Original Research Article

Role of caudal epidural steroid injections in the management of chronic low backache

Sanjeev Sreen¹, Girish Sahni¹*, Sanjeev Arora¹, Arvind Kumar¹, Deepak ¹

¹Dept. of Orthopaedics, Govt Medical College, Patiala, Punjab, India

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ABSTRACT

Introduction: Back pain especially in lumbar region has increased to epidemic proportions in general population. It may have associated radiculopathy. Conservative treatment is mainstay treatment for all eviating pain and radiculopathy. A dependable alternative is epidural steroid injection given in multiple doses.

Materials and Methods: 50 Patients were treated with caudal epidural steroid injection for chronic low backache of more than three months at our institute. They were evaluated clinically before and after epidural steroid on the basis of pain, unrestricted activities of day to day life and work performance on the basis of visual analogue scale and Oswestry disability index.

Results: Patients were followed for one year. They were categorized into excellent, good, fair and poor on the basis of pain alleviation and capability to work. We reported excellent 13, good 15, fair 12 and 10 poor results. Three patients required surgery for disc prolapse. Only complication reported was pain at epidural injection region.

Conclusion: Epidural steroids are slowly proving to be a reliable alternative for all eviating pain and radiculopathy for a short term. It provides significant symptom free time for patients to receive physiotherapy that is crucial for early and adequate rehabilitation.

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1. Introduction

Incidence of pain in lumbar region or low back pain (LBP) seems to threaten to rise to epidemic proportions while calculating frequency of patients reporting to orthopaedic departments and those seeking pain reliefs in day to day practice. In many cases, LBP is associated with sciatica. Lumbar disc herniation, degenerative disc disease, lumbar canal stenosis, facet arthropathy and idiopathic pain are common causes of chronic LBP. A detailed history and general physical examination can provide a valuable information regarding etiology of pain. Observation of gait and posture, range of motion of spine, palpation of spine, heel to toe walk, squat and rise, straight leg raising test (SLR), superficial and deep reflexes, motor and sensory testing are often sufficient to rule out any serious condition that requires immediate further evaluation and intervention. The possibility of referred pain from other organ systems must be kept in mind.

Low back pain when treated by irregular medication, inadequate rest and lack of exercises accelerates towards a chronic phase. Various researches have attributed chronic LBP to internal disc disruptions in lumbar region. In a study by Verrills P et al.,¹ discogenic pain prevalence has been reported as 21.8% by lumbar discography. Plan of treatment should be reassessed if there is no significant improvement in symptoms after 4 to 6 weeks. Epidural steroids are commonly used in intervention al management for pain in many countries including United States.²

First published report of injection of steroids into arthritic joints was in 1951 by Hollander et al.³ Steroids were first used in treatment of lumbar radiculopathy in 1950s and 1960s.⁴ When epidural steroid administration was found to be effective for management of sciatica, it was adapted...
for other types of neural blockade that included facet joint blocks.\textsuperscript{5,6}

Methylprednisolone acetate, triamcinolone diacetate and triamcinolone acetonide etc. have been used for neural blockade for pain management. Concerns regarding steroid toxicity to nerves originate from potential toxicity by multiple chemical entities like polyethelene glycol, benzyl alcohol etc. used in epidural steroid injections. Epidural steroid injections (ESI) provide a significant pain free period for patients to undergo rehabilitation and hence an early recovery to work. Surgical treatment is offered to patients not responding to conservative methods or in patients with worsening neurological deficits.

The aim of this study was to evaluate the functional outcomes in cases of chronic low back ache of more than three months managed by caudal epidural steroid injections at department of orthopaedics, government medical college Patiala.

1.1. Method of caudal epidural injection

We treated 50 cases of LBP with caudal epidural steroids under sterile conditions in operating room under guidance of fluoroscopic control that fulfilled the required inclusion criteria and were not responding to other non surgical and non invasive methods.

Inclusion criteria were chronic low back pain patients with sensory symptoms not responding to conservative management. Exclusion criteria were prior lumbar disc surgery and any motor deficit. Patients were thoroughly examined and routine investigations done.

1.2. Dose formulation

Methyleprednisolone-80 mg, bupivacane 0.5% (6ml), normal saline 32 ml

Patient was put in prone position with a pillow under pubic symphysis. Area of skin over sacral hiatus was infiltrated with 1\% lignocaine. After piercing sacrococcygeal ligament, an 18 gauge Tuohy needle was introduced into sacral canal through sacral hiatus route. Accurate placement of epidural injection needle was confirmed by lateral view of c arm image intensifier and ESI dose was given.

