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Stem Cells Therapy as a Treatment for Discogenic Low Back Pain: A Systematic Review

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ABSTRACT

Background: Low back pain (LBP) is 1 of the most common problems that present in 80% of people. LBP can be caused by some pathologies, with discogenic pain being 1 source. Pain from LBP can become chronic and also cause disability. Treatment options for LBP varied from conservative to operative, and a novel treatment nowadays is using stem cells therapy to treat with pain from LBP.

Methods: Database searches from Pubmed and ScienceDirect from inception to 13 September 2023. A total of 283 discogenic LBP cases from 8 articles. This study measured clinical outcomes using a visual analog scale (VAS) and Oswestry Disability Index (ODI) obtained from each study.

Results: Functional outcomes in patients treated with stem cell therapy showed significant improvement ODI and VAS (P < 0.00001). Improvement also showed in Pfirrmann grade before and after treatment with stem cells (P = 0.005). Subgroup analyses using bone marrow aspirate concentrate also showed significant differences in both ODI and VAS (P < 0.00001).

Conclusion: Stem cells therapy could be beneficial as an option of treatment for discogenic LBP in improving pain and activity of daily living.

Clinical Relevance: Intradiscal stem cell therapy is a promising alternative for managing discogenic low back pain, offering improvements in pain and function.

Level of Evidence: 4.

Biologics

Keywords: discogenic low back pain, stem cells therapy, oswestry disability index, visual analog scale

INTRODUCTION

Low back pain (LBP) is the most common musculoskeletal symptom caused by degenerative joint disease in the lumbar spine. LBP is defined as pain and discomfort between the costal margin and inferior gluteal fold with or without leg pain. An estimated 80% of the normal population will experience LBP in their lifetime, and this has enormous socioeconomic consequences. One of the conditions leading to degenerative joint disease in the lumbar spine is degenerative disc disease, in which this condition will lead to herniation of the intervertebral disc (IVD).

Discogenic pain is a common source of LBP, with an overall prevalence of 26% to 42%. In younger populations, this increases to over 80%. Discogenic LBP is typically persistent with chronic pain and disability, and most treatment resources are directed toward refractory pain symptoms.³ The pathophysiology of discogenic back pain involves an imbalance in the anabolic and

catabolic environments of the extracellular matrix in favor of catabolism. The resultant alteration in disc height affects the biomechanics of the involved spinal segment, which often results in segmental instability.⁴

It is estimated that the annual worldwide LBP incidence in adults is 15%, and the point prevalence is 30%.⁵ In 2020, LBP affected 619 million (95% uncertainty interval 554–694) people globally, with a projection of 843 million (759–933) prevalent cases by 2050.⁶ The high rate of LBP prevalence observed in all regions globally could have some important social and economic consequences, especially considering the substantial cost of care for this condition. For instance, from 2012 to 2014, the direct aggregate costs for all individuals with a spine condition in the USA were US\$315 billion, with a substantial proportion of costs attributed to surgical procedures.⁶

Makkiyah et al said that the prevalence of LBP in middle-aged adults in Indonesia was 44.29% at 12

months.⁷ The Ministry of Health of the Republic of Indonesia stated that the number of LBP incidents in Indonesia in 2018 was 18%. Based on Indonesia's 2017 national and subnational disease burden analysis data, LBP complaints were the main cause of loss of productive years due to disability due to illness and injury in Jakarta in 2017.⁸

Treatment modalities in the management of chronic lumbosacral pain include conservative management with physical therapy, pharmacological therapy, interventional and intradiscal, as well as surgical intervention through fusion or disc replacement. At present, nonsurgical treatment based on physiotherapy and pharmacological interventions remains the first-line treatment option for lumbar discogenic pain. 10

In recent years, there has been an increasing shift toward regenerative therapies for several pathologies across the entire spectrum of medicine. 11 Among the biological disc repair therapies, cell therapy has gained interest as it offers a disc regenerative potential while being minimally invasive. 12 A cell therapy approach aims to address disc inflammation by inhibiting aberrant cytokine production and to promote disc rehydration and height restoration by initiating matrix anabolism, as well as repopulating and stimulating the native cells. 12 As a result of these efforts, number of different regenerative modalities are being considered as treatment options for LBP due to DDD; these include platelet-rich plasma, stem cells, and bone marrow concentrate (BMC). Among these options, stem cell and BMC have shown promising results in the treatment of discogenic LBP.¹¹

Based on all this, we conduct a systematic review of current literature on the role of stem cell therapy treatment for patients with discogenic LBP aiming to evaluate clinical improvement on LBP treated with stem cell therapy.

METHODS

Search Strategy and Study Selection

This study was conducted according to the Preferred Reporting Items for Systematic Reviews and Meta-Analysis guidelines.¹³ A comprehensive search across 2 databases (PubMed and ScienceDirect) from inception to 13 September 2023. The search terms used were "stem cell therapy" AND "discogenic LBP" (Figure 1). The inclusion criteria were (1) patients with discogenic LBP treated with stem cells therapy, (2) a study presents the effectiveness of intradiscal stem cell therapy, and (3) in English. Exclusion criteria were (1) patients had

history of spinal fusion, (2) case report and review, and (3) incomplete data.

Eligibility Criteria and Quality Appraisal

The included studies were of any design reporting on the usage of stem cells for the treatment of discogenic LBP. The inclusion criteria used in this study were (1) published in English, (2) concerned discogenic LBP, and (3) patients had no history of prior surgery at the affected lower back. The exclusion criteria used in this study were (1) review articles, (2) animal studies, and (3) articles unavailable in English. Study quality was assessed with the Cochrane risk of bias tool for randomized controlled trials (RCTs) and the methodological index for non-randomized studies score for non-RCTs (Figure 2, Table 1). Leach included study stated that there was no source of funding for their research.

