Do Cervical Epidural Injections Provide Long-Term Relief in Neck And Upper Extremity Pain? A Systematic Review

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Abstract

Summary of Background Data: The high prevalence of chronic persistent neck pain not only leads to disability but also has a significant economic, societal, and health impact. Among multiple modalities of treatments prescribed in the management of neck and upper extremity pain, surgical, interventional and conservative modalities have been described. Cervical epidural injections are also common modalities of treatments provided in managing neck and upper extremity pain. They are administered by either an interlaminar approach or transforaminal approach.

Objectives: To determine the long-term efficacy of cervical interlaminar and transforaminal epidural injections in the treatment of cervical disc herniation, spinal stenosis, discogenic pain without facet joint pain, and post-surgery syndrome.

Materials and Methods: The literature search was performed from 1966 to April 2014 utilizing data from PubMed, Cochrane Library, US National Guideline Clearinghouse, previous systematic reviews, and cross-references. The evidence was assessed based on best evidence synthesis with Level I to Level V.

Results: There were 7 manuscripts meeting inclusion criteria. Of these, 4 assessed the role of interlaminar epidural injections for managing disc herniation or radiculitis, and 3 assessed these injections for managing central spinal stenosis, discogenic pain with facet joint pain, and post surgery syndrome. There were 4 high quality manuscripts. A qualitative synthesis of evidence showed there is Level II evidence for each etiology category. The evidence is based on one relevant, high quality trial supporting the efficacy of cervical interlaminar epidural injections for each particular etiology. There were no randomized trials available assessing the efficacy of cervical transforaminal epidural injections.

Conclusion: This systematic review with qualitative best evidence synthesis shows Level II evidence for the efficacy of cervical interlaminar epidural injections with local anesthetic with or without steroids, based on at least one high-quality relevant randomized control trial in each category for disc herniation, discogenic pain without facet joint pain, central spinal stenosis, and post-surgery syndrome.

Keywords: Chronic neck pain; Cervical disc herniation; Cervical spinal stenosis; Cervical post-surgery syndrome; Cervical discogenic pain; Cervical epidural injections; Interlaminar epidural injections; Transforaminal epidural injections; Steroids; Local anesthetic

Introduction

Annual estimates of the prevalence of chronic neck pain in the general population of adults ranges from 12.1% to 71.5% with most estimates showing an annual prevalence between 30% and 50% with or without sprain or injury [1-7]. Côté et al. [7] described various grades of chronic neck pain with 5% of patients suffering from Grades III and IV neck pain, both of which are associated with high pain intensity and disability. Overall, they showed the prevalence and impact of neck pain on general health involving 15% of patients reporting Grade II-IV neck pain. Grade II has been defined as high pain intensity with few activity limitations [7]. Similar to low back pain, neck pain is associated with significant economic, societal, and health impact [8-11]. In fact, a report on the state of U.S. health from 1990-2010 describing the burden of diseases, injuries, and risk factors, showed low back pain as the number one disease leading to disability in 1990 and again in 2010, whereas neck pain ranked number 4 during the
same period. In addition, chronic pain as a result of motor vehicle injuries has been shown to be present in 24% to 50% of those involved in motor vehicle injuries [6,12,13].

Neck and upper extremity pain with headache have been shown to be caused by intervertebral discs, cervical facet joints, ligaments, fascia, muscles, and nerve root dura which are capable of transmitting pain. Even though cervical radicular pain receives the most attention [6,14-21], multiple other mechanisms have been described as being responsible for neck and upper extremity pain. Prevalence studies of various structures causing neck and upper extremity pain show an annual incidence of cervical radicular pain of 83 per 100,000 populations [17]. The prevalence of facet joint pain based on controlled diagnostic blocks in patients with neck pain is 36% to 67% [6,22], and 16% to 20% for cervical discogenic pain [23]. The pathogenesis of cervical radicular pain or discogenic pain has been linked to multiple chemicals including metalloproteinases, nitric oxide, interleukin-6, and prostaglandin E2 all of which are irritants of the spinal nerves causing inflammation [6,15,16,18,21]. Cervical epidural injections are among the treatments described in managing neck and upper extremity pain of disc and nerve irritation without involvement of facet joints. Cervical epidural injections are performed utilizing either an interlaminar or transforaminal approach [6,19,20] and are one of the fastest growing modalities of interventional techniques in managing chronic neck pain and upper extremity pain [24-27].

