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Postoperative Morbidity and Mortality in Lumbar Spine Surgery Patients With Chronic Kidney Disease and Chronic Steroid Use

GEORGE THOMAS, BS^{*1*}; JEFF F. ZHANG, BS^{*2*}; TAIMUR CHAUDHRY, BS¹; NEIL D. ALMEIDA, MD³; PUNEET GUPTA, BS¹; JOHN THOMAS, BS⁴; BENNETT R. LEVY, BA¹; NYLE C. ALMEIDA, BS⁵; AND JONATHAN H. SHERMAN, MD⁶

¹George Washington University School of Medicine and Health Sciences, Washington, DC, USA; ²Jacobs School of Medicine and Biomedical Sciences, University at Buffalo, Buffalo, NY, USA; ³Department of Neurosurgery, University at Buffalo, State University of New York, Buffalo, NY, USA; ⁴West Virginia School of Osteopathic Medicine, Lewisburg, WA, USA; ⁵University of Oklahoma College of Medicine, Oklahoma City, OK, USA; ⁶Department of Neurosurgery, West Virginia University School of Medicine, Morgantown, WV, USA

^{*}George Thomas and Jeff F. Zhang contributed equally to the work.

ABSTRACT

Background: Perioperative steroids have traditionally been administered during lumbar spine surgery in order to decrease local inflammation and prevent scar tissue formation, which can otherwise contribute to significant, long-lasting postoperative pain due to the formation of epidural fibrosis around lumbar nerve roots. However, the use of steroids in lumbar spine patients has raised concerns of postoperative wound complications caused by corticosteroid-induced immunomodulatory effects and changes in collagen synthesis. Patients with chronic kidney disease (CKD) undergoing spine surgery are at a particularly elevated risk of various complications due to chronic CKD-related systemic inflammation and endothelial dysfunction. It is currently uncertain whether chronic steroid use in CKD patients exerts a protective effect postoperatively due to decreased systemic inflammation or instead is correlated with increased rates of wound complications.

Results: Using adjusted odds ratios to control for CKD-related comorbidities, our study of lumbar spine fusion patients who were chronic steroid users vs nonusers found no significant differences in rates of postoperative wound infections in later stage CKD patients. However, we also did not observe statistically significant reductions in hospital length of stay or rates of 30-day mortality, sepsis, or cardiac, pulmonary, and renal events.

Conclusions: Our results indicate chronic steroid use neither contributes significantly to rates of wound infections nor exerts a protective effect against postoperative inflammatory complications in lumbar spine patients with CKD.

Clinical Relevance: Our findings do not support the practice of holding steroids in chronic users prior to lumbar spine surgery. Perioperative steroids do not appear to increase the risk of postoperative complications, but neither do they improve lumbar spine patient outcomes.

Level of Evidence: 4.

Lumbar Spine

Keywords: arthrodesis, chronic kidney disease, corticosteroids, lumbar spine, spine fusion, wound complications

INTRODUCTION

Steroids have traditionally been administered during lumbar spine surgery to decrease local inflammation and prevent scar tissue formation,¹ which are major contributors to long-term postoperative pain due to the formation of epidural fibrosis around lumbar nerve roots.² However, the use of steroids in lumbar spine patients has raised concerns of postoperative wound complications caused by corticosteroid-induced

immunomodulation and effects on collagen synthesis.³ While a Cochrane meta-analysis of 37 studies found that shorter courses of perioperative dexamethasone did not have a significant effect on infection rates or wound healing,⁴ chronic steroid use prior to surgery has been reported to increase the risk of surgical site infection, wound dehiscence, and venous thromboembolism.³ However, postoperative steroid administration has also been correlated with improvements in functional recovery time, decreased hospital

length of stay (LOS), and reduced postoperative morphine requirements for pain management following posterior spine fusion.⁵

Chronic kidney disease (CKD) is defined as an estimated glomerular filtration rate (eGFR) of less than 60 mL/min/1.73 m² for 3 months or more, resulting from some form of renal pathology.⁶ Due to improvements in life expectancy through better access to pharmacological therapy, hemodialysis, and kidney transplantation, the number of patients presenting for lumbar spine surgery with a history of CKD is expected to continue to rise in the future.⁷ Patients with CKD are at an increased risk of postoperative complications following lumbar spine surgeries, including infection, hemorrhage requiring blood transfusion, and both 90-day and 1-year mortality, even after controlling for age, sex, and other comorbidities.⁸ The risk of complications has been found to be inversely proportional to declining eGFR: patients with an eGFR <60 mL/min/1.73 m² have a 10-fold risk of developing acute renal failure in the postoperative period compared with controls.⁹ Other common complications observed in CKD patients following spine surgery include deep vein thrombosis (DVT), pulmonary embolism (PE), stroke, hemorrhage, myocardial infarction, respiratory distress syndrome, and shock.¹⁰ It is thought that the increased inflammatory response observed in patients with CKD contributes to endothelial dysfunction, which underlies the pathophysiology for many of the complications observed in CKD patients following surgery.¹¹

Our study set out to examine whether chronic preoperative steroid use improves postoperative outcomes following lumbar spine surgery in patients with CKD. It is uncertain whether chronic steroid use in CKD patients exerts a protective effect postoperatively due to decreased systemic inflammation or whether it is instead correlated with increased rates of wound complications due to worsening of CKD-associated immunodeficiency. In this study, we analyzed morbidity and mortality outcomes in lumbar spine surgical patients with and without chronic preoperative corticosteroid use reported in the National Surgical Quality Improvement Program (NSQIP) database after stratifying patients by CKD staging.

