**SI Joint denervation**

OPERATIVE PROCEDURE

PREOPERATIVE DIAGNOSIS:The patient with Left-sided sacroiliac joint dysfunction following failed back surgery.

POSTOPERATIVE DIAGNOSIS:The patient with Left -sided sacroiliac joint dysfunction following failed back surgery.

PROCEDURES:Left -sided L5 dorsal rami block along with block of lateral branches of S1, S2, and S3.

ASSISTANT:None.

COMPLICATIONS:None.

SPECIMEN:None.

ESTIMATED BLOOD LOSS:Scant.

PREOPERATIVE AREA: All the risks of injections were discussed with the patient in the preop area. The temporary nature of the pain relief and diagnostic nature of the procedure was explained to the patient. The patient completely understood and consented for the procedure understanding the risks and the benefits.

OPERATIVE PROCEDURE: The patient was taken to the operating suite and was placed in prone position on the operating room on a radiolucent table. The 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. Surgical site was also properly marked for the planned procedure. The entry point was decided using C-arm guidance. The skin overlying the entry point was then anesthetized with 3 to 4 cc of 1% lidocaine. After adequate anesthesia the four entry points were then entered with a 22-gauge spinal needle slowly 1) point was for L5-S1 dorsal rami, which was just underneath the L5-S1 facet at the entry part of the L5-S1 facet, 2) point was near the S1 foramen, superolateral border of the S1 foramen, 3) point was superolateral border of S2 foramen, 4) point was superolateral border of the S3 foramen. So, after anesthetizing the skin, the needles were slowly directed under fluoroscopic guidance towards superolateral corners of the foramen at the L5 dorsal rami area. After given appropriate repositions, that position was confirmed taking lateral view a

t the appropriate depth. After confirming, they were appropriately placed in both the views a radiocontrast dye was injected to confirm that there is no OsteoGram and there is no spread to the epidural space. After confirming that, the needle was aspirated one more time. There was negative aspiration for any blood or any CSF. Following which all the needles were injected with a mix of 1 cc of 1% lidocaine and around 0.2 cc of dexamethasone of the solution, which is 10 mg per cc. After injecting at all these levels, we are able to remove the needle safely, and the patient was applied Band-Aid. The patient had only partially offered sacroiliac joint-related pain and the pain went down from 7 to 0.

She does not have any shooting pain in her legs. She is walking comfortably within half an hour after the injection. She was neurologically same as before. She has passed urine. She was discharged home after observation for about 1 hour. She obtained major pain relief in the SI joint area and considered that this pain is related to the instability at the S1 joint following fusions at her lumbosacral spine. She was asked to contact us if any fever, increased pain, or wet dressing. Discharge instructions were also handed over to her. She will follow up with us in two weeks