The effectiveness of cervical epidural injections continues to be intensely debated, in particular for conditions other than disc herniation and radicular pain. Cervical transforaminal epidural injections or selective nerve root blocks are associated with high complication rates and intense debate [6,19,20,28-43]. Complications with interlaminar epidural injections, though reported, are considered much less frequent or fatal compared to cervical transforaminal epidural injections. The important differences between interlaminar and transforaminal epidural injections include that while interlaminar entry delivers the medication close to the assumed site of pathology and the transforaminal approach is the target-specific modality requiring the smallest volume to reach the primary site of pathology and also leading to the site of pathology ventrally.

In addition, numerous complications described in recent years, such as fungal infections in compounded steroids leading to devastating complications [41] and the FDA warning on April 23, 2014 concerning injecting corticosteroids into the epidural space of the spine resulting in rare, but serious adverse events, have led to further controversy and discussions [42,43].

Multiple systematic reviews and guidelines performed by various groups of authors have reached different conclusions about the level of evidence for the effectiveness of cervical epidural injections in managing not only disc herniation and radiculitis, but also other conditions [6,19,20,44,45]. Among the systematic reviews, Diwan et al. [20] identified 34 studies assessing interlaminar epidural injections with the inclusion of 7 randomized trials in the analysis. They concluded that for cervical disc herniation the evidence was good, whereas for axial or discogenic pain, central spinal stenosis, and post-surgery syndrome the evidence was fair. Other reviews were insufficient with multiple deficiencies.

Consequently, this systematic review was undertaken to determine the long-term efficacy of cervical interlaminar and transforaminal epidural injections in the treatment of disc herniation, spinal stenosis, discogenic pain without facet joint pain, and cervical post-surgery syndrome. We utilized only randomized control trials (RCT), either placebo-controlled or active-controlled.

Materials and Methods

The methodology utilized in the systematic review followed the review process derived from evidence-based systematic reviews and meta-analysis of randomized trials [46,47].

The literature search was performed from 1966 to April 2014 utilizing data from PubMed, Cochrane Library, US National Guideline Clearinghouse, previous systematic reviews, and cross-references.

Search strategy

The search strategy emphasized disc herniation, radiculitis, radicular pain, cervicobrachialgia, spinal stenosis, discogenic pain, and post-surgery syndrome in the cervical region or upper extremity pain treated with either interlaminar or transforaminal epidural injections. Search terminology was as follows:

(((((((post laminectomy) OR post-surgery pain) OR discogenic) OR spinal stenosis) OR radiculitis) OR radiculopathy) OR disc herniation) OR upper extremity) OR cervicobrachialgia)) AND (((transforaminal) OR interlaminar) OR epidural)) AND ((upper extremity) OR cervical) filters: Humans

Inclusion criteria

Only adults at least 18 years of age with chronic neck and upper extremity pain of at least 3 months duration were included. Furthermore, participants must have failed previous pharmacotherapy, exercise therapy, physical therapy, etc. prior to treatment with interventional pain management techniques. Only appropriately performed cervical epidural injections were included.

Outcome measures

The primary outcome measure was pain relief and the secondary outcome measure was functional status improvement. Other aspects were also reviewed including psychosocial status, return to work, reduction or elimination of opioid use, other drugs, or other interventions; and complications. All trials showing a 50% or more reduction of pain or at least a 3 point decrease in pain scores in at least 50% of patients were considered as providing efficacy. Short-term improvement was considered as less than 6 months and long-term was considered as 6 months or longer.

