at a later date.

Unfortunately, favorable outcomes are in the minority. Over 500,000 back surgeries are done annually in the United States. Of these, 50% of patients undergoing back surgery will not get the pain relief or desired results they had expected. Ten percent of these patients will be permanently worse following surgery. A surgical procedure on the spine is a non-reversible process. Successful or not, the damage has been done.

"Get a second opinion, preferably from a non-surgical physician..."

With a failure rate of over 60%, one should always reconsider whether it is the proper choice to proceed with back surgery. Get a second opinion, preferably from a non-surgical physician - a neurologist or physical medicine specialist. If you go for another opinion from another surgeon, that is what you are going to get - another surgical opinion. The important fact to remember is that less than 1 out of 100 patients with back pain will ever really need surgery. Even in cases of herniated disc, the natural history is that these will heal with conservative therapies in 4-8 weeks.

Reason #3:
Most Causes of Back Pain Cannot Be Identified

Most back surgeries are performed for the wrong reason. This would explain why there is such a high failure rate of back surgeries in the United States. The mere fact that a patient has lower back pain (or neck pain) - even if the pain has not responded to conservative therapies - is not sufficient justification for spinal surgery. Surgery, in these cases, should not be considered the "last option." It is not an option at all. If there is not an identifiable cause for a patient's back pain (which is very common), there should be no consideration of surgical intervention.

It is common in any given individual, without any back or neck pain symptoms, to have one or more abnormalities on their MRI spine scan. Several studies have shown that up to 70% of individuals without symptoms will have any combination of disc bulging, disc herniation, arthritic spurs and varying degrees of spinal stenosis - and yet they have no symptoms. These people do not need spine surgery, even with MRI abnormalities. Why - because they have no symptoms. What the patient and doctor are seeing is merely radiological changes in the MRI make the mistake of taking any MRI spinal abnormality (an X-ray finding) and telling the patient that this is the cause of their pain and need for surgery. MRI scanning is not necessary, in the majority of cases, for the successful treatment and management of neck or back pain.

For clarification on MRI abnormalities, a few

rules need to be strictly observed when it comes to determining the need for spine surgery. First, annular or disc bulges do not cause symptoms – not neck, back, arm or leg pain. Disc bulging is a common finding in most patients as it is really a normal part of the aging spine -- starting to develop in your late twenties. Disc bulges should never be operated on. The next level of disc abnormality is disc protrusions. Disc protrusions are the extreme form of a disc bulge. They have more bulging than an annular bulge. Occasionally, disc protrusions may be close to or touching an exiting nerve root. This is still not sufficient cause for surgery as the nerve root is not being compressed.

Frankly herniated (or extruded) discs may be a justification for back surgery. Several conditions must be met. The most important condition is that the level at which the disc is herniated must correlate exactly with the patient's symptoms.

> **Example**: If someone has back pain and pain down the side of their right leg, this would suggest anatomically a L_5 lumbar disc problem on the right side. If a patient has a disc herniation at any other level or even L5, but to the left, this would not cause the patient's symptoms. Why? – because it is at the wrong level or on the wrong side. Therefore, in this case even with MRI abnormalities, the findings do not explain the patient's symptoms. Even if the patient does have a disc herniation/extrusion at L5 on the right, back surgery is not necessarily needed.

Remember, the natural history of disc herniation is to heal with conservative therapy in a few weeks. All patients with back and/or leg pain should be treated with conservative, non-invasive therapy as discussed above.

Other MRI spinal abnormalities that may be seen include spinal stenosis and slippage of one vertebra on the other - a condition known as spondylolisthesis. There are different degrees of both of these conditions. There is spinal stenosis and then there is severe spinal stenosis. Many cases of spinal stenosis, arthritic narrowing of the spinal canal, never need to be treated surgically. In the lower back, unless a patient has severe leg pain with walking distances of a block or less, surgery is usually not indicated.

In the neck (cervical spine) a lesser degree of stenosis may suggest the need for surgery. If there is any degree of spinal cord compression in the neck, surgery should be carefully considered. The reason being is that if the affected individual was to have a whiplash type injury, it could temporarily make the existing stenosis momentarily worse. This can result in direct trauma to the spinal cord, resulting in bruising and damage to the cord. This may result in weakness in the arms and legs.

