

## **PE-56. THE POST-LAMINECTOMY SYNDROME REVISITED**

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Our experience with chronic pain patients suffering from post-laminectomy syndrome will be summarized. We are a small pain clinic in a very large county indigent hospital, Dallas, Texas, and over 57% of our patients have post-laminectomy syndrome. This is defined as one or more laminectomies and/or fusions without significant relief of back pain or worse pain. Many of these unfortunate patients have had seven to ten procedures. We are severely limited as to the financial resources and the technical procedures we are able to use to help these unfortunate patients.

Our average post-laminectomy patient has had three procedures on the lumbar spine. The true incidence of failure vs. success is obviously unknown since we only see the failures. We are a very large hospital with a huge orthopedic department, where over twenty thousand double joints are done every year, and where the cost of a prosthetic device itself is between \$7,000 and \$15,000 (the facility fee, surgeon's fee and ancillary costs, are obviously extra). Nevertheless, our pain department is not allowed to insert dorsal columns stimulators, opiate pumps, or perform any other technical procedures.

Under these circumstances, our new patients are usually evaluated by the caudal catheter procedure, using the RACZ catheters (Cauda-Cath TM, Tunnel-Cath TM) and an epidurogram is obtained. Lysis of adhesions is performed and hypertonic saline may be used, along with steroids.

We obtain a great deal of information from the epidurogram and if extensive scarring is prominent, we feel that further technical procedures or more caudal procedures are probably useless.

We would prefer to also implant dorsal column stimulators and obtain the 49% - 75% success rate as quoted in the literature but this is not possible. The same is true for the morphine pumps or long catheters.

Many of our patients have been to numerous pain practitioners after their multiple surgeries, some in other states, and are well versed with the lysis of adhesions, the RACZ catheter and so forth. Nevertheless, they are willing to undergo another trial of these in the hope that they will obtain some relief.

Unfortunately most of these patients are relegated at some point to chronic opiate use. In other words, we end up using chronic long-term opiates in non-malignant pain.

This controversial subject is detailed in the main article. It is the mainstay of our treatment of this condition. Besides opiates, the patients are often receiving a muscle relaxant, a non-steroidal anti-inflammatory agent if appropriate, gabapentin and/or clonazepam, and other adjuvant drugs.

We will show several of these patients, including their surgical scars, their habitual posture with or without corrections in their gait, their facies reflecting suffering or pain and their epidurograms. Surprisingly enough, all these patients were more than eager to be photographed and were most cooperative in this endeavor. For this, we wish to thank them.

To date, the chronic long-term use of Schedule III and Schedule II opiates for this condition has been surprisingly well tolerated. Many of the patients have been on morphine or methadone for over ten years and the side effects have been surprisingly few, consisting of widespread lower body edema from morphine, (probably less 1 out of 10,000) other complications such as constipation, psychiatric and/or psychotic depression, and other side effects have been virtually absent.

Obviously, this is too early to tell whether this is the correct method of treatment for this condition but is the only practical one available to us.

*On request.*