RADIOGRAPHIC EVALUATION OF THORACOLUMBAR STABILIZATION USING TWO DIFFERENT ORTHOSIS SYSTEMS

ABSTRACT

Objective: To evaluate radiographically the stability of the thoracolumbar junction comparing the two types of thoracolumbosacral orthosis (TLSO) most used in our environment, the Jewett and the Boston braces. Methods: After approval by the institutional review board, nine participants were submitted to X-rays in the profile view, with the beam focused on T12, in the orthostatic position, maximal flexion without brace and maximal flexion with the Jewett and the Boston braces. The Cobb angle of the thoracolumbar junction (T10-L2) was measured and the values compared using the student T test (p < 0.05). Results: The Boston brace promoted greater stabilization of the thoracolumbar junction during flexion of the trunk compared to the Jewett brace (p < 0.05). In addition, there was no statistical difference in the Cobb angle of the thoracolumbar junction in the orthostatic (neutral) position and in flexion using the Boston brace. Conclusion: The Boston brace presented greater stabilization of the thoracolumbar region during flexion of the trunk compared to the Jewett brace. Level of Evidence II; Prospective comparative study.

Keywords: Orthotic devices; Spinal injuries; Radiography; Treatment outcome.

INTRODUCTION

The thoracolumbar junction (T10-L2) is the region most prone to thoracic and lumbar spine fractures and the treatment of these fractures is still controversial. Although used for several centuries since the time of Hippocrates, the conservative treatment of transitional fractures was only systematically described by Bedbrook in the 1970s, when bed rest was recommended for 6 to 8 weeks, followed by gradual mobilization.

Study conducted at the Grupo de Coluna do Centro de Reabilitação e Readaptação Dr. Henrique Santillo (CRER – Goiânia/GO).

Correspondence: Rua 70, 351, apto 302, Jardim Goiás, Goiânia, Go. Brazil. CEP 74810-350. murilodaher@uol.com.br

HTTP://dx.doi.org/10.1590/S1851-20181704179128

Coluna/Columna. 2018;17(4):300-2

Received on 04/26/2017 accepted on 08/24/2018
Thoracic Lumbar Sacral Orthoses (TLSO) became popular in the 1980s, and several authors reported good results with this approach in the treatment of burst fractures.4,5

The good results of conservative treatment were confirmed in the 1990s, and some authors began to advocate earlier patient mobilization.6,7 At the same time, there was growing enthusiasm for the surgical approach, seeking a more anatomical reduction of the fracture in an attempt to achieve better clinical results. However, Wood et al.,8 in a prospective, randomized study in the early 2000s, demonstrated that patients with burst fracture without neurologic deficit presented better results with conservative treatment (orthoses) when compared to surgical treatment.

More recently, a number of authors have proposed an even less invasive approach, questioning the use of the brace in more stable thoracolumbar spine injuries.9,10 However, the use of orthoses for the conservative treatment of thoracolumbar junction fractures is still common practice in our field, and there is no consensus regarding the best brace to be used.

The aim of this study is to perform a radiographic evaluation of the stability of the thoracolumbar junction, comparing the two types of TLSO used most often in our specialty, the Jewett brace, and the Boston brace.

**METHODS**

Following approval by the Institutional Review Board (IRB) (50271015.1.0000.0023) we selected nine healthy male volunteers with no history of spinal pathologies. These volunteers, who were all employees or physicians of the institution where the research study was conducted, filled out an informed consent form.

All the participants were taken to the orthopedic workshop (which is licensed to operate by the Brazilian Ministry of Health under ministerial directive No. 793 of April 24, 2012) where two types of custom-made TLSO were produced:

- **Jewett:** orthosis in hyperextension with support in the anterior region of the sternum and pubis, and posterior support at the thoracolumbar junction.11
- **Boston:** custom made orthosis in rigid polypropylene (Figure 2)

These models were chosen because they are the most used in our field for the treatment of thoracolumbar junction fractures.11

Once the braces had been produced, the research subjects underwent spine x-rays with the central beam targeted on T12, in the lateral view, in the neutral orthostatic position, in maximum flexion without brace, and in maximum flexion with the Jewett and Boston braces. Prior to the tests in flexion, the participants were instructed to perform five cycles of flexion and extension of the trunk to familiarize themselves with movement wearing the brace. All the tests were supervised and positioned by one of the authors of the work (VNN) to ensure correct positioning of the patient, uniformity of the test, and correct adjustment of the braces. The tests were performed at a constant distance of 1.8 m using Polymat Plus radiography equipment (Siemens Medical System, Inc, Iselin, NJ) and scanned in CR (Computed Radiography, Fujiﬁlm Medical Systems, USA). Lead protective garments were worn in the area of the thyroid and gonads, and goggles were also worn.

