Although the variety of specialists caring for patients with chronic pain is broad, anesthesiology is the specialty that represents the majority of physicians who use interventional approaches in the treatment of these patients. Anesthesiologists who consider themselves as interventional pain management specialists agree that the spectrum varies widely from those who use only epidural steroid injections in a recovery room setting to those who are fellowship-trained and exclusively provide image-guided spine intervention. Training and skill level among such anesthesiologists vary widely, mainly because until recently, no common comprehensive standards or guidelines existed for interventional pain management physicians. This situation changed in 2001 as the result of the establishment of guidelines set forth by the American Society of Interventional Pain Physicians1 and more comprehensive practice guidelines recently published by the International Spine Intervention Society (ISIS).2 As these standards become more commonplace in this specialty, the gap of varied skill levels and training will narrow with the expectation of improved outcomes based on randomized control trials that are ongoing to further delineate more accurate guidelines for each specific procedure.

Low Back Pain
Low back pain (LBP) is a common problem that has an enormous clinical, social, and economic impact on our society. One estimate is that this condition affects 15% of the US population.3 The impact on overall cost of healthcare is...
staggering when considering the disabling influence of LBP on the working population. According to Manchikanti’s epidemiologic review, probable risk factors for LBP include genetic factors as well as age and smoking however, none were convincingly causal. Possible risk factors include a history of back pain, job dissatisfaction, heavy physical work, obesity, static work posture, and psychosocial factors. Because LBP is the most common symptom seen by interventional pain management physicians and is a common symptom seen by primary care physicians, this review article focuses considerably on diagnosis of LBP and treatment of patients with this condition.

The symptomatology of LBP is non-specific with many possible etiologies. The lumbar spine is a complex structure, and for many years, treatment of patients with LBP was based on speculation. Limited understanding of lumbar spine anatomy, specifically neuroanatomy, and a lack of knowledge of functional anatomy contributed to this approach to treatment.

Fortunately, the dedicated, diligent, and unparalleled work of Nikolai Bogduk did much to change treatment. His text Clinical Anatomy of the Lumbar Spine and Sacrum contains knowledge and science essential to more complete comprehension of pathology, diagnosis, and treatment. This greater awareness of anatomy and function resulted in considerable research data generated by many quality double-blind, controlled trials. These data were translated into precise diagnostics that further enhanced appreciation of complex issues in LBP and dramatically changed the specialty of interventional pain management. Scientific advances coupled with the ever-developing art of medicine will undoubtedly translate into less suffering with greater function and productivity for those who have chronic pain.

Given these fortuitous advances, there is no longer a place for a routine “series of three” injections. Spinal injection procedures are primarily diagnostic and, to a lesser degree, potentially therapeutic. Repeated injections should be considered only in regard to response of previous ones. A poor response precludes repeating the same spinal injection procedure. Furthermore, precise needle placement, an absolute requirement for diagnostic injections, cannot be accomplished unless fluoroscopy and contrast is used. Even for a potentially therapeutic injection such as a conventional (interlaminar) epidural steroid injection, the needle tip (and the desired delivery of corticosteroid) may not consistently reach its target when fluoroscopy is omitted.

The concept of precisely diagnosing a potential anatomic structure responsible for generating LBP rests on the idea that for a structure to be a source of pain, it must have a nerve supply. Hence, a diagnostic nerve block can be administered to test this hypothesis.

Based on several studies by Schwarz et al and Bogduk postulated that precision diagnostic injections can assist in formulating a specific diagnosis in 70% to 80% of those who suffer from LBP.

With respect to the relative contributions of various structures in chronic LBP, Manchikanti et al evaluated 120 patients with a chief complaint of LBP by administering precision diagnostic injections. These injections targeted facet joints via medial branch blocks, intervertebral discs via provocation discography, and sacroiliac joints (SJs) via intra-articular injections. They concluded that the facet joint contributed to chronic LBP in 40% of the population, the intervertebral disc in 26%, and the SJ in 27%. Anecdotal experience among physicians at Advanced Pain Consultants PA, in Voorhees, NJ, indicates that the intervertebral disc is the more frequent significant source of chronic LBP than are lumbar facet joints.

Facet Joint Pain

Facet joints (zygapophyseal joints) are paired synovial joints formed by articulation of the inferior articular process of one vertebra with the superior articular process of the subjacent one. They allow the spine to move in flexion, extension, and rotation.