Data Extraction

Three independent reviewers (R., K.Y., and A.G.) selected the articles included in the study through title and abstract screening and conducting full-text reviews of the selected articles. Any disagreements were resolved by a fourth, independent reviewer (N.P.H.). Initially, in the literature searching and cross-referencing, 86 articles were found, 19 articles were excluded before sceening because of duplication. After titles and abstracts were screened, 11 articles met the eligibility criteria. After a full-text review, 3 articles were excluded (prestudy protocol and nonusable data), and 8 articles were included in the systematic review.

Statistical Analyses

Mean difference and 95% confidence intervals were calculated using the inverse variance method, and study heterogeneity was assessed using I^2 with a value of >50% marked as significant heterogeneity. If the I^2 > 50%, subgroup analysis was carried out. Statistical significance was defined with a P value of <0.05. Statistical analyses were performed by Review Manager 5.4 analysis software.

RESULTS

Patient Characteristics and Demographics

A total of 86 articles were identified, with 8 studies meeting the inclusion criteria after screening. Details of the studied, such as the number of patients, gender, study design, outcomes, and follow-up period, are presented in Table 2. Seven studies including a total of 283

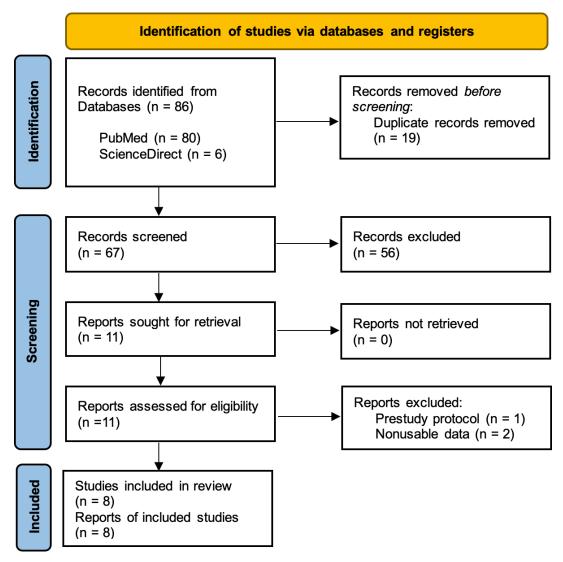


Figure 1. Preferred Reporting Items for Systematic Reviews and Meta-Analysis flowchart.

patients were used in statistical analysis. One study was not included in statistical analysis because the results in the study were grouped. Patients' ages ranged from 35 to 60 years. The follow-up period after stem cell therapy ranged from 12 to 36 months.

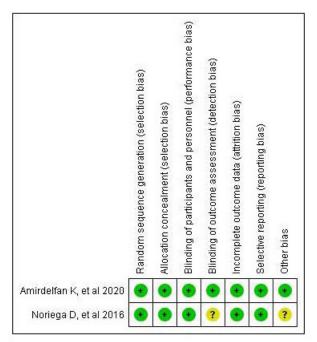
Outcome Measurement and Results

The improvement in the Oswestry Disability Index (ODI) in 7 studies resulted in a significant difference (P < 0.00001) in patients treated with stem cell therapy. Subgroup analysis based on follow-up periods revealed significant reductions in ODI observed across all time points; however, heterogeneity was high ($I^2 = 94\%$; Table 3; Figure 3).

Pain scale using a visual analog scale (VAS) or numeric rating scale in 7 studies before and after treatment using stem cells therapy resulted in significant difference (P < 000001). Subgroup analysis by follow-up period similarly indicated consistent improvement across time points, though heterogeneity remained high ($I^2 = 94\%$; Table 3; Figure 4).

A subgroup analysis of ODI and VAS outcomes in studies using bone marrow aspirate concentrate was conducted across 4 studies. ODI improvement was significant across follow-up periods of 1, 3, 6, and 12 months, with moderate heterogeneity ($I^2 = 58\%$; Table 3; Figure 5). For VAS, it was significantly different in follow-up periods 3, 6, and 12 months. In 1-month follow-up, it included 2 studies but was insignificant (P = 0.17), and the pooled heterogeneity was moderate ($I^2 = 76\%$; Table 3; Figure 6).

Magnetic resonance imaging assessments using Pfirrmann grading scale were available in 5 studies. Two studies included in the meta-analysis showed



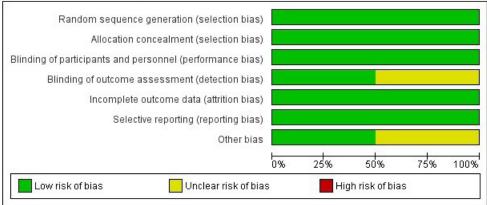


Figure 2. Risk of bias of included randomized controlled trials.

Table 1. Methodological index for non-randomized studies score.

Criteria	Lewandrowski et al, 2023 ¹⁵	Wollf et al, 2020 ¹⁶	Pettine et al, 2017 ¹⁷	Atluri et al, 2021 ¹⁸	Orozco et al, 2011 ¹⁹	Kumar et al, 2017 ²⁰
A clearly stated aim	2	1	2	2	2	2
Inclusion of consecutive patients	2	2	2	2	2	2
Prospective collection of data	0	0	2	2	2	2
Endpoint appropriate to the aim of the study	2	2	2	2	2	2
Unbiased assessment of the study endpoint	1	1	0	0	1	1
Follow-up period appropriate to the aim of the study	2	2	2	2	2	2
Loss of follow-up < 5%	0	1	2	1	2	2
Prospective calculation of the study size	2	2	2	2	1	2
Additional criteria for comparative studies						
An adequate control group	NA	NA	NA	2	NA	NA
Contemporary group	NA	NA	NA	2	NA	NA
Baseline equivalent of groups	NA	NA	NA	2	NA	NA
Adequate statistical analysis	NA	NA	NA	2	NA	NA
Total	11	11	14	21	14	15

Abbreviation: NA, not applicable.

