Indications for and benefits of lumbar facet joint block:
analysis of 230 consecutive patients

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Object. The authors evaluated the effectiveness of using a facet joint block with local anesthetic agents and or
steroid medication for the treatment of low-back pain in a medium-sized series of patients.

Methods. Over a period of 4 years, the authors performed 715 facet joint injections in 230 patients with variable-
length histories of low-back pain. The main parameter for the success or failure of this treatment was the relief of the
pain. For the first injection—mainly a diagnostic procedure—the authors used a local anesthetic (1 ml bupivacaine
1%). In cases of good response, betamethasone was injected in a second session to achieve a longer-lasting effect.

Long-lasting relief of the low-back pain and/or leg pain was reported by 43 patients (18.7%) during a mean follow-
up period of 10 months. Thirty-five patients (15.2%) noticed a general improvement in their pain. Twenty-seven
patients (11.7%) reported relief of low-back pain but not leg pain. Nine patients (3.9%) suffered no back pain but still
leg pain. One hundred sixteen patients (50.4%), however, experienced no improvement of pain at all. In two cases the
procedure had to be interrupted because of severe pain. There were no cases of infection or hematoma.

Conclusions. Lumbar facet joint block is a minimally invasive procedure to differentiate between facet joint pain
and other causes of lower-back pain. The procedure seems to be useful for distinguishing between facet joint pain from
postoperative pain due to inappropriate neural decompression after lumbar surgery. It can be also recommended as a
possible midterm intervention for chronic low-back pain.

Key Words • facet joint • low-back pain • lumbar spine • pseudoradicular pain

Typically hypertrophy and reactive remodeling of the articular processes are the degenerative changes seen in
the lumbar facet joint in aging individuals.3 These facet joints have a close topographic relationship to delicate
neural and vascular structures of the spinal canal.35 These degenerative changes are thought to cause low-back pain.
Anatomically, the ipsilateral dorsal root ganglia supply the lumbar facet joint, segmentally and nonsegmentally.4,41
Some of the sensory fibers from the facet joint may pass through the paravertebral sympathetic trunk, reaching the
L-1 and/or L-2 dorsal root ganglia. Therefore, facet joint pain originating from the lower lumbar levels may be dis-
tributed in L-1 and L-2 areas and is explained as “referred pain.” An extensive network of small nerve fibers and free
encapsulated nerve endings exists in the lumbar facet joint capsule. Low-threshold and high-threshold mechanore-
ceptors fire when the facet joint capsule is stretched or is subjected to localized compressive forces.40

The facet joint is subjected to high stress and strain2 and may be affected by rheumatoid arthritis, ankylosing spondy-
litis, osteoarthritis, and, rarely, synovial cysts and infections. Microtrauma to the facet joint may also cause pain.
The resulting tissue damage or inflammation is likely to cause release of the content of the joint in which high-

Abbreviations used in this paper: CT = computerized tomogra-
phy; MR = magnetic resonance.
RESULTS

Symptom Relief

In 14 patients, the joint could not be punctured because of calcification and partial ossification of the facet joint. In these cases, a pericapsular injection had to be performed. Long-lasting relief of the back and leg pain occurred in 43 patients (18.7%), in whom only two or three injections were required. The pain did not recur during the 12-month follow-up period. All of these 43 patients suffered from acute postoperative pain either after microdiscectomy or osseous decompression secondary to lumbar spinal canal stenosis. In 27 patients (11.7%) the radicular pain disappeared, but they still complained of back pain.

Nine patients (3.9%) reported that they had no longer experienced back pain but still suffered sciatica. Thirty-five patients (15.2%) reported only a partial improvement of the back and leg pain (Table 2).

One hundred sixteen patients (50.4%), however, reported no improvement of any symptom, despite correct positioning of the spinal cannula within the joint (Table 3).

Procedure-Related Complications

In eight patients (3.5%) the wrong level above or below the planned joint was inadvertently injected. After explaining this to the patient, the injection was repeated the next day. Six patients (2.6%) reported a transient increase of pain directly after the injection. Two patients (0.9%) suffered from transient radicular sensory changes. In three patients (1.3%), the dura mater was accidentally punctured, causing temporary paraplegia in one patient that resolved within 3 hours; the two others reported only headache, probably resulting from cerebrospinal fluid leakage, which resolved spontaneously after 48 hours. In two cases the injection was interrupted because the patient experienced severe pain. No infection or symptomatic hematomas were noted (Table 4).

