

# PainWeek®

## Fundamentals of Neuromodulation

---

Peter Pryzbylkowski, MD

# Disclosure

---

- Consultant: Nevro, Abbott, Vertos

# Learning Objectives

---

- Explore the use of electrical signals to block pain
- Review the theory of how neuromodulation works, MOA
- Explore the different products that are currently on the market
- Review the application of the devices in clinical practice
- Review data supporting use of products and their role in decreasing opioid use
- Discuss the process of trial and implantation of devices

# History of Neuromodulation

---

- First used to treat pain in 1967
- Gate theory was published in 1965
- Became more mainstream in 1980s
- 1989 FDA approved use of devices to treat chronic pain from nerve damage in trunk, arms or legs
- Year after year the devices continue to improve upon earlier iterations

# Neuromodulation

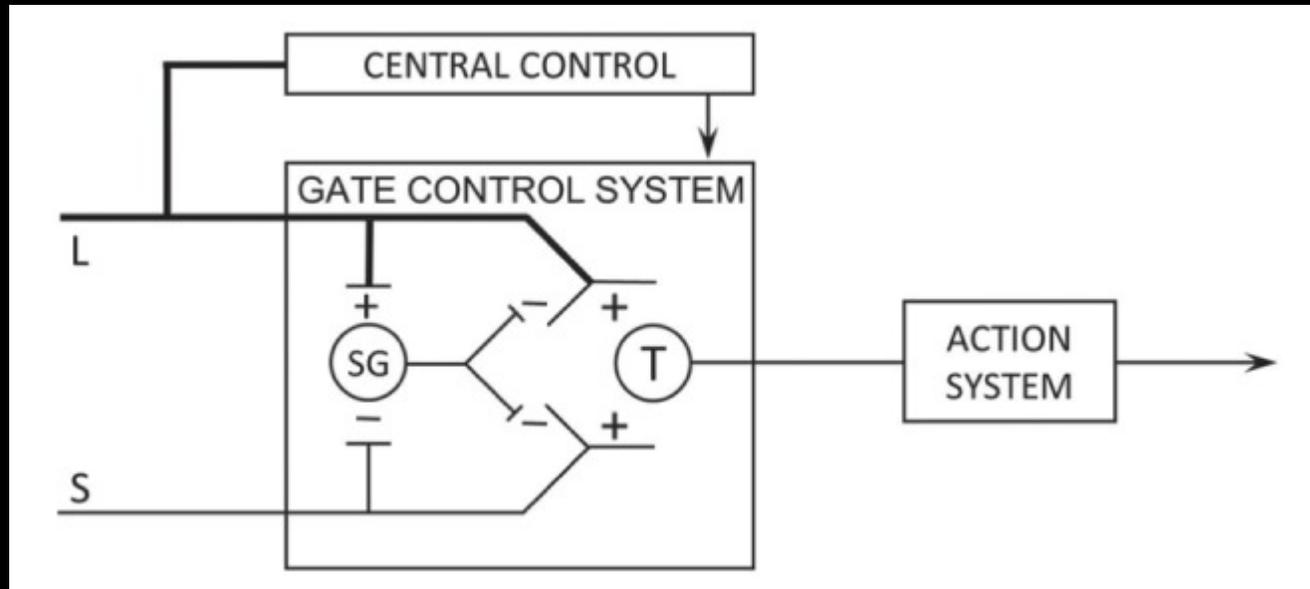
---

- So what is it?
- Application of electrical signals to lessen pain complaints
- Drug/medication = electricity
- Types of neuromodulators
  - Spinal cord stimulators, dorsal column stimulators, dorsal root ganglion stimulators, peripheral nerve stimulators



