

Preface

About a year ago, a patient walked into my office with a history of having undergone a one-sided four-level radiofrequency procedure for lumbar facet joint pain. When asked, he said that he had never had a medial branch block or a facet joint injection prior to the radiofrequency procedure. He had never even *heard* of a pain diary. The four-level radiofrequency rhizotomy procedure had taken approximately 15–20 min to complete and of course it did not help him at all. In the twenty-first century, I wondered how this could have happened. How could the standards of evidence-based medicine be so willfully disregarded? Was it expedience, ignorance, or both? And to make matters more troubling, and what will likely come as no surprise to the reader, is that his case is not unique in having been substandard of care. Further, when put to the test, all too many doctors don't know when they are practicing evidence-based medicine and when they are practicing out of simple dogma. Certainly there are times when evidence-based medicine does not have an answer to our patients' needs or when the answer is not in our patients' interests, but in these times, it is our duty to explain to our patients what treatments are evidence based and what treatments are being offered from clinical experience, anecdotal evidence, or even dogma.

Years ago, my colleague Dr. Joseph Herrera and I launched an interdisciplinary journal called *Current Reviews in Musculoskeletal Medicine*. The purpose of this journal was to provide a platform that would help distill the different specialties' literature in order to provide a uniform set of guidelines for patients with various musculoskeletal disorders. The purpose, to put it another way, was to help move us closer to a day when no matter what doctor you walked into—a rheumatologist, neurologist, orthopedist, physiatrist, internist, or neurosurgeon—the care for any given musculoskeletal problem would follow the same algorithm. The journal is still in service towards this goal and there are many other platforms as well. It will come as no surprise to the reader that we are still a long way off from this lofty but ultimately, hopefully, obtainable goal.

If you treat patients with lower back pain or lumbosacral radiculopathies (e.g., sciatica), then you know that your patients will see different diagnostic and treatment paradigms depending on what doctor's office they happen to walk into.

Sometimes this breakdown occurs along specialities with interventional pain management doctors being more likely to inject, surgeons being more likely to operate, neurologists being more likely to medicate, and family practice doctors being more likely to send patients to physical therapy. Sometimes the disparity in care is within one's own specialty and this disparity sometimes seemingly lacks rhyme or reason. For example, the doctor who performed the four-level radiofrequency rhizotomy on my patient without ever having performed a diagnostic block—the same doctor who performed this four-level rhizotomy tour de force in 15–20 min—is in my specialty of physiatry. How do we explain that and, more importantly, how do we stop things like that from happening in the future?

Medicine remains a mix of science and art. As physicians, we all try to stay in the science as much as we can, but sometimes the data points simply aren't there, or are conflicting, for a particular patient's multifaceted problem and so we get pulled into the art of medicine. Every patient deserves a specific diagnostic and treatment algorithm that fits his or her particular needs in a particular given situation. It is fair and appropriate that as healthcare providers, we should all have our individual styles and techniques. Having said that, there needs to be a common base of understood and accepted knowledge we all pull from. With the journal, Dr. Herrera and I tried to offer that for a range of musculoskeletal problems. With this book, I try in as succinct a form as possible to articulate the evidence-based paradigms for treating common spinal pathologies. In the end, whether a patient walks into the office of a neurologist, neurosurgeon, physiatrist, internist, family practitioner, anesthesiologist, orthopedist, or rheumatologist, that patient's problem should be treated and approached in a similar fashion, and when that fashion is deviated from, there should be a reason.

After reading *Non-operative Treatment of the Lumbar Spine*, when you see a patient with a lumbar spine pathology causing back or leg pain, the reader should know what the research tells us and what it doesn't tell us. The physician reader should know—we should all know—when we are acting with our feet firmly in scientific data and when we are treating patients from dogma or clinical intuition. Dogma and intuition has its place, of course, but we should know and be able to distinguish dogma from fact, science from intuition. Knowing this removes the fear and insecurity from what we do, and it allows us to provide the confident, consistent, excellent care that our patients deserve. Let's get started.

Non-Operative Treatment of the Lumbar Spine

Cooper, G.

2015, XIII, 163 p. 24 illus., 15 illus. in color., Softcover

ISBN: 978-3-319-21442-9