

Epidural-Lysis of Adhesions for Failed Back Surgery Syndrome: A Case Report

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RUSK REHABILITATION



DESCRIPTION

Patient is a 35 year old male with PMH of lumbar laminectomy and cyst resection who presents to the outpatient pain clinic for complaints of persistent peri-rectal pain with radiation into the groin, low back, and BLE. Pain is sharp, throbbing 10 /10. Previous treatment included failed pelvic therapy and pregabalin. MRI of the Lumbar spine revealed diffuse granulation tissue surrounding the lumbar spine and left S1 nerve root. Patient was diagnosed with failed back surgery syndrome. Caudal epidural steroid injection done with minimal transient relief. Given these findings the patient was recommended to have a Racz Catheter Procedure (Epidural Lysis Of Adhesions). This intervention then decreased his pain 80%, from a 10/10 to a 2/10.

MATERIALS/METHODS

Case Report

As the case report is devoid of patient identifiable information, it is exempt from IRB review requirements as per New York University Langone Health policy

DISCUSSION

Around 40% of patients who undergo lumbar spinal surgery develop chronic or worsening low back pain [1]. Failed back Surgery syndrome (FBSS) is pain of unknown origin that exists despite or begins after surgical intervention in the back in the same topographical region. It is a complex syndrome with multiple contributing factors. One factor, as displayed in the patient, is epidural adhesions shown in imaging that induce inflammation at nerve roots [2]. Treatment of FBSS is initially conservative with physical therapy with gabapentinoids. Treatment can then become progressively aggressive with interventional treatments, spinal cord stimulator placements and finally surgical revision. Surgical revision is typically the last treatment modality considered as it has increased morbidity and inferior outcomes than that of spinal cord stimulator placement [3].

FIGURE (FOR PLACEMENT ONLY)



DISCUSSION (cont.)

The Racz Catheter Procedure on this patient was performed in the ambulatory fluoroscopy suite. The patient was placed in the prone position with abdominal/pelvic bolsters. Utilizing fluoroscopy views and by palpation, the sacral hiatus was identified.. A Coude Epidural Introducer Needle was advanced into the sacral hiatus. Contrast was injected through the needle introducer, demonstrating typical epidural spread in lateral and AP views. Then a spring-guided epidural catheter was advanced easily through the introducer needle and directed towards the left of midline of the epidural space at the level of S1-S2. At this level, catheter resistance felt consistent with adhesions. Once negative aspiration of heme or CSF was confirmed, contrast was injected to confirm no arterial or intrathecal spread. Then six ccs depo medrol, lidocaine, and saline was injected into the space followed by a three cc mixture of hylenex, marcaine, and normal saline. Then, the catheter and introducer needle were removed and sterile gauze pressure was applied to the injection site. The patient was then observed for approximately 30 minutes, given post-procedure care and requested follow-up in one to two weeks

CONCLUSIONS

The Racz Catheter procedure or the Epidural Lysis of Adhesions has been shown to improve recalcitrant low back pain in patients with Failed Back Surgery Syndrome. This case highlights a novel intervention that could improve the function of many patients with recurrent or progressive low back pain following surgery.

REFERENCES:

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