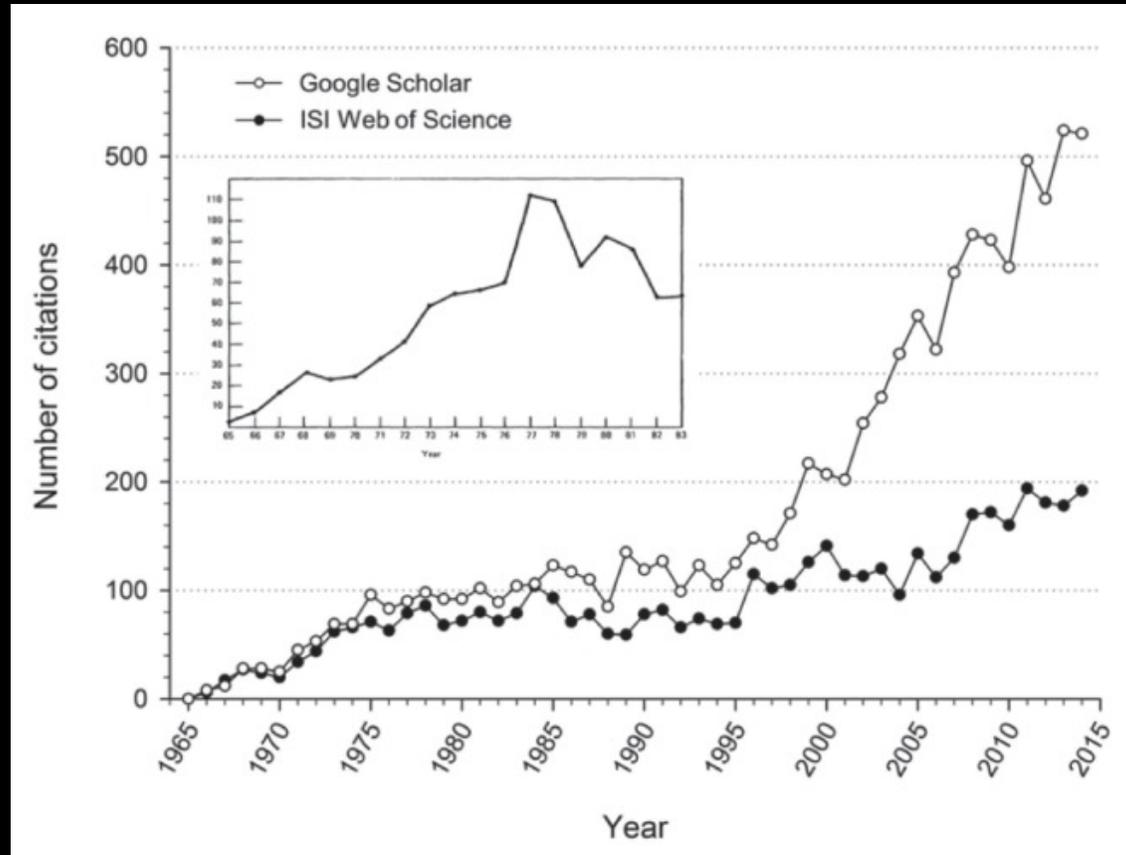
# Gate Control Theory

- Published in 1965 in Science by Melzack and Wall
  - “Pain Mechanisms: A New Theory”
- Revolutionized theory of pain control



Katz, Rosenbloom. The golden anniversary of Melzack and Wall's gate control theory of pain: Celebrating 50 years of pain research and management. Pain Research and Management. 2015 Nov-Dec; 20(6): 285-286  
Melzack, Wall. Pain mechanisms: A new theory. Science. 1965;150:971-9

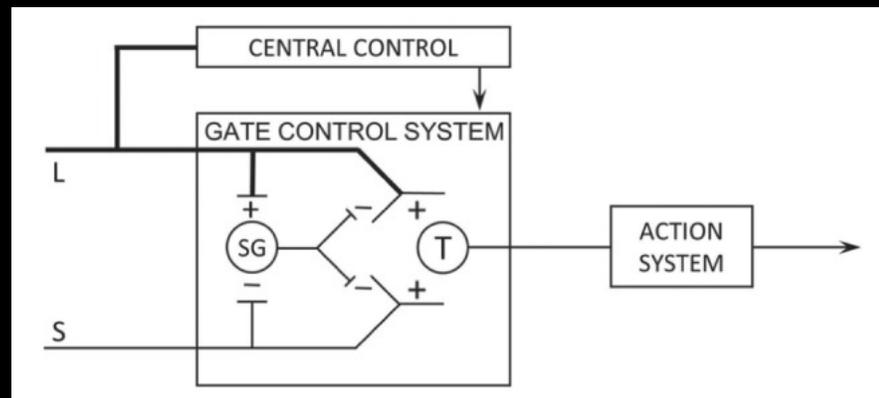
# Gate Control Theory



Katz, Rosenbloom. The golden anniversary of Melzack and Wall's gate control theory of pain: Celebrating 50 years of pain research and management. *Pain Research and Management*. 2015 Nov-Dec; 20(6): 285-286

# Gate Control Theory

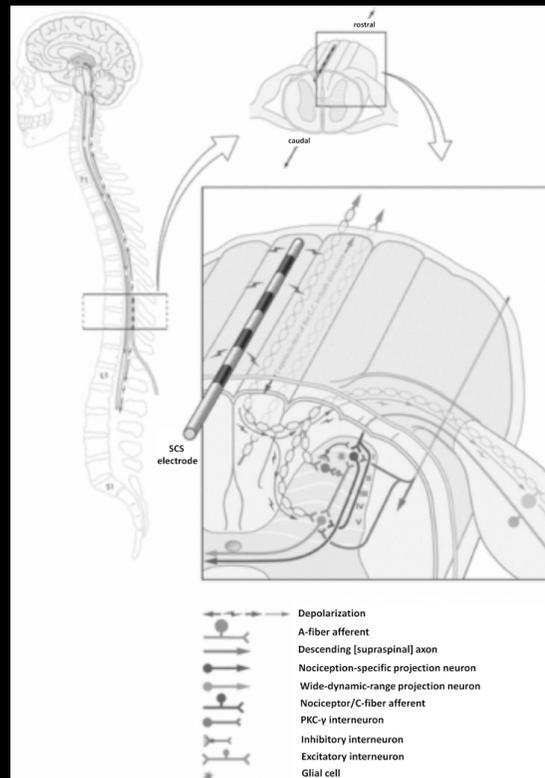
- Gating mechanism in spinal dorsal horn modulates transmission of nerve impulses from afferent fibers to spinal cord transmission cells
  - The gating mechanism is affected by the relative activity in large and small diameter fibers with the former inhibiting transmission (closing the gate) and the latter facilitating transmission (opening the gate)
  - Gating mechanism is also modulated by descending nerve impulses from the brain
  - Burn example



Katz, Rosenbloom. The golden anniversary of Melzack and Wall's gate control theory of pain: Celebrating 50 years of pain research and management. Pain Research and Management. 2015 Nov-Dec; 20(6): 285-286

# Neuromodulation and the Gate Control Theory

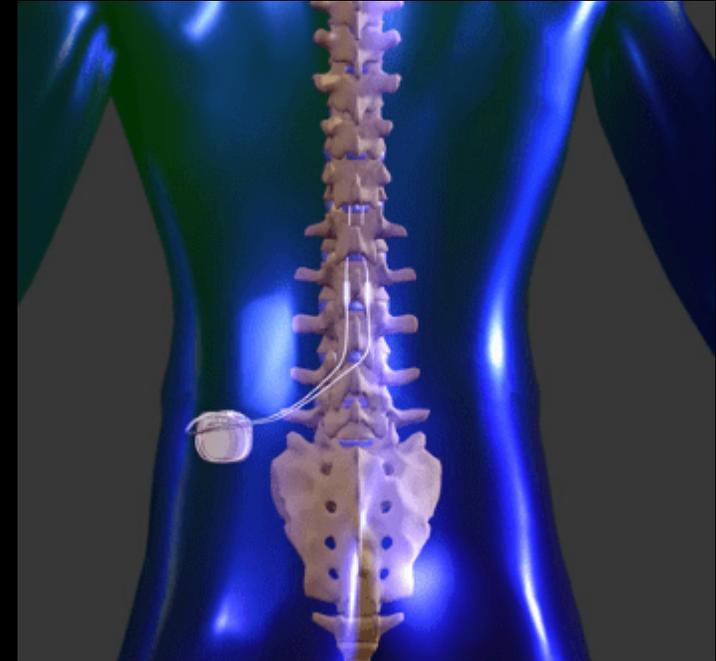
- Conventional SCS devices believed to relieve pain by:
  - Activation of A $\beta$  fibers resulting in variable effects on sensory and pain thresholds
  - Potentiation of inhibition



