



Why Decompression Versus Surgery?

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Now is the time for chiropractors to grasp technology and dominate the back business. No more infighting between the ICA or the ACA; we need to come together as a profession and take our stand in the fight against opioids, epidurals, and spinal surgery to treat back pain. Why nonsurgical spinal decompression (NSSD) versus surgery? Just look at the statistics. Guess what? They are now in our favor.

For those not aware, spine surgeons are typically initially trained as orthopedic surgeons or neurosurgeons and are capable of doing many great things. They repair traumatic injuries; they excise spinal tumors; and they fix congenital abnormalities. However, back pain is big business today.

Why is this happening? Let's face the fact that, except for top-tier physicians who work and teach at hospitals and medical schools, such procedures are not the mainstay of the general population of spine surgeons. About 60% of patients who walk into a spine surgeon's clinic have back pain that will be diagnosed as "ordinary," "axial," "mechanical," "degenerative," "functional," or "nonspecific." Those terms describe flattened discs, black discs, bulging discs, herniated discs (described as "prolapsed discs" in the United Kingdom), and the bony outgrowths known as osteophytes. It is too common for surgeons to point to these ordinary degenerative conditions on an MRI, diagnose "degenerative disc disease," and recommend lumbar spinal fusion surgery as the best choice.

Studies show a low efficacy rate and high costs associated with what many medical doctors are now saying is an unnecessary procedure. There's a problem with this very common procedure, in which the intervertebral disc is excised, and adjacent vertebrae are connected with cages,

screws, plates, rods, and other medical devices. Studies show that lumbar fusion succeeds in barely 40% of patients. In this context, the word "success" does not mean much. In one study, two years after spinal fusion, pain had barely been reduced by half after "successful" procedures, and most patients continued to use painkillers. In another study, two years after surgery, about one-third of patients reported that their pain was as bad as it had been before they'd had the operation, and 14% believed that they were in worse shape after spinal fusion.

Some surgeons have stated, "Eighty to 85% of the time, although they can visualize an anomaly on the X-ray or MRI, they cannot, with any certainty, determine the source of the pain." That's why 10 spine surgeons will propose 10 different solutions; one may recommend fusing the spine at three levels, while another sees no indication for any type of procedure. The ambiguity inherent in diagnosing back pain makes it possible for surgeons to do anything they want. However, they do not want to go under the knife themselves.

Richard Deyo reports, "Chronic back pain is among the most common patient complaints. Its prevalence and impact have spawned a rapidly expanding range of tests and treatments. Some of these have become widely used for indications that are not well validated, leading to uncertainty about efficacy and safety, increasing complication rates, and marketing abuses. Recent studies document—over approximately a decade—a 629% increase in Medicare expenditures for epidural steroid injections; a 423% increase in expenditures for opioids for back pain; a 307% increase in the number of lumbar MRIs among Medicare beneficiaries; and a 220% increase in spinal fusion surgery rates.

At an American Academy of Orthopedic Surgeons conference in the summer of 2010, a hundred surgeons were

polled as to whether they'd personally have lumbar spinal fusion surgery for unspecific low back pain. The answer—from all but one—was “absolutely not.”

Why did they vote against surgery?

The answer is simple; often, the risk-reward ratio just wasn't good enough. So, I ask, why do surgeons continue to pursue this type of operation if the success rate is often below 50%?

According to Cedars-Sinai Medical Center researcher Hyun Bae, “They have their own inherent conflict.” The prominent orthopedic surgeon further explained, “It's not only a financial conflict. It's an emotional conflict. We get paid to do the work. We want to make the patient better. So we concentrate on the good results, and we dismiss the bad results.” Bae added that surgeons cannot be held entirely responsible because they are under constant pressure from patients who beg them to “do something.” Under the circumstances, it's hard not to want to be a hero, but too often, even if the procedure goes well, recovery stalls within weeks.

The American Journal of Medicine observed that about 80,000 spine surgeries fail annually in the United States alone, which is an alarming number. So why don't more choose NSSD as a treatment option? Simply because many doctors buy tables to make money without fully understanding the science and research behind this revolutionary technology.

At Disc Centers of America, we have doctors with six, eight, 11, 12 decompression tables in one clinic. My son and daughter-in-law have gotten three tables in three years of practice. They expound on the research by Dr. Dyer, Dr. Shealy, Dr. Eyerman, and Dr. Leslie of the noted

Mayo Clinic. They are educated, approach patients scientifically, and explain the hazards of failed back surgery syndrome and the consequences of epidurals and other injections. Today's patient needs to be educated, and it is our goal to educate them on the safety and efficacy of nonsurgical spinal decompression.

