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EDITORIAL

Editorial

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'It is better to be wealthy and healthy than poor and sick'. As a teenager I overheard this being declared by a rich acquaintance of my parents. I found it rather disturbing not least because one often has scant influence over one's health and financial status.

Two studies in the previous issue of the European Spine Journal focus on spinal stenosis and both came to us from Scandinavia.

Spinal stenosis occurs when the content of the spinal canal and/or the neuroforamina become compressed. Hypertrophy of facet joints, bulging discs, buckling yellow ligaments and decreased disc height conspire to create the condition. When spinal stenosis becomes clinical, it has a variable presentation with postural induced back and/or leg pain, numbness and neurogenic claudication as coined by Henk Verbiest in the 1960s. So, the diagnosis is both anatomical as seen on MRI or CT and anamnestic. Other investigations such as electrophysiology are not helpful. With the ageing of the population, clinical spinal stenosis is becoming one of the major burdens for both individuals and society.

From the Danish paper on clinical guidelines we learn that surgical decompression without fusion is to be recommended for clinical spinal stenosis, whereas manual therapy, paracetamol, NSAID's, opioids, neurogenic pain medication and muscle relaxants show no beneficial effect. Supervised rehabilitation, however, is useful as it has general beneficial effects on health and no known adverse effects.

So, all this seems to be rather straight forward: we know what the cause of clinical spinal stenosis is, and we know what the best treatment is. Hippocrates would be happy. One more disease solved, tick that box.

The Swedish paper, however, introduces several more socio-economic variables that reveal an important complexity and a whole new dimension to spinal stenosis (and offers a perverse credibility to my parents' sardonic acquaintance). We have little, if any agency over our place of birth, our education level and disposable income. I came away from reading this study with three thoughts:

First, as practitioners we need to actively make an effort to tactfully include these socio-economic factors in the counsel, we give our patients when entering shared decision making leading to informed consent.

Second, yet one more reason to be proactive at a broader level in prevention: to prioritize education, employment, healthier lifestyle, zero cigarettes.

Third, whereas as a reviewer and editor I loathe the killer phrase 'more studies are needed to …', I would really welcome more studies in this field and originating from all over the globe, not only Northern Europe.

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