We noted the pain scores on visual analogue scale (VAS) and Oswestry disability index (ODI) to evaluate the results after caudal ESI. Cases were evaluated as per their ability to perform activities and their ability to return to work before and after the administration of ESI. A total of three epidual doses were given. Second dose was given after a gap of three weeks to patients with insignificant / no pain relief. Third dose was given only in patients not achieving any pain relief after three months. Further follow up in cluded evaluation of VAS and ODI after a periodical gap of three months regularly up to one year. Cases were categorized...
as per excellent, good, fair and poor depending upon pre
decided criteria of pain relief and activity levels as per VAS
and ODI scores.

2. Results

Following step by step outline for performing this
interventional procedure, using high quality fluoroscopic
equipment we made following observations-

1. Total 75 doses of caudal epidural steroids were used in
50 patients.
2. Age of cases varied from 21 to 64 years (mean age 38
year).
3. Number of males was 24 and females 26.
4. 60% of all cases received symptomatic partial pain
relief after first dose within next two days while others
in three weeks.
5. Average duration of pain relief was 42 days (range 12
days to one year).
6. All patients were evaluated by radiological examination
by x rays to rule out any significant or concurrent
abnormality.
7. Further evaluation by magnetic resonance imaging
was done for thirty five cases which showed single
or multiple level lumbar discs prolapsed for 15 cases,
degenerative disc disease in 10 cases and mild to
moderate lumbar canal stenosis in 7 cases.
8. We did not observe any major complication during or
after the procedure.

Table 1: Showing number of epidural doses given

<table>
<thead>
<tr>
<th>Number of patients</th>
<th>Number of ESI doses</th>
<th>Total doses</th>
</tr>
</thead>
<tbody>
<tr>
<td>30</td>
<td>01</td>
<td>30</td>
</tr>
<tr>
<td>15</td>
<td>02</td>
<td>30</td>
</tr>
<tr>
<td>05</td>
<td>03</td>
<td>15</td>
</tr>
</tbody>
</table>

Total 75 ESI were given to fifty patients. Thirty patients
were given single injection, while 15 had two and 5 received
three.

Table 2: Showing sex distribution of cases of ESI

<table>
<thead>
<tr>
<th>Sex of patient</th>
<th>Number of cases</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>24</td>
<td>48</td>
</tr>
<tr>
<td>Females</td>
<td>26</td>
<td>52</td>
</tr>
</tbody>
</table>

We included total 50 cases in this study, 24 were males
and 26 females with chronic LBP.

Out of 50 cases of LBP, Lumbar disc herniation was
seen in 15, lumbar canal stenosis in 7 and degenerative disc
disease in 10 cases while 18 cases had non-specific LBP.

2.1. Follow Up

Follow up was done at one week, three weeks and then every
three months up to twelve months of treatment (post third
ESI 9 months).

Table 3: Showing causes of LBP

<table>
<thead>
<tr>
<th>Cause</th>
<th>Number of cases</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non specific</td>
<td>18</td>
<td>36</td>
</tr>
<tr>
<td>Lumbar disc herniation</td>
<td>15</td>
<td>30</td>
</tr>
<tr>
<td>Lumbar canal stenosis</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>Degenerative disc disease</td>
<td>10</td>
<td>20</td>
</tr>
</tbody>
</table>

Mean pre ESI, VAS was 6.92 while it was 4.62 at twelve
months of treatment.

Table 4: Showing mean VAS score

<table>
<thead>
<tr>
<th>Time interval</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre injection</td>
<td>6.92 (1.19)</td>
</tr>
<tr>
<td>At one week</td>
<td>3.84 (0.77)</td>
</tr>
<tr>
<td>At three weeks</td>
<td>3.64 (0.75)</td>
</tr>
<tr>
<td>At three months</td>
<td>3.92 (0.75)</td>
</tr>
<tr>
<td>At six months</td>
<td>4.13 (0.78)</td>
</tr>
<tr>
<td>At nine months</td>
<td>4.41 (0.88)</td>
</tr>
<tr>
<td>At twelve months</td>
<td>4.62 (0.72)</td>
</tr>
</tbody>
</table>

Mean pre ESI, ODI score was 59.2 while after twelve
months of treatment with ESI it was 44.67

Table 5: Showing ODI score (percentage)

