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Lumbar spinal stenosis

comparison of surgical practice variation and clinical outcome in three national spine registries

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Author: Greger Lønne, Peter Fritzell, Olle Hägg, Dennis Nordvall, Paul Gerdhem, Tobias Lagerbäck, Mikkel Andersen, Søren Eiskjaer, Martin Gehrchen, Wilco Jacobs, Miranda L. van Hooff, Tore K. Solberg



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1 Lumbar spinal stenosis: Comparison of surgical practice variation 2 and clinical outcome in three national spine registries

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4 Greger Lønne^{a,b,c}, M.D., Ph.D., Peter Fritzell^{d,e,f,g}, M.D., Ph.D., Olle Hägg^{h,i}, M.D., Ph.D.,
5 Dennis Nordvall^g, Paul Gerdhem^{j,k}, M.D., Ph.D., Tobias Lagerbäck^{j,k}, M.D., Mikkel
6 Andersen^l, M.D., Søren Eiskjaer^m, M.D., Martin Gehrchenⁿ, M.D., Ph.D., Wilco Jacobs^o,
7 M.Sc., Ph.D., Miranda L van Hooff^{p,q}, M.Sc., Ph.D., Tore K Solberg^{c,r,s}, M.D., Ph.D.,
8

9 ^aDepartment of Orthopaedics, Innlandet Hospital Trust, Lillehammer, Norway

10 ^bNational Advisory Unit on Spinal Surgery, St. Olavs Hospital, Trondheim University Hospital, Trondheim,
11 Norway

12 ^cThe Norwegian Registry for Spine Surgery (NORspine), Northern Norway Regional Health Authority, Norway

13 ^dDepartment of Orthopaedics, Capho St Göran Hospital, Stockholm, Sweden

14 ^eDepartment of Surgical Sciences, Division of Orthopaedics, Uppsala University, Sweden

15 ^fStrömstad akademi, Strömstad, Sweden

16 ^gCulturum Center for Learning and Innovation in Healthcare, Jönköping, Sweden

17 ^hSpine Center Göteborg, Göteborg, Sweden

18 ⁱSwespine Steering Group, Swedish National Spine Register, Jönköping, Sweden

19 ^jDepartment of Orthopaedics, Karolinska University Hospital Huddinge, Sweden

20 ^kDepartment of Clinical Science, Intervention and Technology, Karolinska Institutet, Stockholm, Sweden

21 ^lSector for Spine Surgery and Research, Lillebaelt Hospital, Middelfart, Denmark

22 ^mDepartment of Orthopedic Surgery, Aalborg University Hospital, Aalborg, Denmark

23 ⁿSpine Unit, Department of Orthopaedic Surgery, Rigshospitalet University of Copenhagen, Denmark

24 ^oThe Health Scientist, The Hague, The Netherlands

25 ^pDepartment Research, Sint Maartenskliniek, Nijmegen, The Netherlands

26 ^qDepartment of Orthopedics, Radboud university medical center, Nijmegen, The Netherlands

27 ^rDepartment of Neurosurgery, University Hospital of Northern Norway, Tromsø, Norway

28 ^sInstitute of Clinical Medicine, University of Tromsø The Arctic University of Norway, Tromsø, Norway

32 Corresponding author:

33 Greger Lønne

34 Innlandet Hospital Trust

35 Department of orthopedic surgery

36 Anders Sandvigs gt. 17

37 2629 Lillehammer

38 Norway

40 Mob: +47 971 14 107

41 Email: gloenne@mac.com

44 ABSTRACT

45 **Background:** Decompression surgery for lumbar spinal stenosis (LSS) is the most common
46 spinal procedure in the elderly. To avoid persisting low back pain, adding arthrodesis has

1 been recommended, especially if there is a coexisting degenerative spondylolisthesis.

2 However, this strategy remains controversial, resulting in practice-based variation.

3 **Purpose:** To evaluate in a pragmatic study if surgical selection criteria and variation in use of
4 arthrodesis in three Scandinavian countries can be linked to variation in treatment
5 effectiveness.

6 **Study design:** An observational study based on a combined cohort from the national spine
7 registries of Norway, Sweden, and Denmark.

8 **Patient Sample:** Patients aged 50 and higher operated 2011–2013 for LSS were included.

9 **Outcome Measures:** Patient-reported outcome measures (PROMs) Oswestry disability index
10 (ODI) (primary outcome), numeric rating scale (NRS) for leg pain and back pain, and health-
11 related quality of life (EQ-5D). Analysis included case-mix adjustment. In addition, we report
12 differences in hospital stay.

13 **Methods:** Analyses of baseline data were done by analysis of variance (ANOVA), Chi-
14 square, or logistic regression tests. The comparisons of the mean changes of PROMs at one-
15 year follow-up between the countries were done by ANOVA (crude) and analyses of
16 covariance (ANCOVA, case mix adjustment). There are no conflicts of interest.

17 Funding was received from the Danish Society of Spinal Surgery (\$5,925), the Northern
18 Norway Regional Health Authority (\$5,925) and from Swedish Association of Local
19 Authorities and Regions (\$11,885). The sponsor had no role in the acquisition of data,
20 analysis, or preparation of the manuscript.

21 **Results:** Out of 14,223 included patients, 10,890 (77%) responded at one-year follow-up.
22 Apart from fewer smokers in Sweden and higher comorbidity rate in Norway, baseline
23 characteristics were similar. The rate of additional fusion surgery (patients without, with
24 spondylolisthesis) was: Norway 11% (4%, 47%), Sweden 21% (9%, 56%) and Denmark 28%
25 (15%, 88%). At one-year follow-up the mean improvement for ODI (95%CI) was: Norway 18

1 (17 to 18), Sweden 17 (17 to 18), and Denmark 18 (17 to 19). Patients operated with
2 arthrodesis had prolonged hospital stay.