Innervated by the medial branch originating from the dorsal ramus of the spinal nerve, facet joints can be identified as a source of pain either by placing a needle tip within the joint or by blocking the medial branch nerve that lies outside the joint.

Osteoarthritis and trauma are among the most common conditions leading to pain emanating from facet joints. The primary symptom of pain emanating from this site is that of LBP. By injecting a solution of 10% hypertonic saline solution in the region of the facet joints, Hirsch and colleagues demonstrated that pain can be created in the upper back and thigh regions. Pain frequently is also referred into the groin, buttocks, hip, or lateral and posterior thigh regions (or a combination of these sites). Pain is often described as a “deep, dull ache” and may be either unilateral or bilateral. On physical examination, there may frequently be increased pain with extension, tenderness to palpation over the affected joints, and normal findings on neurologic examination. Electrical stimulation of the medial branch nerves has also assisted in identifying referral pain patterns.

Facet joint injections or medial branch nerve blocks are primarily diagnostic tools. An intra-articular facet injection usually includes use of a steroid such as methylprednisolone, which theoreti-

ically reduces inflammation within the joint, thereby potentially reducing pain. However, injecting steroid into the facet joint does not usually provide lasting relief.

The interventional pain management specialists at Advanced Pain Consultants, PA, routinely administer controlled diagnostic blocks of the lumbar medial branches to determine if a given patient may be a candidate for radiofrequency neurotomy. Dreyfuss et al have demonstrated that clinically significant and prolonged relief from back pain can be achieved with radiofrequency neurotomy of the lumbar medial branches. Patients’ pain must be carefully diagnosed with controlled diagnostic blocks of the lumbar medial branches.
Sacroiliac Joint Pain
Like the facet joint, the SIJ is also a diarthrodial synovial joint with a capsule. Unlike the facet joint, which has a clearly defined innervation, the SIJ has a nerve supply that is not clearly defined and is probably complex. The lack of a clearly defined innervation precludes use of a nerve block as a diagnostic tool for identifying pain emanating from this site.

The SIJ can be the source of LBP in a substantial percentage of cases. Schwarzer et al.14 suggest that this causality may be true in 13% of cases. Using controlled diagnostic injections, Maigne et al.20 suggest the incidence of SIJ dysfunction causing LBP may be as high as 19%.20

Because there is no scientific evidence that history or physical examination can accurately identify the SIJ as a source of pain, controlled intra-articular injections are the only available means of identifying this site as causing such discomfort.21,22

Because innervation of the SIJ is poorly defined and most likely complex, pain emanating from here cannot be diagnosed using nerve blocks. Intra-articular injection of a local anesthetic (e.g., lidocaine or bupivacaine hydrochloride) into the SIJ is the technique of choice used to prove or disprove that it is the etiologic factor.

Based on Advanced Pain Consultants’ experience, patients in whom emanation of pain is suspected—and subsequently confirmed by intra-articular injection—to be from the SIJ, usually present with pain in the lower back, groin, or buttocks (or a combination of these sites). Referred lower extremity pain may also be present.

Fortin et al.23 using asymptomatic volunteers, created a map suggesting that the characteristic location from which SIJ pain may be referred is an area of approximately 3 cm × 10 cm just inferior to the posterior inferior iliac spine. Unfortunately, this same referral pattern is not unique to the SIJ joint; it is also common to the facet joint and lumbar intervertebral disc. Therefore, intra-articular injections of a local anesthetic are necessary for diagnosis.

Discogenic Pain
Because different structures in the lumbar spine share similar innervation, pain patterns do not assist in distinguishing the exact pain generator. Without use of precision diagnostic injection techniques, pain originating from the intervertebral disc, facet, or SIJs is indistinguishable.

Provocation discography involves injection of contrast medium into the disc nucleus to define its morphology; this increase in intradiscal pressure allows simultaneous evaluation of the patient’s response to pain reproduction. Therefore, provocation discography can determine if this anatomic location is a pain source. It is based on the concept that if a particular disc is the source of pain, stressing it should result in reproduction of that pain. Furthermore, if the disc is not the source of pain, when stressed, it should either not cause pain or it may produce pain that is atypical (discordant) of the underlying pain.

