# Decompression and Coflex insertion

Date: First of Report

Patient name

DOB

Preoperative Diagnoses: Disc herniation, left, <\_\_\_\_> with stenosis with bilateral <\_\_\_\_> radiculopathy also some disc degeneration and back pain

Postoperative Diagnoses:

Surgeon: Amit Bhandarkar, M.D.

Assistant: Jennifer

Complications: None

Specimen: None

Blood Loss: <\_\_\_\_>cc

PROCEDURES:

1. Bilateral hemilaminectomy with facetectomy and foraminotomy along with microdiscectomy on the <­­­­\_\_\_\_> for decompression of the traversing and exiting roots
2. Placement of the interlaminar stabilization device, nonsegmental spinal instrumentation
3. Use of operative microscope for assistance in dissection
4. Use of C-arm imagery: AP and lateral lumbar spine images.

On arrival to the operating room patient particulars, allergies, side and site of surgery were confirmed. All imaging studies were checked and relevant studies were put on display.

Sequential compression devices were placed prior to anesthesia. Anesthesia was induced by the anesthesia service and necessary vascular lines and access were established. Patient was then catheterized. The electrophysiology team then inserted needles and electrodes for neuro monitoring. Patient was then positioned prone on Jackson table. Care was taken to pad all bony prominences. We brought in C-arm for localization of our incision site.

Lumbar Region was then prepped and draped in the usual sterile fashion using ChloraPrep solution. A formal timeout was then performed. Antibiotic Cefazolin and 2 g was given before the incision. Roughly 7 cm incision was made posteriorly at the level of L5 and S1 and then extended to cover L4 as well. Skin incision was then carried down deeply to the fascia. Fascia and erector spinae aponeurosis was then cut in the midline using monopolar cautery.

Separate periosteal dissection aided by the Cobb was performed down the spinous process of the lamina at the levels L4-L5 and S1 and the facet capsule were nicely preserved and so was the pedicle for the multifidus while doing the exposure. The level was then confirmed using C-arm lateral view.

Retractors were then positioned to have maximum accessed through a small incision. The loupe assisted microdissection was further carried down to expose the hemilamina and the pars of L4-L5 and S1. Interlamniar space was then exposed and edge of the lamina was then burred using a high-speed bur so as to see the separation of the ligamentum flavum. Care was taken to preserve pass and cutting of the facets to provide postoperative instability.

The pedicle of L4 was identified and was used to confirm adequacy of compression. The facets were undercut. After completing the bony work with the Pars were rechecked and found to be intact. These steps were followed for both L4-5 and L5-S1 levels bilaterally.

After superior edge of the flavum was freed from the underlying dura, dissection was then carried out sufficiently to decompress the canal and to expose the underlying nerve root. The nerve root was retracted medially to see the underlying disc. Hemostasis of the disc space was achieved using bipolar cautery. A stab incision was with a number 15 blade on the annulus and several loose fragments from the area were removed and the annuls was observed to flattened out. Foraminal probes were used to confirm the adequacy of the decompression. These steps were followed for both L4-5 and L5-S1 levels bilaterally.

The dura was then checked and was intact. Adequate hemostasis was then achieved. We irrigated the solution with copious amount of saline plus antibiotic.

The spinous processes were then sculpted so as to accommodate the Coflex device. The interspinous space was then sized. An 8 mm COFLEX device was then implanted at L5 S1 level and 10 mm COFLEX device was then implanted at the L4 - L5 level. The devices were crimped in positon after confirming there position in relation to dura and also checking them radiographically. Both devices were approximately 4 mm away from dura.\*\*\*

Irrigation was then further carried out. Vancomycin powder 250 mg was then rubbed on the muscles and the fascia. Final counts of the patties, gauzes and was done to confirm that all foreign materials outside the surgical wound. Drain was inserted deep to the Fascia. We closed the fascia with #1 Vicryl and subcutaneous test tissue with 2-0 Vicryl. The subcutaneous tissue was then injected with a mix of 30 mg of Toradol, 40 mg of depomedrol and Marcaine for local pain relief. The subcuticular stiches were taken with 5 -0 vicryl. Steri strips were then

Applied and then the sterile dressing. Patient was then turned supine and was then extubated. Patient tolerated the

Procedure well and was stable after extubation was taken to PACU.

X-ray report-

Our AP and lateral lumbar images demonstrated good midline position of Coflex implant at L5 –S1 and L4 -5 . It had nice depth and appeared to be appropriately positioned.

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