# Neuromodulation

---

- FDA approved
  - Alleviation of pain in trunk, arms or legs
  - Chronic regional pain syndrome
    - AKA RSD or causalgia
- Most common indication/usage
  - Failed back surgery syndrome
    - Post laminectomy pain syndrome
    - Chronic pain syndrome
- Pacemaker companies
  - Developed a lot of the initial technology

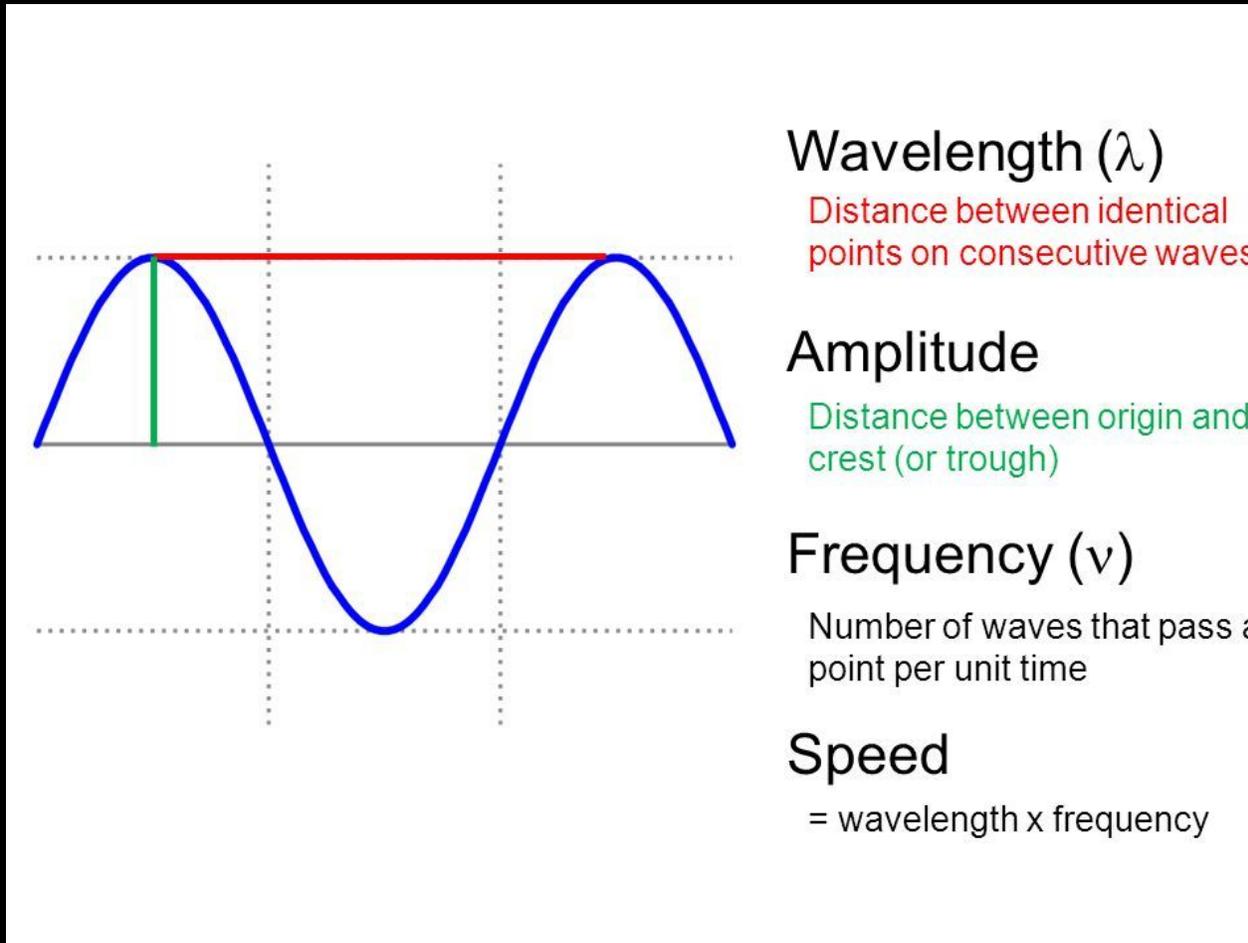


# Amplitude, Frequency, Pulse Width

---

- Parameters we can change with SCS devices
  - Frequency is how often device delivers charge and depolarization
  - Amplitude is relative strength of charge delivered
  - Pulse width is duration of charge delivery
- Tonic or low frequency
  - 20-120Hz range
  - patients perceive individual pulses
- High frequency
  - pulses start to blend so no perception occurs