3 **Conclusions:** Real life data from three national spine registers showed similar indications for
4 decompression surgery, but significant differences in the use of concomitant arthrodesis in
5 Scandinavia. Additional arthrodesis was not associated with better treatment effectiveness.

6

7 Keywords: lumbar spinal stenosis, spine registry, decompressive surgery, case mix
8 adjustment, spine fusion, spine arthrodesis

9

10 INTRODUCTION

11 Low back pain is the leading specific cause for years lived with disability worldwide [1].
12 Narrowing of the spinal canal, known as lumbar spinal stenosis (LSS) is the most common
13 indication for spine surgery in the elderly population. LSS typically causes symptoms of low
14 back pain, lower extremity pain and numbness due to nerve root compression, resulting in
15 walking disability [2]. Decompression of the spinal canal is the key objective of surgery and
16 is considered superior to non-surgical treatment for patients with moderate to severe LSS [3].
17 Often, there is a coexisting degenerative spondylolisthesis, i.e. a slip of one vertebra in
18 relation to another. Traditionally, this radiological finding has been regarded as a sign of
19 segmental instability. Although this interpretation has been disputed, adding surgical fusion
20 between the two vertebrae (arthrodesis) in addition to decompression has been recommended
21 to prevent persisting back pain [4, 5]. However, several recent studies found no effect of
22 additional arthrodesis surgery [6-8]. Due to lack of uniform guidelines in this field, there is a
23 large and possibly unwarranted practice variation in the use of additional arthrodesis [9, 10].
24 In a recent study fusion rate (with, without spondylolisthesis) was considerably lower in
25 university hospitals of Norway (44%, 6%) compare to Boston, US (95%, 29%) [11]. In the

1 US, rising costs connected to arthrodesis of the lumbar spine have attracted the attention of
2 health providers and policy makers. In 2011 spinal fusion accounted for the highest aggregate
3 hospital costs of any surgical procedure performed in U.S. hospitals (\$12.8 billion) [12].
4 The higher cost connected to arthrodesis surgery should be justified by better patient-reported
5 outcome. In 2015, the International consortium for health outcome measurement (ICHOM)
6 recommended a set of patient-reported outcome measures (PROMs) for evaluating surgical
7 treatment of degenerative conditions in the lumbar spine to facilitate clinical studies across
8 nations and centers [13]. The national spine surgery registries of Norway, Sweden, and
9 Denmark were among the collaborators. Scandinavian countries are characterized by a
10 genetically homogenous population, similar social security systems, and public based health
11 care and health insurance systems, facilitating comparative studies [14]. The incidence of
12 surgically treated lumbar spinal stenosis is similar (30-35/100 000/year) based on imputed
13 numbers from the registries. Clinical registries collecting data from everyday practice can
14 evaluate different treatment strategies by linking practice-based variation to patient-reported
15 outcomes in a pragmatic trial. Unlike randomized controlled trials, registry-based studies
16 allow for surgeons and patients preferences to be included in the process prior to surgery, as
17 in the “real world” of clinical practice, and adds external validity to already published data
18 from randomized controlled trails [15]. Such information may aid in guideline development
19 and resource allocation.

20 The aims of this observational multinational register study were to compare practice-based
21 variation in surgical treatment of LSS by; (1) surgical selection criteria (preoperative patient
22 characteristics), (2) type of surgery (decompression only or decompression plus arthrodesis),
23 and (3) to assess if practice-based variations were associated to different patient-reported
24 outcomes (crude and case mix adjusted), in a large combined registry cohort from three
25 Scandinavian countries.

1 **METHODS**

2 This observational study reviews data from the national spine registries of Norway
3 (NORspine), Sweden (Swespine), and Denmark (DaneSpine). Eligible patients were aged 50
4 or older with no history of previous lumbar spine surgery, operated for LSS during 2011,
5 2012, or 2013. At baseline, the surgeon recorded diagnosis and treatment according to
6 standardized questionnaire. The diagnosis of LSS was based on the surgeons' clinical
7 judgment and assessment of magnetic resonance imaging, MRI. Concomitant
8 spondylolisthesis is defined as a visible slip, 3 mm or more, of one vertebra in relation to
9 another. All patients received surgical decompression, some with concomitant arthrodesis.

10 ***The registers***

11 All three national spine registries are designed for quality control and research. The
12 participation is voluntary for the surgical departments as well as the patient. At admission for
13 surgery (baseline), the patient reports data on demographics, risk factors, and PROMs. During
14 the hospital stay, the surgeon records diagnosis, type of surgery, and perioperative
15 complications. At one-year follow-up, questionnaires are distributed from the central national
16 registry office, completed at home by the patients, and returned in pre-stamped envelopes.
17 The treating hospitals are not involved in follow up. The oldest registry, Swespine, has
18 included patients since 1998. Swespine covers approximately 95% of the surgical units in
19 Sweden. Completeness, the proportion of operated patients reported to Swespine, was
20 approximately 75%. NORspine is based on the concept of Swespine, and was founded in
21 2007 (coverage 95%, completeness of 65%). DaneSpine was acquired by the Danish Spine
22 Society from the Swedish Society of Spinal Surgeons in 2009 and has successively been
23 implemented (coverage 80%, completeness 62%).

