Attachment A: Summary of Feedback received from AMA Members

General Comment

Orthopaedic Surgeon

Firstly, I would like to address the Choosing Wisely recommendation by the Faculty of Pain Medicine.

The recommendation states:

Do not refer axial lower lumbar back pain for spinal fusion surgery

This statement is at best erroneous and at worst constitutes medical negligence. I do not know who has vetted this recommendation prior to its release to the general public. I am certain that it has not be approved by any experts in spinal care. Firstly, "axial lower lumbar back pain" is a symptom. There are many causes for this symptom. Although the most common cause is degenerative disease of the lumbar spine, other important causes include neoplastic, infective, traumatic, congenital and deformity conditions affecting the spine. To simply describe a symptom and then advise against referral is irresponsible. When a patient is referred for "spinal fusion surgery", it does not mean that patient will automatically receive spinal fusion surgery. However, it is important that referral is made to the appropriate specialist, which sometimes means a spinal surgeon, in order to assess that patient thoroughly.

Furthermore, the same Choosing Wisely recommendation used 5 references to support its conclusion. Out of the 5 references, 2 of them actually recommended the judicious use of spinal fusion for the treatment of low back pain. The two papers ***(Attachment A.1, A.2)*** *which I have attached (Guidelines for lumbar fusion, Fritzell Volvo prize winner Lumbar fusion for low back pain) concluded that the use of lumbar fusion surgery in low back pain provided better outcome than ongoing non-surgical treatment.*

Therefore, the conclusion of these papers, quoted as "references", actually ***do not*** *support the Choosing Wisely recommendation!*

Spinal Surgeon

First of all I have not seen the proposed definition of 'uncomplicated lower back pain' and in my opinion if it at all exists it is in fact quite rare - at least in patients referred to a surgeon.

In my experience there is already a quite thorough preselection done by GP, physio, chiropractors etc. before a patient reaches the rooms of a surgeon. That implies that have gone already through a number of conservative treatment options at that time. Still the majority would rather not have an operation at the first visit.

But imagine if you run out of options - surgery often is the final hope. Even if we aren't having perfect results in every case there is still a substantial proportion of patient with significant improvement to their physical ability and pain level.

Taking that option completely away would be a disaster in some cases.

One option could be to have a mandatory second opinion required before surgery can be performed. (preferred from a senior spine surgeon).

I would agree on the proposal of non-surgical treatment for unexplained / unclear lower back pain without changes in appropriate imaging (MRI, bone scan etc.)

Unfortunately changes can be subtle and localisation can be difficult.
Also mandatory time period for completed conservative treatment before surgery could be a consideration. The problem often is access to qualified pain physicians and allied health.

Unfortunately often these cases are relatively young people with minimal changes on scans and hard to diagnose , but once the pathology has been identified and all conservative options have been exhausted surgery in some cases has shown dramatic improvements.

This problem is very complex and no one way will work for every patient - so please don't erase surgery as an option! Otherwise in these cases we will have sometimes no reasonable options left than paying them disability pensions without helping them.

This view is also shared by some other spinal surgeons and colleagues of mine.

1. **Is 'uncomplicated axial chronic lower back pain' an appropriate definition?**

Neurosurgeon
To be frank I am not sure that uncomplicated axial ironic back pain is a definition. Chronic axial back pain is always complicated. It would be better to define the pathology. The issue is that the chronic axial back pain may require surgical treatment. It should only be treated surgically when there is clear pathology involving the disc or facet joints, where conservative management has failed and when they have been reviewed by a trained pain management specialist. In those circumstances property counselled patients should have the option of surgical treatment.

Neurosurgeon
No. This is a general description of a symptom without any regards as to the underlying diagnosis. It would be akin to saying "uncomplicated abdominal pain" or "uncomplicated chest pain".

