

Persistent Spinal Pain After Surgery

Failed back surgery syndrome is the traditional name for persistent or recurrent back or leg pain after spinal surgery. The name is misleading and is being replaced by persistent spinal pain syndrome, because the operation often did exactly what it was meant to and the pain continued for other reasons. It is a pain state with many possible causes — not a dead end — and there are genuinely effective options.

THE BIG PICTURE

A pain state to investigate, not a failure

Often the surgery achieved its anatomical goal, yet pain remains. The most useful approach is a careful search for any specific, treatable cause, followed by an individualised plan. Persistent pain after spinal surgery is common enough that it should be discussed openly — and approached constructively when it happens.

IN PLAIN TERMS

It means pain that carries on, or comes back, after spinal surgery. The surgery often did not 'fail' — the pain continued for other reasons, and the job now is to find out why and to help.

1 Why it happens

Usually several factors act together: the wrong target may have been treated, or expectations were higher than what surgery could achieve; a nerve may remain compressed (residual narrowing, a recurrent disc, scar tissue); new problems can develop (adjacent wear, instability, a failed fusion); pain can become neuropathic, or 'wired in'; other sources such as joints and muscles contribute; and mood, stress and coping strongly influence pain. None of this means the pain is imagined — mind and body both matter.

SEEK URGENT REVIEW IF YOU NOTICE

New or worsening leg weakness or numbness, numbness around the saddle area, or any bladder or bowel disturbance (a possible emergency). After surgery: fever, wound discharge, or rapidly escalating pain, which may indicate infection.

2 Finding the cause

The key is to distinguish a specific, treatable cause from diffuse or neuropathic pain. This uses a careful history and examination, a review of the original surgery, an **MRI (often with contrast)**, to tell a recurrent disc from scar tissue), CT or bending X-rays, and diagnostic injections to identify the source. A psychological assessment is often valuable — not because the pain is unreal, but because addressing these factors genuinely helps.

3 Treatment

For most, the best results come from a multidisciplinary, function-focused plan: physiotherapy and reconditioning, appropriate pain medicines (including neuropathic agents, with honest caveats; avoiding long-term strong opioids), psychological therapies, and targeted injections for an identified source. **Spinal cord stimulation** — an implanted device that modulates pain, trialled first — has the best evidence for neuropathic leg pain. **Revision surgery** helps only when there is a clear, correctable target; repeat surgery for diffuse pain tends to disappoint.

A HOPEFUL, REALISTIC GOAL

Many people improve a great deal with a careful, individualised plan focused on function. The aim is often better pain control and quality of life rather than complete cure — and that is achievable.

THE KEY MESSAGE

Persistent spinal pain after surgery is a pain state with many possible causes acting together — not a sign that the surgery failed. The key is a careful search for any specific, treatable cause. Most people are helped most by a multidisciplinary, function-focused plan; spinal cord stimulation has the best evidence for neuropathic leg pain; and revision surgery is reserved for a clear, correctable target. Act urgently on new weakness or numbness, saddle numbness, bladder or bowel changes, or signs of infection.

A NOTE BEFORE YOU START

This information is for general education and does not replace the advice of your clinical team. Please use it to ask better questions, not to make decisions on your own.

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