24 ***Patient-reported outcome measures (PROMs)***

1 We used the ICHOM recommended set of PROMs [13]. The primary outcome was the
2 Oswestry Disability Index (ODI, version 2.1), a standard for measuring back pain related
3 disability, ranging from 0 (no disability) to 100 (bedridden) [16].

4 Secondary outcome measures were numeric rating scales (NRS) for back and leg pain,
5 ranging from 0 (no pain) to 10 (worst conceivable pain). Health-related quality of life was
6 measured with the Euro-Qol-5D (EQ-5D) ranging from -0.596 to 1, with higher scores
7 indicating better quality of life.

8 NORspine used the NRS for leg and back pain, while Swespine and DaneSpine used the
9 Visual Analogue Scale (VAS), ranging from 0-100. Conversion to NRS was done by dividing
10 the VAS score by ten with a stochastic approximation of decimals to the closest integer.

11 ***Data handling and analysis***

12 Anonymous data from the three registers were pooled and stored on the Swespine data server.
13 Missing or out of range data on gender, age, height, or weight were deleted (Figure 1). In case
14 of missing outcome data case exclusion analysis by analysis was used. Furthermore, cases
15 with missing date of surgery and follow-up were excluded.

16 ***Comparisons of data***

17 Analysis of baseline data included PROM-scores, age at date of surgery, gender, height,
18 weight, smoking habits, sick leave, and duration of leg and back pain presented as mean (95%
19 confidence interval), or number (%). Variables were analyzed by analysis of variance
20 (ANOVA), Chi-square, or logistic regression tests. The comparisons of the mean changes of
21 PROMs at one-year follow-up were done by ANOVA (crude) and analyses of covariance
22 (ANCOVA, case mix adjustment). The minimal clinically important change (MCIC) is the
23 minimal PROM score change that is perceived as meaningful by individual patients,

1 irrespective of statistical significance level. The MCIC was defined as 15 for ODI and 2.0 for
2 NRS back pain and leg pain, and 0.15 for EQ-5D [17-19] within groups. To compare
3 clinically meaningful differences in outcomes between groups, we compared the percentage
4 of patients achieving at least 30% improvement of ODI, and NRS back pain and leg pain [18].
5 The absolute 12 months follow up score defining a patient acceptable symptom state was set
6 to $ODI \leq 22$ [20].

7

8 ***Sample size***

9 Due to the large sample size ($n > 10,000$), ODI differences as small as 2 points between the
10 groups would be reported significant (power 90%, significance level 5%), i.e. far below what
11 is considered as clinically relevant [16].

12 ***Non-response analysis***

13 A non-response analysis was performed by comparing all available baseline variables
14 between those who responded to the one-year follow-up with those who did not.

15 ***Ethics***

16 This study was approved by ethical review boards in Norway (REC South-east B:
17 2014/2219), Sweden (Dnr 2015/181-31), and Denmark (Projekt-ID: S-20160091). It was
18 conducted and reported in accordance with the Strengthening the Reporting of Observational
19 studies in Epidemiology (STROBE) checklist and the study protocol, available at
20 clinicaltrials.gov (ID: NCT02897947).

21 ***Funding***

22 Funding was received from the Danish Society of Spinal Surgery (\$5,925), the Northern
23 Norway Regional Health Authority (\$5,925) and from Swedish Association of Local

1 Authorities and Regions (\$11,885). The funding sources had no role in the study design,
2 analysis, and interpretation of data, in the writing of the report, and in the decision to submit
3 the paper for publication.

4 ***Conflict of interest***

5 All authors declare: no support from any organisation for the submitted work; no financial
6 relationships with any organisations that might have an interest in the submitted work in the
7 previous three years; no other relationships or activities that could appear to have influenced
8 the submitted work.

9

10 **RESULTS**

11 ***Baseline***

12 At baseline 14223 were included (Norway: n =3173, Sweden: n = 7389, and Denmark: n =
13 3661). At one-year follow-up, 10890 (77%) responded (Norway: n =2559 (81%), Sweden: n
14 = 5990 (81%), and Denmark: n = 2341 (64%)). Figure 1 shows the exclusion flowchart.

15 Gender, age, and BMI were similar in the three countries. Fewer were smoking in Sweden,
16 and a higher comorbidity rate was found in Norway (Table 1).

17 Mean baseline disability (ODI (95%CI)) was slightly worse in Sweden (44 (43 to 44)),
18 compared to Denmark (41 (40 to 41)) and Norway (40 (39 to 40)). Health related quality of
19 life (EQ-5D \pm SD) was better in Denmark (0.42 (0.41 to 0.43) vs. Sweden (0.37 (0.36 to 0.38))
20 and Norway (0.37 (0.36 to 0.39)). Accordingly, NRS leg pain and back pain intensity were
21 less in Denmark. In this study, the non-responders at one year follow-up (n= 3333) were
22 slightly younger and more often smokers, but otherwise similar to the responders (n=10890)

1 at baseline (Table 2). Multiple levels surgery (two, three levels) was less frequent in Norway
2 (30%, 6%), than in Sweden (34%, 12%) and Denmark (35%, 12%).

3 ***Rate of concomitant arthrodesis***

4 The rate of concomitant arthrodesis was significantly different between the three countries:
5 Norway 11%, Sweden 21%, and Denmark 28%. For the subgroup of patients with
6 concomitant spondylolisthesis, the rate of arthrodesis was higher: Norway 47%, Sweden 56%
7 and Denmark 88% (Figure 2).

