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THE OSTEOPATHIC PROFESSION

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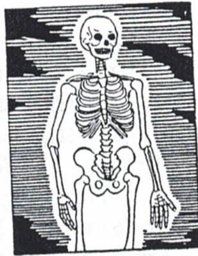

Conservative Management Of Recurring Symptoms In Postlaminectomy Cases*

... by Earl H. Gedney, D.O.

POSTOPERATIVE problems occur in laminectomy even as they do in every other surgical approach to disease. They are usually due to violation of the tissues through or past which the approach must be made, and all other factors being equal, altered physiology as a result of surgical trauma varies directly with proximity of the surgical field to vitally functioning organs. Proximity to nerve trunks serving the lower extremities as well as much of the pelvis most certainly amplifies the danger of complications in this at times perilous avenue to relieve the lumbar disk syndrome. This may explain a good portion of the over 30% unsatisfactory results obtained over this route and may also explain why industrial statistics show better effects from laminectomy without fusion than with—less trauma follows.[1] It may also account somewhat for the relatively high mortality rate and the significantly poor results, about 60% unsatisfactory, in the cervical syndrome when invaded by the surgeon. Most certainly and most lamentably it is the etiological factor in the patient made worse by laminectomy.

These deterring percentages are not only of tremendous importance to the bewildered patient but also to industrial insurance companies. Disk resection with a good result costs one company approximately $1200 while a poor result averages in the vicinity of $6000.[1] It was just good business, then, that this company increased its budget for teaching us doctors and surgeons. Several years after instituting such an educational program results are proving its value. Extension of this type of program is now reflected in national statistics: Laminectomy with favorable results has gradually moved up from 60% to closer to 70% of cases. These industrial statistics are computed from actual examination of patients and not from questionnaires.

This still leaves many patients in as bad or worse condition than before their surgery. Many practicing physicians and a telling number of specialty trained doctors have committed themselves to the emphatic denunciation of laminectomy for the control of pain of segmental origin. It has prompted men to write: "Those of us who see the end results of disk surgery in industry are appalled by the poor end results obtained by men of excellent surgical reputations."[2]

More and more militant opposition is building in an enlightened public as they see around them those whom Hahnemann probably had in mind when he exhorted his pupils not to harm if they could

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not help their patients. To note the mounting force of the opposition one has only to read the lead editorial of one of the foremost surgical publications, to wit: "At a recent Orthopedic Club meeting it was generally conceded that for all practical purposes the results of female industrial disk surgery was practically nil as far as return to former employment of any work requiring the usual back muscle action or expenditure of physical effort is concerned."[3]

Surgical interference in this area without incontrovertible evidence of space-taking material almost never should be countenanced and even then, with or without this testimony, low-back pain should be given every chance to recover under other therapy before surgical exploration is entertained. This therapeutic atmosphere wherefrom approximately one-third of the patients are returned with less than satisfactory results, should not be entered upon in rashness or desperation. Whether to fuse or not to fuse is still debated. The posterior fusion possibilities have probably been fairly well explored and now the vertebral body fusions are getting attention.

There are the adherents of subtotal laminectomy or the total bilateral decompression effort leaving only the major arthrodial and that often with its ligaments left more lax by the extraction of the residual disk substance not yet consumed by phagocytes.[4] The part ligaments play in joint stability has long been known and we hope it will soon receive the attention merited. The mounting controversies and the multiple surgical technics should warn the initiated. We must ask ourselves: Do the "poor end results" warrant the hazardous risk?

Before this pivotal region is violated we must carefully rule out other conditions simultaneously present and often at least contributing toward the chief complaint. If there be any seasonal exacerbation, the collagenous diseases must ever be suspect; indeed, there are some excellent minds who feel that the back problem is mostly a rheumatic one. In the presence of frequent spraining, instability may be suggested, and if so, the patient should be given ample opportunity to recover with appropriate treatment which may include bed rest, traction, external support, proper exercises and in light of our continuing consistently good results: ligament fortification with sclerosing solutions, before surgery is entertained. The acute infections may also cause considerable meningeal irritation and through them backache, even enough to require effective sedation with the opiates. Neoplastic and neurological diseases must never be out of mind.

Despite judicious osteopathic manipulations with active separation at segments in lesion some of our patients have become worse and their pain has evaded control. When this unhoped for situation develops the attending physician will interrupt treatment and recapitulate. He must ask himself whether the case has been correctly diagnosed and the correct course of treatment plotted. He must also ask himself whether his earnest efforts have further irritated an already sprained group of muscles or is there lack of stability which under weight bearing allows the ver-

tebra to "slip out" of position again soon after it has been properly mobilized. Or, has the patient developed some habit mechanism which serves to perpetuate his disability? What about the intrinsic lesser arthrodial involvements?

Has the patient been properly evaluated from the position of the "constitutionally inadequate" and has the psychiatric patient been fairly appraised? Shall we consider re-X-ray? One can be very much surprised by what may be developing concurrently with his treatment program in just a few weeks or months. If the patient suggests X-ray, be sure it is done, if only for medicolegal reasons. The causes of back pain seem almost myriad as we wend our way through them in quest of a diagnosis, but in the light of ever increasing evidence it seems to me every available intelligent roadblock should be placed in front of surgery.

