**Transforaminal Epidural Steroid Injection**

OPERATIVE PROCEDURE

PREOPERATIVE DIAGNOSIS:----

POSTOPERATIVE DIAGNOSIS: ----

PROCEDURES: ----

1.----

2. Epidurography with radiographic interpretation of ----

ASSISTANT: ----

COMPLICATIONS: ----

SPECIMEN: ----

ESTIMATED BLOOD LOSS: ---

PREOPERATIVE PAIN LEVEL:----

POSTOPERATIVE PAIN LEVEL:---

RATIONALE :-----

PREOPERATIVE AREA: ----

All the risks of injections were discussed with the patient in the preop area. Risks included but not limited to stroke, paralysis, infection, hematoma formation, spinal fluid leak were discussed. The temporary nature of the pain relief was also explained to the patient. The alternative options of conservative care were also discussed with the patient. Patient completely understood and consented for the procedure understanding the risks and the benefits. Patient was also appropriately marked for the planned procedure after obtaining full informed consent. Patient was then transferred to the operating area.

OPERATIVE PROCEDURE: The patient was taken to the operating suite he/she was identified by the head nurse and was placed in prone position on a radiolucent table. Patient’s all bony prominences were padded. Patient is relevant studies were put on display his/ her vitals were being monitored, he/she was administered conscious sedation. Patient was in correct position with fluoroscopy on the right side. The patient was prepped and draped in the normal sterile fashion. Surgical time out was then performed to confirm the patient's identification, diagnosis, planned procedure and allergies. Surgical site was also properly marked for the planned procedure.

We were able to bring in the C-arm and nicely visualize the disc in AP view. We were able to square the disc by manipulating the C-arm. subsequently we were able to oblique the C-arm to obtain nice Scotty dog view. The entry point was decided around 7-10cm lateral to the midline using a clamp and C-arm guidance. Skin overlying the entry point and the thoracolumbar fascia was then anesthetized with 3-4 cc of 1% lidocaine. After adequate anesthesia, a spinal needle, which was 22-gauge was slowly inserted towards the direction of the superior articular facet once near the facet joint I was able to navigate the needle underneath the facet into the Kambin’s triangle. The needle was then slowly appropriately positioned in the inferior position of the foramen in the lateral view near the posterior disc line on the lateral view and in the mid-pedicular line in the AP view. We then went ahead and aspirated the needle and confirmed that it is negative for any blood or CSF. After confirmation of negative aspiration we injected the radio contrast dye under live fluoroscopy. A epidurogram resulted there was no vasculogram or myelogram. After further confirming that the needle is appropriately placed we injected into the lateral recess after a test dose of 1 mL of lidocaine the pre mixed solution of 1 mL of 0.25% Marcaine 1 mL of 1% lidocaine and 1 mL of 10 milligram/mL of dexamethasone. The patient was moving the legs and there was no pain radiating down her legs at that point of time.

After injection the patient’s pain went down from --------- to ------------. His/her sitting and lying down SLR was negative. He/she was walking comfortably within half an hour after the injection. He/she was neurologically same as before. He/she passed urine. He was discharged home after observation. He/she was asked to contact us if any fever, increased pain, tingling, numbness or weakness or any signs of infection. Discharge instructions were also handed over to him/her. He/she will also follow up with us in two weeks. if any further questions concern in the meantime, they should contact me at Fairfield Memorial Hospital.