8 ***Perioperative complications and differences in days at hospital***

9 The frequency of dural tear was: Norway 4.8%, Sweden 5.7%, and Denmark 5.3%, $p=0.088$.
10 The frequency of excessive bleeding was: Norway 0.16%, Sweden 0.45%, and Denmark
11 0.30%, $p=0.058$ the frequency of nerve root injury was: Norway 0.16%, Sweden 0.09%, and
12 Denmark 0.03%, $p=0.204$. The overall rate of perioperative complications was: Norway
13 5.5%, Sweden 6.2%, and Denmark 5.0%, $p=0.033$. In the combined cohorts the in hospital
14 surgeon reported complication rate was 5.8% for both decompression only and decompression
15 with additional arthrodesis.

16 In Norway, the mean number of days at hospital (SD) (day 1; day of admission) for patients
17 operated with decompression alone compared to decompression plus arthrodesis was 3.0 (2.8)
18 vs. 7.3 (3.9). In Sweden (day 1; day of admission) the corresponding numbers were 3.6 (3.5)
19 vs. 5.3 (3.1) and in Denmark (day 1; day of operation) 2.0 (1.8) vs. 4.7 (3.2).

20 ***Outcome at one year***

21 At one-year follow-up the mean improvement for ODI (95% CI) was in Norway 18 (17 to 18),
22 Sweden 17 (17 to 18) and Denmark 18 (17 to 19). In the case-mix analysis adjusted for age,
23 gender, BMI, smoking, any comorbidity, and the preoperative value of ODI, the

1 corresponding values were 16 (16 to 17), 18 (18 to 19), and 17 (17 to 17) (Table 3). A MCIC-
2 value of 30% improvement of ODI was achieved by 58% in Norway, 53% in Sweden and
3 50% in Denmark, ($p < 0.001$). ODI score 22 or below was achieved by 64% in Norway, 64% in
4 Sweden and 64% in Denmark ($p = 0.837$). There were no differences in rate of patients
5 reaching MCIC for leg pain or back pain between the countries (Table 3).

6 ***Subgroup analysis***

7 In the combined cohort, patients operated for LSS without spondylolisthesis had an
8 unadjusted mean ODI improvement (95% CI) of 17 (17 to 18) in the decompression only
9 group and 18 (17 to 20) in the decompression plus arthrodesis group. Using case mix adjusted
10 analyses the corresponding numbers were 17 (17 to 18) and 19 (18 to 20). For patients with a
11 concomitant spondylolisthesis, the improvement in unadjusted mean (95% CI) was 17 (16 to
12 18) in the decompression only group and 20 (19 to 21) in the decompression and arthrodesis
13 group. Corresponding case mixed values were 17 (17 to 18) and 18 (18 to 19) (Table 4).
14 When comparing outcomes of patients with and without spondylolisthesis between the three
15 countries, no clinically relevant differences were found (Figure 3).

16

17 **DISCUSSION**

18 To our knowledge, this represents the worlds' largest observational study of patients operated
19 for LSS, and the first comparison across countries using the ICHOM-recommended core data
20 set. Even though the selection criteria for surgery in terms of demographic characteristics,
21 pain intensity and disability were similar, we found a significant practice variation, i.e. use of
22 additional arthrodesis surgery was almost three times higher in Denmark and two times higher
23 in Sweden as compared to Norway (Figure 2). This demonstrates that even in homogenous
24 populations with similar health care systems the treatment traditions can vary considerably.

1 We observed longer hospital stay among patients operated with additional arthrodesis, which,
2 together with the implants used, indicates higher cost but no better treatment effectiveness.
3
4 Our findings are in accordance with a recent Swedish randomized controlled trial (RCT) by
5 Försth et al. of 247 patients showing that additional arthrodesis neither reduced reoperation
6 rates nor improved clinical outcomes (ODI) [6]. A randomized controlled trial from the US by
7 Ghogawala et al. involving 66 patients found that additional arthrodesis surgery for LSS with
8 mild spondylolisthesis reduced the risk for reoperation and gave larger improvement of
9 physical health-related quality of life (generic SF 36) than laminectomy alone [7]. For all
10 other outcomes, including the disease specific ODI, no difference was found. This study has
11 been heavily criticized, also because reoperation rate during follow-up was remarkably high
12 [21]. Higher frequency of reoperations in the US may however reflect potential cultural
13 differences in patient expectations, difference in treatment traditions and incentives for
14 arthrodesis surgery driven by health insurance and reimbursement programs compare to those
15 found in countries like Sweden.

16
17 A Swedish non-randomized registry study of 5390 LSS patients with or without
18 spondylolisthesis operated between 1998 and 2008, found no benefit of additional arthrodesis
19 after two years [8]. Similar results were shown in a Swiss multicenter study from 2017 of 185
20 patients with LSS and spondylolisthesis after three years [22]. A recent Norwegian pragmatic
21 comparative effectiveness study showed marginally better improvement (less than MCIC), of
22 back pain among LSS patients with spondylolisthesis receiving decompression plus
23 arthrodesis. No such association was found for ODI [23].

24

1 We also found a large difference in the use of additional arthrodesis in patients without
2 spondylolisthesis in 2011 – 2013. This treatment strategy has been discussed among spinal
3 surgeons for many years, and is not in accordance with guidelines from 2013, where
4 “decompression alone is suggested for patients with leg predominant symptoms without
5 instability” [2, 4, 9]. The term “instability” is poorly defined, but has been linked to low back
6 pain, a frequent symptom in LSS. This may explain the practice variation, also shown in a
7 previous study where the arthrodesis rate in cases without spondylolisthesis was 29% in
8 Boston (US), compared to only 6% in Norway [11]. We observed a rising rate of arthrodesis
9 from Norway, via Sweden, to Denmark across the countries (Figure 2), but no corresponding
10 trend (dose-response effect) in terms of higher treatment effectiveness (Table 3). In fact, the
11 mean improvement of back pain in the spondylolisthesis group was somewhat higher in
12 Norway (3.6) than in Denmark (2.7), which had the highest rate of arthrodesis (Figure 3).
13 Hence, this study does not support the argument that arthrodesis prevents low back pain
14 related to instability in spinal stenosis patients. The different frequency of multiple level
15 surgery was small, and can neither explain the difference in the fusion rate, nor the lack of
16 difference in outcome.

