



## FACT SHEET SCIATICA

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### Tests:

- Plain x-rays are helpful primarily in ruling out causes of pain such as tumour, infection or fracture.
- The x-ray will usually show degenerative changes. These aging changes are also seen in asymptomatic individuals. In order to be considered significant, the x-ray findings must correlate closely with the symptoms and physical exam.
- If mechanical instability is suspected as a cause of recurrent pain, it can be documented by x-rays taken with the lumbar spine bending forward (flexion) and backward (extension).
- Until recently, myelography was considered the best way to diagnose a herniated lumbar disc. Today, myelography can often be replaced by CT or MRI.
- Asymptomatic 'normal' individuals frequently have asymptomatic herniations on MRI or CT scan, so the findings on an imaging study must correlate exactly with the clinical nerve root syndrome to be meaningful.
- Electromyography may be useful in distinguishing a nerve root lesion from a peripheral nerve lesion (such as of the sciatic or peroneal nerve).

### How is it Treated?

- An estimated 80% to 90% of lumbar disc herniations improve without surgery. As many as 20% of individuals recover completely, while another 60% to 70% are sufficiently improved to be able to live with their remaining pain.
- Surgery has a high failure rate if individuals are not carefully selected.
- Conservative treatment should be tried first, except when there are signs of severe nerve compression.
- The individual is not confined to bed, but is instructed to avoid aggravating activities such as lifting, bending, twisting or prolonged sitting.
- For relief of pain and inflammation, nonsteroidal anti-inflammatory drugs (NSAIDs) may be given. If pain is severe, a mild narcotic may be added. Muscle relaxants are frequently prescribed, however, their effectiveness is due to their sedative action.
- Other treatments such as ice, heat, massage and ultrasound therapy may help relieve pain and muscle spasm.
- As symptoms subside, activity is gradually increased, including physical therapy and/or a home exercise program to strengthen the low back and abdominal muscles and improve aerobic capacity (walking)

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- The individual may attend physiotherapy to learn correct posture and body mechanics.
- Although some individuals may recover completely and permanently, recurrences are common. Therefore preventive and maintenance measures (exercise, proper body mechanics, firm bed, etc.) should be continued indefinitely.
- If there is no improvement after four to six weeks of treatment, further evaluation is necessary.
- Recurrent pain may be due to mechanical instability; if this cannot be managed conservatively by muscle strengthening, good body mechanics, and/or bracing, it is an indication for surgery (fusion).
- CT, MRI, and/or myelography should confirm a herniated disc at the appropriate level to account for the symptoms, before the individual may be considered a candidate for surgery (discectomy).
- Individuals who have persistent back pain as the predominant symptom usually do not benefit from surgery; these individuals may benefit from a pain clinic or rehabilitation program.
- The clearest indications for surgery are progressive muscle weakness (surgery should not be delayed); severe leg pain with objective signs of nerve root compression (nerve tension signs and/or loss of neurological function) not

improved by an adequate trial of conservative treatment, with an imaging study that correlates with the nerve root suspected of compression by clinical exam; recurrent episodes of severe leg pain with objective signs of nerve root compression and a matching defect on imaging studies; and recurrent pain due to proven (flexion-extension x-rays) mechanical instability that cannot be managed conservatively (this is an indication for fusion).

- Bedrest for a few days may be necessary but prolonged bed rest delays recovery.
- Smoking delays recovery, smoking cessation should be considered

### ***What is the Predicated Outcome?***

Most individuals recover in six months or less. Therapy and bed rest may help symptoms, but they do not change the outcome.

### ***What are the Work Restrictions and Accommodations?***

- During the early post-operative stage, sitting must be restricted to no more than 45 to 60 minute intervals with frequent rest periods, which include walking and resting flat. These limits most often begin four to six weeks after surgery.
- Immediately after surgery, sitting (including toilet time) is usually limited to fifteen minutes. These restrictions usually prevent an early return to sedentary jobs unless accommodations are made with these considerations in mind.

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- Activities that require lifting, carrying, stooping and twisting may need to be decreased.
- Job modification may be necessary to avoid heavy lifting, prolonged exposure to vibration, or other activities that promote disc injury.

***What are the Common Precriptions?***

- Anti-inflammatories
- Analgesics
- Possibly mild narcotics initially
- Muscle relaxants
- Steroids
- Possibly narcotics within the first 1-2 weeks post surgery.