Immediately following provocation discography, computed tomography (CT) scanning is done to obtain a static axial view of the intervertebral disc to evaluate the degree of annular disruption. Sachs et al.24 developed the Dallas discogram scale, which grades disruption of the annulus on a four-point scale. A normal nucleogram, one in which contrast is entirely contained within the nucleus, is considered a grade 0 disc. Grades 1 to 3 describe extension of the contrast medium to the inner third, middle third, and outer third of the annulus fibrosis, respectively. Examples include a posterior radial fissure at L4–5 with contrast extravasating into the anterior epidural space (Figure 1) and a grade 3 posterolateral annular disruption on the postdiscography CT scan (Figure 2).

Provocation discography with postdiscography CT imaging can be used to assist patients in making decisions regarding surgical intervention with either conventional spinal fusion techniques or disc replacement surgery. This diagnostic study can also serve to identify patients who may want to consider the less-invasive options such as intradiscal electrothermal annuloplasty (IDET) or other percutaneous disc interventions.

Epidural Steroid Injections
Undoubtedly, the epidural steroid injection (ESI) is the precursor of the more specific spinal injection procedures done today and the most familiar to primary care physicians. Historically, the ESI has been administered primarily as a therapeutic procedure. With widespread use of fluoroscopy and contrast medium, epidural injections into the anterior epidural space (transforaminal approach) also now have a significant diagnostic value.

Anatomically, the epidural space is divided into an anterior and posterior compartment. The anterior epidural...
space is bordered anteriorly by the posterior aspect of the vertebral body, intervertebral disc, and posterior longitudinal ligament. The posterior confines of the anterior epidural space is the thecal sac. The posterior epidural space is bordered by the thecal sac anteriorly and the ligamentum flavum posteriorly.

Three approaches to the epidural space are, historically, the more conventional interlaminar and caudal procedures and the more target-specific transforaminal method.

Despite ESI’s widespread use since first described in 1953,25 most early studies on its efficacy have been criticized because of the use of the blind (ie, without fluoroscopy) technique and hence, the lack of target specificity. Even with experienced clinicians, an epidural needle placed without using fluoroscopy will result in approximately 25% incorrect placements.7,26 Therefore, the fluoroscopically guided approach has become standard of care among interventional pain management physicians, not only for all spinal diagnostic injections, but also for the more conventional caudal and interlaminar epidural steroid injections.

When an intervertebral disc is herniated, a host of inflammatory mediators may affect lumbar nerve roots and result in clinical symptoms of radiculopathy or radicular pain. Inflammatory mediators identified in disc material which may irritate the dorsal root ganglion or dural sleeve include nitric oxide, phospholipase A₂, phospholipase E₂, tumor necrosis factor, interleukins, metalloproteinases, and immunoglobulins.27 Corticosteroids such as methylprednisolone or betamethasone decrease inflammation by inhibiting phospholipase A₂ activity.28,29 Other mediators of inflammation are also most likely inhibited by corticosteroid therapy.

Precisely placing a corticosteroid at the site of the pathologic process and inflammatory cascade should provide improved clinical outcomes. Unlike the more conventional interlaminar and caudal techniques, the transforaminal approach to the epidural space delivers drug very close, if not directly, to the site of the pathologic process. Under fluoroscopic guidance, a transforaminal needle is positioned within the intervertebral foramen just below the pedicle (Figures 3 through 5). Contrast traverses the regional epidural space and outlines the dorsal root ganglion (Figure 6). This more target-specific method is used for diagnostic as well as therapeutic purposes.

Additionally, Derby and colleagues30 demonstrated prognostic value by reporting that patients not responding to relief of radicular pain following transforaminal injections were less likely to benefit from surgical intervention. Riew et al31 demonstrated that transforaminal steroids, as opposed to local anesthetics alone, may decrease the need for surgery, ie, 67% of patients treated with transforaminal local anesthetics alone required an operation, but this rate was reduced to 29% when steroids were given.

Advanced Therapies
Spinal cord stimulation and intrathecal therapy are advanced therapeutic modalities used for treating patients with chronic intractable pain. They are essentially reserved for patients in whom continuing pain is not the symptom, but rather the disease. Together, these modalities consist of technology that is considered “neuromodulatory.”
Neuromodulation is electric or chemical alteration of the central nervous system to significantly reduce chronic pain or improve neurologic function by precise delivery of small doses of electricity or drugs directly to targeted nerve sites.