In its most severe form, quadriplegia could be the outcome. This type of problem does not exist in the lumbar spine. Stenosis in the cervical spine of less than 9 millimeters (mm) may require surgical treatment.

Generally, to be symptomatic, lumbar stenosis of less than 4 mm is required. Slippage of one vertebra on the other (spondylolisthesis) occurs in varying degrees. Unless combined with severe spinal stenosis or other spinal abnormalities causing compression or severe traction of the spinal nerve roots, surgery is not indicated. There are 3 grades of spondylolisthesis. Grades 1 and 2 generally do not

"...the natural history of disc herniation is to heal with conservative therapy in a few weeks."

need surgery. In some cases of Grade 3 spondylolisthesis, surgery may be justified - if the findings explain and directly correlate with the patient's symptoms and neurological findings. Before considering surgery, a patient should have findings of spinal stenosis associated with nerve root compression and spinal cord compromise.

Reason #4:
Spine and Disc Abnormalities Are Not the Cause of Most Cases of Back Pain

Back pain is generally not caused by spine or disc problems. As noted in the introduction, the vast majority of cases of lower back pain—and neck pain for that matter—are not caused by spinal or disc problems. Muscles and other soft tissue support structures in both areas are subject to great stresses and strains as a normal part of daily living. This is where the usual cause of neck and back pain originate. We have all "slept wrong" and woke up with a painful kink in our neck. This usually clears within a few hours, days at the most. Overexertion, doing heavy lifting, yard work or even exercising too much can strain the back muscles and cause lower back pain.
This is compounded by the fact that the majority of Americans have poor back conditioning and are “out of shape.” Unfortunately, obesity and sedentary lifestyles have become endemic in the United States. This is a recipe for disaster when it comes to not only spinal pain, but other conditions such as diabetes, high blood pressure, high cholesterol and heart disease. Central obesity, where the abdomen is the main area of concentration of being overweight, causes the pelvis to tilt forward resulting in added tension on the spine. This pulls on the muscles of the back to maintain body stabilization. These muscles, unda a great deal of tension, are prone to sprains and strains – most common cause of back pain.

Arthritic changes in the lower spine uncommonly cause symptoms. In contrast, cervical (neck) arthritis - if moderate or severe - can cause symptoms of varying degrees of neck pain. This, however, is not a reason for neck spinal surgery. Generally in affected individuals, the arthritic changes are at multiple levels and no one area can be identified as the cause of pain. This condition is known as cervical degenerative disease. The treatment for this is taking non-steroidal, anti-inflammatory agents, ice, moist heat and occasionally massage.

In cases of back pain, acupuncture, massage, and physical therapy in combination with anti-inflammatory agents, ice, heat and back exercises will help clear the majority of cases of back pain.

It is important that all patients with lower back pain continue doing their back exercises regularly to maintain a more healthy back and avoid future attacks of back pain. At no point has neuroimaging (CT or MRI scans) been mentioned in the routine treatment of neck or lower back pain. The treatment of these conditions should be simple home remedies as previously mentioned. If pain is persistent, a visit to a back pain specialist - who is not a surgeon - would be appropriate. A detailed history and physical exam will be performed then a course of conservative therapy should be prescribed.

Conservative therapy is the treatment of choice for almost every cause of neck or back pain. Of course, that is when no serious underlying disease (which is exceedingly rare) is suspected. Narcotic medications should be avoided in most cases of neck and back pain. Pain killers mask the pain and do nothing to clear the cause of pain. Patients generally feel poorly with taking pain medications and find that they get little, if any, lasting relief. Additionally, pain killers are habit forming and addictive. All too many individuals with lower back pain have become "accidental" addicts due to taking powerful pain killers when they are not needed to successfully treat and manage neck and back pain. Conservative, non-invasive,

"Conservative therapy is the first line treatment in almost all cases of non-malignant low back or neck pain."

non-narcotic therapy is the treatment of choice in over 95% of routine cases of back and neck pain.

Reason #5:
The MRI Scan is Lying

Over a lifetime, 90% of all individuals will develop MRI spinal abnormalities which produce no symptoms. MRI spinal abnormalities are not justification for having neck or back surgery. By the time we are 30, our spines start undergoing normal degenerative changes - changes due to the wear and tear of daily living. Of course, this varies from individual to individual for a multitude of reasons including genetics, type of employment, level of physical activity, sports played and history of recurrent physical trauma. The latter is a major reason that professional football players are plagued by early onset of arthritis.