Table 1. Current Procedural Terminology Codes and Descriptions.

Code	Description
22533	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression), single interspace
22534	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression), additional interspace
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression), single interspace
22585	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression), additional interspace
22612	Arthrodesis, posterior or posterolateral technique, single level
22614	Arthrodesis, posterior or posterolateral technique, additional level
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace
22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), additional interspace
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment
22634	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), additional interspace and segment

Note: Listing of current procedural terminology codes used to select lumbar spine fusion patients for this study. All codes were referenced through standardized listings prepared by the American Academy of Professional Coders.¹⁵

METHODS

NSQIP files from 2006 to 2019 were queried for all patients who received lumbar spinal fusion surgery and identified using the current procedural terminology codes displayed in Table 1. These current procedural terminology codes have previously been used in the literature to investigate outcomes for lumbar spinal fusion procedures recorded in the NSQIP database.¹² The eGFR status was calculated for all patients¹³ and used to stratify patients into the following stages of CKD¹⁴:

- Stage 1, normal or high eGFR (eGFR >90 mL/min)
- Stage 2, mild CKD (eGFR 60–89 mL/min)
- Stage 3a, moderate CKD (eGFR 45–59 mL/min)
- Stage 3b, moderate CKD (eGFR 30–44 mL/min)

Table 2. Preoperative univariate associations by chronic kidney disease stage.

Variable	Stage 1 (n = 76,137)				Stage 2 (n = 92,698)				Stage 3a (n = 20,926)				Stage 3b (n = 7551)				Stage 4 (n = 1552)				Stage 5 (n = 869)			
	Steroid (n = 3413)	No Steroid (n = 72,724)	P Value		Steroid (n = 4351)	No Steroid (n = 88,347)	P Value		Steroid (n = 1368)	No Steroid (n = 19,558)	P Value		Steroid (n = 593)	No Steroid (n = 6958)	P Value		Steroid (n = 155)	No Steroid (n = 1397)	P Value		Steroid (n = 45)	No Steroid (n = 824)	P Value	
Sex (women)	1931	35,978	4.65E-16		2786	46,801	<2.2E-16		916	11,455	7.49E-10		372	4411	0.756		90	799	0.864		13	299	0.343	
Diabetes	625	11,349	3.13E-05		810	16,171	0.602		335	5642	0.00052		236	2620	0.3104		65	709	0.042		12	339	0.0612	
Smoker	768	21,263	<2.2E-16		571	13,854	4.06E-06		123	2327	0.00094		39	694	0.0059		11	191	0.0227		12	149	0.1665	
Dyspnea	318	3378	<2.2E-16		445	5474	<2.2E-16		203	1848	1.055E-09		79	794	0.1604		28	177	0.07879		4	84	1	
Independent functional status	3114	70,062	<2.2E-16		4074	85,548	<2.2E-16		1297	18,725	0.03438		534	6528	0.0002586		135	1266	0.1427		37	687	1	
COPD	344	3050	<2.2E-16		483	4446	<2.2E-16		172	1323	1.274E-13		40	569	0.2388		17	90	0.04377		5	64	0.3936	
CHF	15	127	0.001853		44	322	1.48E-08		12	158	0.7545		9	113	1		6	47	0.6451		2	47	1	
Hypertension	1878	33,571	<2.2E-16		2965	55,310	9.49E-14		1093	15,806	0.4145		511	6060	0.5244		136	1268	0.2473		42	673	0.04524	
Dialysis	2	19	0.2421		4	31	0.08007		0	21	0.3962		0	13	0.6171		6	113	0.07784		38	630	0.2763	
Sepsis	154	1289	<2.2E-16		85	767	1.06E-10		16	229	1		13	122	0.419		4	83	0.0968		4	88	1	
Disseminated cancer	387	1485	<2.2E-16		167	1059	<2.2E-16		47	291	1.04E-06		21	116	0.003216		3	33	1		2	16	0.238	
Superficial wound infection	1	12	0.4615		0	5	1		0	0	1		0	2	1		0	0	1		0	0	1	
Deep wound infection	3	51	0.7396		3	23	0.1247		0	6	1		0	3	1		0	3	1		0	1	1	
Weight loss >10%	68	591	2.79E-10		31	425	0.04443		18	88	0.00167		10	31	0.000994		6	19	0.032		0	20	0.6186	
Bleeding disorder	121	992	<2.2E-16		154	1636	9.80E-13		72	589	1.95E-05		34	248	0.01241		9	90	0.8637		2	72	0.4194	
Age ≥70 y	369	5114	3.88E-15		1748	32,244	1.04E-06		798	10,904	0.06311		322	4644	1.76E-09		94	844	1		10	224	0.6047	
Albumin <3.4 g/dL	421	3029	<2.2E-16		290	2410	<2.2E-16		81	761	0.00412		58	396	0.001283		24	237	0.631		19	233	0.4008	
WBC >11,000/ μ L	578	5770	<2.2E-16		583	4940	<2.2E-16		198	1288	<2.2E-16		83	525	4.15E-07		32	142	0.00044		5	83	0.8004	
Platelets <150,000/ μ L	280	3028	<2.2E-16		276	4262	1.29E-05		101	1242	0.1536		52	547	0.4792		21	151	0.3489		11	161	0.4451	
BUN >23 mg/dL	206	2327	2.31E-16		658	9098	<2.2E-16		523	6739	0.005498		404	4491	0.04341		139	1223	0.4219		42	619	0.003679	
BMI ≥30	1498	34,825	1.08E-05		2070	43,256	0.0927		655	10,475	2.91E-05		265	3851	2.29E-06		60	749	0.0003443		10	361	0.004889	

