THE
PRINCESS GRACE
HOSPITAL

# Spinal Injections
## What to expect

# Background

Pain in the spine may be generated from the discs, joints (facet joints), the small nerves that supply these two structures, and the associated muscles around the spine; which may themselves go into spasm. The mechanism whereby problems in these tissues cause pain is complex, though often relates in large part to inflammation developing within the structures.

Many patients suffer from neck pain, back pain, sciatica and other spine related pains. In the vast majority these result from changes of "wear and tear" or "osteoarthritis" arising in the discs and joints of the spine. They may cause pressure on the nerves passing to the limbs and in those circumstances pains in the limbs may arise. When this affects the arms it is called "brachalgia" and when it affects the legs it is called "sciatica".

There are principally two mechanisms where pain may arise from the spine:

Directly as a result of mechanical irritation of the small nerves supplying the worn joints and discs

As a result of inflammation in the worn joints and discs exciting the nerves

Limb pain, either in the arm or leg, may arise from the nerves that pass by these joints and discs on their way to the leg – again these nerves may be excited into causing pain by direct mechanical pressure or inflammation.

Obviously, worn joints and discs are susceptible to inflammation and thus very frequently there is a combination of both mechanical and inflammatory mechanisms at play.

# The most common type of injection

Patients with low back pain and/or sciatica undergoing these injections have steroid infiltrations into the lumbar spine either targeted at the facet joints or epidural space, or perhaps both. Patients with neck pain and/or brachalgia have steroid infiltrations into the cervical spine targeted at the facet joints.

The steroid injection is a very powerful anti-inflammatory drug that may bring the inflammation surrounding the nerves under control, thus easing the pain. Often, the steroid will be injected in a solution with local anaesthetic to cover the pain of the injection.

For the majority, the aim is to provide a pain-free window that enables them to make progress with the appropriate conservative regime of exercise and physiotherapy.

# The aim of the injection

The injections can be used in two forms

## Diagnostic

This involves placing injections of steroid into the facet joints or epidural space (or both). The aim here is to determine whether or not the given targets are responsible for the generation of pain. It is of use when the MRI scan shows changes at many levels and the responsible one has yet to be identified.

It can also be used when changes are seen in the lumbar spine on the MRI scan though the symptoms are not typical and concern remains as to whether the changes are responsible for the symptoms.

## Therapeutic

Steroid injections may bring acute attacks of pain to a close. The likelihood that they will bring to a close an episode of pain (back pain or sciatica) that would not resolve otherwise is low.

A very common aim of the injections is to provide a period of pain relief. This "pain-free window" may be used to develop an exercise regime sufficient to maintain the improvement.

# What happens during the procedure?

The procedure is carried out under local anaesthetic, heavy sedation or light general anaesthetic, which is administered to you by a consultant anaesthetist. Once you are sufficiently prepared for the procedure to be carried out without lasting discomfort, a needle is passed into the spinal canal to lie outside the sac containing the nerves and spinal fluid. Once the needle is satisfactorily positioned, a combination of local anaesthetic and steroid is injected into the spine.

Following the procedure you will be taken to the recovery area in theatres and from there to the ward. After the procedure your arms or legs may feel heavy or tingling and you are likely to feel sleepy. You will be expected to remain and rest in bed for at least an hour after the procedure. For a short time you will have your blood pressure and heart rate monitored at regular intervals. Once you are more awake you will be offered something to eat and drink. Later the same day you will usually be able to go home.

Most patients go home a few hours after the procedure is performed when the sedation has fully worn off. On occasions, if you have a long journey or an existing medical condition which makes day-case treatment difficult, you may wish to stay overnight. This can always be pre-booked. In addition, if unexpectedly you do not feel well enough to go home, we are happy to look after you overnight whilst matters settle.

Under normal circumstances, when the nurses are happy that you have recovered adequately, you are able to leave without further review by your consultant.

## How do I get home?

It is important that somebody comes to collect you.

You may not drive home the same day as having the injections/sedation.

When you get home you are advised to rest and get a good night's sleep. Do not attempt to drive a vehicle, cook, or go to work.

# Risks of the procedure

The procedure is safe and very seldom does it cause any lasting complication.

For female patients, it is vital that you are absolutely certain that you are not pregnant. If there is the smallest chance of this, you must not proceed. The procedure is carried out with x-rays. These will, to some degree, cover the area where the foetus lies, i.e. it too will be exposed to radiation. In addition, there are the potentially harmful effects of the drugs on the foetus.

Female patients may also experience a day or two of minor intermittent bleeding following the procedure. Sometimes females may miss a period or have intermittent bleeding or heavier periods for a few weeks. These effects are temporary.

Some patients experience hot flushes and sweating for a few days - this is more common in post-menopausal women.

Diabetic patients must take special care. The steroid in the injection can disturb your normal diabetic control. It is likely to do so to a mild degree for a day or so. The sugars will tend to run high. You will need to discuss this with your consultant, the anaesthetist and perhaps your diabetic team.

As with any invasive procedure there is a small risk of infection.
There is also a small possibility for the epidural needle to nick the dura (the covering of the spinal cord). Should this occur there could be leakage of cerebrospinal fluid, which could cause a severe "spinal headache". If this should happen, bed rest and an increase in fluid and caffeine intake will frequently alleviate the headache completely.

You will have an opportunity to discuss these issues again with your consultant when the written consent is obtained at the time of your admission. It is very important that you are not unclear in any way about what you are taking on.

If you have any allergies to contrast materials such as iodine or allergic reactions to the preservatives in steroid preparations (given previously in other joints) please inform your consultant before the procedure.

# Results and Follow-up

## What result should I expect after discharge?

Many patients report a temporary exacerbation in their pain, usually 24-48 hours after the procedure. This normally resolves briskly with rest and pain relieving medication.

The sought after improvement will usually not arise until three or four days after the injections and it often may take as long as 2-3 weeks for nerve inflammation to settle. However, these patterns vary by quite a number of days.

## What follow-up will I receive?

You will normally have a follow-up appointment arranged with your consultant for 2-6 weeks after the injections. By this time a response should have occurred if it is going to.

If improvement has arisen a physical therapy regime will be recommended.

What do I do in the event of problems?

Should problems arise after discharge from hospital, help is available from a number of sources.

Firstly, you may wish to contact your consultant's office.

Alternatively, you may telephone the hospital and ask to speak to the Spinal Nurse Specialist. In her absence and out of hours you should ask to speak to the hospital's Duty Manager in charge.

You may, of course, contact your General Practitioner or any emergency service should you so wish.

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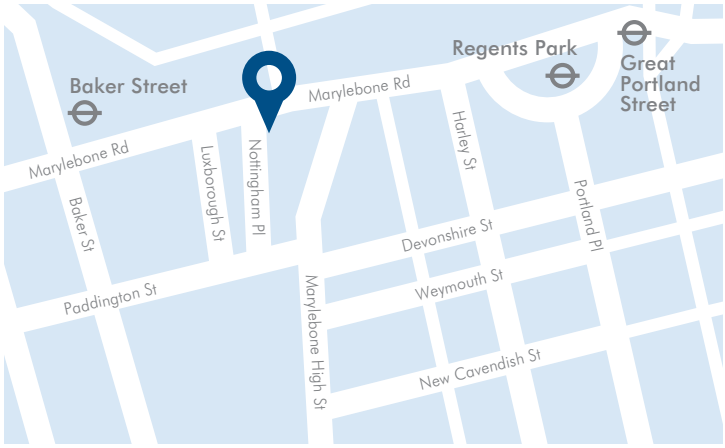


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