Data collection and analysis

A uniform unblinded search strategy was applied. Studies with at least 3 months of outcome measures with appropriate statistical evaluations were reviewed.

At least 2 of the review authors independently, in an unblinded standardized manner, performed the literature search, analyzed the search data, and selected the trials for inclusion. A third author and consensus resolved any disagreements between reviewers.

Methodologic quality or risk of bias assessment

Methodological quality or risk of bias assessment of each individual manuscript was performed using Cochrane review criteria (Appendix
1) for RCTs [48] and interventional pain management quality and risk of bias assessment (Appendix 2) for RCTs [49]. Cochrane review criteria have been utilized in a multitude of reviews. Recently, the American Society of Interventional Pain Physicians (ASIPP) developed a specific instrument for interventional techniques called Interventional Pain Management Techniques - Quality Appraisal of Reliability and Risk of Bias Assessment (IPM-QRB).

The quality of each individual article was independently assessed by 2 review authors who assessed the internal validity of all trials in an unblinded standardized manner. Any discrepancies between the 2 review authors were assessed by a third author and settled by consensus. Randomized trials meeting at least 4 of the 12 Cochrane review criteria or achieving a score of 20 of 48 on IPM-QRB criteria were utilized for analysis. Trials meeting 8 of 12 criteria on the Cochrane review or achieving a score of 32 of 48 on IPM-QRB were considered as high-quality trials. Trials meeting 4 to 7 criteria on Cochrane review or achieving a score of 20 to 31 on IPM-QRB were considered as moderate-quality trials; while studies meeting less than 4 criteria on Cochrane review or achieving a score less than 20 on IPM-QRB were considered as low quality.

Meta-analysis

If there were more than 2 homogenous studies in more than 2 trials of interlaminar or transforaminal injections in managing disc herniation and radiculitis, spinal stenosis, discogenic pain, or postsurgery syndrome, meta-analysis was performed.

Analysis of evidence

The analysis of evidence was performed based on ASIPP’s grading of evidence [50] which was developed from Cochrane criteria of evidence synthesis and multiple other criteria including United States Preventive Services Task Force (USPSTF) analysis of evidence criteria as shown in Table 1.

<table>
<thead>
<tr>
<th>Level I</th>
<th>Evidence obtained from multiple relevant high quality randomized controlled trials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level II</td>
<td>Evidence obtained from at least one relevant high quality randomized controlled trial or multiple relevant moderate or low quality randomized controlled trials</td>
</tr>
<tr>
<td>Level III</td>
<td>Evidence obtained from at least one relevant moderate or low quality randomized controlled trial study or Evidence obtained from at least one relevant high quality non-randomized trial or observational study with multiple moderate or low quality observational studies</td>
</tr>
<tr>
<td>Level IV</td>
<td>Evidence obtained from multiple moderate or low quality relevant observational studies</td>
</tr>
<tr>
<td>Level V</td>
<td>Opinion or consensus of large group of clinicians and/or scientists. At least 60% of studies in the direction of the objective being assessed.</td>
</tr>
</tbody>
</table>

Table 1: ASIPP grading of evidence

Results

The results of the search criteria and selection of trials for inclusion in the systematic review are shown in a flow diagram of study selection as recommended by Preferred Reporting Items for Systematic Reviews and Meta-analysis (PRISMA) (Figure 1) [47].

Overall, there were 34 manuscripts considered for inclusion; however, only 7 randomized trials, either active-controlled or placebo-controlled met inclusion criteria [51-57]. There were 3 RCTs assessing the transforaminal approach [58-60] which failed to meet the inclusion criteria.

