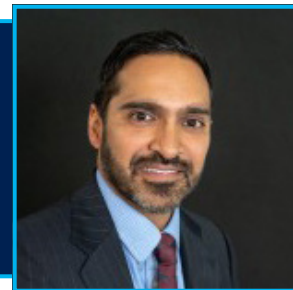


Treating lumbar spinal stenosis: When do you move on from ESIs?

A discussion with Dr. Harry Sukumaran



Q: You recently authored an abstract that examined patients' pain response after the *mild* Procedure, based on the number of epidural steroid injections (ESIs) they received prior. First, what is the *mild* Procedure?

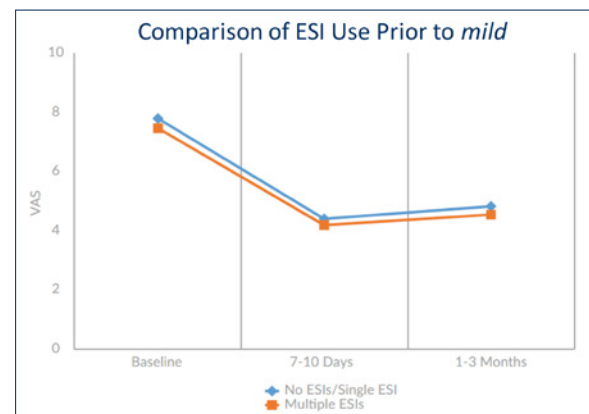
Dr. Sukumaran: *mild* is a technique in which we debulk the hypertrophic ligamentum flavum (HLF), increasing the canal diameter and giving patients a minimally invasive decompression. The patient who is a candidate for the *mild* Procedure has signs and symptoms consistent with lumbar spinal stenosis (LSS) with neurogenic claudication, meaning the patient has discomfort with standing and walking for extended periods of time. They tend to get relief being in a flexed position, using a shopping cart, or sitting/lying down.

Q: What makes *mild* different than the other treatment options typically used to treat LSS?

Dr. Sukumaran: Until *mild* entered my practice, the number one procedure that we did to alleviate the symptoms of LSS was an ESI. Typically, patients do well with the injections, but they experience declining efficacy over time as the stenosis would progress. The reason why I now place *mild* so early in my treatment algorithm is that it's as safe as an ESI, it is minimally invasive, and there are no postoperative restrictions. There really is no downside to having this procedure moved up early in the treatment algorithm. If they've haven't had an epidural, I typically do one first for procedure planning. If they've had epidurals in the past, I move straight to *mild*.

Q: How does your recent research change the way you and other Interventionalists treat LSS?

Dr. Sukumaran: The abstract shows that regardless of the number of ESIs that a patient has, whether it's one or multiple, the long-term pain relief after *mild* isn't any different. This has changed my practice significantly; I may offer them an ESI, but I move to *mild* pretty quickly and the discussion that we have is more about durable, long-term pain relief. It's really changed how I practice.

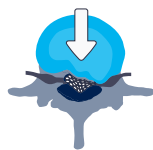


Q: Why aren't ESIs the most effective option for treating neurogenic claudication?

Dr. Sukumaran: It goes back to the pathology. If a patient has disc bulges, hypertrophic facet joints, and HLF, those are all fixed pathologies. Decreasing inflammation with an ESI isn't going to decrease the HLF, and it's not going to decrease the size of the facet joint. An ESI isn't going to have sustained long-term benefit for the patient. What they really need is to be decompressed. And *mild* really allows us to achieve that.



Multiple ESIs
Do Not Improve
mild Outcomes



Decompression
Required to
Treat Stenosis¹



Don't Delay
Patient Care

MOVE2*mild*

Q: Who is the ideal candidate for *mild*?

Dr. Sukumaran: As studies have shown us (as well as my own personal experience), patients that have multiple comorbidities do just as well with *mild* as those who don't. The reason being that LSS is really a constellation of conditions. Circumferential stenosis is often made up of HLF, hypertrophic facets, disc bulge, etc. In my experience, when we debulk that ligament and give more space, most of those patients do quite well.

Q: How does your practice look at treating pain vs. function?

Dr. Sukumaran: If we can get somebody to function better, and we can get them to do the things that give them enjoyment, I think pain relief comes along with that. The number one complaint I have from patients that suffer from LSS is they can't do the things that they used to enjoy in life; they no longer engage in life. Functional restoration is at the forefront when it comes to treating patients with LSS. My joy comes from the patient returning at the two-or four-week mark and saying, "My life is much better, I'm not sure why I didn't do this earlier."

1. Fukusaki, M, et al. Symptoms of Spinal Stenosis Do Not Improve After Epidural Steroid Injection.