Abbreviations: BMI, body mass index; BUN, blood urea nitrogen; CHF, congestive heart failure; COPD, chronic obstructive pulmonary disease; WBC, white blood cells.
Note. Comparison of preoperative variables between lumbar spine fusion patient groups stratified by CKD stage. For each CKD stage, patients with reported chronic steroid use were compared with patients without chronic steroid use using Fisher exact tests. Statistical significance was defined as P value ≤ 0.05 .

Table 3. Postoperative univariate associations by chronic kidney disease stage.

Variable	Stage 1 (n = 76,137)				Stage 2 (n = 92,698)				Stage 3a (n = 20,926)				Stage 3b (n = 7551)				Stage 4 (n = 1552)				Stage 5 (n = 869)			
	Steroid (n = 3413)	No Steroid (n = 72,724)	P Value		Steroid (n = 4351)	No Steroid (n = 88,347)	P Value		Steroid (n = 1368)	No Steroid (n = 19,558)	P Value		Steroid (n = 593)	No Steroid (n = 6958)	P Value		Steroid (n = 155)	No Steroid (n = 1397)	P Value		Steroid (n = 45)	No Steroid (n = 824)	P Value	
Wound infection	101	1127	8.05E-09		154	1281	<2.2E-16		45	349	0.000273		16	146	0.3032		3	50	0.3579		3	42	0.5019	
Pulmonary event	116	1060	4.27E-15		123	1217	2.68E-12		28	426	0.8476		29	219	0.02978		9	89	1		4	73	1	
VTE	109	1117	1.96E-11		129	1482	6.18E-09		16	364	0.07382		22	151	0.02158		3	55	0.268		2	29	0.672	
MACE	28	390	0.03271		58	710	0.00042		25	292	0.3036		5	150	0.03277		6	53	1		1	65	0.2455	
Renal event	16	128	0.0007748		13	288	0.8913		16	99	0.003718		15	86	0.01424		1	66	0.0113		1	4	0.2339	
Death within 30 d	73	252	<2.2E-16		49	403	7.28E-08		9	109	0.5748		4	81	0.4136		3	38	0.7919		0	33	0.4083	
Sepsis	54	768	0.006418		92	766	4.37E-13		31	244	0.002941		20	110	0.004306		5	58	0.8291		4	29	0.08541	
UTI	81	1104	0.0002175		152	1674	1.88E-11		53	548	0.02893		34	247	0.01225		7	69	1		2	12	0.1609	
Transfusion within 72 h	782	10,356	<2.2E-16		941	13,805	<2.2E-16		330	3818	5.59E-05		153	1670	0.3422		53	436	0.4663		11	326	0.05818	
Return to OR	197	2851	3.23E-07		265	3169	3.64E-15		102	872	2.09E-06		47	324	0.0009916		11	121	0.6483		13	89	0.001095	
LOS ≥10 d	515	5763	<2.2E-16		450	4935	<2.2E-16		150	1437	3.95E-06		85	617	3.41E-05		34	322	0.7639		19	333	0.7562	

Abbreviations: CKD, chronic kidney disease; LOS, length of stay; MACE, major adverse cardiovascular event; OR, operating room; UTI, urinary tract infection; VTE, venous thromboembolism.
Note. Comparison of postoperative variables between lumbar spine fusion patient groups stratified by CKD stage. For each CKD stage, patients with reported chronic steroid use were compared with patients without chronic steroid use using Fisher exact tests. Statistical significance was defined as P value ≤ 0.05 .

- Stage 4, severe CKD (eGFR 16–29 mL/min)
- Stage 5, end-stage CKD (eGFR <15 mL/min)

For each CKD stage, patients with reported preoperative corticosteroid use for a chronic condition were compared with patients without reported steroid use (identified in the NSQIP database as “variable name: steroid, condition: yes” or “variable name: steroid, condition: no,” respectively).

