

discharge (69.7%). SNRB was required in 19.6% and surgical intervention in 10.7% within the same admission. Multivariate analysis did not find any parameter to predict treatment failure (Age, gender, motor/sensory deficit, CT/MRI findings). The motor deficit, positive Straight leg raising (SLR) and dural sac compression on CT were higher in the intervention group but did not reach statistical significance. One patient required discontinuation of IV steroids due to elevated blood pressure. **Conclusion:** Despite the insufficient evidence in the literature, IV steroid treatment is still a viable option in ALRP treatment, with pain relief allowing discharge in 70% of patients and a low complication rate. Our study found daily 24mg IV dexamethasone for ALRP to be an effective treatment and helpful in most patients admitted. This study supports the common practice used by spine units.

Keywords: Sciatica; Radiculopathy; Herniated disc; Steroid treatment; Pharmacotherapy

Synonyms: ALRP = Acute lumbar radicular pain, SNRB = Selective nerve root block, SLR = Straight leg raising

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P191: Is stabilisation of contralateral side necessary while using unilateral approach in lumbar fusion surgery at 2 adjacent levels?

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Introduction: Generally, fusion supplemented with bilateral pedicle screw fixation is the widely accepted method of stabilisation to create an ideal environment for fusion of the unstable and the degenerated disc area. Rigid internal fixation by bilateral pedicle screw fixation has its shortcomings in the form of adjacent lumbar segment degeneration and implant-related osteoporosis. Moreover, bilateral fixation was associated with longer surgical time, greater blood loss and involving greater costs. A relatively less rigid fixation in the form of unilateral pedicle screw fixation could reduce the stress shielding and adjacent intervertebral disc degeneration caused by bilateral pedicle screw fixation. Biomechanical studies supported his concept stating that unilateral pedicle screw fixation was sufficient to maintain the stability of the spine. We performed this meta-analysis to compare the safety of unilateral with bilateral instrumented fusion in two-level degenerative disorders of lumbar spine. **Materials and Methods:** We conducted independent and duplicate electronic database search including PubMed, Embase and Cochrane Library till January 2020 for Randomised Controlled Trials(RCTs) comparing unilateral pedicle screw fixation with bilateral pedicle screw fixation for multi-level lumbar

degenerative disorders. Fusion and complication rates were the primary outcomes analysed. Analysis was performed in R platform using OpenMeta[Analyst] software. **Results:** 5 RCTs including 215 patients (Unilateral/Bilateral = 106/109) were included in meta-analysis. There was no significant difference between the two groups regarding fusion rate, complication rate, blood loss, duration of hospital stay, functional outcome scores like Visual Analog Scale (VAS), Oswestry Disability Index (ODI) and Short-Form health survey (SF-36) at final follow-up. Unilateral pedicle screw fixation was associated with a significant reduction in operation time ($p < 0.001$). Compared to open approach, minimally invasive approach showed significant difference in terms of factors like operative time, blood loss, hospital stay, VAS and ODI ($p = 0.004$). **Conclusion:** Our meta-analysis establishes the immediate safety and significant lesser operative period of unilateral pedicle screw fixation in lumbar fusion. However, due to lack of evidence on complications like cage subsidence and adjacent segment disease, unilateral pedicle screw fixation cannot be recommended as an alternative to bilateral pedicle screw fixation for two-level degenerative spinal disease. Our analysis established the lacunae in literature for high-quality evidence on the subject hence we recommend further large multicentre studies with longer follow-up to arrive at a conclusion.

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P192: Management of discal cyst: case report and narrative review

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Introduction: Lumbar discal cyst (LDC) is a rare clinical entity with unclear etiology. First described by Chiba *et al.* in 2001, is believed to be originated from the disc material and as a result of previous disc injury. LDC is defined as an intraspinal extradural cyst with distinct communication with the corresponding intervertebral disc. Clinical history is similar to patients with disc herniation, manifesting as a unilateral single nerve root lesion with neurologic deficits corresponding to the involved nerve root. Discal cyst is one of the different types of cysts that can exist extradurally in the lumbar spine, specifically in the spinal canal and neuroforamen. Imaging nuances such as the location of the cyst, bony changes on CT, contrast filling with discography or myelography, and MRI characteristics can be useful to differentiate between different types of cysts. LDC is almost always located behind the posterior vertebral body, which is also a typical location for herniated discs. On MRI, LDC appears as hypointense on T1-weighted image and hyperintense on T2-weighted image and enhances homogeneously after gadolinium. There are no guidelines