Note: Low risk of bias: 13-16 (noncomparative studies), 20-24 (comparative studies); moderate risk of bias: 9-12 (noncomparative studies), 15-19 (comparative studies); high risk of bias: 0-8 (noncomparative studies), 0-14 (comparative studies).

agic F. Citata							
Study	Study Design (Level of Evidence)	Sample Size and Demographic	Follow-Up, mo	Type and Site of Insertion	Dose, Cells (mean CFU-F)	Main Results	Radiological Results
Lewandrowski et al, 2023 ¹⁵	Retrospective observational cohort (II)	N = 33, mean age = 47.6 y, and M:F = $18:15$	24	Allogeneic polyclonal MSC, intradiscal	5 × 10 ⁶ allogeneic polyclonal MSC + 1% HA		Baseline: Pfirmann grade (mean \pm SD): 4.06 ± 0.72 Result: 3.65 ± 0.81
						 Baseline 82.2; 1 mo 33.1; 3 mo 25.7; 6 mo 20.3; 12 mo 18.1; 24 mo 17.4 (P < 0.001) 1 patient experienced severe LBP for 1 d, but otherwise, no adverse treatment effects were mentioned in the study 	
Wolff et al, 2020 ¹⁶	Retrospective pilot study (II)	<i>N</i> = 33, mean age = 45 y, and M:F = 19:14	2	BMC, Intradiscal	3 mL, cells NA	ODI improvement from baseline • 2 wk 4.2%, 6–8 wk 26.7%; 3 mo 36.4%; 6 mo 55.6%; 12 mo 30.8% NRS improvement from baseline • 2 wk 13.8%, 6–8 wk 45.8%; 3 mo 41.1%; 6 mo 23.5%; 12 mo 38.9%	NA
Pettine et al.	Prospective.	N = 26, mean age =	36	Autologous BMC.	$2-3 \text{ mL}$. 121×10^6	No remarkable adverse event reported ODI score	Baseline:
2017 ¹⁷	nonrandomized (II)	40 y, and M:F = 11:15		Intradiscal	per mL (2,713 per mL)		Pfirrmann Grade IV = 4, Grade $V = 11$.
						• Baseline 82.1; 36 mo 21.9 (P < 0.001) No adverse events related to the study	Grade VI = 15, and Grade VII = 10.
							Result: 8 of 20 patients had improved Pfirrmann grade
Atluri et al,	Open label, prospective	N = (40)	12	Autologous bone	2 mL (each level), 220.2×10^6 mm.	ODI score, intervention vs control	r NA
2021	Controlled study (II)	control), mean age		intradiscal,	mL (4,987 per	mo 28.8 vs 47.3; 6 mo 29.9 vs 48.9; 12 mo	
		= 60 y, and M:F		intraepidural, facet	mL)	31.1 vs 49.5 (P < 0.001) NRS score intervention vs control	
		VAI –		Joint, and 31 Joint		• At baseline 71 vs 66: 1 mo 38 vs 68: 3 mo	
						31 vs 69; 6 mo 37 vs 66; 12 mo 42 vs 71 (P < 0.001)	
Orozco et al,	Pilot study (II)	N = 10, mean age	12	Autologous bone	10^7 cells per disc	ODI score	NA
201115		= 35 y, and M:F = 4:6		marrow cells, intradiscal		• Baseline 25; 3 mo 13; 6 mo 9.4; 12 mo 7.4 (P < 0.0001)	
						VAS scoreBaseline 68.9; 3 mo 26.5; 6 mo 21.6; 12 mo	
Noriega et al	RCT(II)	N = 24 mean age =	12	Allogeneic	$25 \times 10^6 \text{ in } 2 \text{ mL}$	20 (P < 0.0001) ODI score intervention vs control	Baseline (control vs
2016^{21}	(1)	38 y, and M:F =	7	mesenchymal	saline per disc	• Baseline 34 vs 24; 1 wk 27 vs 20; 3 mo 16	intervention): Pfirrmann
		17:71		bone marrow cells,		vs 25; 6 mo 20 vs 30; 12 mo 22 vs 34	$3.15 \pm 0.76 \text{ vs } 3.68 \pm 0.67$
				mradiscal		• Baseline 67 vs 62; 1 wk 63 vs 45; 3 mo 43	Kesuns: $3.78 \pm 0.82 \text{ vs } 3.18 \pm 0.87$
						vs 46; 6 mo 40 vs 51; 12 mo 47 vs 47	

Table 2. Continued.	ıned.						
Study	Study Design (Level of Sample Size and Evidence) Demographic	Sample Size and Demographic	Follow-Up, mo	Type and Site of Insertion	Dose, Cells (mean CFU-F)	Main Results	Radiological Results
Kumar et al, 2017 ²⁰	Phase 1 clinical trial, open label, single arm (II)	N = 10, mean age = 43.5 y, and M:F = 6:4	12	Adipose-derived MSC + HA, Intradiscal	Low dose 2×10^7 cells/disc $(n = 5)$; high dose 4×10^7 cells/disc $(n = 5)$	ODI score • Baseline 42.8; 1 mo 31.2; 3 mo 31.7; 6 mo 21.3; 12 mo 16.8 (P = 0.002) VAS score • Baseline 65; 1 mo 46; 3 mo 43; 6 mo 32; 12 mo 29 (P = 0.002)	Baseline: Pfirrmann Grade IV = 10. Result: No increase in Pfirrmann grade
Amirdelfan et al, 2020 ²²	RCT (I)	N = 100 (6M 30/18M 30), age = 37.9– 44.5 y, and M:F = 53:47	98	Allogeneic MPC +1% HA 1 mL (6 million and 18 million) control: saline and HA; Intradiscal	Low dose: 6 × 10 ⁶ MPC +1 mL 1% HA HA High dose: 18 × 10 ⁶ MPC +1 mL 1% HA		Baseline (control vs intervention): Grade II (0 vs 4), Grade III (12 vs 13), Grade IV (19 vs 32), Grade V (3 vs 4), Grade VI (2 vs 3), Grade VII (3 vs 3), and Grade VII (1 vs 1). Results: No significant improvement in Pfirmann score
						mo 34.6; 12 mo 32.37; 24 mo 37.63; 36 mo 28.24 (P < 0.05)	