"Bulging discs ARE NOT a sufficient reason to justify neck or back surgery."

The normal, age-related development of spinal degenerative changes does not mean that this will cause or is the cause of neck or back pain. The changes - arthritic spurring, bulging discs, mild spinal stenosis and even disc herniation - are all processes of aging. The fact that these changes are apparent on CT or MRI scanning does not mean that they are the cause of the patient's pain. In fact, the majority of the time, the scan findings have nothing to do with the patient's neck or back pain. Spinal surgeons often misinterpret MRI changes in the spine as causes of neck or back pain. The general public has been led down the primrose path of this all-too-common misconception.

This is the most common reason for unnecessary back surgery: A patient has back pain with or without leg pain, the MRI spine shows one or more "abnormalities", the patient has surgery based on the MRI abnormalities. Unless the MRI findings correlate precisely with the neurological exam findings and explain the patient's symptoms, the changes seen on the MRI

study are not causing the patient's symptoms - this is the most common situation. Even in the case of a disc herniation, conservative therapy is indicated as the natural history of herniated discs is to heal with conservative treatment.

Studies have been done looking at the spines (neck and back) of individuals with no history of neck or back pain. Totaling all the studies, several thousand individuals have been studied. The findings in these studies are that there are spinal abnormalities in up to 70% of individuals - people with no history of having any pain at all. Seventy percent! That is a huge number of people walking around with significant MRI abnormalities with virtually no symptoms of neck, back, arm or leg pain! The abnormalities found included disc bulging, disc protrusion, disc herniation, spinal stenosis and varying degrees of arthritic changes—definite MRI findings of spinal abnormalities, but in patients with no symptoms. Obviously, no reasonable physician would suggest to these individuals that they undergo spinal surgery.

"70% of individuals with no history of pain have MRI spine abnormalities."

You cannot fix what is not broke. The findings of the normal processes of an aging spine are not sufficient to justify surgical treatment. This is one of the most common reasons for inappropriate back surgery and the resultant failure of back surgery - leading to a condition known as failed back syndrome or post-laminectomy syndrome - persistent neck or back pain following surgery. Worse yet is the pain after surgery can be—and frequently is—worse. The conclusion of this is that just because an MRI scan shows one or more abnormalities, this does not necessarily explain the cause of pain - more commonly than not - it does not explain the reason a patient is having neck or back pain.

Reason #6:
Complications from Back Surgery are Not Rare

Complications of back surgery are all too common. During back surgery, the surgeon is cutting down to the spine and disc area. Whether it is with a scalpel or laser, the procedure is essentially the same. This means that laser spine surgery offers little, if any, advantage over conventional spine surgery. The spinal nerves are exiting the spine right in the area of the surgical procedure. A spinal nerve can easily be damaged during these back surgery procedures, particularly when multiple levels are operated on. The risk of nerve damage with a multiple level surgery ranges from 5-20%. Pain is the most common consequence of this. Prior back/neck surgeries and smoking increases this risk further.

"Laser spine surgery has the same risk of nerve damage as conventional surgery."

There is a high correlation of smoking (which leads to desiccation of the discs) and having poor outcomes for back (or neck) surgery. Smoking impairs healing after any surgery, but studies have shown that particularly in cases of back surgery, surgical failures and complications are much higher.

Nerve Damage

Once a nerve is damaged, it may or may not heal. If it does heal, this may be incomplete. The end result is the patient has the same or worse pain and may end up with a neurological deficit, either persistent numbness or worse, weakness - such as foot drop or arm weakness. Nerve damage is not always reversible.

"Once a nerve is damaged, it may or may not heal... even if it does, healing may be incomplete."

Infection

Infection is another all too common complication of back (and other) surgeries. The rate of infection is generally about one percent. Some surgeons have higher infection rates, perhaps 2-3%. Developing an infection after spinal surgery is a very serious problem. It requires prolonged courses of antibiotics. If an abscess develops, more surgery to drain this may be needed. With a severe infection, it can takes months to clear up and other

complications can set in. This can also result in more persistent pain and worsening of the pain syndrome.