17
18 We did both crude analysis and case mix analysis. Crude data shows small, not clinical
19 relevant difference in the outcome between those with spondylolisthesis having
20 decompression and fusion, but these differences vanished after the case mix adjustment (Table
21 4).

22 Fox et al. concluded in 1996 that radiological instability was common after decompression for
23 degenerative LSS without spondylolisthesis, but correlated poorly with clinical outcome
24 (back pain) [24]. The quality of some earlier studies advocating additional arthrodesis
25 routinely is low due to small sample sizes, weak design, and outcome based on radiological

1 findings [25]. Moreover, a change towards using more minimally invasive decompression
2 techniques may have reduced the risk for postoperative instability [26]. Previous studies show
3 that arthrodesis adds higher risk of major complications, and even mortality [27]. Like
4 Ghogawala et al., we found no association between the use of concomitant arthrodesis and
5 surgeon reported complications [7].

6

7 Comorbidity rate in NORspine was physician-reported and higher compared to the patient-
8 reported rate in Swespine and DaneSpine. However, outcomes were similar, also when
9 adjusting for comorbidity (Table 3). Between countries with larger diversity in demographic,
10 socio-economic and cultural features, case mix adjustment may be more important.

11

12 Even if the differences in effects sizes were smaller than considered as clinically relevant,
13 subgroups of patients may benefit from additional arthrodesis. This should be investigated
14 further in studies utilizing more precise data on radiological findings and with long term
15 follow-up to assess reoperation rates.

16 ***Quality assurance***

17 Loss to follow-up may bias the results. Two Scandinavian studies found that a loss to follow-
18 up of as high as 23% would not bias conclusions about overall treatment effects [28, 29].

19 They found, similar to our results, that non-responders were younger and more likely
20 smokers. Therefore, it would be reasonable to assume that loss to follow up did not bias our
21 results.

22 ***Strength and limitations***

23 Register-based studies in general have advantages such as large sample sizes and high
24 external validity, but also limitations due to lack of randomization, lower follow-up rates, and

1 lower internal validity compared to closely monitored clinical trials. In contrast to RCTs, this
2 study allows surgeons and patients preferences to be included in a shared decision-making
3 process prior to surgery, like in the “real world” of clinical practice. Still, there is increasing
4 evidence in the literature that observational studies, conducted according to STROBE check
5 list, report corresponding results similar to those found in RCTs [30].

6 There are limitations associated with this work. Even though registry data were collected
7 prospectively for quality control and research, the hypotheses were decided on in retrospect.
8 In addition, we did not have exact data on reoperation rates and only one-year follow-up.
9 Reoperation rates may be as high as 20% at long term (3 to 5 years) [6], but previous studies
10 have shown that clinical outcomes are stable up to 5 years [6].

11 “In Scandinavia it is recommended to try conservative treatment prior to surgery for lumbar
12 spinal stenosis. Previous studies show that the content of non-operative care is hard to define
13 [31], and the effects of different conservative treatment alternatives are ambiguous. Since no
14 uniform Scandinavian guidelines for such treatment exist, the type of preoperative
15 conservative treatment was not recorded in the registries, only duration of symptoms.

16 The use of the ICHOM concept and adding case mix analyses makes comparisons more
17 credible, but a relative small set of baseline variables has been used for case mix adjustment.

1 CONCLUSION

2 Real life data from three national spine registers showed similar indications for
 3 decompression surgery, but significant differences in the use of concomitant arthrodesis in
 4 Scandinavia. Additional arthrodesis was not associated with better treatment effectiveness.

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47 **LEGENDS**

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49 Figure 1: Flowchart showing study enrolment.

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51 Figure 2: Four bar charts showing rate of arthrodesis in lumbar spinal stenosis with or without
52 spondylolisthesis in Norway, Sweden, and Denmark.

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- 1 Figure 3: Four bar charts showing the mean improvement in Oswestry Disability Index (ODI),
- 2 Numeric rate score (NRS) leg pain, NRS back pain, and Euro-Qual – Five Dimensions (EQ-
- 3 5D) in patients without and with spondylolisthesis in Norway, Sweden, and Denmark.
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1 **Table 1 Baseline characteristics of patients operated in Norway, Sweden, and Denmark**