Fisher exact tests were used to find statistically significant univariate differences in preoperative comorbidities and postoperative outcomes between patients with and without corticosteroid use (Tables 2 and 3). Composite outcomes were created for the following postoperative events: renal events (postoperative dialysis and acute kidney injury), pulmonary events (prolonged intubation, repeat intubation, and pneumonia), wound events (organ space infection, wound dehiscence, surgical superficial site infection, and deep wound infection), venous thromboembolic events (VTEs) (PE and DVT), and major adverse cardiac events (MACEs) (myocardial infarction, cardiac arrest, and stroke). Rates of sepsis, urinary tract infection (UTI), return to operating room (OR), extended LOS (defined as ≥ 10 days), and 30-day mortality were also analyzed. A P value of ≤ 0.05 was required for a determination of statistical significance. For each stage of CKD, all preoperative variables with a P value ≤ 0.20 were selected for multivariate logistic regression modeling. Multivariate logistic regression modeling was done for each CKD stage to identify the adjusted odds ratios (aOR) of increased or decreased odds of postoperative outcomes in patients with chronic steroid use compared with patients without chronic steroid use (Table 4). A Bonferroni-adjusted P value ≤ 0.017 was then used to determine significance in our analysis of aOR with associated confidence intervals.

RESULTS

Stage 1 CKD: eGFR ≥ 90 mL/min

Overall, 76,137 patients were identified with Stage 1 CKD who underwent lumbar spinal fusion surgery. Of these patients, 4.48% ($n =$

3413) reported preoperative chronic steroid use. On univariate analysis of perioperative comorbidities, significant differences between chronic steroid users and nonusers were found for rates of gender ($P = 4.65E-16$), diabetes ($P = 3.13E-05$), smoking status ($P < 2.2E-16$), dyspnea ($P < 2.2E-16$), functional status ($P < 2.2E-16$), chronic obstructive pulmonary disease (COPD) ($P < 2.2E-16$), congestive heart failure ($P = 0.001853$), hypertension ($P < 2.2E-16$), sepsis ($P < 2.2E-16$), cancer ($P < 2.2E-16$), weight loss ($P = 2.79E-10$), bleeding disorder ($P < 2.2E-16$), advanced age ($P = 3.88E-15$), hypoalbuminemia ($P < 2.2E-16$), leukocytosis ($P < 2.2E-16$), thrombocytopenia ($P < 2.2E-16$), uremia ($P = 2.31E-16$), and obesity ($P = 1.08E-05$).

Univariate analysis of postoperative outcomes found significant differences between patients with and without chronic steroid use for rates of wound infections ($P = 8.05E-09$), pulmonary events ($P = 4.27E-15$), VTE ($P = 1.96E-11$), MACE ($P = 0.03271$), renal events ($P = 0.0007748$), 30-day mortality ($P < 2.2E-16$), sepsis ($P = 0.006418$), UTI ($P = 0.0002175$), transfusion within 72 hours ($P < 2.2E-16$), return to OR ($P = 3.23E-07$), and extended LOS ($P < 2.2E-16$).

Multivariate analysis found that patients with chronic steroid use have significantly increased adjusted odds of the following outcomes: wound infections (aOR = 1.458, CI = 1.119–1.900, $P = 0.00512$), pulmonary events (aOR = 1.514, CI = 1.191–1.924, $P = 0.000704$), 30-day mortality (aOR = 2.134, CI 1.528–2.980, $P = 8.48E-06$), and transfusion within 72 hours (aOR = 1.270, CI 1.135–1.422, $P = 2.98E-05$).

Stage 2 CKD: eGFR 60 to 89 mL/min

A total of 92,698 patients were identified with Stage 2 CKD who underwent lumbar spinal fusion surgery. Of these patients, 4.69% ($n = 4351$) reported preoperative chronic steroid use. Univariate analysis of perioperative comorbidities found significant differences between chronic steroid users and nonusers for rates of gender ($P \leq 2.2E-16$), smoking status ($P = 4.06E-06$), dyspnea ($P < 2.2E-16$), functional status ($P < 2.2E-16$), COPD ($P < 2.2E-16$), congestive heart failure ($P = 1.48E-08$), hypertension ($P = 9.49E-14$), sepsis ($P = 1.06E-10$), cancer ($P < 2.2E-16$), weight loss ($P = 0.0443$), bleeding

disorder ($P = 9.80\text{E-}13$), advanced age ($P = 1.04\text{E-}06$), hypoalbuminemia ($P < 2.2\text{E-}16$), leukocytosis ($P < 2.2\text{E-}16$), thrombocytopenia ($P = 1.29\text{E-}05$), and uremia ($P < 2.2\text{E-}16$).

Univariate analysis of postoperative outcomes found significant differences between patients with and without chronic steroid use for rates of wound infections ($P < 2.2\text{E-}16$), pulmonary events ($P = 2.68\text{E-}12$), VTE ($P = 6.18\text{E-}09$), MACE ($P = 0.00042$), 30-day mortality ($P = 7.28\text{E-}08$), sepsis ($P = 4.37\text{E-}13$), UTI ($P = 1.88\text{E-}11$), transfusion within 72 hours ($P < 2.2\text{E-}16$), return to OR ($P = 3.64\text{E-}15$), and extended LOS ($P < 2.2\text{E-}16$).

