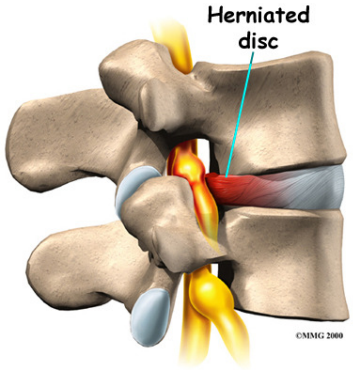
SpineFAQs Lumbar Herniated Disc

What is a herniated lumbar disc?



Disc herniation occurs when the nucleus in the center of the disc pushes out of its normal space. The nucleus presses against the annulus, causing the disc to bulge outward. Sometimes the nucleus herniates completely through the annulus and squeezes out of the disc. Although daily activities may cause the nucleus to press against the annulus, the body is normally able to withstand this pressure. However, as the annulus ages, it tends to crack and tear. It is repaired with scar tissue. This process is known as degeneration. Over time, the annulus weakens, and the nucleus may begin to *herniate* (squeeze) through the damaged annulus. At first, the pressure bulges the annulus outward. Eventually, the nucleus may herniate completely through the outer ring of the disc.

Vigorous repetitive bending, twisting, and lifting can place abnormal pressure on the shock-absorbing nucleus of the disc. If great enough, this increased pressure can injure the annulus, leading to herniation. A lumbar disc can also become herniated during an *acute* (sudden) injury. Lifting with the trunk bent forward and twisted can cause a disc herniation. A disc can also herniate from a heavy impact on the spine, such as falling from a ladder and landing in a sitting position.

Herniation causes pain from a variety of sources. It can cause *mechanical pain*. This is pain that comes from the parts of the spine that move during activity, such as the discs and ligaments. Pain from inflammation occurs when the nucleus squeezes through the annulus. The nucleus normally does not come in contact with the body's blood supply. However, a tear in the annulus puts the nucleus at risk for contacting this blood supply. When the nucleus herniates into the torn annulus, the nucleus and blood supply meet, causing a reaction of the chemicals inside the nucleus. This produces inflammation and pain. A disc herniation may also put pressure against a

spinal nerve. Pressure on an irritated or damaged nerve can produce pain that radiates along the nerve. This is called *neurogenic pain.*

What are the symptoms of a herniated disc?

Many cases of lumbar disc herniation result from degenerative changes in the spine. The changes that eventually lead to a disc herniation produce symptoms gradually. At first, complaints may only be dull pain centered in the low back, pain that comes and goes over a period of a few years. Doctors think this is mainly from small tears in the annulus. Larger cracks in the annulus may spread pain into the buttocks or lower limbs.

When the disc herniates completely through the annulus, it generally causes immediate symptoms, with sharp pain that starts in one hip and shoots down part or all of the leg. Commonly, patients no longer feel their usual back pain, only leg pain. This is likely because painful tension on the annulus releases when the nucleus pushes completely through.

Disc herniations produce inflammation when the nucleus comes in contact with the body's blood supply (mentioned earlier). The inflammation can be a source of throbbing pain in the low back and may spread into one or both hips and buttocks. A herniated disc can press against a spinal nerve, producing symptoms of nerve compression. Nerve pain follows known patterns in the lower limbs. It can be felt on the side of the upper thigh, in the calf, or even in the foot and toes. Pressure on the nerve can also cause sensations of pins, needles, and numbness where the nerve travels down the lower limbs. If this happens, a person's reflexes slow. The muscles controlled by the nerve weaken, and sensation in the skin where the nerve goes is impaired.

Rarely, symptoms involve changes in bowel and bladder function. A large disc herniation that pushes straight back into the spinal canal can put pressure on the nerves that go to the bowels and bladder. The pressure may cause low back pain, pain running down the back of both legs, and numbness or tingling between the legs in the area you would contact if you were seated on a saddle. The pressure on the nerves can cause a loss of control in the bowels or bladder. This is an emergency. If the pressure isn't relieved, it can lead to permanent paralysis of the bowels and bladder. This

condition is called *cauda equina syndrome*. Doctors recommend immediate surgery to remove pressure from the nerves.

How do you diagnose the problem?

Diagnosis begins with a complete history and physical exam. I will ask questions about your symptoms and how your problem is affecting your daily activities. These will include questions about where you feel pain and whether you have numbness or weakness in your legs. I will also want to know what positions or activities make your symptoms worse or better. I rely on your report of pain to get an idea which disc is causing problems and if a nerve is being squeezed. Then I examine you to determine which back movements cause pain or other symptoms. Your skin sensation, muscle strength, and reflexes are also tested.

Imaging

X-Rays - X-rays are of minor help in diagnosing disc herniations. The discs don't actually show up on X-rays. However, I can tell if the space between the vertebrae is smaller than normal. This can be an indication that wear and tear on one or more discs is causing problems. However, many peoples' X-rays show degeneration of the discs. This is because degeneration in the discs is part of aging, like skin that wrinkles with time.

MRI - When more information is needed, I usually order *magnetic resonance imaging* (MRI). The MRI machine uses magnetic waves rather than X-rays to show the soft tissues of the body. It gives a clear picture of the discs and whether a herniation is present. This machine creates pictures that look like slices of the area I am interested in. The test does not require special dye or a needle.

Myelogram/CT Scan - I may combine the CT scan with *myelography.* To do this, a special dye is injected into the space around the spinal canal, called the the *subarachnoid space*. When the CT scan is performed, the dye highlights the spinal cord and nerves. The dye can improve the accuracy of a standard CT scan for diagnosing a herniated disc. I use this test primarily if someone has had surgery on their spine with metal hardware, or if they cannot have an MRI, such as patients with a pacemaker.