Abbreviations: BMC, bone marrow concentrate; CFU-F, colony forming unit-fibroblast; HA, hyaluronic acid; LBP, low back pain; M:F, male:female; MPC, mesenchymal precursor cell; MSC, mesenchymal stem cell; MS, not applicable or not available; NRS, numeric rating scale; ODI, Oswestry Disability Index; RCT, randomized controlled trial; SI, sacroiliac; VAS, visual analog scale.

Table 3. Statistical analysis results.

Outcome Measure	No of studies	Mean Difference (95% CI)	P	I ² (Heterogeneity)
ODI	7	21.57 (19.47, 31.08)	< 0.00001	94% (high)
VAS	7	38.97 (36.01, 41.93)	< 0.00001	94% (high)
ODI after BMAC treatment	4	16.99 (12.65, 21.33)	< 0.00001	58% (moderate)
VAS after BMAC treatment	4	36.06 (28.35, 43.76)	< 0.00001	76% (moderate)
Pfirrmann improvement	2	0.44 (0.13, 0.75)	0.005	0% (low)

Abbreviations: BMAC, bone marrow aspirate concentrate; ODI, Oswestry Disability Index; VAS, visual analog scale. *Note:* Boldface indicates statistical significance.

tudy or Subgroup .1.1 1 Month	Mean	injection SD		post Mean	injectio SD		Weight	Mean Difference IV, Random, 95% CI	Mean Difference IV, Random, 95% CI
mirdelfan 2020 (18 Million MPC)	50.67	3.11	30	37.33	2.94	30	4.3%	13.34 [11.81, 14.87]	
mirdelfan 2020 (6Million MPC)	52.07	3.11	30	36.83	2.99	30	4.3%	15.24 [13.70, 16.78]	1
itluri 2021	46.1	12.6	40	33.4	15.4	40	3.2%	12.70 [6.53, 18.87]	-
umar 2017		15.03	10		13.86	10	1.7%	11.60 [-1.07, 24.27]	
ewandrowski 2023	44.81	14.35	33	19.69	11.62	33	3.1%		-
oriega 2016 Subtotal (95% CI)	34	24.22	12 155	20	17.32	12 155	1.1% 17.7%	14.00 [-2.85, 30.85] 15.31 [12.63, 17.99]	•
leterogeneity: Tau² = 4.85; Chi² = 1 est for overall effect: Z = 11.18 (P <			0.01);	l² = 66%					
.1.2 3 Months									
mirdelfan 2020 (18 Million MPC)	50.67	3.11		32.89	3.05	30		17.78 [16.22, 19.34]	•
mirdelfan 2020 (6Million MPC)	52.07	3.11	30	32.59	2.99	30	4.3%		
tluri 2021	46.1	12.6	40	28.8	17.1	40	3.1%	17.30 [10.72, 23.88]	
umar 2017		15.03	10	31.7	14.22	10	1.7%	11.10 [-1.72, 23.92]	
ewandrowski 2023	44.81	14.35		15.38	12.83	33	3.1%	29.43 [22.86, 36.00]	
oriega 2016		24.22	12		20.78	12	1.0%	18.00 [-0.06, 36.06]	
rozco 2011 ubtotal (95% CI)	25	12.96	10 165	25	12.97	10 165	1.9% 19.3%	0.00 [-11.36, 11.36] 18.27 [14.94, 21.60]	
eterogeneity: Tau ² = 9.50; Chi ² = 2 est for overall effect: Z = 10.76 (P <			0.0004	i); l² = 7	6%				
1	· 0.0000	''							
.1.3 6 Months mirdelfan 2020 (18 Million MPC)	50.67	3.11	30	31.7	2.94	30	4.3%	18.97 [17.44, 20.50]	
mirdelfan 2020 (18 Million MPC)	52.07	3.11	30	28.25	3.05	30	4.3%		
rtluri 2021	46.1	12.6	40	29.9	16.5	40	3.1%		
uun 2021 umar 2017			10	21.3	7.42	10		16.20 [9.77, 22.63]	000 <u>000</u>
		15.03	3 T T T				2.1%	21.50 [11.11, 31.89]	
ewandrowski 2023	44.81	14.35		13.48	10.16	33	3.2%	31.33 [25.33, 37.33]	1088
oriega 2016	34	24.22 12.96	12	20	24.25	12	0.9%	14.00 [-5.39, 33.39]	in
rozeo 2011				9.4	8.54	10	2.3%	15.60 [5.98, 25.22]	
rozco 2011								Made and inc - 1-1-	I
rozco 2011 settine 2017 subtotal (95% CI)	0	0	0 165	0	0	0 165	20.2%	Not estimable 21.40 [17.70, 25.09]	•
ettine 2017	0 33.92, d	0 f=6(P =	0 165	0			20.2%		•
ettine 2017 Subtotal (95% CI) Heterogeneity: Tau² = 13.81; Chi² =	0 33.92, d	0 f=6(P < 1)	0 165 0.000	0 001); I² =	: 82%	165		21.40 [17.70, 25.09]	•