Methodological quality assessment

A methodological quality assessment of all randomized trials meeting inclusion criteria was performed utilizing Cochrane review criteria as well as ASIPP’s IPM-QRB instrument as shown in Tables 2 and 3. After combining duplicates, there were 6 randomized trials evaluating long-term response of 6 months or longer [51-56] with one trial [57] with a follow-up of less than 6 months. Four of the trials were considered as high quality [51-54] based on Cochrane review methodological criteria scores of over 8, as well as ASIPP’s IPM-QRB assessment scores over 32. The other 3 trials were considered moderate quality with scores of 4 to 7 on Cochrane review criteria and 20 to 31 on ASIPP’s IPM-QRB [55-57].
<table>
<thead>
<tr>
<th></th>
<th>Manchikanti et al. [51]</th>
<th>Manchikanti et al. [52]</th>
<th>Manchikanti et al. [53]</th>
<th>Manchikanti et al. [54]</th>
<th>Castagnera et al. [55]</th>
<th>Stav et al. [56]</th>
<th>Pasqualucci et al. [57]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Randomization adequate</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>U</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Concealed treatment allocation</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>U</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Patient blinded</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>U</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Care provider blinded</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>U</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Outcome assessor blinded</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>U</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Drop-out rate described</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>All randomized participants analyzed in the group</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Reports of the study free of suggestion of selective outcome reporting</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Groups similar at baseline regarding most important prognostic indicators</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Co-interventions avoided or similar</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Compliance acceptable in all groups</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Time of outcome assessment in all groups similar</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

Y = Yes; N = No; U = Unclear

Table 2: Methodological quality assessment of randomized trials utilizing Cochrane review criteria
Table 3: Methodologic quality assessment of randomized trials utilizing ASIPPs utilizing IPM – QRB

Characteristics of included trials
Of the 7 included trials of interlaminar epidural injections, 4 assessed patients with disc herniation [51,55-57], one trial included patients with disc related axial pain without disc herniation or radiculitis [52], one trial included patients with central spinal stenosis [53], and one trial assessed patients with post-surgery syndrome [54]. All of the trials were of an active control design. Only one trial had follow-up of less than 6 months [57]. There were no true placebo-controlled trials. One trial did identify itself a placebo-controlled design utilizing intramuscular steroids in the control group [58]. There were no trials of transforaminal epidural injections in the cervical spine meeting inclusion criteria for methodological quality assessment.

Study characteristics
Table 4 describes study characteristics and results of RCTs of cervical interlaminar epidurals.
<table>
<thead>
<tr>
<th>RA, AC, F</th>
<th>Cervical discogenic pain</th>
<th>Quality Scores:</th>
<th>Cochrane = 10/12</th>
<th>IPM-QRB = 44/48</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local anesthetic with steroids = 60</td>
<td>Local anesthetic or with Celestone</td>
<td>Average number of injections = 5 to 6 for 2 years</td>
<td>pain relief and &gt;50% functional status improvement</td>
<td>LA 68% vs LA with steroid 77% Successful: LA 75% vs LA with steroid 82%</td>
</tr>
<tr>
<td>RA, AC, F</td>
<td>Cervical spinal stenosis</td>
<td>Quality Scores:</td>
<td>Cochrane = 10/12</td>
<td>IPM-QRB = 42/48</td>
</tr>
<tr>
<td>Total = 60</td>
<td>Local anesthetic only = 30</td>
<td>Local anesthetic with steroids = 30</td>
<td>Local anesthetic or with Celestone</td>
<td>Average number of injections = 3 to 4 for 2 years</td>
</tr>
<tr>
<td>RA, AC, F</td>
<td>Cervical post surgery syndrome</td>
<td>Quality Scores:</td>
<td>Cochrane = 10/12</td>
<td>IPM-QRB = 42/48</td>
</tr>
<tr>
<td>Total = 56</td>
<td>Local anesthetic only = 28</td>
<td>Local anesthetic with steroids = 28</td>
<td>Local anesthetic or with Celestone</td>
<td>Average number of injections = 3 to 4 for one year</td>
</tr>
<tr>
<td>RA, AC, B</td>
<td>Cervical herniation and radiculitis</td>
<td>Quality Scores:</td>
<td>Cochrane = 7/12</td>
<td>IPM-QRB = 25/48</td>
</tr>
<tr>
<td>Total = 24</td>
<td>Local anesthetic + steroid = 14</td>
<td>Local anesthetic + steroid + morphine = 10</td>
<td>Number of injections = 1</td>
<td>Pain relief, visual analog scale, work status</td>
</tr>
<tr>
<td>RA, AC, B</td>
<td>Cervical herniation and radiculitis</td>
<td>Quality Scores:</td>
<td>Cochrane = 7/12</td>
<td>IPM-QRB = 25/48</td>
</tr>
<tr>
<td>Total = 42</td>
<td>Cervical epidural steroid lidocaine injections = 25</td>
<td>Steroid/lidocaine injections into posterior neck muscles = 17</td>
<td>Number of injections = 1 to 3</td>
<td>Pain relief, change in range of motion, reduction of daily dose of analgesics, return to work</td>
</tr>
<tr>
<td>RA, AC, B</td>
<td>Cervical herniation and radiculitis</td>
<td>Quality Scores:</td>
<td>Cochrane = 7/12</td>
<td>IPM-QRB = 25/48</td>
</tr>
<tr>
<td>Total = 40 of 160</td>
<td>Pain control of greater than 80%, single vs continuous</td>
<td></td>
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</tbody>
</table>

