Spinal Cord (2000) 38, 386–387

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Letters to the Editor

Failed back syndrome

In the otherwise comprehensive, enjoyable review of 'failed back syndrome' Pearce[1] does some patients a disservice by dismissing two common conditions. Firstly, far from being a 'vague, global term' post-traumatic stress disorder has objective diagnostic criteria described by the American Psychiatric Association.[2] The well-recognised findings of, briefly, an extreme life-threatening event with consequent hyper-arousal, flashbacks, poor rapport, avoidance behaviour and failing relationships for more than 1 month are a very specific, objective, reproducible group of findings. Shell-shocked soldiers are no longer dismissed as lacking moral fibre but, instead, are recognised as suffering from an uncontrollable reaction to dreadful events. The precise diagnostic criteria may evolve for research or audit but this combination of symptoms is too common to be dismissed and provides a basis for explanation and treatment.

The second group of patients which Pearce neglects are those with fibromyalgia. He may not believe the condition exists but the American College of Rheumatology does and describes objective, diagnostic criteria.[3] Diagnosis of this condition may prevent the need for unnecessary further investigations and result in successful treatment.[4]

Pearce suggests that the creation of these diagnostic criteria by experts and learned bodies is an artificial exercise but such criteria provide a focus for research and treatment strategies in every medical speciality. Discussing whether a condition is an illness, diagnosis or syndrome is hair-splitting when what is important is to recognise the problem and then do something about it. Pearce admits that the term 'failed back syndrome' itself lacks a precise definition and it is disingenuous to imply that the two illnesses above are equally vaguely defined when evidence exists to the contrary. Chronic, low back pain can be due to many different diseases and we should welcome contributions from all branches of medicine to clarify the underlying cause, if possible.

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Aspects of failed back syndrome: role of litigation

Failed back syndrome is a difficult subject. The article by Dr Pearce[1] is helpful but it over simplifies certain issues.

He discusses pain in neurological terms and states that a back sprain should recover within 1–3 weeks. He acknowledges that older patients with previous backache may take longer to recover.

When litigation is involved leg radiation if present is often L2, 3, 4-diffuse or front of thigh not below the knee (non anatomical) as opposed to non litigation L5, S1 back and side of buttock, thigh to foot (anatomical distribution).

He fails to mention the question of referred pain which was delineated by Kellgren.[1,2,3] Injections were experimentally made into the interspinous ligaments and other deep structures.

He found segmental areas of pain which differed from the classic neurological segments described by Foerster.

This pattern of pain from deep structures whether it be discogenic in origin or from other related structures, because it does not correspond to the neurological dermatomes, can deceive the examining doctor and suggest that the patient's complaints are not genuine.

A further point is that Dr Pearce describes spondylolisthesis as being 'a congenital defect in the interarticular part of the neural arch, allowing a slip, usually of L5 on S1'. It is not congenital. It is considered to be a stress fracture acquired in adolescence.[4]

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Aspects of the failed back syndrome: role of litigation

I am grateful to Dr Alan McLean for his interest and comments. I do not dismiss or underrate the importance of a spectrum of anxiety, depressive and stress induced symptoms in relation to what he rightly says is 'an extreme life threatening event', but such circumstances are rare in many cases mis-labelled PTSD following back injuries or strains. Post-traumatic stress disorder (PTSD) remains an entirely arbitrary collation agreed by committee consensus, but it does not have any objective criteria. The term may be useful for further research and investigation, but it should not in my view be applied indiscriminately.

Fibromyalgia is even more imprecise, with only the sign of tender spots, or trigger points as so-called objective characteristics. In a community study, the rheumatologists Croft *et al* note: 'Scepticism persists however, about the distinctive nature of this condition... Tender points are a measure of general distress. They are related to pain complaints but are separately associated with fatigue and depression. Fibromyalgia does not seem to be a distinct disease entity'.[1] In clinical practice, I have found the term wholly unsatisfactory.

I humbly suggest that all treatment should when possible be based on accurate diagnosis. The distinguished physician JG Scadding has spent many years in emphasising the fundamental importance[2] of the principle that symptoms may represent an illness, a syndrome or a diagnosis, a distinction necessary if we are to make any progress in these difficult painful disorders. It is easy, but often futile, to treat ill-defined symptoms rather than attempting to make painstaking, precise diagnoses as a rational basis for management of both the patient and his illness, whether organic, psychogenic, or contrived.

Dr Silver makes the interesting point that 'when litigation is involved, leg radiation if present is often L2, 3, 4-diffuse and non-anatomical as opposed to non-litigation L5, S1 anatomical pain', I agree with his suggestion that pain arising in deep structures can deceive the examining doctor, but if this is related, as he suggests, to litigation, why should a legal process affect the 'genuine' behaviour and pattern of any organic pain? This vital issue, he highlights, but offers no explanation.

Although many orthopaedic surgeons continue to regard spondylolisthesis as the consequence of a congenital defect in the pars interarticularis, I agree that it can indicate the progression from a pars interarticularis stress fracture to spondylolysis and to spondylolisthesis.[3] The diagnosis of spondylolysis cannot be made on physical examination alone; single photon emission computed tomography (SPECT) scanning shows pars interarticularis stress lesions undiagnosable on planar technetium-99 bone scan.[4]

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Aspects of the failed back syndrome: role of litigation

As one whose practise encompassed the fields of acute spinal cord injury, and back pain problems, I have a reasonable degree of familiarity with the literatures relevant to both areas. In our monthly Spine Program's Journal Club, eight spine surgeons, fellows, and residents meet to review and discuss approximately four articles monthly. We routinely screen a number of journals for relevant articles. Articles on back pain and particularly chronic pain already have a number of journals for publication, and I do not believe that *Spinal Cord* should join them. Not only does it detract from its main mission, which is to publish articles of relevance to the field of spinal cord injury, but in this case it is an article that does not usefully add to the body of literature in the field.

Increasingly, *Spinal Cord* is becoming the journal of choice for the publication of high quality articles relating to spinal cord injury. Let's keep it that way.

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Editorial Comment

In reply to Dr Wing

An interesting point. However, the Journal is not restricted to spinal cord injury, and the scope specifically states all aspects of spinal injury and disease may be dealt with. The argument about pain could equally be made to exclude spasticity and bladder dysfunction etc, since other journals also deal with these aspects.

Further correspondence on this topic is welcome.

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