SHUMAKER MELINDA S

P23323

DATE OF PROCEDURE: 08/25/2017

PREOPERATIVE DIAGNOSIS: SEVERE LUMBAR CANAL STENOSIS PREDOMINANTLY AT L4-L5 WITH COMPONENT LEFT-SIDED RADICULAR PAIN WITH AXIAL BACK PAIN.

POSTOPERATIVE DIAGNOSIS: SEVERE LUMBAR CANAL STENOSIS PREDOMINANTLY AT L4-L5 WITH COMPONENT LEFT-SIDED RADICULAR PAIN WITH AXIAL BACK PAIN.

PROCEDURES:

1. BILATERAL LAMINAR FORAMINOTOMY AT L4-5 WITH DECOMPRESSION AT L4-5.
2. USE OF INTERSPINOUS STABILIZATION DEVICE COFLEX.
3. USE OF MICROSCOPE FOR BETTER VISUALIZATION

SURGEON: AMIT BHANDARKAR, M.D.

ASSISTANT: None

COMPLICATIONS: None.

BLOOD LOSS: Less than 50 cc.

SPECIMEN: None.

IMPLANT USED: Coflex paradigm spine.

PREOPERATIVE AREA: The patient was seen in the preoperative area. The nature of the procedure which involved spine incision, decompression, and insertion of colfex were explained to the patient in detail. The patient was also explained about her lumbar canal stenosis, her pathology, the risks involved with the procedure, chances of dura tear, nerve damage, spinal fluid leak, infection, and clot formation was explained to the patient in detail. The patient understood the risks and the benefits of the procedure. Understanding that, she verbalized agreement with the current plan and consented for the procedure. The patient was appropriately marked for the site of the procedure. She had more pain on the left side.

DESCRIPTION OF PROCEDURE: After appropriate consent the patient, the patient was wheeled into the operating room where the patient was identified by the head nurse. The patient was administered anesthesia by the anesthetist. She received general anesthesia. All the IV lines were hooked up. A urinary catheter was inserted, and neuro monitoring lines were hooked up. Once they were all hooked up, the patient was then administered general anesthesia. The patient was then place in prone position on a radiolucent Jackson table. All of the body prominences were padded. We obtained our baseline and in the meantime the patient was prepped in the usual sterile manner and was draped free. C-arm was brought in the field. At this point in time, we carried out a time out to confirm patient site, side, and the diagnosis. The patient's allergies were also reconfirmed. Next, the C-arm was brought in to identify the incision site which was made over the spinous process of L4-5. We made a small incision and then infiltrated the area with saline plus antibiotics solution. We used Bovie to nicely go to the subcutaneous tissue and the fascia. We then again reconfirmed the C-arm to make sure we had the right location. We the dissected the muscle surface area fully from the pars of L4 to pars of L5 and the lamina, the partial facet joint, the interspinous space, and the pars were exposed. A self-retaining retractor was inserted to keep that exposed part open. We nicely irrigated the wound and we achieved hemostasis . Next was confirmed our level of lamina foraminotomy. We used a burr to then go ahead and do the bony work. We did clean up the facets using the burr. We then made a small window into the inferior part of the lamina to reach the ligamentum of flavum. We also used a disc punch to burr the fibrous tissue over the interspinous area intralaminar space. The patient has a Baastrup’s disease. We were able to slowly deburr that area and nicely define the ligamentum of flavum attachments inferior lamina. It was quite thickened in the ligamentum of flavum. I then started with a small curette and I developed a window between the ligamentum of flavum and the inferior lamina of L4. Once that was obtained I was able to pass a blunt hook and tease out the remaining ligamentum of flavum and then I pulled the ligamentum of flavum out seprating it from dura. I was able to completely excise the ligamentum of flavum from both sides. I was able to do it more on the left side than on the right side. At the time dura started to get exposed, we then brought in the microscope for better visualization. I then went ahead and did a lamina foraminotomy on both sides further. We then into the lateral recess. We then undercut the facet joints and cut the ligamentum of flavum which was kind of narrowing the lateral recess. We encountered large bleeding vessels at that point in time. The dura was kind of enlarged from almost being pencil size to almost a test tube size. It was nicely decompress. I went ahead and retracted the nerve root to work on the left side and retract the nerve root medially and both areas of the nerve roots had increased. I was able to nicely remove the overlying ligamentum of flavum thickening and the overlying of the joints on the medial aspect to have room for the nerve roots. I pulled nerve roots with a foraminal probe. The patient did not have any jumping or any neuro monitoring change at that point of time and the decompression was thorough. I had hemostasis around the disc space and went down there and reached the disc. The disc was nice and intact. There was no lamina fragment and there was enough mobility for the nerve root. I decided not to go ahead and do a discectomy at that point in time. Then I went ahead on the other side which was right side where I also went ahead and decompressed that area thoroughly. I was also able to go ahead and retract the nerve root to insure its mobility. I was able to pass a foraminal probe and was able to pass the foramina out and no jumping or changes in neuro monitoring area. I reexamined the disc. It was pretty intact. There was no herniated or bulging fragment. There was some circumferential foraminal bulge but there was sufficient room for the nerve roots to come out. After that was completed, I was concerned if the patient had enough room for the nerve root and mobility of the nerves around and achieved hemostasis. I irrigated the wound thoroughly with bacitracin solution. I when ahead and carried out further hemostasis, minimize any bleeding. After that, I applied bone wax at different locations so as to prevent any bone bleed. Once this was achieved, I put in a small gelfoam layer above the exposed dura. I started sculpting the spinous process to receive the coflex. I nicely sculpted the spinous process of both areas. She had enough bone density to receive the Coflex and then I crimped off the Coflex and hammered a #12 coflex in. It was appropriately sized. A little lip of the spinous process at both the areas I was able to nicely snugly fit the coflex. I then trimmed the Coflex with in position. We put the COFLEX with three teeth down. The patient was also checked for any dura leak. We did not observe any dural leak at this point in time. We did valsalva maneuver to check that there was no CSF leak. A thorough wash was given once again and after that, we ensured that the COFLEX was nice snugly fitting. We then went ahead with the closure. We closed the interspinous area with a #1 Vicryl and then we subsequently closed the fascial layer tightly with #1 Vicryl. Then we closed the surrounding fat and subcutaneous tissue with 2-0 Vicryl and the subcuticular stitches were taken with 5-0 Vicryl. The patient was then applied Prineo mesh and a small Telfa dressing was applied to the wound. There was minimal oozing so we would not put drain in the tissue. The patient also got Vancomycin in the intraoperative site. The patient was also infiltrated a cocktail of Torodol, Marcaine, and Dexamethasone in the surrounding area for postoperative pain relief and a sterile dressing placed.

We were able to extubate the patient immediately in the or after we turned her supine she was wheeled into recovery area where she received Morphine, Fentanyl for pain control. The pain was nicely well controlled. The patient tolerated the procedure very well. She was the taken to observation. The patient has minimal pain in the postoperative area where she was taken after the surgery. She was pretty, alert, and was able to walk by herself without any difficulty. She was explained the post op care of the incision also limitations which should be avoiding lifting, bending, twisting. She was also given a lumbar belt. She was thoroughly counseled about the pain medications. She understood about properly taking them.

She was observed in the ambulatory care area for around four hours after the procedure and was then discharged home on pain medication. The patient will be seen in the clinic in two weeks. If the patient has any further questions or concerns, she is to call Prairie Spine number.