A total of 4 studies met the inclusion criteria and evaluated the role of cervical interlaminar epidural injections in disc herniation or radiculitis [51,57-59]. There was only one high quality randomized trial performed with a single and continuous epidural group design under fluoroscopic guidance [51]. The remaining 3 studies of the epidural injections were performed blindly [57-59]; one study described as a placebo-controlled design, administered steroids in the control group [58]. Yet another study utilized morphine as an additive to the injected solution [57]. Finally, the last study [59] compared continuous versus single epidural injections providing up to approximately 8 injections in the single group and assessed pain relief for only 6 months. The quality of these 3 studies performed without fluoroscopy was moderate.

Only one out of four randomized trial enrolled 120 participants with 60 subjects in each group, either with local anesthetic alone or local anesthetic plus steroids.

All the studies showed significant improvement compared to baseline, while there was no significant improvement among the groups, except in the study by Stav et al [56] where intramuscular steroid injections served as controls. However, this study enrolled only a small number of patients and provided only one injection. These results have not been replicated with improvement in a significant proportion of patients with only one epidural injection. The largest randomized trial by Manchikanti et al [51] showed significant improvement from the baseline at all levels, including function as well as disability. Of the 4 randomized trials meeting the inclusion criteria evaluating cervical interlaminar epidural injections, all of them showed positive results for the long-term; however, there was only one study for which the results were strong [51].

### Axial or discogenic pain

There was only one study evaluating axial discogenic pain and the role of cervical interlaminar epidural injections in patients without disc herniation, radiculitis, or facet joint arthropathy [52]. This study showed positive results. This was a large study performed in a contemporary interventional management practice setting using an active-controlled design with 60 patients in each group. This study showed positive results at all levels whether local anesthetic was utilized alone or combined with steroids, both in pain relief as well as functional status.

### Spinal stenosis

There was only one randomized trial meeting the inclusion criteria in the evaluation of central spinal stenosis in the cervical spine [53]. This study was of an active-controlled design and a preliminary report, but showed positive results.

### Post-surgery syndrome

There was only one randomized trial evaluating the effectiveness of cervical interlaminar epidural injections in post-surgery syndrome with or without steroids with an active-controlled design, but with preliminary results [54]. The results were positive at 3, 6, and 12 months both for pain and functional status with or without steroids.

### Meta-analysis

No meta-analysis was performed, as none of the trials were homogeneous for a specific condition. Only cervical disc herniation and radiculitis had a multiplicity of trials; although they were not homogeneous. Among the 4 trials, one study compared local anesthetic with local anesthetic and steroids, a second study compared local anesthetic with steroids or steroid plus morphine, and the third trial compared local anesthetic with steroid or intramuscular steroids, and the fourth trial compared bupivacaine with methylprednisolone acetate in a short-term follow-up. In addition, follow-up was 2 years for one trial [51], one year for 2 of the trials [55,56], and only 6 months for one trial [57]. Only one of the 4 trials [51] was conducted with fluoroscopy. The methodologic quality assessment also showed differences with one trial being high quality [51] and the remaining trials being moderate quality [55-57].