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However, even today, back surgery is growing in record numbers in our country. Patients who have not done well are referred to as “failed backs,” and they often return to the operating room repeatedly, losing ground after each procedure. About one in five patients who undergo spinal surgery for a degenerative disorder returns for a revision procedure—a second operation. Even when the fusion is deemed to be “radiologically perfect”—meaning that an X-ray shows the vertebrae have grown together and the hardware is positioned correctly—the fusion itself imposes increased stress at other vertebral segments. That often results in “adjacent segment deterioration,” a condition where the vertebral level above or below degrades, causing more pain. A second back surgery has a 30% chance of success. That prognosis drops to 15% for a third back surgery, and 5% for a fourth. Oregon Health and Science University spine medicine researcher Roger Chou believes that surgeons should be required to reveal the odds to their patients before going forward. “If [the surgeon] said, ‘Yes, we can do this \$70,000 surgery, but you know, there's still more than a 50% chance that you're going to have a lot of pain, and you still won't be able to work, and you're going to need pain medicine, and you'll have complications related to the surgery’—and all this is well documented—then most people would say, ‘I don't want it.’”

My son, Dr. Jason Kaplan, states approximately 30% of his patients have had surgery. In an article in a medical trade journal, orthopedic surgeon Terry Amaral made note of some things that can go wrong that are rarely mentioned to surgical candidates. “The spinal cord is right next to where we are putting the screws in; we are working near where the nerve roots exit,” he observed. “If you perforate that area, the patient will experience weakness or even paralysis. Then in the front of the spine, there are other things to be concerned about, like the aorta, the vena cava, the lungs.”

Other risks go unspecified. The spinal screws are misplaced in 5 to 10% of all fusion procedures. After spinal fusion, infection is common. Nerves may be jostled and inflamed, resulting in dull, diffuse, aching, or sharp stinging pain in the legs that may or may not ever go away. Supportive spinal ligaments and muscles disturbed during the surgery rarely work with the same efficiency, and that incompetence may result in more back pain. Despite risks and mediocre outcomes, the number of spinal fusions performed in the United States grew from 61,000 in 1993 to more than 465,000 in 2011—more than a 600% increase, accounting for more than 60% of the spinal fusion surgery performed worldwide. It's the most expensive form of elective surgery in the United States, costing about \$40 billion annually. For 20 years, the Dartmouth Atlas of Health Care has documented variations in how medical resources are allocated in the United States. In 2011, the university's Institute for Health Policy and Clinical Practice, which produces the atlas, reported a puzzling finding: The prevalence of spine surgery in Casper, Wyoming, was nearly six times higher than it was in the Bronx, New York. Even more baffling, the rate in St. Cloud, Minnesota, was twice that of Rochester, Minnesota, the home of the Mayo Clinic, only 150 miles away.

Renowned orthopedic surgeon Dr. Timothy Kremchek had back surgery and talks about how he regrets it. He says he'd recommend nonsurgical spinal decompression before an injection or epidural because there is no downside.

The fact remains that surgery is big business that is often governed by greed. Although there are exceptions, most European and UK surgeons avoid the procedure, while US surgeons are quick to operate and fuse the spine. Oxford University Hospital's orthopedic surgeon Jeremy Fairbank stated, "I end up sending most of my patients with chronic pain to rehabilitation programs and, therefore, end up fusing a tiny number of highly motivated patients. If you have a spinal fusion operation, you are off work for four to eight weeks and sometimes longer. A rehab program takes one to three weeks." Lumbar spinal fusion is an operation with a bad reputation.

So what do we do? We change the paradigm. Let's face the facts. It is estimated that there is an 80% chance that every American will suffer back pain during their lifetime. Often governed by insurance companies, they go to their primary care provider. Their medical doctor will likely recommend over-the-counter pain medication or prescription medication to relieve the pain temporarily. Depending on the doctor's assessment and how he or she feels, the patient will respond, and the doctor may even consider the patient a candidate for an epidural or spine surgery. We now know this can often be a poor option.

Then there's nonsurgical spinal decompression and chiropractic care, which research and experience show are the safest, most effective options for most cases of back pain. Unfortunately, too many people end up in a medical doctor's office instead of a chiropractor's office, which accounts for the rampant use of medications and surgery for back pain, particularly in the US. That's why back surgery, and medical management of back pain in general, is too frequent, too costly, and too ineffective, and why chiropractic care should be the first option when dealing with back pain.

It is our job to tell the story and educate the masses. We reduce costs by reducing unnecessary surgeries. That is our job and our mission.



Dr. Eric S. Kaplan, is President of DISC Centers of America, the largest group of Chiropractic clinics in the U.S.A., utilizing Non-Surgical Spinal Decompression. He has worked with two Presidents of the United States and two U.S. Surgeon Generals. He is CEO of Concierge Coaches, www.conciergecoaches.com, the #1 Chiropractic firm in Spinal Decompression and Neuropathy training nationwide.