DISCUSSION

In this study the group of patients that benefited from facet joint block contained mainly individuals with acute postoperative uncontrollable local and pseudoradicular pain. In these patients, because CT scanning excluded the possibilities of recurrent disc prolapse and insufficient de-

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**TABLE 1**

<table>
<thead>
<tr>
<th>Level</th>
<th>Unilat (%)</th>
<th>Bilat (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>L5–S1</td>
<td>59 (25.7)</td>
<td>44 (19.1)</td>
</tr>
<tr>
<td>L4–5</td>
<td>49 (21.3)</td>
<td>14 (6)</td>
</tr>
<tr>
<td>L3–4</td>
<td>12 (5.2)</td>
<td></td>
</tr>
<tr>
<td>more levels</td>
<td>52 (22.6)</td>
<td></td>
</tr>
</tbody>
</table>

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**TABLE 2**

Outcome according to patient-rated responses

<table>
<thead>
<tr>
<th>Outcome Category</th>
<th>No. of Patients (%)</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>excellent</td>
<td>43 (18.7)</td>
<td>complete relief of back &amp; lower-extremity pain; no further analgesics necessary; no pain during follow up of 6–12 mos</td>
</tr>
<tr>
<td>good</td>
<td>27 (11.7)</td>
<td>disappearance of lower-extremity pain, but not low-back pain; mild analgesics used</td>
</tr>
<tr>
<td>fair</td>
<td>44 (19.1)</td>
<td>only partial relief of low-back pain and lower-extremity pain</td>
</tr>
<tr>
<td>poor</td>
<td>116 (50.4)</td>
<td>no relief, unable to work; strong analgesic used regularly</td>
</tr>
</tbody>
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A. Bani, U. Spetzger, and J. M. Gilsbach
Indications and benefits of lumbar facet joint block

Despite the diversity of symptoms, it was possible in 121 patients (52.6%) to identify and treat by injection one level and side selectively. Unfortunately CT scans of the lumbar spine do not reveal early degenerative changes in the facet joint, and they were unable to demonstrate facet joint inflammation. Using sophisticated methods like single-photon emission CT scanning to identify the affected joint is expensive, time consuming, and in our opinion unnecessary.

On the other hand, if the clinical picture and the radiological features do not help to indicate the one level or side to be treated, it is necessary to inject the two or three lower levels bilaterally. The effect of multisegmental injections is questionable. Additionally, it was an unpleasant experience for 22.6% of the patients in this series.

There was no need for the infiltration of the skin with a local anesthetic. One predictor of an optimum position of the cannula is the fact that we cannot inject more than 1 ml into the joint. A periarticular injection is also helpful in some of the cases in which facet joint syndrome is suspected; however, the effect is short with a mean duration of 1 week (in 14 patients [6%] in this series) in contrast to an exact intraarticular injection that may yield 1 to 3 months of relief or longer. Despite great care in inserting the spinal needle, the first author (A.B.) punctured the dura in two of the first 10 cases, which can be explained as a learning curve.

Postoperative pseudoradicular pain may be minimized by making an intraoperative intraarticular injection of corticosteroid into the opened joint. Similar results can be obtained if one also coagulates the joint, although there is no long-term difference in the response between percutaneous facet joint coagulation and facet joint injection with corticosteroids.

All except two injections were performed using fluoroscopy. With this simple method it was possible to visualize the joint in 227 patients (99%) in the oblique position so that the spinal needle could be introduced. Only in three cases was an additional CT scan required to determine the exact localization of the cannula in the joint, because of obesity, scoliosis, and interbody cages, respectively. Performing the injection under fluoroscopy has many advantages including less exposure to radiation, the short duration of the procedure, and lower costs. A percutaneous blind injection of the facet joint is not recommended and was practically not possible in this series, because the position of the cannula had to be corrected at least once in all the 715 joints injected.