Multivariate analysis found that patients with chronic steroid use had significantly increased adjusted odds of the following perioperative outcomes: wound infections (aOR = 2.218, CI = 1.780–2.765, $P = 1.33\text{E-}12$), VTE (aOR = 1.423, CI = 1.110–1.825, $P = 0.00540$), sepsis (aOR = 2.202, CI = 1.634–2.967, $P = 2.09\text{E-}07$), UTI (aOR = 1.535, CI = 1.208–1.950, $P = 0.000446$), transfusion within 72 hours (aOR = 1.358, CI = 1.225–1.504, $P = 5.09\text{E-}09$), and return to OR (aOR = 1.687, CI = 1.421–2.002, $P = 2.07\text{E-}09$).

Stage 3a CKD: eGFR 45 to 59 mL/min

A total of 20,926 patients were identified with Stage 3a CKD who underwent lumbar spinal fusion surgery. Of these patients, 6.54% ($n = 1368$) reported preoperative chronic steroid use. Univariate analysis of perioperative comorbidities found significant differences between chronic steroid users and nonusers for rates of gender ($P = 7.49\text{E-}10$), diabetes ($P = 0.00052$), smoking status ($P = 0.00094$), dyspnea ($P = 1.055\text{E-}09$), functional status ($P = 0.03438$), COPD ($P = 1.274\text{E-}13$), cancer ($P = 1.04\text{E-}06$), weight loss ($P = 0.000167$), bleeding disorder ($P = 1.95\text{E-}05$), hypoalbuminemia ($P = 0.00412$), leukocytosis ($P < 2.2\text{E-}16$), uremia ($P = 0.005498$), and obesity ($P = 2.91\text{E-}05$).

Univariate analysis of postoperative outcomes found significant differences between patients with and without chronic steroid use for rates of wound infections ($P = 0.000273$), renal events ($P = 0.003718$), sepsis ($P = 0.002041$), UTI ($P = 0.02893$), transfusion within 72 hours ($P = 5.39\text{E-}05$), return to OR ($P = 2.09\text{E-}06$), and

Table 4. Adjusted OR for postoperative complications by CKD stage.

Outcome and CKD Stage	Adjusted OR	95% CI	P Value
Wound Infection			
Stage 1	1.458	1.119–1.900	0.00512
Stage 2	2.218	1.780–2.765	1.33E-12
Stage 3a	1.577	1.048–2.373	0.0287
Stage 3b	1.114	0.542–2.289	0.768
Stage 4	0.468	0.130–1.686	0.246
Stage 5	1.689	0.487–5.856	0.408
Pulmonary Event			
Stage 1	1.514	1.191–1.924	0.000704
Stage 2	1.010	0.752–1.356	0.944
Stage 3a	1.063	0.681–1.661	0.786
Stage 3b	1.654	0.989–2.766	0.0550
Stage 4	0.843	0.398–1.784	0.656
Stage 5	0.811	0.276–2.377	0.703
Venous thromboembolism			
Stage 1	1.293	0.993–1.684	0.0561
Stage 2	1.423	1.110–1.825	0.00540
Stage 3a	0.624	0.336–1.158	0.135
Stage 3b	2.209	1.306–3.735	0.0031
Stage 4	0.550	0.161–1.869	0.338
Stage 5	1.703	0.366–7.928	0.497
MACE			
Stage 1	1.248	0.7977–1.952	0.332
Stage 2	1.148	0.775–1.700	0.489
Stage 3a	0.929	0.507–1.702	0.814
Stage 3b	0.127	0.017–0.925	0.0417
Stage 4	0.665	0.257–1.719	0.401
Stage 5	0.236	0.031–1.768	0.160
Renal event			
Stage 1	0.773	0.320–1.865	0.567
Stage 2	0.561	0.228–1.381	0.209
Stage 3a	3.873	1.993–7.526	6.44E-05
Stage 3b	1.922	0.944–3.914	0.0715
Stage 4	0.098	0.013–0.732	0.0235
Stage 5	6.34E-08	0–inf	0.998
Death within 30 d			
Stage 1	2.134	1.528–2.980	8.48E-06
Stage 2	1.252	0.814–1.924	0.305
Stage 3a	1.650	0.772–3.530	0.196
Stage 3b	0.973	0.331–2.853	0.960
Stage 4	0.612	0.170–2.194	0.451
Stage 5	1.78E-07	0–inf	0.986
Sepsis			
Stage 1	0.940	0.662–1.335	0.731
Stage 2	2.202	1.634–2.967	2.09E-07
Stage 3a	0.975	0.585–1.626	0.925
Stage 3b	1.869	1.004–3.479	0.0483
Stage 4	0.940	0.360–2.457	0.901
Stage 5	2.296	0.750–7.022	0.145
Urinary tract infection			
Stage 1	1.050	0.775–1.422	0.750
Stage 2	1.535	1.208–1.950	0.000446
Stage 3a	0.946	0.635–1.409	0.788
Stage 3b	1.826	1.130–2.951	0.0138
Stage 4	1.171	0.508–2.699	0.711
Stage 5	2.506	0.525–11.946	0.249
Transfusion within 72 h			
Stage 1	1.270	1.135–1.422	2.98E-05
Stage 2	1.358	1.225–1.504	5.09E-09
Stage 3a	1.046	0.878–1.245	0.611
Stage 3b	0.961	0.746–1.238	0.761
Stage 4	1.203	0.833–1.737	0.324
Stage 5	0.368	0.177–0.765	0.00738
Return to operating room			
Stage 1	1.186	0.973–1.445	0.0905
Stage 2	1.687	1.421–2.002	2.07E-09
Stage 3a	1.276	0.948–1.719	0.107
Stage 3b	1.103	0.684–1.777	0.687
Stage 4	0.940	0.476–1.856	0.860
Stage 5	3.744	1.844–7.602	0.000258
Length of stay ≥ 10 d			
Stage 1	0.988	0.854–1.145	0.882
Stage 2	1.144	0.981–1.334	0.0853
Stage 3a	0.970	0.750–1.254	0.820
Stage 3b	1.031	0.728–1.461	0.859
Stage 4	1.024	0.659–1.590	0.916
Stage 5	0.876	0.464–1.656	0.686