	Norway (n = 3173)	Sweden (n = 7389)	Denmark (n = 3661)	(P-value)
Total (n = 14223)				
Age, years (SD)	67.5 (9.0)	68.9 (8.9)	68.6 (9.1)	<0.001*
BMI, kg/m ² (SD)	27.3 (4.3)	27.4 (4.1)	27.1 (4.4)	0.002*
Females, n (%)	1701 (54%)	4075 (54%)	2006 (55%)	0.595 [†]
Smokers, n (%)	660 (21.1%)	678 (9.3%)	792 (22.0%)	<0.001 [†]
Any comorbidity, n (%)	804 (25.4%)	591 (8.0%)	352 (9.6%)	<0.001 [†]
Neurological comorbidity, n (%)	76 (2.4%)	201 (2.8%)	84 (2.3%)	0.334 [†]
Heart comorbidity, n (%)	686 (21.7%)	313 (4.3%)	201 (5.4%)	<0.001 [†]
Cancer comorbidity, n (%)	91 (2.9%)	77 (1.0%)	67 (1.8%)	<0.001 [†]
Preoperative PROM				
ODI (95% CI)	40 (39 to 40)	44 (43 to 44)	41 (40 to 41)	<0.001*
NRS leg pain (95% CI)	6.6 (6.5 to 6.7)	6.4 (6.3 to 6.4)	5.8 (5.7 to 5.9)	<0.001*
NRS back pain (95% CI)	6.4 (6.4 to 6.5)	5.6 (5.6 to 5.7)	5.1 (4.9 to 5.2)	<0.001*
EQ-5D (95% CI)	0.37 (0.36 to 0.39)	0.37 (0.36 to 0.38)	0.42 (0.41 to 0.43)	<0.001*
Preoperative duration of leg pain >1 year, n (%)	3173 (68%)	4996 (68%)	3661 (55%)	<0.001 [†]
Preoperative duration of back pain >1 year, n (%)	2470 (78%)	5567 (75%)	2473 (68%)	<0.001 [†]

2 ODI = Oswestry Disability Index, NRS = Numeric Rating Scale, EQ-5D = Euro-Qol-5D 3 levels, BMI = Body Mass Index, 95%CI = 95% confidence interval

3 * ANOVA F-test

4 † Pearson's Chi-square test

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1 **Table 2 - Baseline characteristics of responders and non-responders**

Total (n = 14223)	Responders n = 10890 (77%)	Non-responders n = 3333 (23%)	P value
Age, years (SD)	68.7 (8.8)	67.9 (9.7)	<0.001*
BMI, kg/m ² (SD)	27.3 (4.2)	27.4 (4.6)	0.297*
Females, n (%)	5905 (54%)	1827 (55%)	0.360 [†]
Smokers, n (%)	1449 (14%)	681 (21%)	<0.001 [†]
Any co-morbidity, n (%)	1299 (12%)	448 (13%)	0.020 [†]
Neurological co-morbidity, n (%)	265 (2.4%)	96 (2.9%)	0.151 [†]
Heart co-morbidity, n (%)	910 (8.4%)	290 (8.7%)	0.531 [†]
Cancer co-morbidity, n (%)	166 (1.5%)	69 (2.1%)	0.031 [†]
Preoperative duration of leg pain >1 year, n (%)	7017 (64%)	2164 (65%)	0.604 [†]
Preoperative duration of back pain >1 year, n (%)	8032 (74%)	2478 (74%)	0.496 [†]
Preoperative PROM values			
ODI (SD)	40 (16)	43 (16)	<0.001*
NRS leg pain (SD)	6.3 (2.5)	6.2 (2.6)	0.112*
NRS back pain (SD)	5.6 (2.7)	5.7 (2.7)	0.205*
EQ-5D (SD)	0.40 (0.31)	0.36 (0.32)	<0.001*

2 *Data are shown as mean (SD), or number (%). P-values for comparison between responders and non-responders are shown. PROM = Patients Reported Outcome Measures.*

3 *Student's t-test

4 [†]Pearson's Chi-square test

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1 **Table 3 Improvements in PROMs by country**

Total (n = 10890)	Norway (n = 2559)	Sweden (n = 5990)	Denmark (n = 2341)	ANOVA F-test (P-value)
ODI				
ODI, mean diff (95%CI)	18 (17 to 18)	17 (17 to 18)	18 (17 to 19)	0.081*
ODI, mean diff case-mix adj (95%CI)	16 (16 to 17)	18 (18 to 19)	17 (17 to 17)	0.010*
ODI % > MCIC (95%CI)	64 (62 to 66)	60 (59 to 61)	65 (63 to 68)	<0.001 [‡]
ODI % ≤ 22 (95%CI)	64 (62 to 66)	64 (63 to 65)	64 (61 to 66)	0.837 [‡]
NRS leg pain				
NRS leg pain, mean diff (95%CI)	3.2 (3.1 to 3.4)	3.1 (3.0 to 3.2)	2.9 (2.7 to 3.1)	0.008*
NRS leg pain, mean diff case-mix adj (95%CI)	3.2 (3.2 to 3.3)	3.2 (3.1 to 3.2)	2.7 (2.6 to 2.8)	<0.001*
NRS leg pain % > MCIC (95%CI)	64 (62 to 66)	63 (62 to 65)	66 (63 to 68)	0.263 [‡]
NRS back pain				
NRS back pain, mean diff (95%CI)	3.0 (2.9 to 3.2)	2.4 (2.3 to 2.4)	2.2 (2.0 to 2.3)	<0.001*
NRS back pain, mean diff case-mix adj (95%CI)	2.9 (2.9 to 3.0)	2.5 (2.4 to 2.5)	2.0 (2.0 to 2.1)	<0.001*
NRS back pain % > MCIC (95%CI)	64 (62 to 66)	61 (59 to 62)	62 (60 to 64)	0.038 [‡]
EQ-5D				
EQ-5D, mean diff (95%CI)	0.28 (0.26 to 0.29)	0.27 (0.26 to 0.28)	0.28 (0.26 to 0.29)	0.323*
EQ-5D, mean diff case-mix adj (95%CI)	0.27 (0.26 to 0.28)	0.28 (0.28 to 0.29)	0.25 (0.24 to 0.26)	<0.001*