The Cobb angle of the thoracolumbar junction (upper plateau of T10 and lower plateau of L2) was measured, and the values were compared with the patient in the orthostatic position without a brace, in ﬂexion without a brace, and in ﬂexion wearing either the Jewett brace or the Boston brace. Extension radiographs were not taken, in order to minimize exposure to radiation, as the main function of the orthosis is to avoid kyphotic deformities.

In addition, all the participants were asked the following questions: Which brace gave you a sense of greater stability? Which brace did you feel most comfortable wearing?

The data were collected and recorded in a spreadsheet (Excel - Microsoft Office 2013) and subsequently transferred to SPSS - IBM software version 23 for statistical analysis. Quantitative variables were presented with their means and standard deviations. Comparison of means was performed using the paired sample t-test. All tests were applied accepting a 5% probability of error and considering a 95% conﬁdence interval.

**RESULTS**

The study participants were 9 volunteers with an average age of 28.8 years (±2.1) and mean Body Mass Index of 26.5 Kg/m² (±3.0). The Cobb angles are described in Table 1.

| Evaluation                  | Mean (Standard Deviation) |
|-----------------------------|---------------------------|
| Neutral orthostatic         | 7.0° (5.7)                |
| Maximum flexion without brace | 28.0° (6.1)              |
| Flexion with Boston         | 7.9° (6.5)                |
| Flexion with Jewett         | 12.3° (7.4)               |

There was no association between mobility of the thoracolumbar junction and BMI using either brace.

Comparison of thoracolumbar junction angulation is described in Table 2. Kyphotization with the Boston brace was significantly lower than that permitted with the Jewett brace. In addition, there was no statistical difference between the neutral position and wearing the Boston brace.

All participants reported that the Boston brace gave them a sense of greater stability, except for one who was indifferent. In addition, 7 participants said that the Jewett brace was more comfortable, although one participant said there was no difference, and one found the Boston brace more comfortable.
Table 2. Comparison of the degree of kyphosis with and without the use of the braces.

| Evaluation                                      | Mean (Standard Deviation) | p     |
|------------------------------------------------|---------------------------|-------|
| Flexion with Boston                             | 79° (6.5)                 | 0.021*|
| Flexion with Jewett                             | 12.3° (7.4)               |       |
| Maximum flexion without brace                   | 28.0° (6.1)               | <0.001*|
| Flexion with Boston                             | 79° (6.5)                 |       |
| Maximum flexion without brace                   | 28.0° (6.1)               | <0.001*|
| Flexion with Jewett                             | 12.3° (7.4)               |       |
| Orthostatic in neutral position                 | 70° (5.7)                 | 0.626*|
| Flexion with Boston                             | 79° (6.5)                 |       |
| Orthostatic in neutral position                 | 70° (5.7)                 | 0.044*|
| Flexion with Jewett                             | 12.3° (7.4)               |       |

*Student-t test for paired samples.

DISCUSSION

Adequate treatment of thoracolumbar junction fractures is still a controversial issue. Although there are more recent studies showing that some fractures can be treated with early ambulation and without a brace, this practice is not yet the most common.1,10 In the study by Bailey et al.,9 only patients with burst fractures with segmental kyphosis below 35° were included in the sample. The patients were randomized to wear the brace or not, and the clinical and radiographic results were compared. Although the main evaluation, performed at 3 months of follow-up, did not show any functional difference between the groups, in the earlier evaluation the group that wore the brace experienced less pain and less kyphosis of the segment, but did not achieve statistical significance. In addition, this study used post-cast orthoses, with a design similar to that of the Jewett brace, which was the orthosis with the least ability to stabilize the thoracolumbar segment in our study.

The study by Ohana et al.10 is a retrospective cohort study that assessed patients treated with and without a brace. Although the lack of a standard indication of brace usage was mentioned, non-use of orthosis in fractures with a more stable aspect (initial kyphosis of 9.7° in the group treated with a brace and 5.7° in the group treated without a brace, with no statistical difference) is usually recommended. Only wedge fractures (type A1 according to the AO classification) which are very stable fractures, in which brace stabilization may lose its function, were treated. Moreover, the assessment was only radiographic after one year of follow-up, not allowing evaluation of the potential pain relieving action of the brace in the early phase of the treatment.