Abbreviations: CKD, chronic kidney disease; MACE, major adverse cardiovascular event.

Note: Adjusted OR for each postoperative outcome variable stratified by CKD staging. For each CKD stage, multivariate logistic regression modeling used patients without chronic steroid use as the reference group to determine adjusted ORs. Statistical significance was defined as a Bonferroni-adjusted P value ≤ 0.017 .

extended LOS ($P = 3.95E-06$). Multivariate analysis found that patients with chronic steroid use had significantly increased adjusted odds of renal events (aOR = 3.873, CI 1.993–7.526, $P = 6.44E-05$).

Stage 3b CKD: eGFR 30 to 44 mL/min

A total of 7551 patients were identified with Stage 3b CKD who underwent lumbar spinal fusion surgery. Of these patients, 7.85% ($n = 593$) reported preoperative chronic steroid use. Univariate analysis of perioperative comorbidities found significant differences between chronic steroid users and nonusers for rates of smoking status ($P = 0.0059$), functional status ($P = 0.0002586$), cancer ($P = 0.003216$), weight loss ($P = 0.000994$), bleeding disorder ($P = 0.01241$), advanced age ($P = 1.76E-09$), hypoalbuminemia ($P = 0.001283$), leukocytosis ($P = 4.15E-07$), uremia ($P = 0.04341$), and obesity ($P = 2.29E-06$).

Univariate analysis of postoperative outcomes found significant differences between patients with and without chronic steroid use for rates of pulmonary events ($P = 0.02978$), VTE ($P = 0.02158$), MACE ($P = 0.03277$), renal events ($P = 0.01424$), sepsis ($P = 0.004306$), UTI ($P = 0.01225$), return to OR ($P = 0.0009916$), and extended LOS ($P = 3.41E-05$). Multivariate analysis found that patients with chronic steroid use had significantly increased adjusted odds of VTE (aOR = 2.209, CI 1.306–3.735, $P = 0.0031$) and UTI (aOR = 1.826, CI 1.130–2.951, $P = 0.0138$).

Stage 4 CKD: eGFR 16 to 29 mL/min

A total of 1552 patients were identified with Stage 4 CKD who underwent lumbar spinal fusion surgery. Of these patients, 9.99% ($n = 155$) reported preoperative chronic steroid use. Univariate analysis of perioperative comorbidities found significant differences between chronic steroid users and nonusers for rates of diabetes ($P = 0.042$), smoking status ($P = 0.0227$), COPD ($P = 0.04377$), weight loss ($P = 0.032$), leukocytosis ($P = 0.00044$), and obesity ($P = 0.0003443$).

Univariate analysis of postoperative outcomes found a significant difference between patients with and without chronic steroid use for rates of renal events ($P = 0.0113$). Multivariate analysis

found that patients with chronic steroid use did not have significantly increased adjusted odds of any postoperative outcomes.

Stage 5 CKD: eGFR <15 mL/min

A total of 869 patients were identified with Stage 5 CKD who underwent lumbar spinal fusion surgery. Of these patients, 5.18% ($n = 45$) reported preoperative chronic steroid use. Univariate analysis of perioperative comorbidities found significant differences between chronic steroid users and nonusers for rates of hypertension ($P = 0.04524$), uremia ($P = 0.003679$), and obesity ($P = 0.004889$).

Univariate analysis of postoperative outcomes found a significant difference between patients with and without chronic steroid use for rates of return to OR ($P = 0.001095$). Multivariate analysis found that patients with chronic steroid use had decreased adjusted odds of transfusion within 72 hours (aOR = 0.368, CI 0.177–0.765, $P = 0.00738$) and increased adjusted odds of return to OR (aOR = 3.744, CI 1.844–7.602, $P = 0.000258$).