Persistent Pain

Persistent pain due to any number of causes, following back surgery, is very common. The surgery itself causes scar tissue to form around the area operated on. Spinal hardware such as pedicle screws put in to stabilize the spine can cause pain. These screws are put into the vertebral bodies to secure metal plates or other hardware to stabilize a spine that has had some bone cut out. This is frequently done with inserting bone fragments, for a fusion procedure, to further add more stability of the spine. The pedicle screws can cause pain in and of themselves. They can be put in slightly incorrectly and be touching an adjacent nerve root. The fusion can fail to take and therefore the spine is not as stable as it should be. All of these things combined can result in additional pain or worsening of existing pain. Take the pedicle screws out does not always result in clearing the pain-plus it requires an additional back surgery.

Anesthesia Complications

To have back surgery, or any other major surgery, a patient has to have general anesthesia. General anesthesia opens an entirely different Pandora's Box of potential complications. Complications associated with general anesthesia can include heart trouble (irregular heartbeats), lung problems, bronchitis or worse pneumonia, stroke, venous thrombosis and even death. Fortunately, with modern day anesthesia, the risk of complications with general anesthesia is low unless you have pre-existing heart or lung disease or smoke.

Narcotic Addiction

Lastly, narcotic addiction is all too common of a problem following back

surgery. Many patients are taking narcotic pain killers prior to surgery. After the surgery is over, pain continues or is worse, so the patient is given more and even stronger narcotics to control pain. It is a vicious cycle: pain persists and worsens, and more narcotics are taken. As the effects of lower potency narcotics wear off, stronger pain killers are needed. This is how patients end up taking Oxycontin, hydromorphone (Dilaudid), morphine derivatives, Fentanyl and other powerful, highly addictive narcotics. They become addicted to these drugs and cannot get off of them, even if they want to (many do not.) The body becomes used to the effect of narcotics and therefore "craves" the feeling of being on these pain killers. The combination of persistent pain and being on long term, relatively high dose narcotics, is a downward spiral, ultimately leading to disability and a miserable quality of life. Imagine... much of all of the above could have been avoided, had the patient not had unnecessary back (or neck) surgery in the first place. Add multiple spinal surgeries to this mix and the complication rate and risk for narcotic addiction and disability goes up astronomically.

Reason #7:
Never-Ending Surgery Cycle

Spinal surgery tends to lead to more spine surgery without any hope of improving. In fact, spinal surgery puts additional stress on the spine, which leads to more pain. Some spine surgeons then use that new pain as justification for additional surgery. The root of the problem is the fact that back pain is not an indication for back surgery, any more than neck pain is an indication for neck surgery. Surgery done for the sole purpose of relieving back or neck pain is doomed to failure.

Back surgery fails for a number of reasons. The three main reasons for failed back surgery are:

1. Surgery was not indicated in the first place,
2. The surgical procedure performed would not have achieved the desired outcome,
3. Correct surgery performed but did not get the intended result. Complicating factors include diabetes, smoking, autoimmune diseases, vascular disease and poor surgical technique. Procedures

performed primarily for reasons of secondary gain such as worker's compensation or other liability legal claims predict a poor outcome as well.

The main message here is that there are many reasons not to have back surgery. Unfortunately, over 500,000 Americans undergo spine surgery annually. Over fifty percent will have little or no relief of the symptoms for which surgery was performed. The initial choice to operate on a patient with back pain subjects them to an invasive procedure that actually never would relieve their pain in the first place.

A large study published in the well-respected medical journal, Spine, showed that more spine surgeries are performed per capita in the United States than any other country. Back surgery rates were 40% higher here than in any other country.

For many patients with chronic back pain, the actual cause cannot be identified. If the source of pain cannot be positively identified, surgery is not going to fix it. The result of unnecessary spine surgery is greater and more pain.

The cost of treating back pain in the United States is $25 billion annually. Factoring in Worker's Compensation claims and lost wages accounts for another $25 billion a year. Including rehabilitation costs, the global medical cost of treating neck and back pain in the United States approaches $90 billion a year.

Some spinal surgeons get follow up MRI scans on the operated areas and of course, these studies are going to show additional abnormalities - evidence of prior surgery. Once again, the incorrect conclusion is made that, "Oh, there are more spinal abnormalities on the MRI, so you need more surgery."

Remember: spinal surgery will never "fix" back (or neck) pain. More surgery is not going to help most who have failed their first back surgery, but that is precisely what is done - more surgery, increased failure, more complications and adding to an already bad problem. Add obesity, smoking

and other medical problems such as diabetes, heart or lung disease and this leads to an almost 100% guarantee of surgical failure, more pain, poor quality of life and of course, disability.