### Analysis of evidence

Since there was no meta-analysis feasible, qualitative evidence was synthesized based on the specific condition for which the cervical interlaminar epidural injections were provided. Table 4 shows the results of all the included randomized trials with the effectiveness of interlaminar epidural injections for 4 specific conditions, namely, disc herniation or radiculitis, axial or discogenic pain, central spinal stenosis, and post-surgery syndrome.
Level of evidence

Based on ASIPP’s grading of evidence criteria, the evidence is considered at 5 levels [50].

Cervical disc herniation

For cervical disc herniation or radiculitis, based on one relevant high-quality, large fluoroscopically directed active-controlled trial with local anesthetic with or without steroids [51], in conjunction with 3 moderate quality smaller randomized trials with positive results [55-57], the evidence is Level II supporting the benefit of cervical interlaminar epidural injections.

Axial or discogenic pain

For cervical axial or discogenic pain without facet joint pain, based on one relevant high-quality, large fluoroscopically directed active-controlled trial with local anesthetic with or without steroids [54], the evidence is Level II supporting the benefit of cervical interlaminar epidural injections.

Spinal stenosis

For cervical central spinal stenosis or cervical radiculitis, based on one relevant high-quality, fluoroscopically directed active-controlled trial with local anesthetic with or without steroids [53], the evidence is Level II supporting the benefit of cervical interlaminar epidural injections.

Post-surgery syndrome

For cervical post-surgery syndrome based on one relevant high-quality, fluoroscopically directed active-controlled trial with local anesthetic with or without steroids [54], the evidence is Level II supporting the benefit of cervical interlaminar epidural injections.

Summary of evidence

In summary, there is Level II evidence for cervical interlaminar epidural injections administered in managing disc herniation, central spinal stenosis, discogenic pain, and post-surgery syndrome with local anesthetic with or without steroids based on high-quality RCTs.

Discussion

This systematic review on the effectiveness of cervical epidural injections in managing chronic neck pain with or without upper extremity pain assessed the efficacy of interlaminar epidural injections. There were, however, no randomized trials available for cervical transfemoral epidural injections. Based on relevant high-quality RCTs, the evidence shown here is Level II with at least one RCT for each pathologic condition, namely – cervical disc herniation and radiculitis, cervical central spinal stenosis, discogenic pain without facet joint pain or disc herniation, and cervical post-surgery syndrome utilizing local anesthetic alone or with steroids.

Cervical disc herniation is readily diagnosed and one of the most common indications for surgical interventions in the spine. It is also believed that the course and prognosis of any spinal pain secondary to disc herniation and other causes are favorable; however, some patients continue to have persistent and disabling symptoms 2 years or longer and many undergo surgery. A multitude of surgical interventions in managing neck pain are becoming increasingly popular. The utilization of surgical interventions has increased 8-fold for anterior cervical discectomy and fusion from 1990 to 2004 with a 28-fold increase in those over 65 years of age [61]. Overall there is concern about increasing surgical interventions and the success rate of these interventions, as they frequently result in post cervical surgery syndrome [62-70].

Similarly, assessments in Medicare populations [24-27] showed an increase of 142% from 2000 to 2011 per 100,000 Medicare beneficiaries of cervical and thoracic transforaminal epidural injections and 123% of cervical and thoracic interlaminar epidural injections [24]. However, these increases are significantly less than other cervical and thoracic facet joint interventions, which showed respective increases of 359% for cervical and thoracic facet joint nerve blocks and 836% for cervical and thoracic neurolytic procedures [27]. Overall, the contribution of thoracic spine interventions is considered minor compared to cervical spine ailments.