DISCUSSION

While perioperative steroid use in patients undergoing lumbar spine surgery has been associated with reduced postoperative pain, hospital LOS, and time to return to work,^{5,16} the effect of chronic preoperative steroid use in CKD patients undergoing lumbar spine surgery has not previously been studied in the literature. Several studies have shown that lumbar spine patients with CKD are at increased risk of blood transfusion requirements, postoperative intensive care unit transfer, DVT/PE, sepsis, and longer hospital stays compared with controls.^{8,10,17} A study by Bains et al of 12,276 spine fusion patients also found that CKD patients are at significantly higher risk of postoperative mortality compared with controls; however, their study did not examine rates of wound complications and noted that CKD patients in their analysis had multiple comorbidities, which were not controlled for and likely contributed to their observed increase in postoperative mortality.¹⁸

The etiology of postoperative thromboembolic events in CKD patients is unclear and proposed to be either related to chronic inflammation¹¹ or

secondary to derangements in procoagulant and fibrinolytic pathways due to uremia and excess loss of serum proteins in the urine.¹⁹ Impaired wound healing in CKD patients is also thought to be caused by chronic inflammation and endothelial dysfunction,²⁰ as well as disruption of normal platelet function and hemostasis.²¹ Increased rates of wound infection occur due to impairment of lymphocyte, macrophage, and neutrophil function¹⁸ resulting from the interruption of immune signaling processes by uremic toxins.²² Thus, it has been uncertain whether steroid use in postoperative CKD patients may improve rates of VTE, MACE, renal and pulmonary events, and wound healing due to reduction of systemic inflammation or, conversely, exacerbate risks of wound complications and sepsis by disrupting collagen deposition and immune function.

Steroid use in patients to treat autoimmune-mediated causes of proteinuric kidney disease is not uncommon. However, the risk of steroid-associated adverse effects has been reported to be much higher in these patients compared with controls, with hypertension, diabetes, obesity, and infection found to be the most common side effects.²³ Short-term dexamethasone use in surgical patients has not been found to result in significant differences in rates of postoperative wound infection or healing between treated patients and controls.⁴ Perioperative intravenous methylprednisolone has similarly been shown to decrease inflammatory cytokine production and reduce time to normal locomotive status following spine surgery in animal models, without producing significant effects on granulocyte and monocyte numbers or activity.²⁴ However, chronic preoperative steroid use has previously been associated with increased risk of postoperative surgical site infection, UTI, PE, and readmission in lumbar spine fusion patients.³

In contrast to the findings of Ranson et al.,³ our study of lumbar spine fusion patients with CKD receiving chronic steroids found no significant differences in rates of postoperative wound infections between patients with and without preoperative chronic steroid use for moderate or severe CKD subgroups (Stages 3a, 3b, 4, and 5). However, chronic steroid use was also not found to have a significant effect on reducing hospital LOS or rates of MACE, pulmonary and renal events, 30-day mortality, or sepsis in

patients with later stages of CKD (Stages 3b, 4, and 5). While rates of MACE, renal events, sepsis, and return to OR were initially found to be elevated in CKD patients using chronic steroids compared with CKD patients not using chronic steroids, when adjusted for age, sex, functional status, and other comorbidities, these differences were not observed in our calculation of aOR. This result suggests that increased rates of CKD-related comorbidities play a significant role in rates of postoperative outcomes observed in prior studies that did not adjust for differences in age, sex, functional status, and comorbidities between steroid users and nonusers. We would also hypothesize that increased rates of dialysis and more stringent medication management of advanced CKD patients (Stages 3a, 3b, 4, and 5) may contribute to the improved postoperative outcomes compared with mild to moderate CKD patients (Stages 1 and 2).

While chronic perioperative steroid use was not found to result in increased wound complications in later stage CKD patients undergoing lumbar spine fusion surgery, we also did not observe statistically significant reductions in hospital LOS or rates of 30-day mortality, sepsis, or cardiac, pulmonary, and renal events. However, our analysis was limited by heterogeneity of CKD subgroup sizes and uncertainty about steroid dosage and length of use in the chronic steroid CKD group. Studies stratifying patient groups by steroid dosages or length of use are warranted to further evaluate for dose-related steroid treatment-related benefits in postoperative CKD patients.

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REFERENCES

1. Ranguis SC, Li D, Webster AC. Perioperative epidural steroids for lumbar spine surgery in degenerative spinal disease. A review. *J Neurosurg Spine*. 2010;13(6):745–757. doi:10.3171/2010.6.SPINE09796