Electrical tests to locate more precisely which spinal nerve is being squeezed. Several tests are available to see how well the nerves are functioning, including the *electromyography* (EMG) test. This test measures how long it takes a muscle to work once a nerve signals it to move. The time it takes will be slower if a herniated disc has put pressure on a spinal nerve.

What treatment options are available?

Unless your condition is causing significant problems or is rapidly getting worse, most doctors will begin with nonsurgical treatment. At first, I may want your low back immobilized. Keeping the back still for a short time can calm inflammation and pain. This might include one or two days of bed rest. Lying on your back can take pressure off sore discs and nerves. However, most doctors advise against strict bed rest and prefer their patients to do ordinary activities using pain to gauge how much is too much. In rare cases in which bed rest is prescribed, it is usually used for a maximum of two days. A back support belt is sometimes used for patients with lumbar disc herniation. The belt can help lower pressure inside the problem disc. Patients are encouraged to gradually discontinue wearing the support belt over a period of two to four days. Otherwise, their trunk muscles begin to rely on the belt and start to *atrophy* (shrink).

I often will prescribe certain types of medication for patients with lumbar disc herniation. At first, you may be prescribed anti-inflammatory medications such as aspirin or ibuprofen. Severe symptoms that don't go away may be treated with narcotic drugs, such as codeine or morphine. But narcotics should only be used for the first few days or weeks because they are addictive when used too much or improperly. Muscle relaxants may be prescribed if the low back muscles are in spasm. Pain that spreads down the leg is sometimes relieved with oral steroids taken in tapering dosages.

I often have patients work with a physical therapist. Therapy treatments focus on relieving pain, improving back movement, and fostering healthy posture. A therapist can design a program to help you prevent future problems. The first goal of treatment is to control symptoms. Your therapist will help you find positions and movements that ease pain. Treatments of heat, cold, ultrasound, and electrical stimulation may be used in the first few sessions. Lumbar traction may also be used at first to ease symptoms of

lumbar disc herniation. In addition, your therapist may use hands-on treatments such as massage or spinal manipulation. These forms of treatment are mainly used to help reduce pain and inflammation so you can resume normal activity as soon as possible. The therapist shows you how to keep your spine safe during routine activities. You'll learn about healthy posture and how posture relates to the future health of your spine. You'll learn about *body mechanics*, how the body moves and functions during activity. Therapists teach safe body mechanics to help you protect the low back as you go about your day. This includes the use of safe positions and movements while lifting and carrying, standing and walking, and performing work duties.

Next comes a series of strengthening exercises for the abdominal and low back muscles. Working these core muscles helps patients begin moving easier and lessens the chances of future pain and problems. Aerobic exercises such as walking or swimming are used for easing pain and improving endurance. Your therapist will work closely with me and your employer to help you get back on the job as quickly as reasonably possible. You may be required to do lighter duties at first, but as soon as you are able, you'll begin doing your normal work activities. Your therapist can do a work assessment to make sure you'll be safe to do your job. Your therapist may suggest changes that could help you work safely, with less chance of re-injuring your back.A primary purpose of therapy is to help you learn how to take care of your symptoms and prevent future problems. You'll be given a home program of exercises to continue improving flexibility, posture, endurance, and low back and abdominal strength. The therapist will also discuss strategies you can use if your symptoms flare up.

Some patients who continue to have symptoms are given an *epidural steroid injection* (ESI). Steroids are powerful anti-inflammatories. In an ESI, medication is injected into the space around the lumbar spinal nerves where they branch off of the spinal cord. This area is called the *epidural space.* Some doctors inject only a steroid. Most doctors, however, combine a steroid with a long-lasting numbing medication. Generally, an ESI is given only when other treatments aren't working. But ESIs are not always successful in relieving pain. If they do work, they often provide only temporary relief.

Most people with a herniated lumbar disc get better without surgery. As a result, doctors usually have their patients try nonoperative treatments for at

least six weeks before considering surgery. But when patients simply aren't getting better, or if the problem is becoming more severe, surgery may be suggested.

What about surgery?

If the symptoms you feel are mild and there is no danger they'll get worse, surgery is not usually recommended. However, if signs appear that pressure is building on the spinal nerves, surgery may be required, sometimes right away. The signs doctors watch for when reaching this decision include weakening in the leg muscles, pain that won't ease up, and problems with the bowels or bladder.

Laminotomy and Discectomy - The *lamina* forms a roof-like structure over the back of the spinal canal. In this procedure, a thumbnail-sized piece of the lamina is removed (*laminotomy*) so I can more easily take out the problem disc (*discectomy*). This procedure is mainly used when the herniated disc is putting pressure on a nerve and causing pain to spread down one leg.

Microdiscectomy - *Microdiscectomy* is now the standard surgery for lumbar disc herniation. The procedure is used when a herniated disc is putting pressure on a nerve root. It involves carefully taking out part of the problem disc (discectomy). By performing the operation with a surgical microscope or operative loupes, I only need to make a very small incision in the low back. Categorized as *minimally invasive surgery*, this surgery is thought to be less taxing on patients. I also believe that this type of surgery is easier to perform, that it prevents scarring around the nerves and joints, and that it helps patients recover more quickly. This is done as an outpatient.

What about fusion surgery?

Typically, if this is the first or second time the disc is ruptured, I recommend discectomy alone. If this is the third time the same disc has ruptured, or if there is evidence of severe disc degeneration or instability, I will likely recommend fusion.