# Amplitude, Frequency



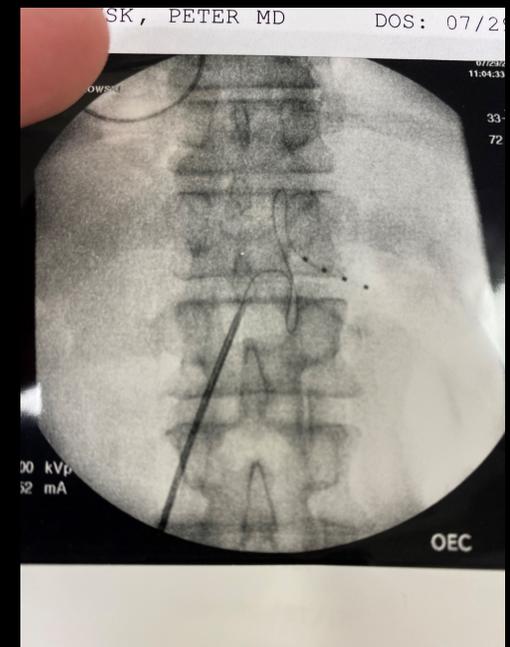
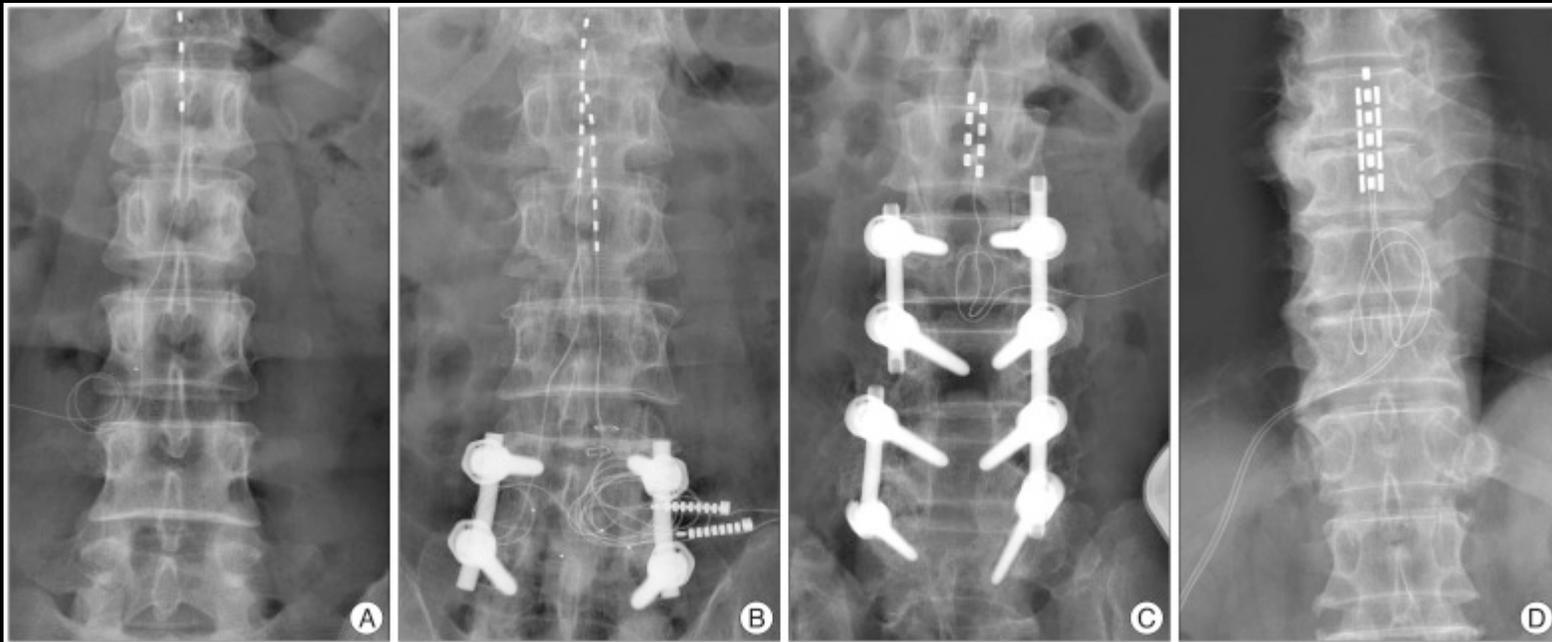
# Traditional vs High Frequency vs DRG

---

- Traditional AKA “low frequency,” “tonic”
  - Tens unit sensation, paresthesia present, can go up to 1200Hz
- High frequency, paresthesia not present, 10,000Hz
- DRG (dorsal root ganglion) stimulators
  - Low frequency, used for focal pain locations

# Electrodes

- Typically 8 electrodes per lead with two leads typically used
- Surgeons can place paddle leads with different configurations
- DRG 4 electrodes



# Evidence for Neuromodulation

---

- Kumar study
- RCT conventional medical management (CMM) vs SCS for neuropathic pain
  - Primary outcome was patients reporting 50% or more relief of leg pain
  - Secondary outcomes were improvement in back pain, QOL, functional capacity, use of medication, patient satisfaction
- Compared with CMM group the SCS group saw
  - Improved back and leg pain, better QOL, greater treatment satisfaction

Kumar, Taylor, Jacques et al. Spinal cord stimulation versus conventional medical management for neuropathic pain: a multicentre randomized controlled trial in patients with failed back surgery syndrome. *Pain*. 2007 Nov;132(1-2): 179-88

# Evidence for Neuromodulation

---

- Deer study
- Multicenter, prospective RCT
  - Following successful trial 100 patients were randomized after implant to receive 12 weeks of tonic stim followed by 12 weeks of burst
  - Primary endpoint assessed the noninferiority of the within-subject difference between tonic and burst for mean daily VAS score
    - Burst stimulation is non inferior to tonic stim
    - Significantly more subjects 70.8% preferred burst over tonic; preference was sustained over 1 year

Deer, Slavin, Amirdelfan et al. Success using neuromodulation with burst (sunburst) study: results from a prospective randomized controlled trial using a novel burst waveform. *Neuromodulation*. 2018 Jan;21(1):56-66

# Evidence for Neuromodulation

- SENZA Study
- Head to head study of low vs high frequency
- 24 month outcomes
  - Sustained, clinically superior outcomes
  - Long term, durable pain relief: 24 MONTHS
    - 76% responder rate
    - 2.4 cm VAS for both back and leg pain
  - Only device labeled as paresthesia-free
  - “Top Pain Paper of the Year”

Kapural, Leonardo et. al. Novel 10-kHz High-frequency Therapy (HF10 Therapy) Is Superior to Traditional Low-frequency Spinal Cord Stimulation for the Treatment of Chronic Back and Leg Pain: The SENZA-RCT Randomized Controlled Trial. Anesthesiology Vol. 123 No 4. October 2015.

