

[REDACTED] [REDACTED]
Date of Admission: 04/06/2005
Date of Operation: 04/06/2005

Physician:
Room Number: SIU

OPERATIVE REPORT

SURGEON
[REDACTED]

ASSISTANT
[REDACTED]

P.A.

PREOPERATIVE DIAGNOSIS (ES)

1. Herniated nucleus pulposus, L4-5.
2. Herniated nucleus pulposus on the right at L5-S1.

POSTOPERATIVE DIAGNOSIS (ES)

1. Herniated nucleus pulposus, L4-5.
2. Herniated nucleus pulposus on the right at L5-S1.

OPERATION

1. Bilateral L4-5 laminoforaminotomies with discectomy.
2. Right-sided L5-S1 laminoforaminotomy and discectomy.

ANESTHESIOLOGIST
[REDACTED]

ANESTHESIA

General endotracheal anesthesia.

ESTIMATED BLOOD LOSS

25 cc.

COMPLICATIONS

None apparent.

INDICATIONS

The patient is a [REDACTED]-year-old lady who was involved in a motor vehicle accident. Since that time, she has had significant bilateral lower extremity symptomatology. She did have some back pain, but this was not a predominant feature. Her MRI scan indicated two-level degenerative change with a more acutely herniated disk centrally. I discussed with the patient, the risks, benefits, and alternatives of surgery. She has failed a long course of conservative therapy thus far. We elected to

AAHS PATIENT CARE INQUIRY (PCI: OE Database AAG)
[REDACTED]

[REDACTED]

Date of Admission: 04/06/2005

Date of Operation: 04/06/2005

Physician:

Room Number: SIU

OPERATIVE REPORT

push forward with decompressive laminotomies at both these levels in an attempt to avoid a fusion procedure. The patient and her parents expressed understanding of the risks, benefits, and alternatives of surgery and did wish to proceed.

PROCEDURE/FINDINGS

The patient was brought to the operating room and kept in a supine position on the operating room stretcher. After intravenous antibiotics and a bolus of steroids were given, the patient was placed under general endotracheal anesthesia. At this point, the patient was carefully turned to a prone position onto a Jackson table. After final positioning, all pressure points and sensitive areas were checked and found to be free of compression. The lumbosacral region was prepped and draped in a sterile fashion. A skin incision was designed from approximately L4 through the top of S1. A skin incision was then made with a #10 blade and carried down to the lumbosacral fascia using Bovie electrocautery on low current. The paraspinous muscles were taken down in a subperiosteal fashion on the patient's right side at the L4-5 and L5-S1 levels and on the patient's left side at just at the L4-5 level. At this point, two surgical instruments were placed into the wound, and a lateral lumbosacral spine x-ray was performed. This helped to identify the correct levels. With the correct levels identified, attention was turned first to the L5-S1 level. Using a combination of Leksell rongeurs, Kerrison rongeurs, and the Anspach drill with the small cutting bur, we were able to perform a laminotomy with a generous foraminotomy over the nerve root. As predicted by the MRI, there was a large bulge of disk material at the L5-S1 disk space. A 15 blade was used to incise the posterior longitudinal ligament with gentle protection on the nerve root and medial dura. I was able to enter the disk space, and piecemeal removal of several sizable pieces of disk material was undertaken. At the end of the disk decompression, I could appreciate no pressure on the exiting nerve root at the L5-S1 level. Therefore, attention was turned to the L4-5 level initially on the right side where, again, using a combination of Leksell rongeurs, Kerrison rongeurs, and the Anspach drill, we were able to perform a generous foraminotomy and a laminotomy at this level. As predicted by the MRI again, there was a very large, even larger bulge of disk at this L4-5 level versus L5-S1. A 15 blade was used to incise the posterior

AAHS PATIENT CARE INQUIRY (PCI: OE Database AAG)

[REDACTED]

Page 2 of 3

[REDACTED]

Date of Admission: 04/06/2005
Date of Operation: 04/06/2005
Physician:
Room Number: SIU

OPERATIVE REPORT

longitudinal ligament, and we were able to decompress the disk space in the standard fashion. Special care was taken to enter the disk space at both these levels to remove any loose disk material and help to prevent a re-herniation. Attention was turned to the patient's left side where, again, a laminoforaminotomy was performed. On this side fortunately, where the decompression from the other side, there was not a significant amount of compression from the disk. Therefore, I did not enter the disk on the right side. After the diskectomy bilaterally, I felt we had achieved an excellent decompression on the interspace. A final check of the nerve roots bilaterally at the L4-5 level and on the right side at the L5-S1 level showed them to be widely free of compression. Therefore, the wound was copiously irrigated with warm saline solution. A very small amount of Gelfoam, which was soaked in Depo-Medrol was placed over the exposed nerve roots and dura. Attention was then turned to closing. Hemostasis was assured with bipolar and Bovie electrocautery.

The fascial layer was tightly approximated using #1 Vicryl in an interrupted fashion. The subcutaneous tissues were approximated using a combination of 0 and 1-0 Vicryl. Subcuticular sutures were used of 3-0 Vicryl. Benzoin, Steri-Strips, and a sterile dressing were applied on the skin. The patient was then gently turned back to a supine position on the operating room stretcher, awakened, and taken to the recovery room in stable condition, having tolerated the procedure well.

[REDACTED]

DD: 04/06/2005 1310
DT: 04/06/2005 1108
TR.JEM
Document Id: 01039953

[REDACTED]

Electronically Signed 04/06/05 1731
[REDACTED]

A [REDACTED]
R [REDACTED]