About 25% of patients with low-grade spondylolisthesis don't respond to any type of nonsurgical treatments. Patients in whom symptoms become intolerable and interfere with their daily function, patients suffering a progressive course and patients with a neurological deficit are candidates of surgery.

The commonly used accepted technique to reconstruct the affected segment is pedicle screw instrumentation but the procedure of choice for surgery is a field of conflict.

Posterolateral fusion (PLF) and posterior lumbar interbody fusion (PLIF) are of widely accepted fusion techniques. PLIF was firstly introduced by Cloward in 1940. Some of the studies have represented the PLIF as the superior technique, but comparable results of both techniques have shown by other trials.

In a surgical candidate patient with spondylolisthesis, the aim of treatment is obviously to make the patient capable of getting back to normal life.

The goal of this study was to compare the two common techniques of fusion in terms of decreasing the disability.
in patients with low-grade degenerative and isthmic spondylolisthesis.

**Methods**

This prospective study involved 102 patients with isthmic and degenerative spondylolisthesis of low grade who admitted to Neurosurgical Department of Poursina Hospital, Guilan, Iran between 2012 and 2014. Based on the day patients visited the clinic, they were randomly assigned into two different groups. Group A included 51 patients in whom the used fusion technique was PLF and Group B composed of 51 patients who were operated on with PLIF. Pedicle screw fixation was the applied technique for reconstruction of the affected segment in both groups. Surgeries were carried out by a single team consisted of an associate professor of neurosurgery, an assistant professor of neurosurgery and a neurosurgical resident of the Guilan University of Medical Science (GUMS).

**Inclusion criteria**

patients with the diagnosis of degenerative and isthmic type spondylolisthesis of Grade 1 and 2 who failed to respond to conservative therapy and age between 18 and 75. Patients who reported any prior spinal surgery for spondylolisthesis or had a history of alcohol abuse and patients with an inadequate disk space for performing PLIF were excluded. This study was approved by Ethical Committee of GUMS, and all patients signed a consent form.

On admission, a questionnaire containing ODI was completed by the patient under supervision of a resident of neurosurgery.

In the operation room, all patients were positioned prone. After a midline incision and complete bony exposure, subperiostal dissection continued till transverse processes were exposed. Decompressive procedure was done thorough laminectomy, medial facetectomy and extensive foraminotomy. Then after pedicle screw fixation, in PLF Group (A), PLF was done by autografting with bone chips and in PLIF Group (B), after a complete discectomy, lumbar interbody fusion was done by polyetheretherketone cages. A brace was prescribed for 3 months and then was tapered off if fusion was achieved.

All the patients were informed of a scheduled follow-up program explained by residents and they were asked to complete the same questionnaire using Oswestry Disability Index (ODI) in the day after surgery, after 6 months and after 1-year.

Statistical analysis was performed using repeated measure ANOVA with post hoc tests (Bonferroni method) of IBM SPSS statistics version 21. All of the tests were two-tailed and a $P < 0.05$ was considered to be statistically significant.

**Results**

A total of 102 patients with low-grade spondylolisthesis of isthmic and degenerative type were enrolled in our study; including 51 patients in Group A (PLF) and 51 patients in Group B (PLIF). A summary of demographic features has shown in Table 1. The basic demographic features such as sex and age did not differ significantly, but the distribution of types of spondylolisthesis showed a significant difference between two groups ($P = 0.025$).

The mean values of ODIs before surgery, the day after surgery, 6 months and 1-year after surgery showed no significant difference between the groups [Table 2].

Analyzing the course of ODIs over the study period using repeated measure ANOVA, both groups followed a descending pattern that was statistically significant for both of them ($P < 0.0001$) [Table 3 and Figure 1]. Comparison of the mean ODIs of two groups over the whole period of study, using an adjustment for multiple comparisons (Bonferroni test) did not show a significant statistical difference ($P = 0.074$). It has been demonstrated that the mean value of ODIs was insignificantly lower in Group B (difference of the mean values of ODIs: 5.03 ± 2.77; 95% confidence interval: −0.49–10.55) [Table 4].