OPEN

Leonardo Kapural, MD, PhD\*  
Cong Yu, MD‡  
Matthew W. Doust, MD§  
Bradford E. Gliner, MS¶  
Ricardo Vallejo, MD, PhD||  
B. Todd Sitzman, MD, MPH#  
Kasra Amirdelfan, MD\*\*  
Donna M. Morgan, MD‡‡  
Thomas L. Yearwood, MD, PhD§§  
Richard Bundschu, MD¶¶  
Thomas Yang, MD‡‡  
Ramsin Benyamin, MD||  
Abram H. Burgher, MD§

\*Center for Clinical Research and Carolina Pain Institute at Brookstone, Wake Forest Baptist Health, Winston-Salem, North Carolina; †Swedish Pain Center, Seattle, Washington; ‡The Pain Center of Arizona and HOPE Research Institute, Phoenix, Arizona; ‡Clinical and Regulatory Affairs, Nevro Corp., Menlo Park, California; ||Millennium Pain Center, Bloomington, Illinois; #Advanced Pain Therapy, PLLC, Hattiesburg, Mississippi; \*\*Pain Medical Group, Inc., Walnut Creek, California; ††Pain Consultants of Oregon, Eugene, Oregon; ‡‡Comprehensive Pain & Rehabilitation, Pascagoula, Mississippi; ¶¶Coastal Orthopedics and Pain Medicine, Bradenton, Florida

Funding for this study was provided by Nevro Corp.

Correspondence:  
Leonardo Kapural, MD, PhD,  
Carolina Pain Institute at Brookstone,  
Wake Forest Baptist Health,  
605 Cotton Street,  
Winston-Salem,  
NC 27103.  
Email: lkapural@ccrpain.com

Received, October 12, 2015.  
Accepted, July 9, 2016.

Copyright © 2016 by the  
Congress of Neurological Surgeons. This  
is an open access article distributed under  
the terms of the Creative Commons  
Attribution Non-Commercial NoDerivs  
License 4.0 (CC BY-NC-ND), which permits  
downloading and sharing the work  
provided it is properly cited. The work  
cannot be changed in any way or used  
commercially.

## Comparison of 10-kHz High-Frequency and Traditional Low-Frequency Spinal Cord Stimulation for the Treatment of Chronic Back and Leg Pain: 24-Month Results From a Multicenter, Randomized, Controlled Pivotal Trial

**BACKGROUND:** Pain relief with spinal cord stimulation (SCS) has focused historically on paresthesia overlapping chronically painful areas. A higher level evidence supports the use of SCS in treating leg pain than supports back pain, as it is difficult to achieve adequate paresthesia coverage, and then pain relief, in the low back region. In comparison, 10-kHz high-frequency (HF10) SCS therapy does not rely on intraoperative paresthesia mapping and remains paresthesia-free during therapy.

**OBJECTIVE:** To compare long-term results of HF10 therapy and traditional low-frequency SCS.

**METHODS:** A pragmatic randomized, controlled, pivotal trial with 24-month follow-up was conducted across 11 comprehensive pain treatment centers. Subjects had Visual Analog Scale scores of  $\geq 5.0/10.0$  cm for both back and leg pain, and were assigned randomly (1:1) to receive HF10 therapy or low-frequency SCS. The primary end point was a responder rate, defined as  $\geq 50\%$  back pain reduction from baseline at 3 months with a secondary end point at 12 months (previously reported). In this article, 24-month secondary results are presented. Non-inferiority was first assessed, and if demonstrated the results were tested for superiority.

**RESULTS:** In the study, 198 subjects were randomized (101 HF10 therapy, 97 traditional SCS). One hundred seventy-one subjects (90 HF10 therapy, 81 traditional SCS) successfully completed a short-term trial and were implanted. Subjects averaged  $54.9 \pm 12.9$  years old,  $13.6 \pm 11.3$  years since diagnosis, 86.6% had back surgery, 88.3% were taking opioid analgesics. At 3 months, 84.5% of implanted HF10 therapy subjects were responders for back pain and 83.1% for leg pain, and 43.8% of traditional SCS subjects were responders for back pain and 55.5% for leg pain ( $P < .001$  for both back and leg pain comparisons, non-inferiority and superiority). At 24 months, more subjects were responders to HF10 therapy than traditional SCS (back pain: 76.5% vs 49.3%; 27.2% difference, 95% CI, 10.1%-41.8%;  $P < .001$  for non-inferiority and superiority; leg pain: 72.9% vs 49.3%; 23.6% difference, 95% CI, 5.9%-38.6%;  $P < .001$  for non-inferiority and  $P = .003$  for superiority). Also at 24 months, back pain decreased to a greater degree with HF10 therapy (66.9%  $\pm$  31.8% than traditional SCS (41.1%  $\pm$  36.8%,  $P < .001$  for non-inferiority and superiority). Leg pain also decreased to a greater degree with HF10 therapy (65.1%  $\pm$  36.0%) than traditional SCS (46.0%  $\pm$  40.4%,  $P < .001$  for non-inferiority and  $P = .002$  for superiority).

**CONCLUSION:** This study demonstrates long-term superiority of HF10 therapy compared with traditional SCS in treating both back and leg pain. The advantages of HF10 therapy are anticipated to impact the management of chronic pain patients substantially.