Another reason that one spinal surgery leads to more spine surgery—even in successful cases of surgery—is that the levels above and below the operated level are compromised. These levels are put under that much more constant strain and trauma. Over the next 3-4 years after the first surgery, it is not uncommon to find problems at these additional spinal levels. This may necessitate additional spinal surgery - particularly if the first surgery is done on a patient in his/her forties or fifties (certainly even more so if surgery is done in the thirties.) It is not unusual to find patients such as this who have had two or three - even more - spinal surgeries. Occasionally, these same patients have had both neck and back operations. The majority do poorly. The failure rate with second spine surgery in the same area approaches 70%. Patients who have 3 or more spine surgeries experience greater than 90% failure rate.

Spinal Fusions

Of the half million back surgeries performed annually, about one third are fusions. The overall complication and failure rate for fusions is higher than most other spine surgeries.

Microdiscectomies

A note about microdiscectomy spine surgery: while this procedure is promoted as less invasive with shortened recovery time – the re-operation rate is significantly higher than standard spine surgery. Often, the victim of a failed microdiscectomy procedure is then subjected to a traditional spine surgical procedure.

Recovery: Time-Consuming and Costly

Recovery from spine surgery is not a minor matter. With a straight forward lumbar laminectomy for a disc herniation, recovery - in a successful surgery - may be 6-8 weeks. A fusion procedure, particularly at multiple levels, may take well over a year. During this recovery time, patients will be sent for varying courses of physical therapy and rehabilitation. This is time

consuming and quite expensive.

Bonus:
Consequences of Unnecessary Spinal Surgery — "Failed Back Syndrome"

Failed back syndrome, or post-laminectomy syndrome, is the term given to patients who have had back surgery, but continue to have pain or worsening of their pain. As state previously, the root of the problem is the fact that back pain is not an indication for back surgery, any more than neck pain is an indication for neck surgery. Surgery done for the sole purpose of relieving back or neck pain is going to lead to more pain. Even worse, the scarring created as a natural result of surgery can lead to additional pain that can even be more difficult to treat. All too many spinal surgeons make the false assumption that if a patient has back pain and there is an MRI abnormality, which this is the cause of the pain and surgery is necessary. In actuality, just the opposite is true. Most causes of back (neck) pain cannot be identified.

If you see a spine surgeon, you will get a surgical opinion. This very commonly includes a surgery recommendation.

Failed back syndrome (FBS) has many different causes. Some of these include operating at the wrong level, failure to remove the entire herniated disc fragment, trauma to the exiting nerve root, continued pressure on the nerve root, scar tissue and inflammatory changes at the site of surgery.
Back surgery typically involves removing some of the boney part of the spine. This can result in spinal instability associated with excessive movement at the site of surgery. This causes additional spinal trauma and pain. Predisposing factors to FBS include smoking, diabetes, vascular disease (hardening of the arteries), poor pre-surgical physical condition or other diseases that predispose to weak immune system (e.g. rheumatoid, lupus, sarcoidosis, depression, alcohol abuse.)

FBS symptoms include persistent dull back pain, which can vary in intensity. At times, patients can have sharp back pains that may radiate down one or both legs. Patients may have abnormal painful numbness in their legs. In almost all cases of failed back syndrome, more surgery is the worst thing that can be done, as this only compounds the already bad situation.

"It is estimated that there are 2-3 million Americans suffering with Failed Back Syndrome "

There are 80,000 new cases of Failed Back Surgery every year in the United States. Approximately 20% of these cases will undergo a second spine surgery. Of those that have spinal fusions, over 50% will never return to work. Spinal fusions have a much higher rate of failure than other types of spine surgery. It is estimated that there are 2-3 million Americans suffering from failed back syndrome.

Additional Bonus:

What Are The Conditions That May Require Back Surgery?

The reasons to have back or neck surgery are few. ***All criteria for successful spinal surgery must be met prior*** to considering or undergoing spine surgery.

1. General good health.

2. Non-smoker or stop smoking.

3. Spinal stenosis in the lower back of sufficient degree to cause claudication - pain in the legs with walking any distance that clears promptly with rest.

