PREOPERATIVE DIAGNOSES:,1. Extruded herniated disc, left L5-S1.,2. Left S1 radiculopathy (acute).,3. Morbid obesity.,POSTOPERATIVE DIAGNOSES:,1. Extruded herniated disc, left L5-S1.,2. Left S1 radiculopathy (acute).,3. Morbid obesity.,PROCEDURE PERFORMED: , Microscopic lumbar discectomy, left L5-S1.,ANESTHESIA: , General.,COMPLICATIONS: , None.,ESTIMATED BLOOD LOSS: ,50 cc.,HISTORY: , This is a 40-year-old female with severe intractable left leg pain from a large extruded herniated disc at L5-S1. She has been dealing with these symptoms for greater than three months. She comes to my office with severe pain, left my office and reported to the Emergency Room where she was admitted for pain control one day before surgery. I have discussed the MRI findings with the patient and the potential risks and complications. She was scheduled to go to surgery through my office, but because of her severe symptoms, she was unable to keep that appointment and reported right to the Emergency Room. We discussed the diagnosis and the operative procedure in detail. I have reviewed the potential risks and complications and she had agreed to proceed with the surgery. Due to the patient's weight which exceeds 340 lb, there was some concern about her operative table being able to support her weight and also my standard microlumbar discectomy incision is not _____ in this situation just because of the enormous size of the patient's back and abdomen and I have discussed this with her. She is aware that she will have a much larger incision than what is standard and has agreed to accept

this.,OPERATIVE PROCEDURE: ,The patient was taken to OR #5 at ABCD General Hospital. While in the hospital gurney, Department of Anesthesia administered general anesthetic, endotracheal intubation was followed. A Jackson table was prepared for the patient and was reinforced replacing struts under table to prevent the table from collapsing. The table reportedly does have a limit of 500 lb, but the table has never been stressed above 275 lb. Once the table was reinforced, the patient was carefully rolled in a prone position on the Jackson table with the bony prominences being well padded. A marker was placed in from the back at this time and an x-ray was obtained for incision localization. The back is now prepped and draped in the usual sterile fashion. A midline incision was made over the L5-S1 disc space taking through subcutaneous tissue sharply with a #10 Bard-Parker scalpel. The lumbar dorsal fascia was then encountered and incised to the left of midline. In the subperiosteal fashion, the musculature was elevated off the lamina at L5 and S1 after facet joint, but not disturbing the capsule. A second marker was now placed and an intraoperative x-ray confirms our location at the L5-S1 disc space. The microscope was brought into the field at this point and the remainder of the procedure done with microscopic visualization and illumination. A high speed drill was used to perform a laminotomy by removing small portion of the superior edge of the S1 lamina and the inferior edge of the L5 lamina. Ligaments and fragments were encountered and removed at this time. The epidural space was now

encountered. The S1 nerve root was now visualized and found to be displaced dorsally as a result of a large disc herniation while the nerve was carefully protected with a Penfield. A small stab incision was made into the disc fragment and probably a large portion of disc extrudes from the opening. This disc fragment was removed and the nerve root was much more supple, it was carefully retracted. The nerve root was now retracted and using a series of downgoing curettes, additional disc material was removed from around the disc space and from behind the body of S1 and L5. At this point, all disc fragments were removed from the epidural space. Murphy ball was passed anterior to the thecal sac in the epidural space and there was no additional compression that I can identify. The disc space was now encountered and loose disc fragments were removed from within the disc space. The disc space was then irrigated. The nerve root was then reassessed and found to be quite supple. At this point, the Murphy ball was passed into the foramen of L5 and this was patent and also into the foramen of S1 by passing ventral and dorsal to the nerve root and there were no obstructions in the passage of the device. At this point, the wound was irrigated copiously and suctioned dry. Gelfoam was used to cover the epidural space. The retractors were removed at this point. The fascia was reapproximated with #1 Vicryl suture, subcutaneous tissue with #2-0 Vicryl suture and Steri-Strips for curved incision. The patient was transferred to the hospital gurney in supine position and extubated by Anesthesia, subsequently transferred to Postanesthesia Care Unit in

stable condition.