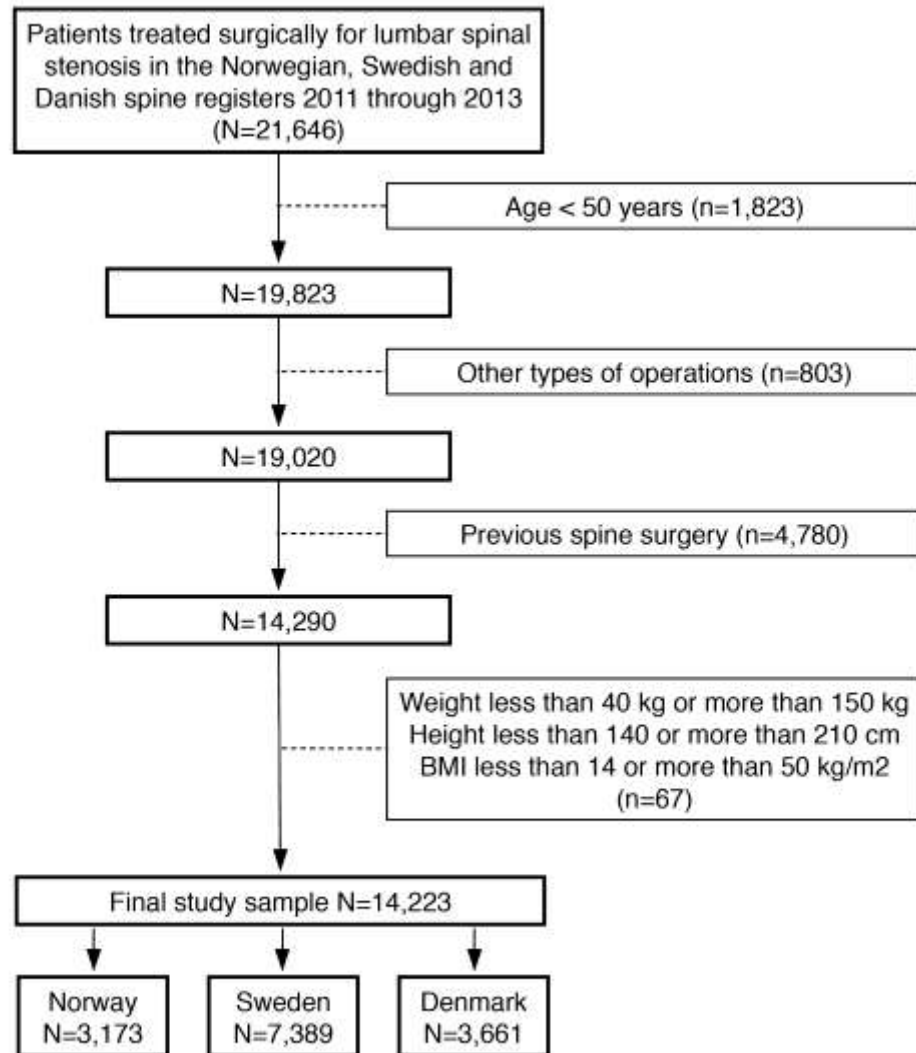
2 Data are shown as mean (95%CI), or % (95%CI). P-values for comparison between the groups are shown. . PROMs = Patient Reported Outcome Measures SD = Standard deviation, CI=
3 Confidence interval, ODI = Oswestry Disability Index, NRS = Numeric Rating Scale, EQ-5D = Euro-Qol-5D 3 levels, MCIC = Minimal Clinically Important Change. Adjusted mean presented
4 as predicted value. *Anova F-test, [†] Student's t test, [‡] Pearson's Chi-square test

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1 **Table 4: Improvements in PROMs by type of surgery in the combined cohort of Norway, Sweden and Denmark.**

<i>Crude</i>	Mean outcome difference (95%CI)			
	ODI	NRS Leg Pain	NRS Back Pain	EQ-5D
No spondylolisthesis				
Decompression only (n=7791)	17 (17 to 18)	3.0 (2.9 to 3.0)	2.3 (2.3 to 2.4)	0.26 (0.25 to 0.27)
Decompression and arthrodesis (n=761)	18 (17 to 20)	3.0 (2.8 to 3.3)	2.7 (2.3 to 3.0)	0.29 (0.26 to 0.31)
<i>p-value (Student's t-test)</i>	0.169	0.529	0.002	0.073
Spondylolisthesis				
Decompression only (n=925)	17 (16 to 18)	3.3 (3.1 to 3.5)	2.6 (2.3 to 2.8)	0.26 (0.24 to 0.29)
Decompression and arthrodesis (n=1413)	20 (19 to 21)	3.6 (3.4 to 3.8)	3.1 (3.0 to 3.3)	0.32 (0.31 to 0.34)
<i>p-value (Student's t-test)</i>	<0.001	0.029	<0.001	<0.001
<i>Case mix adjusted*</i>				
No spondylolisthesis				
Decompression only (n=7791)	17 (17 to 18)	3.1 (3.0 to 3.1)	2.4 (2.4 to 2.5)	0.27 (0.26 to 0.27)
Decompression and arthrodesis (n=761)	19 (18 to 20)	3.0 (2.9 to 3.2)	2.7 (2.6 to 2.9)	0.30 (0.29 to 0.32)
<i>p-value (Student's t-test)</i>	<0.001	0.710	<0.001	<0.001
Spondylolisthesis				
Decompression only (n=925)	17 (17 to 18)	3.2 (3.1 to 3.3)	2.5 (2.4 to 2.6)	0.27 (0.25 to 0.28)
Decompression and arthrodesis (n=1413)	18 (18 to 19)	3.2 (3.1 to 3.3)	2.6 (2.5 to 2.7)	0.29 (0.28 to 0.30)
<i>p-value (Student's t-test)</i>	0.010	0.965	0.077	0.035