ettine 2017 subtotal (95% CI) leterogeneity: Tau² = 13.81; Chi² = 'est for overall effect: Z = 11.35 (P ≪	0 33.92, d	0 f=6(P =	0 165 0.000	0			20.2 % 4.3%	21.40 [17.70, 25.09]	•
ettine 2017 subtotal (95% CI) leterogeneity: Tau² = 13.81; Chi² = 'est for overall effect: Z = 11.35 (P < .1.4 12 Months	0 33.92, d < 0.0000	0 f=6(P < 1)	0 165 0.000	0 001); I² =	: 82%	165		21.40 [17.70, 25.09]	•
uettine 2017 subtotal (95% CI) leterogeneily, Tau² = 13.81; Chi² = est for overall effect. Z= 11.35 (P ∘ .1.4 12 Months unirdelfan 2020 (18 Million MPC)	0 33.92, d < 0.0000 50.67	0 f= 6 (P < 1) 3.11	0 165 0.000	0 001); l² = 28.19	: 82% 3.16	165	4.3%	21.40 [17.70, 25.09] 22.48 [20.89, 24.07]	•
ettine 2017 vubtotal (95% CI) etetrogeneity: Tau² = 13.81; Chi² = est for overall effect Z = 11.35 (P ∘ .1.4 12 Months umirdelfan 2020 (18 Million MPC) mirdelfan 2020 (6Million MPC)	0 33.92, d < 0.0000° 50.67 52.07 46.1	0 f = 6 (P < 1) 3.11 3.11	0 165 0.000 30 30	0 001); I² = 28.19 31.92	3.16 3.16	30 30	4.3% 4.3%	21.40 [17.70, 25.09] 22.48 [20.89, 24.07] 20.15 [18.56, 21.74] 15.00 [7.96, 22.04]	· <u></u>
vettine 2017 vubtotal (95% CI) feterogeneity: Tau* = 13.81; Chi* = est for overall effect Z = 11.35 (P < .1.4 12 Months wirdelfan 2020 (18 Million MPC) mirdelfan 2020 (6Million MPC) tluri 2021	0 33.92, d < 0.0000° 50.67 52.07 46.1	0 f = 6 (P < 1) 3.11 3.11 12.6	0 165 0.000 30 30 40	0 001); I ² = 28.19 31.92 31.1	3.16 3.16 18.9	30 30 40	4.3% 4.3% 2.9%	21.40 [17.70, 25.09] 22.48 [20.89, 24.07] 20.15 [18.56, 21.74] 15.00 [7.96, 22.04] 26.00 [14.89, 37.11]	·
uettine 2017 subtotal (95% CI) leterogeneily, Tau ² = 13.81; Chi ² = fest for overall effect. Z = 11.35 (P · .1.4 12 Months umirdelfan 2020 (18 Million MPC) mirdelfan 2020 (6Million MPC) tluri 2021 umar 2017	0 33.92, d < 0.0000 50.67 52.07 46.1 42.8 44.81	0 f = 6 (P = 1) 3.11 3.11 12.6 15.03	0 165 0.000 30 30 40 10	0 001); l² = 28.19 31.92 31.1 16.8 11.8	3.16 3.16 3.16 18.9 9.77	30 30 40 10	4.3% 4.3% 2.9% 2.0%	21.40 [17.70, 25.09] 22.48 [20.89, 24.07] 20.15 [18.56, 21.74] 15.00 [7.96, 22.04] 26.00 [14.89, 37.11] 33.01 [26.92, 39.10]	·
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ettine 2017 Authotal (95% CI) deterogeneity. Tau² = 13.81; Chi² = deterogeneity. Tau² = 9.16; Chi² = deterogeneity. Tau² = 9.16; Chi² = deterogeneity. Tau² = 9.16; Chi² = deterogeneity. Tau² = 18.24; Chi² = deterogeneity. Tau² = 2.42; Chi² = deter	33.92, d < 0.00000 50.67 52.07 46.1 42.8 44.81 34 25 23.50, df: < 0.00000 50.67 52.07 44.81 28.56, d < 0.00000 50.67 52.07 56.7 56.47 56.48, df = < 0.000000	0 (F = 6 (P = 6 (P = 1))) (S = 6 (P = 1)) (S =	0 165 c 0.0000 30 30 30 30 30 30 30 30 30 30 30 30	0 0 001); F = 28.19 31.92 31.1.1 11.8 22 7.4 11.8 25.36 6.07 27.13 25.36 6.07 22.9 23.74 17.5 = 64%	3.16 3.16 18.9 9.77 10.6 24.22 7.27 4% 3.36 3.32 8.35 9.3%	30 30 40 10 33 12 10 165	4.3% 4.3% 2.9% 2.0% 3.2% 0.9% 20.0% 4.3% 4.3% 4.3% 4.3% 4.3% 10.9%	22.48 [20.89, 24.07] 22.48 [20.89, 24.07] 20.15 [18.56, 21.74] 15.00 [7.96, 22.04] 26.00 [14.89, 37.11] 33.01 [26.92, 39.10] 12.00 [7.38, 31.38] 17.60 [8.39, 26.81] 21.98 [18.74, 25.21] 23.54 [21.90, 25.18] 26.71 [25.11, 28.31] 38.74 [33.08, 44.40] 28.61 [23.69, 33.53] 27.77 [26.07, 29.47] 28.33 [26.69, 29.97] 39.20 [29.76, 48.64] 28.70 [26.31, 31.08]	-100 -50 0 50

Figure 3. Oswestry Disability Index forest plot.