Exacerbation of the patient's pain simultaneously or shortly after mobilization with facet separation need be no criteria for discounting its value and discontinuing its use. The patient should be warned of this possibility since many times there is lysis of adhesions in and about these parts with subsequent edema and sometimes temporary mild pressure on the nerve as it emits from and through the involved intervertebral foramen. This may cause the pain to be exaggerated, but it rapidly recedes as the reparative processes complete the healing initiated by the osteopathic maneuver. Traction, bed rest on a hard mattress, and sufficient sedation are invaluable at this juncture. X-ray films will aid our decisions as will careful consideration of other proven orthopedic principles.

Let us remember that those patients who go to surgery for intractable back pain, especially those with fusion in whatever form, are forever denied the benefits they might receive through normalization of the tissues in the vicinity of the intervertebral foramen by active separation of the articular facets. Most of our patients are referred back to their physicians for further manipulations after stabilization with sclerosing solutions in order that they may glean added improvement from all possible therapeutic instruments in the amelioration of their condition. This often has spelled the difference and tips the balance toward a happier result and comes of staunch though exacting adherence to the principles set down by those who preceded us.[5]

As this is being written there are in our files fourteen postlaminectomy problem cases which have been treated by our methods. Two of these people have discontinued treatment because they felt they were not getting relief from their injections. Both were thought to have acquired sufficient stability to have obtained relief from their pain, and one later found this desired relief from relatively few treatments in a clinic well known for its use of the derivatives of the pitcher plant.[6] He had been operated upon twice without improvement. The other patient has been operated without fusion and might have enjoyed some relief through manipulation had he continued with our treatments. Two other patients are still under treatment and will be reported at a later date; however, considerable progress has

been noted to date despite the fact that one is of twenty-four years' standing without fusion and the other of three years with screw arthrodesis.

The other ten cases are considered controlled and have returned to their original occupation. Three of them were female patients who received no benefit from their surgery. None had fusion performed. One has returned to waiting on tables in a hotel; another tends her shop all day and makes pottery in her spare time, though she still has some pain getting out of bed in the morning, and the third one handles a full time factory job, keeps house and renders nursing care to an invalid husband in the bargain. This last woman had a foot drop and to illustrate what may be done when we adopt a never-say-die attitude in therapeutics: she has almost completely recovered from it after three years of postoperative lost function. Their admitted and apparent ages were 39, 44 and 45. There were radicular complaints in two and both were thought to have progressive degeneration in the disks above the area operated — each requiring approximately three treatments into the L-4 disk ligaments with one woman, the one with the foot drop, needing two into L-3. All needed treatment into the sacroiliac ligaments. It took nine for one and eleven for the other two, averaging about ten and ending respectively a seven, four and three year search for an effective remedial agent.

All the males but one had their operations without benefit of fusion and he had a screw arthrodesis. All had enjoyed some relief from their pain, enough to return to their original occupation, but it had lasted only from two to seven years with an average of 4.4. Just over half of them had radicular complaints, each at L-4. All were thought to have undergone progressive degeneration in disks adjoining those resected. In all but one case their recurrences were triggered by comparatively innocent trauma and that one, a workman's compensation case, just happened to be carrying a length of pipe when he stepped down one step he did not see coming. Their ages ranged from 27 to 50 averaging exactly at 40. L-4 needed treatment in all cases, taking approximately four treatments each, while only three required help at L-3 and two at L-5 with an average of about two injections in each instance. The posterior sacroiliac ligaments were treated in each patient and took from four to ten injections with a mean of six.

Conclusions

1. Postlaminectomy patients with uncontrolled pain may be presented with a new and hopeful approach to their problem.
2. Sacroiliac joint instability is again the only constant factor.[7]
3. A rational approach to the intervertebral disk syndrome with sclerosing solutions continues to be effective and also continues to strengthen the theory that the unstable sacroiliac joint is the root of the low back evil.

Norristown, Pa.

REFERENCES

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Stock Market

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option which means a profit; he may then let the other lapse.

A straddle. This also consists of two separate options, one a call and one a put. Both are identical as to stock, contract price and time of expiration. Only in this case the contract price is usually the current market price which means that the option for either the put or call will be exercised at that fixed price. If the market falls, the holder will invoke his put and let the call lapse, and vice-versa in case of a market rise.

Puts and calls — contracts, that is — may be purchased for 30, 60 or 90 days' expiration or longer as agreed to by parties to the transaction. The cost of buying a put or call? It may be set at the current market price plus a premium, or at so many points above or below the market. In each case, the price is the result of negotiation between buyer and seller. And, in every case, the options can be allowed to lapse without penalty — although, of course, they become worthless after the time of expiration.

Naturally, sellers of puts and calls—and the brokers involved—want to make their profit, too. So there is a standard premium on these options which the buyer pays. It is generally about $137 on 100