PubMed

Format: Abstract

Full text links

ELSEVIER FULL-TEXT ARTICLE

Best Pract Res Clin Rheumatol. 2010 Apr;24(2):241-52. doi: 10.1016/j.berh.2009.11.005.

Sciatica.

Valat JP[1], Genevay S, Marty M, Rozenberg S, Koes B.

Author information

Abstract

Sciatica is a symptom rather than a specific diagnosis. Available evidence from basic science and clinical research indicates that both inflammation and compression are important in order for the nerve root to be symptomatic. Tumour necrosis factor-alpha (TNF-alpha) is a key mediator in animal models, but its exact contribution in human radiculopathy is still a matter of debate. Sciatica is mainly diagnosed by history taking and physical examination. In general, the clinical course of acute sciatica is considered to be favourable. In the first 6-8 weeks, there is consensus that treatment of sciatica should be conservative. We review and comment on the levels of evidence of the efficacy of patient information, advice to stay active, physical therapy analgesics, non-steroidal anti-inflammatory drugs (NSAIDs), epidural corticosteroid injections and transforaminal peri-radicular injections of corticosteroid. There is good evidence that discectomy is effective in the short term. but, in the long term, it is not more effective than prolonged conservative care. Shared decision making with regard to surgery is necessary in the absence of severe progressive neurological symptoms. Although the term sciatica is simple and easy to use, it is, in fact, an archaic and confusing term. For most researchers and clinicians, it refers to a radiculopathy, involving one of the lower extremities, and related to disc herniation (DH). As such, the term 'sciatica' is too restrictive as nerve roots from L1 to L4 may also be involved in the same process. However, even more confusing is the fact that patients, and many clinicians alike, use sciatica to describe any pain arising from the lower back and radiating down to the leg. The majority of the time, this painful sensation is referred pain from the lower back and is neither related to DH nor does it result from nerve-root compression. Although differentiating the radicular pain from the referred pain may be challenging for the clinician, it is of primary importance. This is because the epidemiology, clinical course and, most importantly, therapeutic interventions are different for these two conditions. It should, however, be emphasised that the quality of the available evidence is rather limited due to a considerable heterogeneity in the study populations included in the trials. This makes generalisation of findings across studies, and to routine clinical practice, a challenge. Prevalence estimates of radicular pain related to DH also vary considerably between studies, which is, in part, due to differences in the definitions used. A recent review showed that the prevalence of sciatic symptoms is rather variable, with values ranging from 1.6% to 43%. If stricter definitions of sciatica were used, for example, in terms of pain distribution and/or pain duration, lower prevalence rates were reported. Studies in working populations with physically demanding jobs consistently report higher rates of sciatica compared with studies in the general population.

PMID: 20227645 DOI: 10.1016/j.berh.2009.11.005

[PubMed - indexed for MEDLINE]

Publication Types, MeSH Terms

LinkOut - more resources

PubMed Commons

PubMed Commons home

0 comments

How to join PubMed Commons