DEGENERATIVE LUMBAR SPINE DISEASE

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Mr Keyourmand Ashkian BA BSc MB BCh FRCP FRCS FRCPS FRCP FRCS (Edinburgh) MD is a neurosurgeon at Bupa Cromwell Hospital, the London Neurosurgery Partnership and King’s College Hospital where he is also a Reader.

Background

Degenerative lumbar spine disease (DLSD) is a condition affecting the lumbar spine with or without neural compression. Imaging evidence of DLSD is found in the majority of people over the age of 70. However, many symptomatic patients, a significant proportion of whom present with radicular neural signs or symptoms, have a normal or nearly normal lumbar spine. In addition, some patients will present with back pain, numbness, and weakness.

Diagnosis of degenerative lumbar spine disease

The primary symptom of DLSD is back pain. This is present in 12 to 35 percent of the Western world's population. It is often chronic or disabling, representing a significant medical problem. Patients with radicular neural signs and symptoms due to DLSD will present with neural compression and its rate of development.

Management of degenerative lumbar spine disease

Management of DLSD requires a multi-disciplinary team approach comprising of, at least, neurosurgeons/spinal surgeons, neuro-radiologists, pain specialists and physiotherapists. It is important to provide the patient with an effective treatment plan for their particular symptoms. Although patients with DLSD represent the biggest group of patients seen in a general neurosurgical clinic, only a small proportion will ever need surgery.

In patients presenting with acute sub-acute isolated back pain, without neural compression or spinal instability, conservative measures are likely to settle the pain in the majority. Such measures include weight reduction; structured exercise programmes; analgesics such as paracetamol, non-steroidal anti-inflammatory drugs or opioids; physiotherapy; spinal manipulation by qualified osteopaths or chiropractors; and acupuncture. In patients with chronic pain (more than one year), epidural injections, transcutaneous electrical nerve simulation (TENS) and combined physical and psychological rehabilitation programmes may be of additional benefit. The role of surgery in such patients remains controversial. Spinal fusion may benefit selected patients. When instability (degenerative spondylolisthesis) complicates back pain, spinal fusion may achieve good pain control. Percutaneous spinal instrumentation systems may be available, allowing minimally invasive surgery with more rapid recovery and a shorter hospital stay. 

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In patients with DLD and radicular pain, conservative measures are usually sufficient to improve the symptom in six to eight weeks. If severe pain persists beyond this time, or if a motor neurological deficit, such as a foot drop, is present, serious consideration should be given to surgery. The timing of surgery is particularly important if neurological recovery is to be achieved. The aim of surgery is to decompress the neural elements and the most common operations performed are lumbar laminectomy and lumbar microdiscectomy. The recent development of endoscopic microdiscectomy technique allows day-case local anaesthetic surgery with the additional benefit of excellent cosmetic results. Spinal cord stimulation remains an effective treatment in patients with severe pain especially if pain persists despite decompressive surgery.

**Prognosis of degenerative lumbar spine disease**

The prognosis of patients with DLD depends on the underlying diagnosis, delivery of prompt treatment and psycho-socio-economic factors. Well motivated patients with a good social support network are more likely to recover well and resume work. Despite all the treatment available, some 10 percent of patients become chronically disabled, especially with back pain. In others, conservative and surgical measures are effective in improving the symptoms. Spinal stenosis and radicular pain respond well to surgery with up to 90 percent pain relief. When motor weakness is present or in patients with cauda equina syndrome, the timing of surgery is crucial in determining any neurological recovery with the best results seen in patients operated within 48 hours of presentation. The prognosis for recovery of sensory deficits such as numbness and paraesthesia is less predictable.

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