**KEY WORDS:** Back pain, Chronic pain, Leg pain, Paresthesia, Spinal cord stimulation

Neurosurgery 0:1-10, 2016

DOI: 10.1227/NEU.00000000000001418

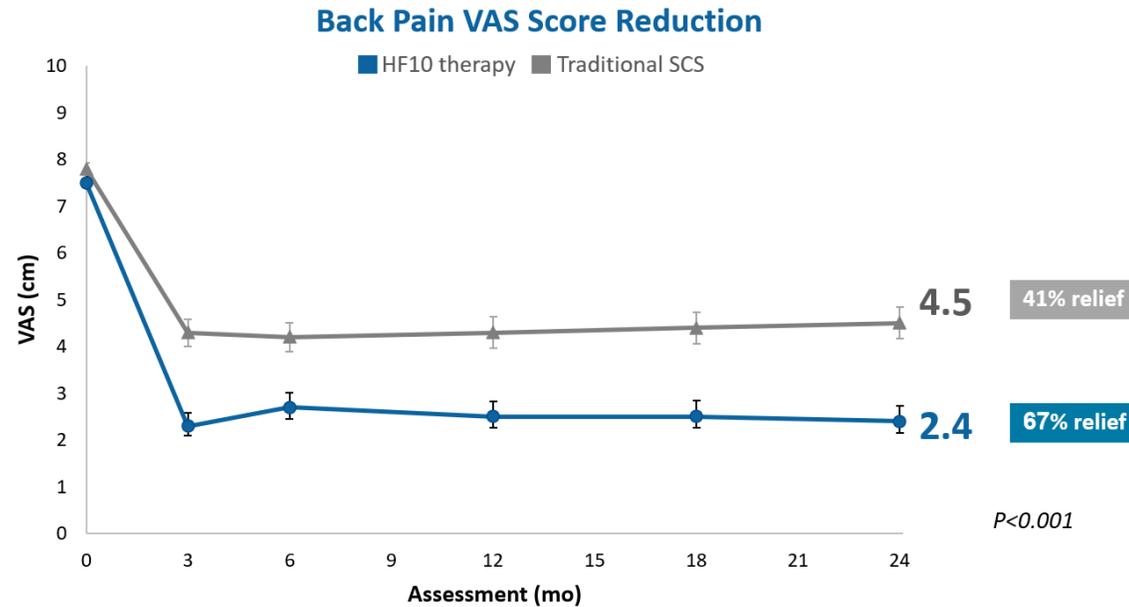
www.neurosurgery-online.com

**ABBREVIATIONS:** HF10, 10-kHz high-frequency therapy; IPG, implantable pulse generator; MCD, minimal clinically important difference; PI, permanent implant; ODI, Oswestry Disability Index; SCS, spinal cord stimulation; VAS, Visual Analog Scale

**E**ffective pain relief with spinal cord stimulation (SCS) has historically been critically dependent on overlapping stimulation-induced paresthesias with chronically painful areas. Although efficacy of SCS for the treatment

# Evidence for Neuromodulation....High Frequency

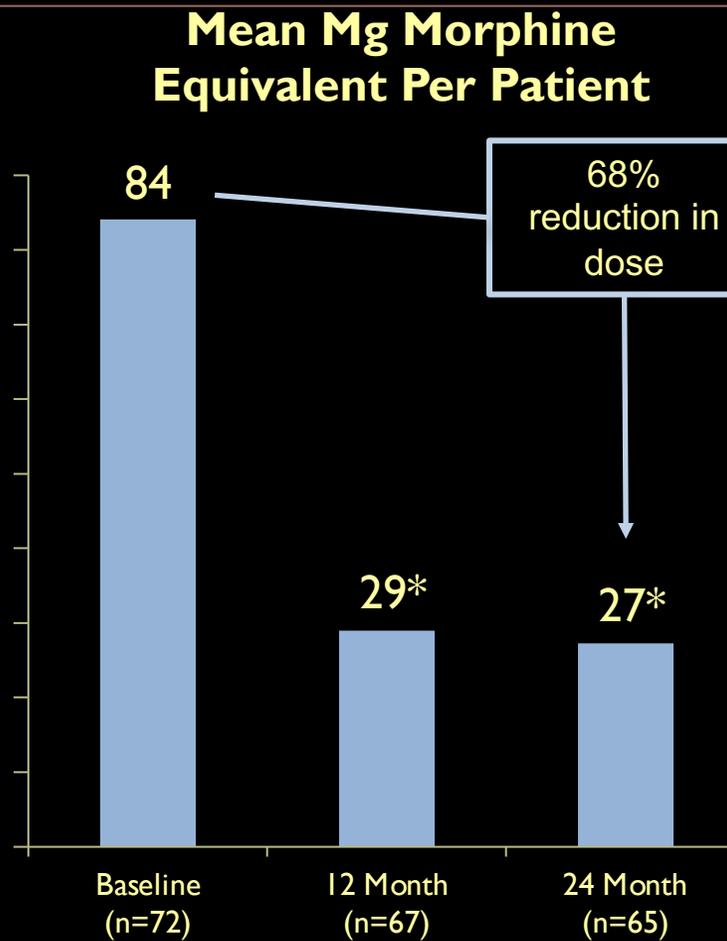
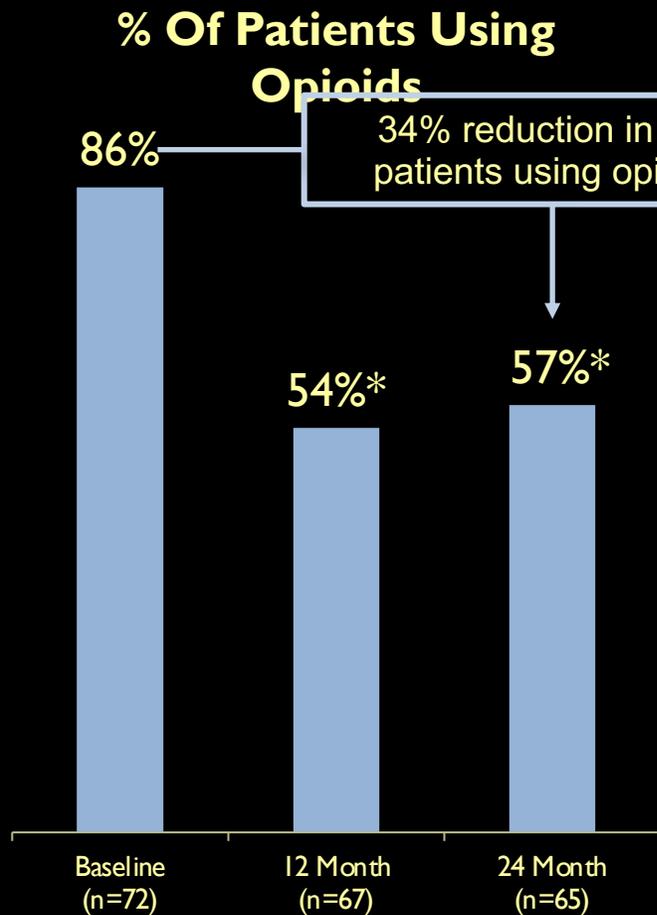
## DURABLE BACK PAIN RELIEF TO 24 MONTHS