<table>
<thead>
<tr>
<th>Time interval</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre injection</td>
<td>59.2</td>
<td>7.54</td>
</tr>
<tr>
<td>At one week</td>
<td>26.01</td>
<td>4.40</td>
</tr>
<tr>
<td>At three weeks</td>
<td>25.35</td>
<td>3.66</td>
</tr>
<tr>
<td>At three months</td>
<td>24.57</td>
<td>2.78</td>
</tr>
<tr>
<td>At six months</td>
<td>23.01</td>
<td>4.40</td>
</tr>
<tr>
<td>At nine months</td>
<td>41.29</td>
<td>7.53</td>
</tr>
<tr>
<td>At twelve months</td>
<td>44.67</td>
<td>7.48</td>
</tr>
</tbody>
</table>

3. Results

We obtained excellent results in 26 percent, good in 30
percent, fair in 24 percent while poor in 20 percent patients.
4. Discussion

Back pain especially in lumbar region has become a routine problem due to faulty postures, lack of exercises, and excessive burden on spine with or without history of minor to moderate trauma. Prolonged use of analgesics is neither advisable nor beneficial. Lumbar tractions, various physiotherapy techniques, manipulations, all have been used for LBP but with inconsistent results. Surgical interventions are recommended for incessant cases or with a deteriorating neurological status only. With such a limited armamentarium, there are a big number of unsatisfied / unrelieved patients of LBP visiting various orthopaedic departments.

Epidural steroid injections can be used by caudal, interlaminar or transforaminal approaches. Robechi and Capra, (1952) and Lievre (1953) described use of ESI by transforaminal route while use of corticosteroids by caudal epidural space was reported in 1957 by Cappio. We used caudal epidural technique and found satisfying results.

Corticosteroids exert both anti inflammatory and immunosuppressive effects. These have various modes of action like membrane stabilization and inhibition of neural peptide synthesis.

Panayiotis JP et al (2001) conducted a study on treatment of lumbosacral radicular pain with epidural steroid injections. They concluded that 68% of patients were asymptomatic, 20% had no change in pre injection radicular symptoms, and 12% had various degrees of pain relief.

Peng et al (2007) observed in a study over 42 patients that leakage of chemical mediators or inflammatory cytokines produced in a painful disc into epidural space through annular tear could lead to injury to adjacent nerve roots and might constitute the primary pathophysiological mechanism of radiating leg pain in patients with discogenic low back pain but with no disc herniation.

Ackerman et al (2007) documented change of pain score and functional score only after 2 weeks of treatment with ESI and followed cases up to 24 weeks. We could obtain comparable results after second ESI at three weeks. In a meta-analysis study, Choi H J et al (2013) studied long term benefits of epidural steroids in LBP in terms of pain, disability and subsequent surgery. There study suggested benefits for less than six months only. We achieved short term benefits of pain relief for 9 to 12 months after caudal ESI.

In a systemic review by Jun L et al (2016) for comparing effectiveness of transforaminal versus caudal ESI for managing lumbosacral radicular pain, the outcomes and clinical significance of 6 prospective studies were summarized. They found both transforaminal and caudal ESI to be similarly effective. Transforaminal ESI was more effective for pain over duration of less than six months and caudal ESI exhibited better impact on both pain and functionality over a longer period (12 months). The current study obtained significant pain relief by caudal route in 80 percent cases over a period of three months and moderate relief in 56 percent cases over twelve months. Only three patients required further surgery as they were not relieved of pain and radicular symptoms even after two ESI. Singh H et al (2018) concluded that better results can be obtained with caudal ESI in patients presenting earlier.

ESI should not be given to antenatal patients (due to fluoroscopy exposure), cases with any bleeding disorder, any local or systemic infections. These should be avoided in patients with allergy to local anaesthetic agents and patients with congestive cardiac failure and diabetes mellitus. Corticosteroids may cause adrenal dysfunction and suppression of hypothalamic – pituitary axis suppression in larger doses. Though Dural puncture (0.5 to 5%), bacterial meningitis, aseptic meningitis and epidural abscess have been reported with use of ESI .we reported complication of pain at the ESI site only in 4 patients. This was managed with conservative means.

5. Conclusion

ESI can be used as alternate method of treatment to patients with chronic LBP not responding to other conventional non surgical methods of treatment. They may reduce the need of subsequent surgeries. Caudal ESI can be given easily and are a day care procedure only. When done under adequate aseptic conditions and a good quality fluoroscope, caudal ESI are a relatively safe procedure in experienced hands in carefully selected cases.

6. Source of Funding
None.

7. Conflict of Interest
None.

8. Consent of Patients
Taken

9. Ethical committee approval
Taken

References

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**Author biography**

**Sanjeev Sreen** Associate Professor

**Girish Sahni** Associate Professor

**Sanjeev Arora** Senior Resident

**Arvind Kumar** Associate Professor

**Deepak** Junior Resident

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