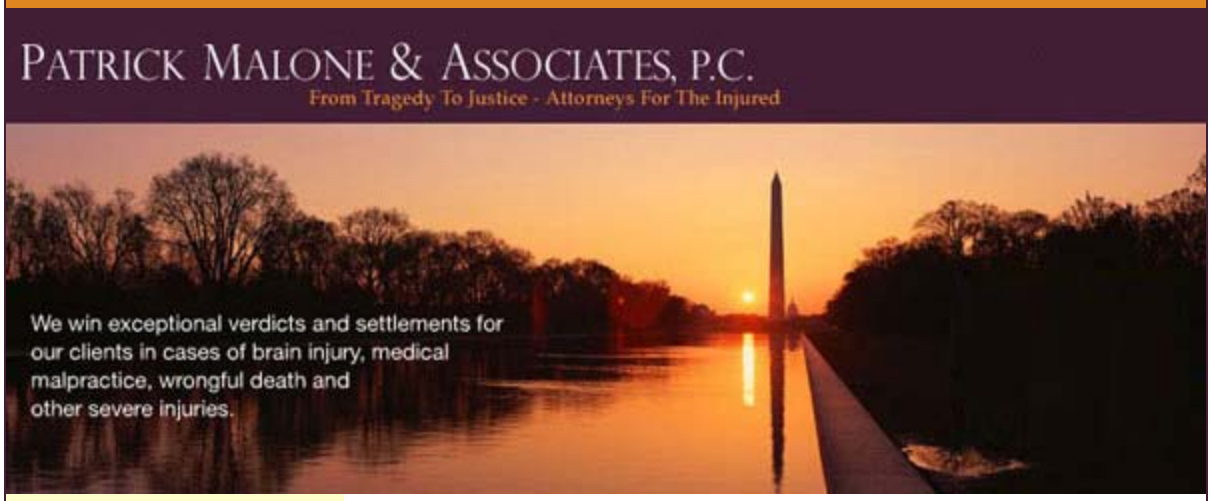
Getting the Best Medical Care: a Newsletter from Patrick Malone



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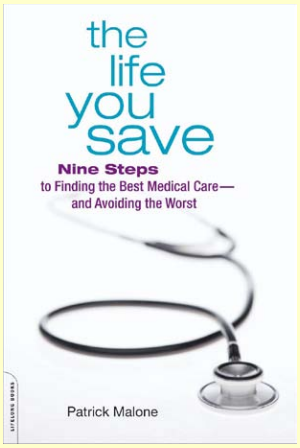
The Life You Save: Nine Steps to Finding the Best Medical Care -- and Avoiding the Worst



Better Care for Your Aching Back

Greetings!

Back pain is the fifth most common complaint people bring to a primary care doctor. At some point, almost everyone experiences low back pain, and those who deal with it regularly can fall victim to a host of misguided treatments.

I've written before in my patient safety blog about the dangers of spinal laser surgery and premature imaging for low back pain.

Now, new studies confirm that caregivers routinely ignore best practices for treating back pain. A study published in JAMA Internal Medicine showed that doctors prescribe powerful, addictive narcotics instead of other recommended painkillers, and recommend unwarranted diagnostic imagery. Another study in the Journal of the American Medical Association about spinal injection therapy didn't yield the widespread positive outcomes hoped for.

Knowing how back pain is routinely treated incorrectly can help you find the right treatment when and if your back demands attention.

Getting the Facts About Drug Therapy

Here's just one of the prominent problems in getting correct treatment for back pain: the chance you'll be prescribed dangerous addictive drugs that are no more effective in pain relief than other drugs.

As reported by the Los Angeles Times, doctor referrals for physical therapy remained steady during the study period of 1999 to 2010, but prescriptions for narcotic painkillers increased by half as prescriptions for nonopiate drugs fell by the same amount.

Somehow, doctors aren't getting--or are choosing to ignore--the message. The study's authors referred to a 2007 analysis that narcotics provided little to no benefit in cases of acute back pain and

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that they weren't effective in cases of chronic back pain.

The researchers also called the increased use of diagnostic imaging for back pain "inappropriate," and said that the radiation exposure could cause cancer. Medical guidelines recommend avoiding early imaging or other aggressive treatments, except in rare cases, but the use of computed tomography (CT) or magnetic resonance imaging (MRI) had increased by 57%.

The study from 2007 projected 1,200 additional future cancers would be created by the 2.2 million lumbar CTs performed in the U.S., according to the authors.

Be Wary of Spinal Injections

The recent report on spinal injection research was described by Dr. John Mandrola on KevinMd.com as "a shocker." He identified five important points in the article:

1. Injection use varies substantially. Just as some doctors are notorious for overprescribing some kinds of drugs, relatively few doctors are responsible for a disproportionately high percentage of injections. Critically, there are no data to show that higher use rates associate with better outcomes.

2. Injections are not equal. Different parts of the back anatomy can be injection targets, and different drugs (local anesthetics, steroids, pain meds, etc.) can be injected. Injections are given at different stages of disease-acute, subacute and chronic. So many variables make profound review of the topic difficult at best.

