

**Interventional Remedies: Are We On The Right Path?**

A high flyer in an international business having head office in the United States of America was brought lying down in a large vehicle with an improvised bed. He was suffering from agonizing pain in the lower back for two years. He had kilos of investigations and tens of X-rays, CT scans and MRI films with him. The pain did not allow him to meet goals of the day-to-day activities leaving aside frequent travel he had to do on a weekly or daily basis that was the requirement of his work. He was the kind of person who would take breakfast in the US, lunch at London and then having dinner back home in the US and so forth. He had quite a few aggravating factors including pain on sitting, standing and walking and least on lying prone in the bed. So, he was bed bound mostly and rarely ventured going from one place to another lying prone in the vehicle with the improvised bed. He was conducting meetings over phone instead of his office or meeting rooms. Naturally, being the head of a big business, he could not meet the work challenges. He got the opinion of the best doctors in the US with loads of investigations which did show some small posterior bulges of the disks, mild degenerative disk disease and some positive stress tests for the sacroiliac joints. He had been subjected to medications, exercises, manipulations, heat therapy, diathermies, TENS with lifestyle modification advices but to no avail. He was losing business and more importantly the morale having become tied down to the bed. Having failed in the conservative management over six months, he was repeatedly admitted in the hospitals in the US. He was given epidural steroids, sacroiliac joint injections, facet joint injections with steroids and also dorsal root blocks with radiofrequency. With the chronicity of the condition and advice on interventions he had some relief but he continued to have recurrences. Soon after, he was asked to avoid travel, be on relative rest and exercises. He did not get free of pain and continued to be more and more bed bound. After almost two years of therapy failing to give him relief, he was posted for some surgical intervention for a small bulge. That was the point he chose to seek another opinion in India having fed up with punctures in his body with the fear of having his back cut open.

It took me an hour and a half of detailed history and examination to ascertain his condition to find that he did have repeated abuse of his back primarily due to his lifestyle of being sedentary devoid of any physical activity or exercise over and above the superadded frequent traveling with inadequate rest. Not having found any other major cause to cause that much of pain, I advised him to ignore his pain and get back to his feet and improve flexibility of the spine. It was shocking for him to believe that on one end were the major interventions including surgical at a place back home where there are so called "Gods of Medicine" having supremacy over the world asking him to have more interventions and rest, and on the other hand by asking him to ignore everything and bear pain to get back to doing activities. The fear was alleviated to some extent with the example that I gave him. Pain is a signal that warns us that there is something wrong. We have to go into the depth to find the cause. We do have to respect pain and ascertain the cause of pain; like the law abiding citizens would stop at a red signal at a cross-road even in the middle of the night. After having addressed the cause of pain, if we know there is something alarming, we treat and try to alleviate pain and also give directions on whether to take rest, medication or whatever intervention. But if we do not find anything serious to make the patient take rest or take to the bed, we may take steps like in any warranted management and ignore pain even if that occurs while performing the activities. Coming back to the example of red signal at the cross-roads, if there is a technical glitch in the signaling system (equated to the body giving a signal of pain), you would wait for a reasonable length of time but jump the light after waiting but then after looking around pass safely ignoring the red signal. With this example in his mind he moved further and ventured into activities ignoring his pain. He was advised general flexibility and strengthening exercises and asked to gradually initiate activities to get up from the bed, sit, stand and walk, increasing gradually. He started to slowly perform his day-to-day activities leading to indulging in work and travel routines over the next few weeks. He was given no further so called interventions or subjected to surgery, which were initially lined up for him by others. He started attending his office and resumed his maddening travel routines by the end of three months. He started traveling sitting in the car and resumed his travel schedule more or less as before but added with adequate rest in between and following flexibility and strengthening exercises of the back without stopping at any signal of pain. I met him 6 months later and he did not experience any pain or apprehensions making him get to the bed or stopping him from work.

By giving the example of just the above case I am not trying to prove that the interventions are not needed or not good at all. Nor can one single case give the verdict on their efficacy or the lack of it. There is plenty in the literature to prove or disapprove the fact. But the point I wish to make here is that it is important to get to the root cause of the issues bothering the patients. Get to the depth of the diagnosis and then decide about what are the options available. Here, I would like to quote another example of one of the gastroenterologists who superannuated from our institute about 15 years ago when the endoscopic interventions were gaining popularity and were being done rampantly in the private hospitals almost on every patient having any gastrointestinal trouble. He joined a private institution after having served in a heavily attended government hospital. He was jokingly asked if he was making huge sums by putting a tube into the upper and lower openings in all the patients whether logically indicated or not. He laughed. Are we trying to sail in the same boat? There is no doubt that these are important tools to aid the diagnosis or help treat but one has to be judicious in choosing which patient requires what. If we see a load of patients with low backache, the cause in all would be different. If we try to just show what options we have or what lucrative options we have, almost in all, some or the other intervention would happen to be indicated one way or the other. If we keep a limited choice of what we know and what we have rather than what the patient would need based on his thorough clinical examination and investigations, we may not be doing justice to the patient by just choosing one of the interventional techniques without considering all the treatment options.

If we go through the literature on the interventional management of low backache or other conditions, in the recent past there has been a spurt in the publications on interventions. Even most of the conferences, workshops and CMEs are filled with programs on interventions of various kinds. It is regarded as an in-thing in the modern era. Those not having their hands into interventions feel deprived and inferior to the highly regarded interventionists. It is not a bad thing to learn. Going further into most of the review articles including meta-analyses on interventions, the glaring facts that come to light are that most studies portraying benefits of intervention have a very low level of evidence or are poorly designed studies. Further to that where conservative management, interventions and surgical management of patients with low back ache were studied, in the long term follow up beyond six months, there was no superiority found in the interventions and the surgical management in patients having low backache over other methods. Here, perhaps, the choice of the patients where one particular line of treatment would be beneficial compared to another would have to be made on case to case basis. Unless we have all the options open and then decide on what would be the best under the circumstances would still have to be done after a thorough understanding and examination of the patient. This is being ignored by most as is observed looking at the practice of the youngsters taking a hasty decision. Many of the misdirected proponents of having a needle in one hand and the ultrasound probe in the other have probably forgotten the 'Art of Medicine' and keep forgetting that one new glaring option is not enough to hold good for all. Are we forgetting the principles of medicine and specifically rehabilitation where we have to look at the patient as a whole and not just look at one particular ailment with one option of intervention alone? This is what I have also found in the youngsters while examining them that they are forgetting or ignoring options other than interventions when asked about treatment of common disorders. When we are deficient in the evidence, doing well-designed studies with good power are needed to prove the case of interventions but even after that interventions would not be the only option to replace other aspects of management.

In our clinical practice, we come across quite a few patients who come with dilemmas whether to take one treatment or the other. This happens specially so when we are in a referral hospital or in a well-established clinical practice. On the other hand, with the lure of doing something really positive, impressive or different for the patients, interventions have become the order of the day. We are becoming more and more restless in order to achieve the best in a short-time with the aided technological advances and newer techniques being introduced to manage various conditions, specifically management of pain. Having an armamentarium of ultrasonic and fluoroscopic guidance, the added precision of approach to the deeper structures, generally not available with the blind procedures, has probably lured the treating physiatrist to be more aggressive to choose interventions. I would imagine, no physiatrist should forget the basic principles of thorough history, detailed examination and only then he should draft his management outline based on the problem areas of the patient and offer him all that is necessary and not just do an intervention alone. Think big, holistically for the patient and not through the narrow hole of a needle guided just by imaging.

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