The results of this systematic review are similar to some previous reviews [19,20]; they doubt, however, correlate with other reviews that have not been performed appropriately due to an inadequate literature search. Furthermore, the results from lumbar epidural injections have also been reciprocated to the cervical spine. While the results may be similar in the entire spine, whether it is cervical, lumbar or thoracic, the evidence in the lumbar spine has been inappropriately synthesized. Of importance, the systematic review by Pinto et al [71] which showed the efficacy of epidural injections for short-term relief without lack of efficacy for long-term. The criteria for long term is arbitrary, most studies use 6 months and greater as long term. Further it is unrealistic to expect one or two ESI to provide long term relief of 12 months or longer in spinal stenosis and compare these outcomes with patients who are on long term analgesic therapy or those who undergo surgery. In contrast, Manchikanti et al [72-74] and others [67-78] have shown contradictory results showing the efficacy of epidural injections with caudal, interlaminar, and transforaminal approaches for both the short term and long term when the analysis was performed appropriately. Pinto et al’s [71] results have been criticized for multiple deficiencies [74,77,78]. Pinto et al was criticized for utilizing methodological quality assessment criteria developed for physiotherapy, that the instrument was not validated for interventional techniques [74,79] and which differed substantially from criteria developed by the Cochrane review group [48]. In contrast, in this systematic review we utilized strict methodological and bias assessment review criteria utilizing the well-established Cochrane review criteria instrument [48], as well as the recently developed IPM-QRB instrument [49], which incorporates all the ingredients necessary in the assessment of interventional techniques. In fact, the deficiencies of Cochrane review criteria have been addressed by others [78]. In addition, Pinto et al [71] also included a multitude of heterogeneous studies that were labeled as homogeneous and conducted meta-analysis leading to inappropriate conclusions [74]. The authors, in fact, have indicated erroneously that the studies were homogeneous based on the fact that reviewers decided that local anesthetic injection was a placebo [74]. Such a methodology invalidates the entire concept of meta-analysis of homogeneous studies. Pinto et al [71], similar to others [80-84], have utilized methodologies without attention to any clinical aspects. Pinto et al [71] also failed to consider the varying effects of placebo and nocebo, impure placebo, and the effects of injecting inactive solutions into active structures, concluding that injection of active solutions into active structures was placebo when it did not meet their criteria [6,85-87]. In addition, multiple randomized trials, specifically of
epidural injections utilizing only local anesthetic [51-54,88-95], have shown significant clinical effects. These effects were equal in the majority of the trials with the exception of a slight superiority in disc herniation confirmed by experimental studies [96,97] and a systematic review [78].

The underlying mechanism of action of epidurally administered steroids, local anesthetic the risks of local anesthetic have not been well understood [98-107]. Steroids and local anesthetics have been described to exert their mechanism of action by a neural blockade that alters nociceptive input, the reflex mechanism of afferent fibers, self-sustaining activity of the neurons, and the pattern of central neuronal activities [6]. In addition, corticosteroids have been shown to reduce inflammation by inhibiting either the synthesis or release of a number of proinflammatory mediators and by causing a reversible local anesthetic effect. The emerging evidence also shows the long-lasting effect of local anesthetics. It has been postulated that local anesthetics provide relief by multiple mechanisms that include the suppression of nociceptive discharge, the blockade of sympathetic reflex arc, the blockade of axonal transport, the blockade of sensitization, and anti-inflammatory effects [6]. Clinical as well as experimental evidence shows a lack of significant difference between local anesthetic alone or with steroids indicating that corticosteroids may be unnecessary for spinal injections. A common problem encountered with any epidural injection, however, is inaccurate needle placement, as this leads to inaccurate placement of the injectate [19,20]. Consequently, proponents for fluoroscopic guidance in epidural injections advocate utilizing this technique in order to assure that medications reach the appropriate desired intervertebral space [108-111]. Furthermore, target specificity of epidural injections has also been questioned in the utilization of interlaminar cervical epidural injections [108-111].