3. Evaluating the benefits of a treatment is best accomplished through a systematic review of all scientific literature. Sometimes called meta analysis, these comprehensive reviews yield the best information for making clinical decisions. The Cochrane Collaboration conducted such a review for spinal injections in 2008 and found that only 6 of 18 trials showed significant results for at least one outcome in favor of the injection. No clear pattern of benefit emerged. The researchers concluded: "There is insufficient evidence to support the use of injection therapy in subacute and chronic low-back pain. However, it cannot be ruled out that specific subgroups of patients may respond to a specific type of injection."

4. A more recent meta analysis studied epidural injections for sciatica. The Annals of Internal Medicine report found a very small improvement in the short-term-6 points on a 100-point scale. No long-term benefit was noted for sciatica, a broad diagnosis for various kinds of pain affecting the hip, back and/or leg caused by compression of the sciatic nerve. These researchers concluded: "The small size of the treatment effects raises questions about the utility of this procedure in the target population."

5. Only one country-Belgium-recommends spinal injections. Clinical guidelines in the U.S., U.K. and Europe do not recommend injection therapy for low back pain. In general, they prefer pain relievers such as nonsteroidal anti-inflammatory drugs (NSAIDs) including ibuprofen and aspirin, muscle-strengthening exercises, behavioral therapy, spinal manipulation and, if necessary, opioid pain killers.

The older JAMA article concluded: "Patients with low back pain differ in their clinical presentation and may respond differently to treatments. Injection therapy of any kind may be beneficial in individual cases or subgroups. Nevertheless, given the weak scientific evidence base and the availability of noninvasive and more effective alternatives, physicians and policy makers should not recommend the use of injection therapy for patients with low back pain and sciatica."

Mandrola was surprised. He thought it was logical to inject anti-inflammatory drugs directly to the source of the problem. "You would have thought comparison studies would have strongly favored local injections," he wrote. "But that's the thing with evidence-based medicine: Just because something makes sense, and smart doctors think it so, does not mean it is so."

As he noted, many patients referred for spinal injections, especially older folks, also take blood-thinning drugs, such as warfarin (Coumadin), Clopidogrel (Plavix), heparin, Lovenox, etc. Interrupting that regimen, which is necessary to deliver other drugs in spinal injections, can be risky.

Surgery as a Last Resort

Back surgery has long been controversial; sometimes it results in not relieving pain, or even making it worse. Back and spine surgery risk factors include permanent nerve damage or even paralysis; spinal hematoma (collection of blood) puts pressure on nerves that also can cause paralysis.

I've represented several patients in malpractice cases; they walked into the hospital for their back surgery and never walked again. Check out my backgrounder on spine surgery malpractice here.

Except for acute injuries and serious conditions, other, less invasive measures such as physical therapy, weight loss and analgesics should be considered as first-line treatments, especially for what's often promoted as new and better kinds of surgery.

Recently, so-called "breakthrough" spinal surgeries have proved significantly riskier than promised. My recent patient safety blog about a snazzy new surgery to promote bone growth instead of the more traditional bone graft illustrates the dangers of being too eager to embrace what sounds fantastic.

The product is a protein that's implanted to encourage bone growth and fuse the gaps between vertebrae. Grafts harvest bone from another part of the body or a cadaver to encourage fusion of the vertebrae. The latter procedure doesn't carry the risks that have been suggested might occur with the implant, including male sterility, bone growth problems, cancer and back and leg pain.

Laser spine surgery is another treatment you don't undertake lightly. As noted in my blog, it substitutes the laser beam for electrical current. In both cases, the idea is to burn off sensitive nerve endings between the vertebrae. But with either device, pain relief can be short term because the nerve endings grow back. See also our backgrounder on laser spine surgery malpractice.

Watchful Waiting Can Be Your Friend

Any treatment that isn't necessary is poor treatment. Disease is never 100% avoidable, Mandrola pointed out, but a healthful, balanced lifestyle reduces the risk of facing tough treatment decisions. When disease strikes, "if it is safe to wait," he advised, "taking a conservative approach, giving the body time to heal itself, is often just as good as having a sharp object stuck into you."

As the authors of the recent study noted, if doctors and patients follow the established treatment guidelines, routine back pain usually improves within three months.

For more information, see my backgrounder.

Recent Health Care Blog Posts

Here are some recent posts on our patient safety blog that might interest you.

- Harm to patients in surgery is increasingly blamed on technology and equipment, from malfunctions to staff not having the right training.
- Surgeons who own a financial stake in the devices they implant in patients make decisions that aren't always in the patient's best interests. A scandal now erupting in Detroit concerns spinal implants.
- It's not just an annoyance when the nurse doesn't respond to the call button. Staff shortages in hospital wards are downright dangerous for quality patient care.

Past issues of this newsletter:

Here is a quick index of past issues of our newsletter, most recent first.

Here's to a healthy 2013!

Sincerely,

Patrick Malone
Patrick Malone & Associates