	Pre	injectio	n	Post	l Injectio	on		Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Random, 95% CI	IV, Random, 95% CI
2.1.1 1 Month									
Amirdelfan 2020 (18 Million MPC)	71.47	4.68		40.97	4.4	30	4.0%	30.50 [28.20, 32.80]	1,7
amirdelfan 2020 (6Million MPC)	69.67	3.56	30	40.9	4.48	30	4.0%	28.77 [26.72, 30.82]	
atluri 2021 kumar 2017	71 65	12.7	40 10	68 46	17	40 10	3.0%	3.00 [-5.62, 11.62]	101_0
	2000			200000			2.7%	19.00 [8.71, 29.29]	
lewandrowski 2023 noriega 2016	82.2 67	14.31 24.25	33 12	33.1 63	17.86 24.25	33 12	3.2% 1.5%	49.10 [41.29, 56.91] 4.00 [-15.40, 23.40]	
Subtotal (95% CI)	07	24.20	155	03	24.20	155	18.5%	24.78 [17.47, 32.09]	
Heterogeneity: Tau ² = 64.41; Chi ² =	72.10 d	f= 5 (P :		1011:12:	03%	100	10.070	24.10[11.41,02.00]	
Test for overall effect: Z = 6.64 (P <			. 0.000	,01,,1 -	- 33 70				
2.1.2 3 Months									
Amirdelfan 2020 (18 Million MPC)	71.47	4.68	30	35.26	4.64	30	4.0%	36.21 [33.85, 38.57]	±
amirdelfan 2020 (6Million MPC)	69.67	3.56	30	30.28	4.48	30	4.0%	39.39 [37.34, 41.44]	
atluri 2021	71	22	40	31	25	40	2.7%	40.00 [29.68, 50.32]	- No. 100
kumar 2017	65	12.7	10	43	16.3	10	2.3%	22.00 [9.19, 34.81]	10 80 0
lewandrowski 2023	82.2	14.31	33	25.7	16.65	33	3.2%	56.50 [49.01, 63.99]	_
noriega 2016	67	24.25	12	43	31.18	12	1.2%	24.00 [1.65, 46.35]	
orozco 2011	68.9	10.44	10	26.5	17.71	10	2.3%	42.40 [29.66, 55.14]	
Subtotal (95% CI)			165			165	19.9%	39.41 [34.22, 44.60]	•
Heterogeneity: Tau ² = 28.48; Chi ² = Test for overall effect: Z = 14.89 (P			< 0.000	001); I²=	83%				
2.1.3 6 Months									
Amirdelfan 2020 (18 Million MPC)	71.47	4.68	30	34.6	4.41	30	4.0%	36.87 [34.57, 39.17]	<u> </u>
amirdelfan 2020 (6Million MPC)	69.67	3.56	30		4.56	30	4.0%	43.74 [41.67, 45.81]	_
atluri 2021	71	22	40	37	24	40	2.8%	34.00 [23.91, 44.09]	5140
kumar 2017	65	12.7	10	32	14	10	2.5%	33.00 [21.28, 44.72]	20 1000 37
lewandrowski 2023	82.2	14.31	33		13.77	33	3.4%	61.90 [55.12, 68.68]	
noriega 2016	67	24.25	12	40	27.71	12	1.4%	27.00 [6.17, 47.83]	
orozco 2011	68.9	10.44	10		18.97	10	2.2%	47.30 [33.88, 60.72]	
Subtotal (95% CI)			165			165	20.3%	42.06 [35.62, 48.49]	•
Heterogeneity: Tau² = 52.54; Chi² = Test for overall effect: Z = 12.81 (P			< 0.000	001); l² =	90%				
2.1.4 12 Months									
Amirdelfan 2020 (18 Million MPC)	71.47	4.68	30	30	4.73	30	4.0%	41.47 [39.09, 43.85]	<u> </u>
amirdelfan 2020 (6Million MPC)	69.67	3.56	30	30.58	4.73	30	4.0%	39.09 [36.97, 41.21]	
atluri 2021	71	22	40	42	28	40	2.6%	29.00 [17.96, 40.04]	10 Table 1
kumar 2017	65	12.7	10	29	16.6	10	2.3%	36.00 [23.05, 48.95]	
lewandrowski 2023		14.31	33		14.95	33	3.3%	64.10 [57.04, 71.16]	
noriega 2016		24.25	12		37.64	12	1.0%	20.00 [-5.33, 45.33]	
orozco 2011	68.9	10.44	10	20	20.55	10	2.1%	48.90 [34.61, 63.19]	
Subtotal (95% CI)	50.00	6 0 (10	165	2042 17	0000	165	19.4%	42.31 [35.94, 48.69]	_
Heterogeneity: Tau ² = 48.29; Chi ² = Test for overall effect: Z = 13.01 (P			< 0.000	JU1); In=	: 89%				
2.1.5 24 Months									
Amirdelfan 2020 (18 Million MPC)	71.47	4.68	30	35.17	5.03	30	4.0%	36.30 [33.84, 38.76]	4.
amirdelfan 2020 (6Million MPC)	69.67	3.56	30	24.8	4.83	30	4.0%	44.87 [42.72, 47.02]	-
lewandrowski 2023		14.31	33		13.22	33	3.4%	64.80 [58.15, 71.45]	
Subtotal (95% CI)	01.1	14.01	93			93	11.4%	48.07 [37.47, 58.67]	•
Heterogeneity: Tau ² = 83.25; Chi ² =			< 0.000	001); l²=	97%				
Test for overall effect: Z = 8.89 (P <	0.00001								
2.1.6 36 Months	123				1200			12-22-12-2-13-2-1	62
Amirdelfan 2020 (18 Million MPC)	71.47	4.68		24.95	5.4	30	4.0%	46.52 [43.96, 49.08]	pat-
amirdelfan 2020 (6Million MPC)	69.67	3.56	30	27.3	5.03	30	4.0%	42.37 [40.16, 44.58]	-
pettine 2017	56.7	18.36	26	21.9	22.44	26	2.6%	34.80 [23.66, 45.94]	
Subtotal (95% CI)			86	700		86	10.6%	43.32 [39.11, 47.54]	•
Heterogeneity: Tau ² = 8.95; Chi ² = 1 Test for overall effect: Z = 20.13 (P			.U1); l²	= 76%					
Total (95% CI)			829			820	100 0%	38.97 [36.01, 41.93]	
Heterogeneity: Tau ² = 55.72; Chi ² =	550.04	df = 22 /		000013-	2 - Q400		100.070		
Test for overall effect: Z = 25.78 (P			r ~ 0.t	,0001);	- 94%				-50 -25 0 25 50
Test for subgroup differences: Chi			- n n	006) 12	- 77 /0.				Pre injection Post Injection
restroi supproup dillerences; Chr	- 22.14,	ui – 5 (f	- 0.0	000), i*:	- 77.4%				