TABLE 3
Summary of complications in 22 patients

<table>
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<tr>
<th>Complications</th>
<th>No. of Patients</th>
<th>Reaction</th>
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<tbody>
<tr>
<td>wrong level injected</td>
<td>8</td>
<td>injection repeated</td>
</tr>
<tr>
<td>transient increase of pain</td>
<td>6</td>
<td>no specific therapy</td>
</tr>
<tr>
<td>puncture of subarachnoid space</td>
<td>3</td>
<td>no specific therapy</td>
</tr>
<tr>
<td>severe pain</td>
<td>2</td>
<td>interruption</td>
</tr>
<tr>
<td>transient hypesthesia</td>
<td>2</td>
<td>no therapy</td>
</tr>
<tr>
<td>transient paraplegia</td>
<td>1</td>
<td>no therapy</td>
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TABLE 4
Summary of data in 116 patients in whom symptoms did not respond to facet joint injections

<table>
<thead>
<tr>
<th>Signs &amp; Symptoms</th>
<th>No. of Patients</th>
<th>CT or MR Finding</th>
<th>Conclusion</th>
<th>Pain Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>chronic back pain w/ or w/out radiation</td>
<td>44</td>
<td>degenerative changes, no disc prolapse, no spinal canal stenosis</td>
<td>conservative therapy</td>
<td>none</td>
</tr>
<tr>
<td>chronic postdiscectomy syndrome</td>
<td>37</td>
<td>scar tissue &amp; in 7 recurrent disc prolapse</td>
<td>7 reop</td>
<td>5 improved</td>
</tr>
<tr>
<td>spinal canal stenosis</td>
<td>29</td>
<td>spinal canal stenosis</td>
<td>laminotomy &amp; osseous decompression</td>
<td>19 w/ good results, 2 w/ no improvement</td>
</tr>
<tr>
<td>acute pain after percutaneous nucleotomy</td>
<td>6</td>
<td>no disc prolapse, no signs of disc prolapse</td>
<td>wrong indication (nerve root injury?)</td>
<td>none</td>
</tr>
</tbody>
</table>
In 28 patients the facet joint injections were performed as an additional attempt at pain therapy, because other alternatives were insufficient. In these patients, the response to the injection was questionable (Table 5).

In no case was a simultaneous facet joint and periradicul injection performed. The periradicular injection may perhaps be helpful in cases of suspected postoperative periradicul fibrosis and venous congestion in the lumbar root canal nerve root, which is thought to be one of the causes of low-back pain with radicular irritation.5,13

Because the facet joint behaves similarly to a myofacial trigger point, the effect of a local anesthetic usually lasts longer than its pharmacological effect. In this series, however, there were 28 patients (12.2%) who reported alleviation of the symptoms, which we could not correlate with the effect of the facet joint injection; the indication was questionable (Table 5).

3,13 The facet joint may be responsible for at least some degree of low-back pain with pseudoradicular and radicular radiation.2,3,7,8,11,12,15,17,21,24,26–28,30,37,43 Experimentally, a marked reduction of the nerve activity occurs in facet tissue injected with local anesthetic and corticosteroid agents.2 Therefore, percutaneous facet joint injection aims to denervate the facet joint, from which the pain seems to originate.

### CONCLUSIONS

The primary role of facet joint block should be diagnostic. It can also be used as an additional therapy for suspected facet joint syndrome in patients in whom symptoms fail to respond to conservative treatments of low-back pain.

Although our results for the symptomatic relief of pain have been roughly graded, we think it is mainly because of the nature of the disease. Our clinical impression is that this method is beneficial and warrants continuous application.

Finally, successful rehabilitation of the patients should be feasible due to prolonged pain relief provided by this treatment.

### REFERENCES


### TABLE 5

<table>
<thead>
<tr>
<th>Indication</th>
<th>No. of Patients</th>
<th>CT or MR Finding</th>
<th>Level Injected</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>unspecific back pain</td>
<td>9</td>
<td>multisegmental lumbar facet degeneration</td>
<td>L3–4, L4–5, &amp; L5–S1 bilaterally</td>
<td>very unpleasant, short improvement</td>
</tr>
<tr>
<td>pain after multiple disc ops (&gt;4)</td>
<td>4</td>
<td>scar tissue, degenerative disc space</td>
<td>op level</td>
<td>no improvement</td>
</tr>
<tr>
<td>analgesic addiction after multiple disc ops</td>
<td>4</td>
<td>no recurrent disc prolapse</td>
<td>op level</td>
<td>no improvement</td>
</tr>
<tr>
<td>pain after percutaneous neurectomy</td>
<td>4</td>
<td>protrusion, no neural compression</td>
<td>op level</td>
<td>2 no improvement, 1 op interrupted due to pain</td>
</tr>
<tr>
<td>extreme obesity w/ low-back pain</td>
<td>7</td>
<td>severe lumbar degenerative changes</td>
<td>L3–4, L4–5, &amp; L5–S1 bilaterally</td>
<td>very unpleasant, 2 short improvement, 2 no improvement</td>
</tr>
</tbody>
</table>
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