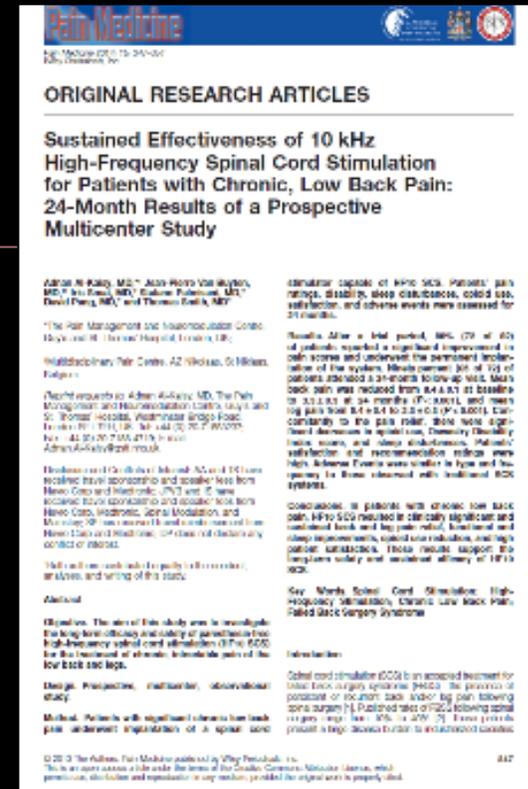
HF10 Therapy: Superior Back Pain All Time Points Measured

Kapural, Leonardo et. al. Novel 10-kHz High-frequency Therapy (HF10 Therapy) Is Superior to Traditional Low-frequency Spinal Cord Stimulation for the Treatment of Chronic Back and Leg Pain: The SENZA-RCT Randomized Controlled Trial. Anesthesiology Vol. 123 No 4. October 2015.

# Decreased Opioid Use in SENZA-EU Trial with HF10 therapy After 2 Years



\* p-value < 0.001 compared to Baseline

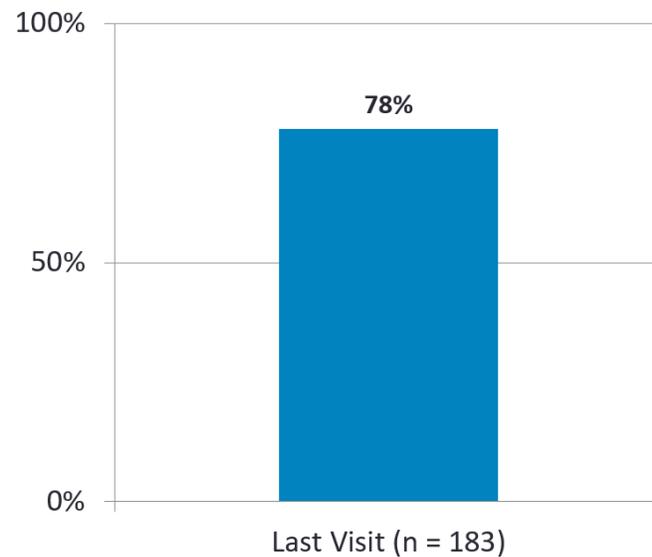


# Opioid Reduction in Real World Practice

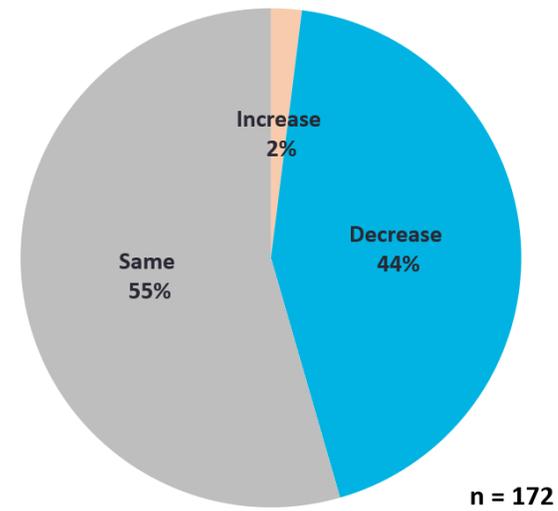
## Results in My Permanent Implant Patients



Responder Rate ( $\geq 50\%$  pain relief)