Figure 4. Visual analog scale forest plot.

statistically significant improvement in Pfirrmann grade (P = 0.005) with low heterogeneity ($I^2 = 0\%$; Table 3; Figure 7). Other studies showed varied results. In the study by Pettine et al, 8 of 20 patients showed improved Pfirrmann grade. In the study by Noriega et al, 21 the control group had worsened Pfirrmann grade at the end of the follow-up. Although limited, these results suggest the potential of stem cell therapy to influence disc morphology, warranting further investigation with larger samples.

DISCUSSION

Regenerative treatments using stem cell therapy sourced from the human body are gaining popularity across medical fields. In orthopedics, it offers a promising alternative for patients with degenerative conditions who opt to avoid surgery. This therapy aims to stimulate the body's natural regenerative mechanisms, especially in the IVDs, potentially alleviating pain in patients affected by degenerative disc disease over time.

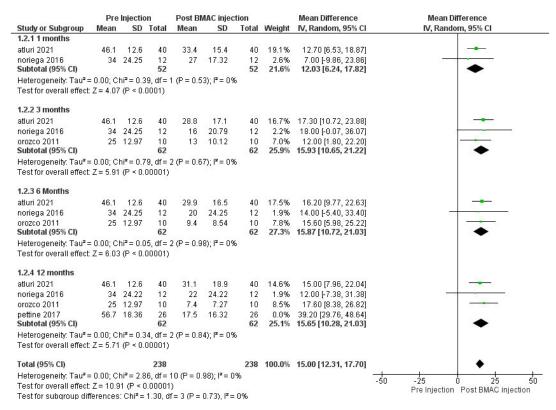


Figure 5. Oswestry Disability Index improvement with bone marrow aspirate concentrate.

	Pre	Injectio	n	Post BI	MAC injec	tion		Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Random, 95% CI	IV, Random, 95% CI
2.2.1 New Subgroup									1
atluri 2021	71	22	40	38	23	40	9.8%	33.00 [23.14, 42.86]	
noriega 2016	67	24.25	12	63	24.25	12	6.7%	4.00 [-15.40, 23.40]	- -
Subtotal (95% CI)			52			52	16.6%	19.75 [-8.56, 48.07]	
Heterogeneity: Tau ² =	= 358.83	; Chi² = 1	6.82, df	= 1 (P =	0.009); l ² =	= 85%			
Test for overall effect	: Z = 1.37	P = 0.1	17)						
2.2.2 3 Months									
atluri 2021	71	22	40	31	25	40	9.7%	40.00 [29.68, 50.32]	_
noriega 2016	67	24.25	12	43	31.18	12	5.9%	24.00 [1.65, 46.35]	
orozco 2011	68.9	10.44	10	26.5	17.71	10	8.9%	42.40 [29.66, 55.14]	
Subtotal (95% CI)			62			62	24.5%	38.98 [31.32, 46.64]	•
Heterogeneity: Tau² :				2 (P = 0.3)	36); I² = 2%	6			
Test for overall effect	: Z = 9.98	3 (P < 0.1	00001)						
2.2.3 6 Months									
atluri 2021	71	22	40	37	24	40	9.8%	34.00 [23.91, 44.09]	
noriega 2016	2000	24.25	12	40	27.72	12	6.3%	27.00 [6.16, 47.84]	
orozco 2011	68.9	10.44	10	21.6	18.97	10	8.7%	47.30 [33.88, 60.72]	
Subtotal (95% CI)			62			62	24.7%	37.25 [26.62, 47.89]	•
Heterogeneity: Tau² =				2 (P = 0)	$.18$); $I^2 = 4$	3%			
Test for overall effect	: Z = 6.86	6 (P < 0.1	00001)						
2.2.4 12 Months									
atluri 2021	71	22	40	42	28	40	9.5%	29.00 [17.96, 40.04]	
noriega 2016	67	24.25	12	47	34.64	12	5.5%	20.00 [-3.92, 43.92]	
orozco 2011	68.9	10.44	10	20	20.55	20	9.4%	48.90 [37.81, 59.99]	
pettine 2017	82.1	13.26	26	21.9	22.44	26	9.8%	60.20 [50.18, 70.22]	-
Subtotal (95% CI)			88			98		41.19 [24.26, 58.13]	
Heterogeneity: Tau² =				lf=3 (P •	< 0.0001);	$I^2 = 869$	6		
Test for overall effect	Z = 4.77	7 (P < 0.1	00001)						
Total (95% CI)			264			274	100.0%	36.06 [28.35, 43.76]	•
Heterogeneity: Tau ² :	= 131.62	Chi² =	45.48, d	f= 11 (P	< 0.0000	1); $I^2 = 7$	6%		-50 -25 0 25 50
Test for overall effect	Z = 9.17	7 (P < 0.1	00001)						pre injection Post BMAC injection
Test for subgroup dif	ferences	: Chi ² =	1.81, df	f = 3 (P =	0.61), $I^2 =$	0%			pro injection i oat bando injection

Figure 6. Visual analog scale improvement with bone marrow aspirate concentrate.

	pre i	injectio	on	post	injecti	ion		Mean Difference	Mean Difference					
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Random, 95% CI		IV, R	andom, 95%	6 CI		
lewandrowski 2023	4.05	0.72	33	3.65	0.81	23	57.4%	0.40 [-0.01, 0.81]			12 m			
noriega 2016	3.68	0.66	20	3.18	0.87	20	42.6%	0.50 [0.02, 0.98]						
Total (95% CI)			53			43	100.0%	0.44 [0.13, 0.75]			•			
Heterogeneity: Tau² = Test for overall effect:				1 (P =	0.76);	l² = 0%		ř	-2 -2	-1 ire inled	0 tion posti	1 niection	2	

Figure 7. Pfirmann improvement.