2. Mohi Eldin MM, Abdel Razek NM. Epidural fibrosis after lumbar disc surgery: prevention and outcome evaluation. *Asian Spine J.* 2015;9(3):370–385. doi:10.4184/asj.2015.9.3.370
 3. Ranson WA, White SJW, Cheung ZB, et al. The effects of chronic preoperative steroid therapy on perioperative complications following elective posterior lumbar fusion. *Global Spine J.* 2018;8(8):834–841. doi:10.1177/2192568218775960
 4. Polderman JAW, Farhang-Razi V, van Dieren S, et al. Adverse side-effects of dexamethasone in surgical patients-an abridged Cochrane systematic review. *Anaesthesia.* 2019;74(7):929–939. doi:10.1111/anae.14610
 5. Fletcher ND, Ruska T, Austin TM, Guisse NF, Murphy JS, Bruce RW. Postoperative dexamethasone following posterior spinal fusion for adolescent idiopathic scoliosis. *J Bone Joint Surg Am.* 2020;102(20):1807–1813. doi:10.2106/JBJS.20.00259
 6. No authors listed. Chapter 1: definition and classification of CKD. *Kidney Int Suppl (2011).* 2013;3(1):19–62. doi:10.1038/kisup.2012.64
 7. Han I-H, Kim K-S, Park H-C, et al. Spinal surgery in patients with end-stage renal disease undergoing hemodialysis therapy. *Spine (Phila Pa 1976).* 2009;34(18):1990–1994. doi:10.1097/BRS.0b013e3181abbdf
 8. Puvanesarajah V, Jain A, Hess DE, Shimer AL, Shen FH, Hassanzadeh H. Complications and mortality after lumbar spinal fusion in elderly patients with late stage renal disease. *Spine (Phila Pa 1976).* 2016;41(21):E1298–E1302. doi:10.1097/BRS.0000000000001618
 9. Martin CT, Pugely AJ, Gao Y, Mendoza-Lattes SA, Weinstein SL. The impact of renal impairment on short-term morbidity risk following lumbar spine surgeries. *Spine (Phila Pa 1976).* 2015;40(12):909–916. doi:10.1097/BRS.0000000000000890
 10. De la Garza Ramos R, Jain A, Nakhla J, et al. Post-operative morbidity and mortality after elective anterior cervical fusion in patients with chronic and end-stage renal disease. *World Neurosurg.* 2016;95:480–485. doi:10.1016/j.wneu.2016.06.096
 11. Casas A, Mallin A, Blasco-Lucas A, et al. Chronic kidney disease-associated inflammation increases the risks of acute kidney injury and mortality after cardiac surgery. *Int J Mol Sci.* 2020;21(24):24. doi:10.3390/ijms21249689
 12. Pennicooke B, Santacatterina M, Lee J, Elowitz E, Kallus N. The effect of patient age on discharge destination and complications after lumbar spinal fusion. *J Clin Neurosci.* 2021;91:319–326. doi:10.1016/j.jocn.2021.07.006
 13. Levey AS, Coresh J, Tighiouart H, Greene T, Inker LA. Measured and estimated glomerular filtration rate: current status and future directions. *Nat Rev Nephrol.* 2020;16(1):51–64. doi:10.1038/s41581-019-0191-y
 14. Farrington K, Covic A, Aucella F, et al. Clinical practice guideline on management of older patients with chronic kidney disease stage 3b or higher (egfr <45 ml/min/1.73 m²). *Nephrol Dial Transplant.* 2016;31(suppl 2):ii1–ii66. doi:10.1093/ndt/gfw356
 15. AAPC. *CPT Code Lookup.* <https://www.aapc.com/codes/code-search/>.
 16. Waqas M, Shallwani H, Shamim MS, Ahmad K. Perioperative steroids for lumbar disc surgery: a meta-analysis of randomized controlled trials. *Surg Neurol Int.* 2017;8:42. doi:10.4103/sni.sni_478_16
 17. Adogwa O, Elsamadicy AA, Sergesketter A, et al. The impact of chronic kidney disease on postoperative outcomes in patients undergoing lumbar decompression and fusion. *World Neurosurg.* 2018;110:e266–e270. doi:10.1016/j.wneu.2017.10.147
 18. Bains RS, Kardile M, Mitsunaga L, et al. Does chronic kidney disease affect the mortality rate in patients undergoing spine surgery? *J Clin Neurosci.* 2017;43:208–213. doi:10.1016/j.jocn.2017.05.014
 19. Wattanakit K, Cushman M. Chronic kidney disease and venous thromboembolism: epidemiology and mechanisms. *Curr Opin Pulm Med.* 2009;15(5):408–412. doi:10.1097/MCP.0b013e32832ee371
 20. Seth AK, De la Garza M, Fang RC, Hong SJ, Galiano RD. Excisional wound healing is delayed in a murine model of chronic kidney disease. *PLoS One.* 2013;8(3):e59979. doi:10.1371/journal.pone.0059979
 21. Maroz N, Simman R. Wound healing in patients with impaired kidney function. *J Am Coll Clin Wound Spec.* 2013;5(1):2–7. doi:10.1016/j.jccw.2014.05.002
 22. Espi M, Koppe L, Fouque D, Thaumat O. Chronic kidney disease-associated immune dysfunctions: impact of protein-bound uremic retention solutes on immune cells. *Toxins (Basel).* 2020;12(5):300. doi:10.3390/toxins12050300
 23. Oh GJ, Waldo A, Paez-Cruz F, et al. Steroid-associated side effects in patients with primary proteinuric kidney disease. *Kidney Int Rep.* 2019;4(11):1608–1616. doi:10.1016/j.ekir.2019.08.019
 24. Vidal PM, Ulndreaj A, Badner A, Hong J, Fehlings MG. Methylprednisolone treatment enhances early recovery following surgical decompression for degenerative cervical myelopathy without compromise to the systemic immune system. *J Neuroinflammation.* 2018;15(1):222. doi:10.1186/s12974-018-1257-7
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Corresponding Author: Jonathan H. Sherman, Department of Neurosurgery, West Virginia University School of Medicine, Morgantown, WV 26505, USA; jsherman0620@gmail.com

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