In view of all these factors, use of the brace is still a very common practice in the treatment of patients with thoracolumbar junction fractures. Despite several reports of good results,6,7 little is known about the best orthosis to be used at this time.

The Jewett or hyperextension orthosis is one of the most used. Although American literature predominantly uses prefabricated and adjustable orthoses, in our field this is not the most common practice due to the high cost of these devices.

Our study demonstrated that the Boston brace provides greater stabilization of the thoracolumbar junction during flexion than the Jewett brace. It has also been shown that even during forced flexion with the Boston brace, there is no kyphosis of this region in relation to the neutral position, which did not happen during flexion with the Jewett brace.

These results suggest that the Boston brace is a better treatment option for thoracolumbar spine fractures than the Jewett brace, especially in cases requiring greater stability (e.g., burst fractures with a lower degree of kyphosis than necessary for surgical indication).

Our study has several limitations, such as sample size and evaluation of the intact region (without the presence of a fracture). However, it was the only study found in the literature that assessed the radiographic mobility of the region most affected by fractures, comparing the two main types of orthosis used in our field.

CONCLUSION

The Boston brace provides greater stabilization of the thoracolumbar region during flexion of the trunk than the Jewett brace.

All authors declare no potential conflict of interest related to this article.

REFERENCES

1. Holmes JF, Miller PQ, Panacek EA, Lin S, Home NS, Mower WR. Epidemiology of thoracolumbar spine injury in blunt trauma. Acad Emerg Med. 2001;8(9):866-72.
2. Bradford DS, Akbaria BA, Winter RB, Seljeskog EL. Surgical stabilization of fractures and fracture dislocations of the thoracic spine. Spine 1977;2:195-96.
3. Bedbrook GM. Treatment of thoracolumbar dislocation and fractures with paraplegia. Clin Orthop Relat Res. 1984;189:142-9.
4. Denis F Armstrong GW, Sears K, Matts L. Acute thoracolumbar burst fractures in the absence of neurologic deficit. A comparison between operative and nonoperative treatment. Clin Orthop Relat Res. 1984;189:142-9.
5. Reid DC, Hu R, Davis LA, Sabo LA. The nonoperative treatment of burst fractures of the thoracolumbar junction. J Trauma. 1988;28(8):1188-94.
6. Cantor JB, Lebwohl NH, Garvey T, Eismont FJ. Nonoperative management of stable thoracolumbar burst fractures with early ambulation and bracing. Spine (Phila Pa 1976). 1993;18(9):971-6.
7. Chow GH, Nelson BJ, Gebhard JS, Brugman JL, Brown CW, Donaldson DH. Functional outcome of thoracolumbar burst fractures managed with hyperextension casting or bracing and early mobilization. Spine (Phila Pa 1976). 1996;21(18):2170-5.
8. Wood K, Buttermann G, Melbod A, Garvey T, Hansen R, Sechrest V. Operative compared with nonoperative treatment of a thoracolumbar burst fracture without neurological deficit. A prospective, randomized study. J Bone Joint Surg Am. 2003;85-A(10):173-81.
9. Bailey CS, Dvorak MT, Thomas KC, Boyd MC, Paquet S, King BA. Nonoperative treatment of thoracolumbosacral orthosis and no orthosis for the treatment of thoracolumbar burst fractures: interim analysis of a multicenter randomized clinical equivalence trial. J Neurosurg Spine. 2009;11(3):295-303.
10. Ohana N, Shnirin D, Rash E, Sassin A, Atar D. Is there a need for lumbar orthosis in mild compression fractures of the thoracolumbar spine?: A prospective study comparing the radiographic results between early ambulation and without lumbar orthosis. J Spinal Disord. 2000;13(4):305-8.
11. Patwardhan AG, Li SR, Gawn T, Lorenz M, Meade KP, Zindrick M. Orthotic stabilization of thoracolumbar injuries. A biomechanical analysis of the Jewett hyperextension orthosis. Spine (Phila Pa 1976). 1990;15(7):654-61.
12. Vaccaro AR, Oner C, Kepley CK, Dvorak M, Schnake K, Bellabarba C, et al. AOSpine thoracolumbar spine injury classification system: fracture description, neurological status, and key modifiers. Spine (Phila Pa 1976). 2013;38(20):2029-37.