Regenerative medicine therapies have shown potential for sustained relief and, in certain cases, may provide curative outcomes. In recent years, allogeneic stem cell transplantation has gained increasing interest as an alternative to autologous BMC transplantation. Another source of mesenchymal stem cells (MSCs) is BMC, which can be derived from either autologous or allogeneic bone marrow aspirate. BMC can be harvested from the posterior superior iliac spine of the patient 16–18 or obtained from an allogeneic donor and subsequently processed following good manufacturing practice standards. 21

Multiple studies^{3,4,9–11,23–25} investigating the potential of MSC therapy for degenerative disc disease have consistently concluded that MSCs may offer a promising treatment approach for this condition. Although the precise mechanisms by which MSCs can alleviate disc degeneration remain unclear, evidence suggests that intradiscal injection of MSCs could serve as a potential treatment option for patients with chronic LBP. MSCs are considered strong candidates for regenerating IVDs, as they aim to replenish disc tissue and rejuvenate its functionality by promoting matrix synthesis through the implanted cells. Furthermore, MSCs may exert positive effects on the surrounding native cells.²⁶ Animal studies have shown that MSCs injected into the nucleus pulposus not only survive but also proliferate, potentially leading to improvements in the condition of degenerated discs.4

This systematic review and meta-analysis evaluated the effects of stem cell therapy on VAS, ODI, and disc morphology (Pfirrmann grade) in patients with discogenic LBP. Across studies, stem cell therapy showed statistically significant improvement in VAS/Numeric Rating Scale, ODI, and Pfirrmann improvement, suggesting substantial benefits for pain relief and functional outcomes in patients with discogenic LBP. High heterogeneity in overall analyses indicates variability in study outcomes, likely due to differences in intervention types, follow-up periods, and patient populations. Subgroup analyses by follow-up period and intervention type (bone marrow aspirate concentrate) reduced heterogeneity to some extent, suggesting the effects

of stem cell therapy on disability may be durable over time.

The magnetic resonance imaging findings, although limited in scope, provide preliminary evidence that stem cell therapy may positively affect disc degeneration, as indicated by changes in Pfirrmann grade. However, varied results across studies underscore the need for standardization in imaging protocols and extended follow-up to ascertain the true impact on disc morphology. These findings, while promising, are derived from a small subset of studies, highlighting the need for more robust evidence with larger, standardized sample sizes.

Wu et al,²⁴ Zhang et al,¹⁰ and Yolcu et al¹¹ reported improvements in discogenic LBP after stem cell therapy. Yolcu et al observed improvement at 3 months, 6 months, and 12 months, although the quantitative gains were slightly lower at the 12-month follow-up. In contrast, Wu et al and Zhang et al compared only the baseline data with final follow-up outcomes.

The observed outcomes may be linked to the introduction of anabolic growth factors and stem cells into the degenerated IVD, effectively counteracting its catabolic environment. Increased levels of growth factors and cytokines have been shown to enhance cellular proliferation of both annulus fibrosus and nucleus pulposus cells, enhance glycosaminoglycan content, stimulate collagen synthesis, and upregulate gene expression related to extracellular matrix proteins that are essential for IVD function. This synergistic effect likely plays a significant role in improving the overall condition of the disc. ¹⁶

Sanapati et al⁹ also stated in their study that regenerative therapies, including MSCs, may be effective in treating discogenic LBP, with the potential to decelerate or even halt the degenerative process of the IVD. However, they also suggested that the effectiveness of MSC injections could be improved by combining them with growth factors present in platelet-rich plasma.

Although no adverse events were reported following MSC injections, Meisel et al¹² emphasized that evidence regarding the efficacy and safety of cell therapy remains limited due to potential biases and small sample sizes. Similarly, Schneider et al³ found that the quality

of evidence for the effectiveness of intradiscal biological treatments was very low. This finding highlights the need for further research, particularly focusing on the efficacy and safety of MSC injections.

The authors acknowledge the limitations of this study. Variations in stem cell dose and cell types may influence the findings. Diverse reporting tools and follow-up times posed challenges in harmonizing results, and the small sample sizes in some studies may have contributed to bias. Different standards for patient selection across studies may potentially lead to a good outcome bias. Studies included in this review clearly stated no direct funding for their research, but several authors were affiliated with companies that manufactured the device used for their interventions, which may introduce a potential motivational bias. Future studies could benefit from more disclosure on author affiliations and potential conflicts of interest to further enhance objectivity.

Further research is necessary to compare the outcomes of stem cell therapy with standard treatments in long-term follow-up studies. Additionally, the optimal dose and variations in stem cell types required further investigation, as did establishing consistent patient selection criteria to ensure more accurate assessments of treatment efficacy.

CONCLUSION

Stem cells therapy could be beneficial as an option for the treatment for discogenic LBP in improving pain and activity of daily living. Future prospective studies with control subjects as a comparison of the effectiveness are strongly recommended to be conducted to verify this finding and also explore more effects regarding the use of stem cells.

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