Orthopaedic Surgeon
In a modern spine practice, no fusion surgery is performed when disc replacement surgery is a better alternative. The scientific literature would support the statement that disc replacement surgery is superior to fusion surgery in the right patient demographic. Most spinal surgeons do not perform disc replacement surgery which is a reflection mostly of being neurosurgically trained. But those that do, only perform disc replacement surgery in the setting of a patient with a 'precision diagnosis'. It would be my advice therefore that the descriptors for lumbar fusion surgery, when radiculopathy, trauma, malignancy, deformity (such as spondylolisthesis, scoliosis, sagittal imbalance or kyphotic deformity) and infection do not exist, do not use the word 'uncomplicated' but instead only allow the use of this item number in the presence of a 'precision diagnosis'. This would effectively disallow the use of lumbar fusion surgery for 'back pain of unknown origin' OR 'back pain of presumptive origin', and would also see the end of a lot of 'rogue' surgery, which unfortunately is quite rife in the spinal community. 'Precision Diagnosis' would have to list the common interventional diagnostic methodologies which modern spine surgeons use daily so that unless a patient had (and this of course is in the absence of those other pathologies mentioned above) a positive discogram (Dallas Protocol) for more than one level, or a positive response to a discal block for single level, or a positive response to medial branch block with subsequent failure of medial branch ablation, then the item number cannot be used. There should also exist some exclusions in the precision diagnosis for example, sacro-iliitis should be actively excluded (I see one patient a week that has had many spinal surgeries performed for the missed diagnosis of sacro-iliac pain) as should osteoporosis (osteoporosis causes back pain as a result of suboptimal skeletal integrity and the resultant continual microfracturing and remodelling).

The issue with the word 'uncomplicated' is that any surgeon who wants to perform lumbar fusion surgery on a patient will be able to find a reason as to why his or her patient is complicated and so I fear this will be ineffectual in stemming the tide.

Orthopaedic Surgeon

To the definition of 'uncomplicated axial back pain', consider adding:

... to include:

- *all modalities of imaging which demonstrate degenerate change only;*
- *scoliosis of Cobb angle 25 degrees or less;*
- *spondylolisthesis of Grade 1 severity or less.*

Orthopaedic Surgeon

Uncomplicated" axial back pain refers to the treatment of an MRI finding rather than a clinical problem identified by the surgeon and confirmed on appropriate imaging Radiculopathy confirmed on MRI, Tumour, Infection, Fracture with resultant instability

2. **Is there any place for surgical treatment of low back pain without radiculopathy? Please describe possible indications.**

Neurosurgeon
There are many instances where surgery is appropriate. This includes loss of sagittal balance of the spine. This is where there is a loss of alignment requiring correction of the degree of lumbar lordosis. The person may experience significant back pain, difficultly mobilising and pain associated with compensatory mechanisms involving the pelvis and lower limbs which is not a radiculopathy. There is back pain associated with facts arthropathy which can create back pain associated with instability or severe arthritis of the facet joints which should be treated surgically if conservative management has failed. There are many other examples such as severe disc pathology.

Neurosurgeon
Yes. Surgical treatment of low back pain without radiculaopathy may be required for neoplastic, traumatic, deformity or infective conditions. In degenerative conditions, surgical treatment as a last resort can provide better outcome than ongoing non-surgical treatment in the well selected and well-informed patients. (See the attached references.

Orthopaedic Surgeon
Most definitely – spondylolisthesis (structural instability), infective discitis, malignancy, sagittal imbalance, failed previous back surgery, iatrogenic instability (so called post-laminectomy syndrome) to name just a few.

Orthopaedic Surgeon
Possibly. Scoliosis of greater than 25 degrees, especially where radiologically progression is demonstrated; Spondylolisthesis of greater than Grade 1 severity, especially where radiological progression is demonstrated.

3. **If surgery is performed for low back pain without radiculopathy, are there any pre- or post-operative requirements in care?**

Neurosurgeon

Surgical treatment for back pain should only occur in the context of multidisciplinary setting with appropriate consideration and trial of conservative management including exercised based management and cortisone injections for instance. It is may standard practice to involve a pain management specialist to ensure that there are no reasonable alternatives and ensure that all other conservative avenues have been pursued or at least discussed. Post-operatively phyioltherpay and pain management are often required.

