

## COMMENTARY

Commentary on Article 124\_15, Elnaz Farajirad, Hadi Tohidi, Mohammad Farajirad, *Asian J Neurosurg* 2016 (3);287-291.

## Psychiatric disorders in low backache patients: A neurosurgeon's nightmare!!!

Low backache (LBA) with negative imaging findings is perhaps one of the most frustrating diagnoses, which a neurosurgeon makes among a heavy load of patients in his outpatient clinic. Recently, the burden of LBA on neurosurgical clinics have shown an upward trend secondary to an actual increase in lumbar spine diseases due to stressful lifestyle and poor back protection measures. However, it is imperative not to forget about the other confounding factors associated with LBA, which can include psychological, somatic, functional, substance abuse, financial, or litigation considerations. Many times it becomes difficult for the physician to place the patients in one particular etiology group as the many of them frequently overlap each other.

While analyzing an unpublished data from our own tertiary care hospital, we found that almost 60 LBA patients were seen in four consecutive outpatient clinics. The mean age was 42.8 years (range: 22–75 years). The female to male ratio was 1.4:1. All patients came with primary complaints of backache confined to the lumbar region as a primary symptom. Twenty-four patients also had radiation of pain to right lower limb while 20 had it on the left. Seven patients had bilateral radiation of pain. Magnetic resonance imaging (MRI) revealed diagnoses of lumbar disc disease in 16 patients, lumbar canal stenosis in four, and spondylolisthesis in eight patients. MRI was negative in 11 patients (26.8%). Thirteen patients only had X-rays with them initially, and the rest came without any imaging. Surgery was clearly indicated in 22 (54%) of the patients where MRI was available ( $n = 41$  patients). Rest 19 either had no neural compression or had equivocal imaging findings. Therefore the data from our clinic clearly shows that almost half the patients seen won't require any neurosurgical intervention. These patients are actually prone for developing psychiatric manifestations over the course of time owing to multiple revisits to the clinic without any satisfaction.

Furthermore, it is important to know that we have excluded those MRI negative patients who keep coming to our clinics even if nothing surgically can be done. Hence, how can we try to change the course of events? First and foremost, specialty spine clinics are the need of the hour. Second and more importantly, neurosurgeons should be able to screen these patients and should be able to classify these patients on the basis of etiology and here it becomes imperative to screen all these patients of

LBA without neural compression for the underlying psychiatric/psychological disorders. Many case studies have been published on this critical issue, but not in the neurosurgical literature. Hence, most of us often either neglect or are not even aware of the impact of psychological factors associated with LBA. Christensen *et al.* recently surveyed Danish population suffering from chronic LBA and compared their degree of mental stress as compared to general population.<sup>[1]</sup> They inferred that self-reported symptoms of somatization, anxiety, phobic anxiety, obsessive-compulsive, depression, and hostility are all more common among patients with low back pain compared to the general population. Similarly, literature also has evidence of the cognitive deficits caused by chronic LBA and moreover, getting worse after long-term opioid intake.<sup>[2]</sup> Single-photon emission computed tomography images have also revealed the brain blood flow alterations in the patients with LBA affecting the prefrontal cortex primarily.<sup>[3]</sup> Hence, we can for sure conclude that LBA is not restricted just to the back as chronic pain often leads to changes in its cerebral perception and which may also be indirectly related to the various psychiatric disorders.

Therefore, it is necessary to evaluate higher mental functions and psychological aspects of pain in patients with chronic symptoms and a negative MRI. A collaboration of neuro-psychiatric physicians should come in together and start working cohesively. This will surely bring down the number of revisits of such patients to our hospitals which will help in arriving at the correct diagnosis of psychiatric disorders relatively early in course, reduce the abuse of analgesics and inadvertently helps decongesting our clinics.

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