



Lumbar Spinal Stenosis & Neurogenic Claudication

PATIENT INFORMATION GUIDE

What Is Spinal Stenosis?

Your spinal nerves run through a canal in the center of your spine and exit through small openings on each side. **Stenosis** means that space has narrowed, usually slowly over many years: the joints of the spine enlarge with arthritis, a ligament along the back of the canal thickens and buckles inward, and the discs bulge. In some people one vertebra also slips slightly forward on the one below it. Together, these changes crowd the nerves that run to your legs. Many people have stenosis on an MRI and feel fine — it matters only when it causes symptoms.

What Neurogenic Claudication Feels Like

Neurogenic claudication is leg pain or weakness brought on by standing and walking because the nerves are pinched. Standing upright and leaning back make the canal smaller. Sitting and bending forward open it back up.

Common Symptoms

- Aching, cramping, or burning in the buttocks, thighs, or calves
- Numbness or tingling in one or both legs
- Legs that tire, feel heavy, or “give out” with walking
- Low back pain, often milder than the leg symptoms

The Typical Pattern

- **Worse** with standing, walking, and walking downhill
- **Better** within minutes of sitting down or bending forward
- Easier to walk leaning on a shopping cart or walker
- Cycling is often easier than walking

Is It the Nerves or the Circulation?

Poor blood flow to the legs also causes leg pain with walking. Circulation pain usually eases when you simply *stop and stand still*; bending forward makes no difference. If you smoke, have diabetes, or have weak pulses in your feet, we may check your circulation before treating your spine — some people have both.

What to Expect & How We Evaluate It

Stenosis is usually not dangerous or rapidly progressive. For many people symptoms stay about the same for years; some improve and some slowly worsen. Most treatment decisions are about **quality of life** — how far you can walk and what you want to do — not preventing an emergency. An MRI shows *where* the narrowing is and *what* is causing it, which determines which treatments can help. Standing X-rays check for slippage.

What You Can Do

- **Stay active.** Rest does not make stenosis better. Walk in intervals, resting briefly when symptoms start.
- **Physical therapy** focused on core strength, hip flexibility, and flexion-based exercise.
- **Stationary bike, recumbent bike, or pool exercise** to build endurance without triggering symptoms.
- **Weight loss and stopping smoking** both reduce the load on the spine and help healing.
- **Non-opioid medications** to manage flares, as directed by your provider.

Important: When to Seek Care Right Away

Go to the emergency room if you develop **new numbness in the groin, genitals, or inner thighs, loss of control of your bladder or bowels, or rapidly worsening weakness** in your legs. These are rare, but they need urgent evaluation. Call our office promptly for a new foot drop or a sudden change in your symptoms.

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Abilene Pain Locations

Main: 1925 Hospital Place

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Spinal Stenosis: Treatment Options

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There is no single best treatment for stenosis. The right option depends on **what is causing the narrowing on your MRI**, how much your symptoms limit you, your health, and your goals.

Epidural Steroid Injection (ESI)

Using X-ray guidance, we place a steroid and numbing medicine in the space around the narrowed nerves to calm inflammation.

What to expect: For stenosis, relief is usually partial and temporary — often weeks to a few months — and the injection does not change the narrowing itself. Because the benefit is modest, we use them selectively: to get you through a flare, to make walking and therapy possible, or to help confirm which level is causing your symptoms. We space injections out and limit how many you receive. Steroid can raise blood sugar for several days, and blood thinners must be reviewed before the procedure.

MILD Procedure (Minimally Invasive Lumbar Decompression)

Through a small skin opening and under X-ray guidance, small pieces of the **thickened ligament** at the back of the spinal canal are removed to make more room for the nerves. No implant is left behind. **Who it is for:** MILD only works when a thickened ligament is a major cause of narrowing in the *central* canal — your MRI has to show this. It does not treat narrowing caused mainly by a disc, by bone spurs at the side openings, or by significant slippage. In a randomized study, patients who had MILD along with ongoing non-surgical care walked and functioned better than patients who continued non-surgical care alone.

Interspinous Spacer

A small implant is placed through a small incision between two bony points on the back of the spine. It holds that level slightly bent forward — the position that relieves you when you lean on a shopping cart — keeping the canal more open when you stand and walk. **Who it is for:** Moderate stenosis at one or two levels in patients whose symptoms clearly improve with bending forward and who have not improved after at least six months of non-surgical treatment. It is not used when there is significant slippage or instability, or with weak bones. Risks include fracture of the bone the implant rests on, the implant shifting, and symptoms that persist; some patients later need traditional surgery. Insurance coverage varies, and we verify it before scheduling.

Surgical Evaluation

Surgery — most often a **decompression (laminectomy)**, which removes the bone and ligament pressing on the nerves, sometimes with a **fusion** if the spine is unstable — is the most complete way to open the canal. For significant stenosis, surgery generally produces greater improvement than non-surgical care, with a longer recovery and greater risk. We recommend a surgical opinion when weakness or symptoms are severe or progressing, when there is significant slippage or instability, when narrowing involves several levels, or when less invasive options have not worked or do not fit your anatomy. **A surgical evaluation is a consultation, not a commitment** — and we continue to manage your care either way.

OPTION	INCISION	IMPLANT	ANESTHESIA	TYPICAL DOWNTIME
Epidural injection	None (needle)	No	Local ± sedation	Same or next day
MILD	Small skin opening	No	Local + sedation	1–2 days
Interspinous spacer	Small incision	Yes	Sedation or general	Days; lifting limits for weeks
Decompression surgery	Larger incision	Only if fused	General	Weeks to months

The Honest Summary

Injections can relieve symptoms for a while but do not change the narrowing. MILD and spacers create more room without major surgery, but only for the right anatomy. Surgery is the most definitive, with the longest recovery. We match the option to **your MRI, your symptoms, and your goals** — and tell you plainly when an option is not a good fit.

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