2 *Data adjusted for age, gender, BMI, smoking, comorbidity, and baseline PROM values. PROMs = Patient Reported Outcome Measures, ODI = Oswestry Disability Index, NRS = Numeric
3 Rating Scale, EQ-5D = Euro-Qol-5D 3 levels.
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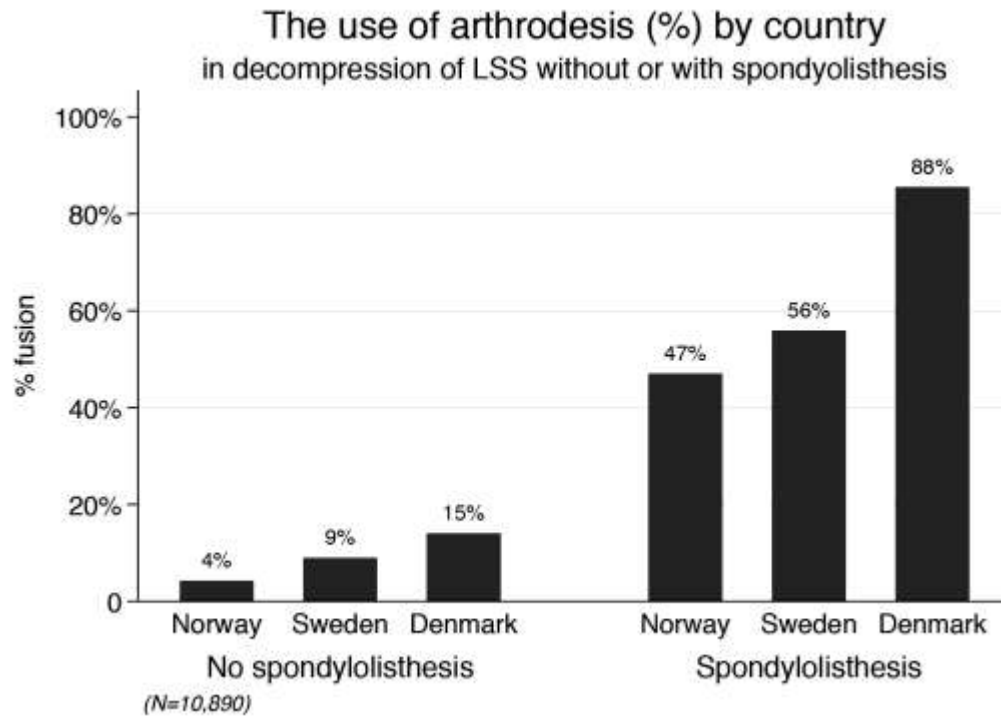


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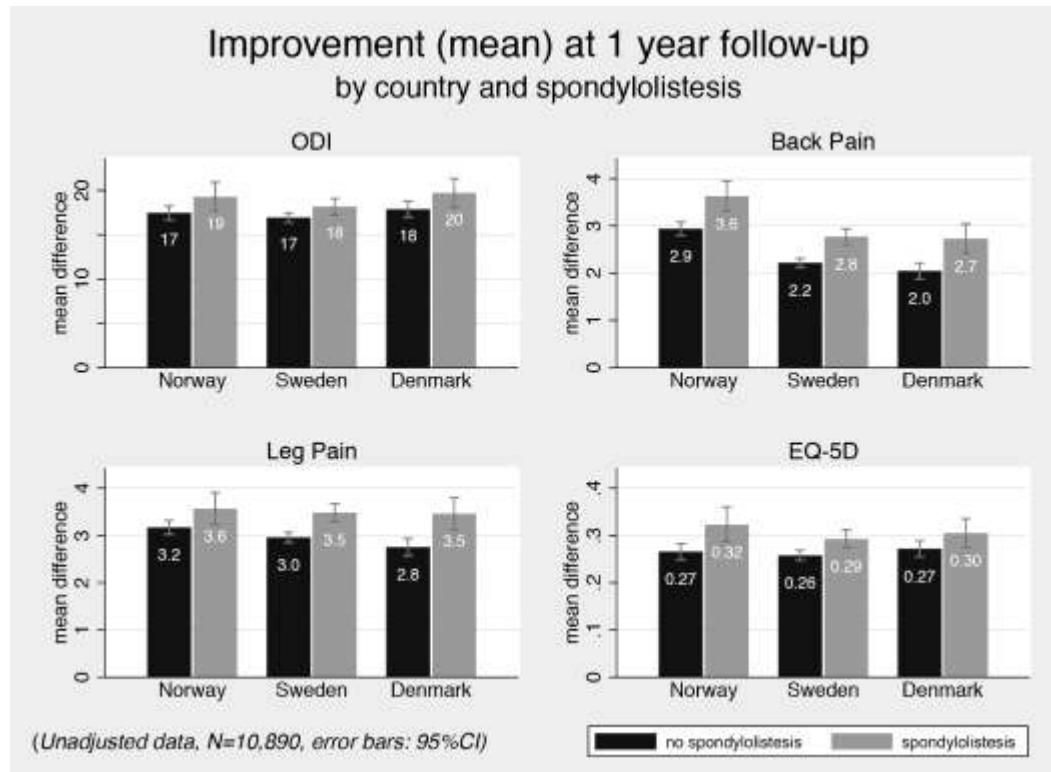
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