Employing electricity to treat pain dates back hundreds of years and was usually met with significant skepticism. However, in 1967, Shealy and associates reintroduced the use of electricity in treatment of pain based on the Melzack and Wall’s gate control theory.33 Gate control theory has been well accepted in the management of chronic pain.

In the early 1970s, spinal cord stimulation technology lost enthusiasm as technical failures and poor patient selection resulted in limited success in treating patients with chronic pain. During the past 30 years, however, many well-controlled studies have provided a substantial level of clinical experience. Subsequently, more specific patient selection criteria (Figure 7) and technologic changes have resulted in successful utilization of electricity in management of chronic pain. Many common chronic pain conditions such as chronic radiculopathy, neuralgia, peripheral ischemia pain, and phantom limb pain respond to electrical neuromodulation (Figure 8).

Currently, the drugs approved by the US Food and Drug Administration for intrathecal use include morphine sulfate, baclofen and, most recently, ziconotide. Other drugs commonly administered by physicians experienced with this technology include other opioids such as hydromorphone as well as agents such as bupivacaine and clonidine hydrochloride. Intrathecal therapy is used for malignant and nonmalignant pain as well as for spasticity not relieved with oral agents.

Systemic analgesics administered either orally or transdermally, as well as other conservative modes of therapy, are usually effective in reducing symptoms in most patients with malignant and in those with nonmalignant pain. However, for patients with chronic pain not responding to more conventional treatment modalities, intrathecal therapy may be an option. It is reserved for those who failed all of the more conservative approaches, including systemic delivery of analgesic medications such as the many sustained-release opioids that are now available. Intrathecal therapy is considered a last-resort therapy. When delivered intrathecally, opioids exert a potent analgesic effect via spinal and supraspinal receptors, without significantly affecting motor, sensory, and sympathetic reflexes.

The most recent advance in intrathecal therapy is the now marketed ziconotide, a synthetic equivalent of a conotoxin derived from a marine snail. Ziconotide selectively and reversibly blocks N-type voltage-sensitive calcium channels, thereby inhibiting the release of neurotransmitters from primary afferent nociceptors located in the dorsal horn of the spinal cord. Although slow titration is required to minimize the occurrence of adverse effects, tolerance to ziconotide does not appear to develop. Early clinical experience suggests that individual response can differ markedly.34 Ziconotide is currently not being used as a first-line intrathecal medication.

**Figure 7. Patient selection criteria for advanced pain therapies.**

**Table 1. Most common chronic pain conditions that respond to spinal cord stimulation.**

**Table 2. Checklist for patient selection criteria for advanced pain therapies.**

- Failed back surgery syndrome
- Arachnoiditis
- Chronic radiculopathies
- Neuralgias
- Complex regional pain syndrome
- Peripheral neuropathies
- Peripheral ischemia pain
- Postherpetic neuralgia
- Phantom limb pain

**Percutaneous Disc Decompression**

A wide variety of new percutaneous procedures directed to the intervertebral disc (eg, percutaneous endoscopic laser discectomy and percutaneous discectomy) has been developed to provide patients with a minimally invasive procedure that may serve to avoid conventional open surgical techniques. These percutaneous techniques hold several theoretical advantages over their more aggressive surgical counterparts. However, widespread acceptance of these newer modalities remains limited primarily because of the lack of randomized controlled trials.

**Comment**

Low back pain usually is self-limiting, but when it persists and is unresponsive to rehabilitation and analgesics, precise determination of the source of pain becomes key to planning proper treatment. Patients with LBP may demonstrate varied clinical scenarios, none of which, unfortunately, helps in determining the exact source of the pain. A precise spinal diagnostic evaluation can identify the correct anatomic site of such discomfort in most patients. An epidural steroid injection is one of many tools used by interventional pain management specialists to identify and treat the responsible anatomic source of pain.
physicians. Use of image-guided procedures and contrast media affords pain management physicians a methodology for precision diagnostics. When patients present to their primary care physician with a complaint of low back pain and there is no response to conservative treatment such as analgesics and physical therapy, it would be appropriate to obtain magnetic resonance imaging scans and refer these patients to a pain management physician. The interventional pain specialist will be able to precisely diagnose the etiology of the pain and determine whether further rehabilitation, therapeutic injections, or a surgical evaluation would be prudent.

References