Neurosurgeon

Would need more consideration but perhaps only after appropriate revue by pain management specialist and a clear pathology of the spine.

Neurosurgeon

The pre- and post-operative requirements are the same for all patients undergoing spinal surgery, regardless of the aetiology of the back pain.

Orthopaedic Surgeon

Pre-operatively a precision diagnosis has to be made, conservative therapies have to have been proven to fail and psychometric disturbance has to be excluded. Pre-operative care can run from anything like core-strength exercises all the way to referral to a bariatric surgeon for gastric bypass surgery. Post-operative care is very individualised and patient specific – this is a huge subject but usually revolves around core strength, occupational specific rehab, recreational specific rehab and education. Then of course if you perform such surgery on a very healthy 90 year old for deformity then no rehab is appropriate.

4. **What would be a form of words to prevent spinal fusion being performed and claimed inappropriately for unexplained low back pain?**

Neurosurgeon

Would need more consideration but perhaps only after appropriate revue by pain management specialist and a clear pathology of the spine.

Neurosurgeon

Axial Low Back Pain Surgery does not exist. Surgery cannot cut away the systemic failings that lead to pain symptoms, nor does it cut out a disease that leads to back pain symptoms. This is in stark contrast to other surgeries that cure disease by removing a lesion or tumour or fix a fracture. Critically though this does not mean that skilfully selected patients with Axial Low Back Pain and structural deficits do not require Surgery. Surgery remains merely a stepping stone to achieving the ultimate goal of optimizing the intimate inter-relationship between structure and function that is required in all systems whether biological or mechanical to work effectively, remain pain free robust and healthy. When surgery is adopted for Chronic Axial Low Back Pain due to advanced structural break down Functional Movement Proficiency Rehabilitation is an imperative part of the overall management.

Concisely "Spinal Fusion Surgery for Chronic Axial Low Back Pain should only be considered when spinal structural deficits are evaluated by the surgeon and physical therapist to be compromising the patients ability to participate in effective, specific and distinctive Functional Movement based Therapy which is an imperative element to restoring patient function regardless of whether surgery is deemed necessary as part of the optimization of the critical Structure and Function Inter-relationship".

Neurosurgeon

Spinal fusion should not be performed inappropriately for unexplained low back pain.

Orthopaedic Surgeon

(please refer to paragraph three of the comment in question 1)

Essentially the 'presence of a precision diagnosis, following 9 months failure of conservative therapies'. This would be followed by link to a descriptor which would be an extensive list of inclusion and exclusion criteria as to what constitutes a precision diagnosis.

5. **Do you have other recommendations that would improve outcomes in surgery for low back pain without radiculopathy?**

Neurosurgeon

The outcomes for surgery for low back pain are very dependent on patient selection. Those with a defined and localised pathology do better. The figures quoted are different for Workers Compensation patients and those without a compensable injury. It should always be remembered that failed surgery for back pain has also only failed after failed conservative management, however about 65% of patients have significant improvement in pain and they would not have experienced that improvement without surgery. It can be life changing for some patients.

Neurosurgeon

Only perform such surgery in the appropriate patients.

Orthopaedic Surgeon

This is a huge subject. Limiting item numbers is partly the answer – the rest requires appropriate surgeon training and a philosophy change towards non-fusion surgery – which is coming. Improving outcomes is about proper patient selection, application of appropriate surgical technology matched to the pathology and in a round-about kind of way if the item numbers put a handbrake on surgeons not able to do this then I believe outcomes will be improved.

Orthopaedic Surgeon

In my opinion, uncomplicated axial chronic low back pain without radiculopathy is NOT a surgical condition.

6. Is there any additional information or evidence that the department should consider?

Neurosurgeon
There is clear evidence in the literature supporting surgery for back pain for the appropriate indications.

Orthopaedic Surgeon
Please read the attached references. The same ones that the Faculty of Pain Medicine used to "support" their Choosing Wisely statement:

- *Guidelines for lumbar fusion*
- *Fritzell Volvo prize winner Lumbar fusion for low back pain.*