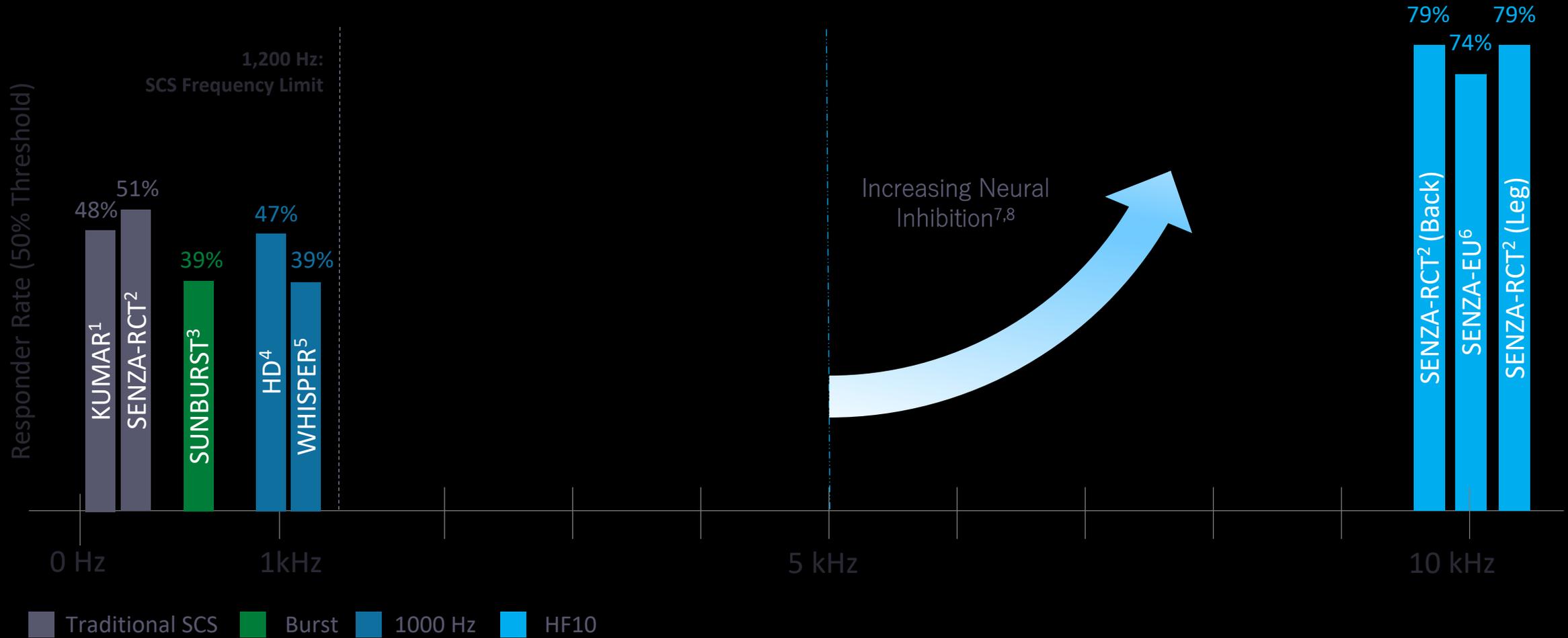
Last Visit Medication Change of IPG Patients



Average number of months between IPG procedure and last visit is 17.3 (min=1.0, max=48.8)

Rev 2020195A

# Frequency Matters



# Procedure Overview (Trial)

---

- Only pain procedure that requires psychiatric/psychological clearance by insurance company
  - Patient is malingering or faking symptoms
  - Patient will call if there is infection or issues with device
  - Most of these patients have undergone previous spine surgery
  - Large scar present on back



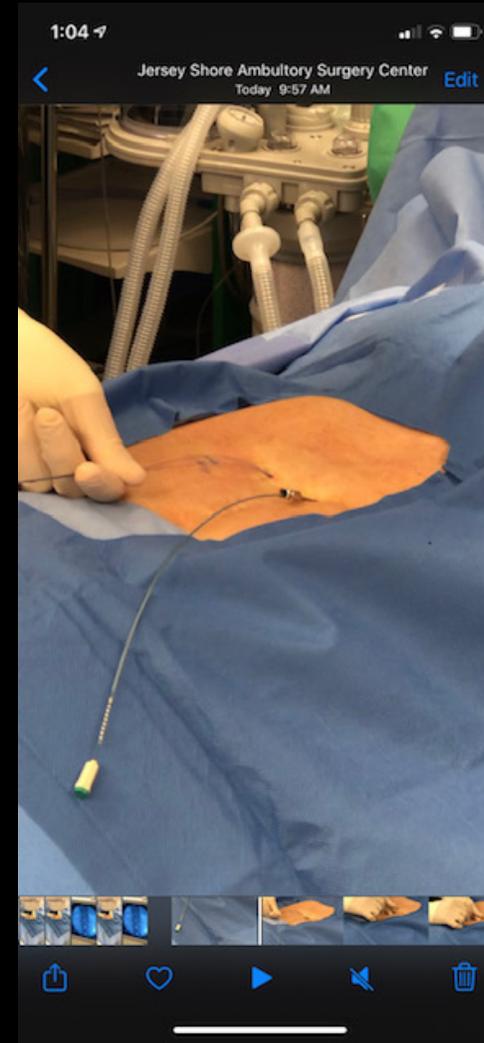
# Procedure Overview (Trial)

---

- Placement of percutaneous electrodes into epidural space
- Just like performing an epidural. Done under xray
  - Rather than injecting medication electrodes are placed
  - Trial leads stay in place for 5-7days and are connected to a battery
    - If >50% pain reduction
    - Implant can be performed

# Procedure Overview (Trial)

---



# Procedure Overview (Trial)

---



# Procedure Overview (Permanent Implant)

---

- Leads are again placed into epidural space and then tunneled under skin to a battery
  - Battery, which powers the device, is placed in the flank
- Battery
  - Rechargeable vs Non-Rechargeable



# Complications/Risks of Procedure

---

- Infection
  - Epidural abscess
    - Paralysis
- Bleeding
  - Epidural hematoma
    - Paralysis
- Lead migration/lead fracture
  - Loss of efficacy

# Contraindications

---

- Severe uncontrolled psychological disorders
  - Schizophrenia, depression, bipolar disorder
- Bleeding disorder
- Use of blood thinners or NSAIDs
- Active infection
- Relative contraindication
  - Need for continued MRI studies
    - Most newer devices have MRI approval

---

# Questions