Multiple authors have assessed prognostic factors for cervical epidural injections [112-117]. In a retrospective evaluation [112], the influence of chronic opioid use is shown as a negative predictive factor for response to cervical epidural steroid injections. This concept has been addressed in multiple publications for surgical interventions. In fact, studies have shown that opioid withdrawal is a difficult task [118-121]. Another assessment [114] showed that patients who required narcotics for their symptom management prior to the procedure showed poor pain relief. Radiographic assessment as a prognostic factor was evaluated in 2 assessments [113,122]. In one manuscript [113] it was shown that magnetic resonance imaging (MRI) predicted therapeutic response to epidural injections in patients with cervical radiculopathy and concluded that patients with central canal stenosis achieved a significantly better functional outcome after cervical epidural steroid injections than those without. In contrast, others [115,116] have shown better improvement with disc herniation than spinal stenosis which is also reflected in the findings of lumbar epidural injections.

It is crucial that safety be considered in the utilization of epidural injections [19]. Multiple risks include bleeding, non-fluoroscopic performance of the procedure, heavily sedated patients or those under general anesthesia, and performing the procedure above C5-C6 level [19]. Serious complications can occur including spinal cord trauma or nerve trauma, infection, and epidural hematoma, even though intravascular penetration, subarachnoid puncture, and injection of particulate steroids into the radicular artery are major complications specifically with cervical transforaminal.

Multiple technological modifications have been described to improve the safety and efficacy of transforaminal epidural injections [122-125].

There is a wide array of literature to improve the safety of cervical transforaminal epidural injections with a posterior approach, extraradicular technique, utilizing special needles and catheters, etc. The detailed description of these aspects is beyond this manuscript [19]. The limitations of this systematic review include the paucity of high-quality literature for each modality, with only a total of 7 RCTs available, 4 of them assessing disc herniation, and one randomized high-quality trial assessing spinal stenosis and discogenic pain and post surgery syndrome. In addition, among the 4 trials available assessing disc herniation, there was only one high-quality trial. Consequently, without homogeneity among the randomized trials, we were unable to perform meta-analysis. In addition, all evidence was obtained from active-controlled trials, specifically for long-term improvement. Active-controlled trials compare 2 different procedures or drugs, thus, some may consider this as a weakness. One trial, described as placebo controlled, used intramuscular steroids, which also is an active-controlled trial. The majority of analytical flaws in evidence synthesis are based on methodologists repeatedly considering one of the drugs as placebo and comparing both drugs or both groups rather than baseline to follow-up periods, which is the only solution in active-controlled trials. Thus, the strengths of active-controlled trials include comparative evaluation, which has become pivotal in modern spine research given the difficulty associated with the design of appropriate placebo-controlled trials. However, there have been descriptions of appropriate placebo design, even in interventionl techniques, in recent years with an inactive substance injected into an inactive structure. Thus, even though we considered active-controlled trials as a limitation, there are also multiple strengths to the use of active-controlled trials in deriving the evidence of efficacy. Furthermore, the strength of evidence we provided is qualitative evidence rather than quantitative evidence. We believe that this is appropriate since it is essential to assess the evidence appropriately rather than reach inappropriate conclusions with improper assessment.

The evidence seems to appear somewhat stronger for disc herniation with a multiplicity of studies in support and an absence of any negative studies to contradict these findings, even though only one was of high quality for spinal stenosis, discogenic pain, and post surgery syndrome. There was only one trial in each category that was of high quality. Both long-term studies with a large number of patients assessing disc herniation and discogenic pain were of active control nature.

Conclusion

This systematic review, with a proper assessment of methodological quality and risk of bias, shows Level II evidence, which supports the benefit of cervical interlaminar epidural injections based on at least one high-quality, relevant RCT for each etiology studied: disc herniation, discogenic pain without facet joint pain or disc herniation, central spinal stenosis, and post-surgery syndrome.

References