For each group, mean values of ODIs before surgery represented a significant difference compared to the value of 6 months later and 1-year after surgery ($P < 0.001$ for both groups). Other comparisons of mean values of ODIs at different points in time has been illustrated in Table 5.

The interaction of sex and age with the courses of mean values of ODIs during the study period has been displayed in Figures 2-6. Analyzing the interactions using two-ways ANOVA reviled no effect of gender and age on the course of ODIs related to two methods of surgery ($P = 0.620$ and $P = 0.079$, respectively).

**Discussion**

In our study, both methods of fusion resulted in a remarkable decrease of ODIs after 1-year of follow-up. Compared with PLF group, PLIF group reported a less degree of disability that was not of statistical significance.

| Table 1: Basic characteristic features of the study population |
|-----------------|-----------------|-----------------|
| Variable        | Groups          | $P$             |
| Age             | A               | B               | 0.250 |
| Gender (%)      | Male            | Female          | 0.836 |
|                 | 17.8            | 19.5            |       |
|                 | 82.2            | 80.5            |       |
| Type of spondylolisthesis (%) | Degenerative I | Isthmic I | 0.025 |
|                 | 53.3            | 15.6            |       |
|                 | 24.4            | 14.6            |       |
|                 | 11.1            | 14.6            |       |
|                 | 20.0            | 46.3            |       |
Measuring and comparing the disability index between two groups at four points in time showed no significant differences between them and the mean value of ODIs related to PLIF group did not differ significantly with the
PLF group during the whole period of study. The effect of fusion techniques on ODIs in age and sex groups was similar [Figure 2].

In the Ekman et al. study on a population of 163 patients with isthmic spondylolisthesis in 2007, a significant decrease of disability was reported after 2 years of follow-up. Unlike our study they used Disability Rating Index (DRI) to determine disability and to compare it between groups. DRI had a significant reduction from preoperative period to 2 years after surgery, but they find no significant difference in disability between groups at any time interval.[16]

Cheng et al. conducted a study in 2008 that was performed prospectively on 138 patients with spondylolisthesis; they didn’t find any statistical significant difference in the results of the Oswestry scores in a 4 years follow-up ($P = 0.041$).[14]

In 2010, Barbanti Bròdano et al. in their study on 71 patients with low-grade isthmic spondylolisthesis showed that both PLF and PLF techniques had an acceptable clinical outcome, but without statistically significant differences ($P > 0.05$). They assessed clinical outcome and to define it, what they used was ODI, Roland Morris Disability Questionnaire, visual analog scale (leg score and back score), persistent low back pain and persistent sciatica.[21] Unlike our study, they did not assess the disability of patients separately.

Three years later in a meta-analysis by Ye et al., they used random effect model of analysis in order to assess the improvement of ODI. They revealed that after surgery, pooled difference in mean ODI reduction was not significantly different in functional activity when comparing two groups.[19]
In a recent study on 50 patients with lumbar isthmic spondylolisthesis, Habib also used ODI to study disability. Unlike what we found, they demonstrated a significant better long term ODI in PLIF group. A follow-up program of 18 months was scheduled for patients.12

Because lessening the disability and turning patients back to their normal lives is an important target in managing these patients, our findings can be helpful in choosing the better surgical approach.

Finally, we have to mention some of the limitations of our study. The two groups were not matched in terms of the type of spondylolisthesis. The level of spondylolisthesis was not considered in this study. We can't easily introduce PLF and PLIF the same methods in terms of outcome because of the small sample size, short duration of follow-up, low statistical power and variance of spondylolisthesis type and level distribution which acts as a confounder.

Randomization and enrolling age and sex-matched groups in a multidisciplinary follow-up program was strength of this study.

Despite the large number of trials in this field, the fusion method of choice for spondylolisthesis remains as a field of conflict.

Higher-quality observational studies with high power and long term follow-up is required to assess the comparative effectiveness of two techniques.

The substantial reduction of disability resulted by both of techniques was noteworthy in this study.

References


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