4. Spinal stenosis in the cervical spine of less than 9 mm associated with even slight spinal cord deformity. The risk of se-

vere spinal cord damage in the neck is high if combined with traumatic injuries to the neck, such as whiplash trauma.

5. Disc herniations that are clearly causing nerve root compression and these findings correlate exactly with the patient's complaints and findings on neurological exam. Conservative therapy should always be tried first.

6. Stenosis of the neural foramen (the opening where the nerve roots exit the spine). If a patient has definite symptoms of this condition, he/she should have numbness, pain and weakness in the distribution of the compressed nerve. For example, a right C_6 nerve root compression will not cause left arm pain or weakness.

7. Bulging discs ARE NOT a sufficient reason to justify neck or back surgery.

8. Additional reasons to have spine surgery include other more serious problems such as tumors, cancer or fractures of the spine.

About The Authors

Daniel Kassicieh, D.O. is a Board-Certified Neurologist and medical director of Sarasota Neurology, P.A. He has been practicing in Sarasota for over 25 years.

Dr. Kassicieh is a Fellow of the American Academy of Neurology and the American College of Neuropsychiatrists. Both of these honors were awarded to him on the basis of his extensive research experience, medical publications and continued support of patients and their families who are affected with neurological disorders.

Dr. Kassicieh is a sought-after public speaker and is frequently a presenter both within the medical community and in the public forum. He has appeared regularly on local television and is considered an expert in a number of areas within his specialty.

Memberships

- American Academy of Neurology
- American Association for the Study of Headaches
- National Spasmodic Torticollis Association
- National Parkinson Foundation
- American Academy of Psychiatry & Neurology
- Dystonia Medical Research Foundation
- American Osteopathic Association
- American Osteopathic College of Neurology & Psychiatry
- Florida Osteopathic Medical Association

Why is Dr. Kassicieh a D.O. Instead of an M.D.?

The "D.O." designation stands for Doctor of Osteopathic Medicine and indicates a slightly different course of education than is involved in obtain-

ing an "M.D." D.O.s have approximately 100 classroom hours than M.D.s do.

This additional training is focused on the Osteopathic (from osteo, "bone" and pathos, "disease") aspects of medicine, specifically, the musculoskeletal system, which is made up of the nerves, muscles, and bones. This additional training gives Doctors of Osteopathic medicine a better understanding of how an injury or illness in one part of the body can affect another part of the body—particularly those related to the spine.

Dr. Kassicieh chose to obtain this superior training in order to better diagnose and treat his patients, since Neurology is inherently tied to the musculoskeletal system. In fact, the practice of non-surgical orthopedic medicine is intrinsically involved in Osteopathic clinical treatment, thus increasing the scope and holistic nature of Dr. Kassicieh's neurology services.

Dr. Harvey Kaltsas, Acupuncture Physician, is a graduate of Williston Academy (’65) and Amherst College (‘69), an alumnus of Boston University School of Law (’72), the University of Saskatchewan (’73), and the North American College of Acupuncture (’75), and a graduate of the New England School of Acupuncture (’77). Since apprenticing with Drs. John Ho Fen Shen and James Tin Yau So, he has been practicing acupuncture and Oriental medicine for 36 years.

Dr. Kaltsas has been President of the Florida State Acupuncture Association and the American Association of Acupuncture and Oriental Medicine (AAAOM) and is currently Vice President of the National Guild of Acupuncture and Oriental Medicine. As Chair of the Florida Board of Acupuncture he co-wrote most of the regulations governing the practice of acupuncture in Florida. In 1993 Dr. Kaltsas was commended by the People’s Republic of China for his contributions to the field of acupuncture, and in 1996 he was named Acupuncturist of the year by AAAOM. He is the only acupuncturist ever to deliver testimony regarding acupuncture to the US Senate (June, 1993), and in 2008-9 he served as Legislative Chair for AAAOM and as official liaison to AAAOM’s lobbyist in Washington, D.C.

For the past four years Dr. Kaltsas has served as visiting acupuncturist at the annual conferences of the National Foundation for Women Legislators. He is in private practice in Sarasota, Florida and has recently authored Acupuncture Works – the Proof, a compendium of 157 peer-reviewed studies documenting the cost-effectiveness of acupuncture. He was co-founder of Sarasota's Academy of Chinese Healing Arts (since renamed East West College) and now teaches 17 nationally approved Continuing Education courses online at www.hkacup.com .