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Most patients with sciatica get no worthwhile relief from epidural steroids

Research question Do patients with unilateral sciatica get any lasting benefit from epidural injections of corticosteroids?

Answer No. Epidural injections of steroids with bupivacaine give a few weeks' pain relief to a small minority of patients. There are no benefits beyond six weeks

Why did the authors do the study? The evidence evaluating epidural corticosteroids for people with sciatica is inconclusive. Many of the studies to date are small and short term. Methods are heterogeneous and results are mixed. These authors wanted a more definitive and methodologically sound evaluation of this extremely common procedure.

What did they do? 228 English adults took part in their randomised controlled trial comparing lumbar epidural injections of triamcinolone (80 mg) and bupivacaine (0.25%, 10 ml), with a placebo (2 ml of saline injected into the interspinous ligament). Participants had had unilateral sciatica for up to 18 months. All had tried physiotherapy and analgesics. They were recruited from hospital outpatient clinics, randomised, treated with up to three injections over six weeks, then followed up regularly for 12 months.
The authors defined a response to treatment as a 75% improvement in the Oswestry disability questionnaire for low back pain. They also collected data on quality of life (short form 36 questionnaire); use of other treatments, including analgesics and surgery; self reported pain; employment; and days off work.

The trial was double blind and adequately powered. All analyses were conducted according to the principle of intention to treat.

What did they find? After three weeks, 15/120 (13%) patients treated with epidural steroids had responded to treatment compared with 4/108 (4%) of those given placebo (P = 0.016, number needed to treat 11.4). Between six weeks and one year after treatment, however, the authors could find no differences between the groups for any measure of outcome. At the end of the trial, just under a third of the patients in each group had a 75% improvement, but only 26 patients were completely pain free. Overall the steroid injections did not improve patients' symptoms or quality of life, or help them get back to work. Steroids did not reduce patients' need for other treatments. About 15% of patients in both groups needed surgery. Analyses looking for a subgroup that might benefit drew a blank. The third of patients with acute sciatica (symptoms lasting 1-4 months) tended to do better overall than the two thirds with chronic sciatica (symptoms lasting 4-18 months), but epidural steroids with bupivacaine made no difference in the medium or long term to either subgroup.

What does it mean? This large and methodologically sound trial confirms that for patients with well defined sciatica, the benefits of epidural steroids are modest and brief. In general, patients referred to UK hospitals with sciatica have chronic pain and disability. Epidural injections of steroids combined with bupivacaine do not seem to help them. It's time to move on and look for other more effective treatments, preferably prescribed as part of a multidisciplinary package.

Arden NK, Price C, Reading I, et al. A multicentre randomized controlled trial of epidural corticosteroid injections for sciatica: the WEST study. *Rheumatology* 2005;44:1399-406

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Editor's choice

Vice versa

It may seem perverse to support the banning of one vice while calling for the legalisation of another. But in both cases, the rationale has little to do with morals and everything to do with improving public health.

The first vice, smoking in enclosed public places, is thankfully likely to become a thing of the past in England, when UK members of parliament take part in a free vote on a ban next month. Last year's proposed compromise—to allow smoking in pubs that don't serve food—was widely criticised as unworkable and likely to increase health inequalities (p 194). A total ban now looks inevitable, bringing the United Kingdom in line with Bhutan, Cuba, Ireland, Italy, Malta, New Zealand, Norway, and several states in the United States.

For the remaining doubters, however, a paper in this week's journal may bring them round (p 227). It suggests that no effective technical solution currently exists for reducing the effects of environmental tobacco smoke in public places, and that the tobacco industry cannot be trusted to advise us on such matters. Newly released internal documents from British American Tobacco (BAT) show that, although BAT was successfully promoting air filtration systems as a means of combating cigarette smoke (and therefore as an alternative to a total ban on smoking in public places), company executives knew that the filters were ineffective.

The other vice at issue is prostitution, or being paid for sex. Many countries have now decriminalised prostitution, but so far only the Netherlands has put prostitutes on the same legal footing as other workers. The UK government's new strategy, published last week, tends more to the Swedish model, which criminalises men who pay for sex. In Sweden this seems to have reduced street prostitution but possibly by driving prostitutes "underground" or forcing clients to look to other countries. The UK strategy allows more than one prostitute to work in the same place, which should improve safety for individual sex workers. However, it stops well short of allowing licensed premises. This is a mistake. As Petra Boynton and Linda Cusick point out in an editorial this week (p 190), properly licensed premises would mean that the worst aspects of the sex trade—child prostitution, trafficking, and slavery and the exploitation of vulnerable people—could be tackled. Licensing premises would encourage sex workers' access to health and social care.

Juliet, a prostitute based in London, also writing in this week's journal (p 245), believes that the UK government has "failed enormously." She argues that neither having sex nor getting paid are inherently degrading, abusive, exploitative, or harmful. The problems, she says, are the associated coercion, drug dependency, and lack of choices, not prostitution itself. It is surely time for an end to the arguments of moral opprobrium and for some bolder steps towards legalisation if we are to improve public health and human rights.

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