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Interventional Question 1. In patients with low back pain, do fluoroscopically-guided epidural steroid injections decrease the duration of pain, decrease the intensity of pain, increase the functional outcomes of treatment and improve the return-to-work rate?

There is insufficient evidence to make a recommendation for or against the use of caudal epidural steroid injections in patients with low back pain.

Grade of Recommendation: I

Southern et al¹ investigated the efficacy of fluoroscopic caudal epidural steroid injections for the treatment of chronic lumbar discogenic pain. Patients with chronic low back pain (LBP) with evidence of disc pathology without stenosis (n=97) received at least one fluoroscopically-guided caudal epidural injection with 12 mg of betamethasone and 8 cc of 0.5% lidocaine. Disability (Roland Morris Disability Questionnaire, RMDQ), pain (Visual Numeric Pain Scale, VNS) and patient satisfaction (North American Spine Society, NASS, patient satisfaction questionnaire) were assessed before and after the injection. Eighty-four patients were included in follow-up analysis. Patients were classified as procedure failure (if a discography

and/or surgery was needed after injection) or success (score of 1-2 on NASS patient satisfaction, >50% reduction in VNS and >2-point change in RMDQ score). After at least one year, 19 patients were classified as successes and 65 as failures. Patient satisfaction was 45%. The patients classified as successes had significantly lower baseline pain scores. The authors concluded that patient satisfaction exceeds reported rate of efficacy of fluoroscopically-guided caudal epidural steroid injections in patients with chronic lumbar discogenic pain. This study provides Level IV evidence that roughly 20% of patients with chronic discogenic LBP will experience at least 50% reduction in pain following caudal epidural steroid injections.

158 Recommendations were developed based on a specific definition, inclusion/exclusion criteria, and the resulting literature which excluded conditions such as presence of a neurological deficit or leg pain experienced below the knee, among others. Given the **exclusion criteria**, these guideline recommendations address a subset of low back pain care as opposed to low back pain in its entirety. This clinical guideline is not intended to be a fixed treatment protocol; it is anticipated that there will be patients who require more or less treatment than what is outlined. This clinical guideline should not be construed as including all proper methods of care or excluding other acceptable methods of care reasonably directed to obtaining the same results. The ultimate judgment regarding any specific procedure or treatment is to be made by the physician and patient in light of all circumstances presented by the patient and the needs and resources particular to the locality or institution.