The use of interspinous distraction implants to increase spinal canal cross-sectional area and thus reduce spinal claudication symptoms has gained in popularity during the past decade. The first of these devices approved for sale in the U.S., is the X-Stop spacer (St. Francis Medical Technologies, Inc., Alameda, CA). The X-stop was approved despite a 50% clinical failure rate in the clinical trial that were reviewed, due primarily to the low morbidity of the original procedure and the absence of a less invasive clinically effective alternative. Subsequent studies have demonstrated variable outcomes and there is only one prospective four year outcome study published.

This prospective study evaluated outcomes in 29 consecutive stenotic patients treated with this device. ‘Exclusion criteria were radicular motor deficit, conus/cauda-lesion, manifest osteoporosis, spondylolisthesis more than grade 1 at the stenotic level and scoliosis with a Cobb angle more than 20°, and patients with symptoms unresponsive to postural alteration.’ Forty-six patients were originally enrolled in the study, but for a variety of reasons (e.g. 5 patients did not achieve the minimum postoperative period of 24 months) were not included in the evaluation.

On the whole, lumbar pain decreased by 33% and leg pain by 64% using VAS outcome data. A little less than half the patients (47%) treated were self-proclaimed to be very satisfied. “According to the criteria stated earlier, clinical success could be achieved in 36.4% (n = 16) of the [enrolled 46 originally enrolled, two were lost to f/u] patients. Fourteen of the patients, including the 2 patients who had the implant removed and were contacted by phone, had to undergo revision surgery. … Mean time until implant removal was 15.4 _ 18.4 months.”
Transrectal ultrasound (TRUS)-guided biopsy has become the standard procedure to diagnose prostatic carcinoma. There is some controversy regarding the best method of alleviating pain during prostate biopsy. Periprostatic nerve block (PNB) is a gold standard anesthetic technique during transrectal ultrasound (TRUS)-guided prostate biopsy. Recent studies showed that PNB alone is insufficient as analgesic. We compared the efficacy of tramadol and intraprostatic nerve block (INB) in addition to PNB.

This prospective double blinded placebo controlled study of 150 consecutive patients, included randomization into three groups. Group A received PNB with INB with 1% lignocaine. Group B received oral tramadol with PNB. Group C patients were administered PNB only with 1% lignocaine. Patients were asked to grade the pain level using 11 point linear visual analog scale (VAS) at the time of ultrasound probe insertion, at time of anesthesia, during biopsy, and 30 min after biopsy.

Group A (Nerve block with INB): Patients were given multivitamin (Vitamin c and vitamin b₁₂) as placebo tablet 3 h before the procedure. Nerve block using 5 ml 1% lignocaine was injected just lateral to the junction between prostate base and seminal vesicle just before biopsy. Group B (Tramadol): Patients were given 100 mg tramadol tablet 3 h before procedure and 1% lignocaine used for PNB and 0.9% NaCl was used for intraprostatic injection. Group C (Control): Same as group A expect 0.9% NaCl was used for intraprostatic injection.

PNB provides better pain control in TRUS-guided prostate biopsy but still there is need of additional analgesic in the form of tramadol or INB. Tramadol has advantage of oral intake and analgesic effect at time of probe insertion and at nerve block. Both tramadol and INB may be used in combination along with PNB.'
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"OK, Mr. Nurtz. Time to get you prepped for surgery."