PROCEDURE: ,Transforaminal Epidural, lumbar.,INFORMED CONSENT: , The risks, benefits and alternatives of the procedure were discussed with the patient. The patient was given opportunity to ask questions regarding the procedure, its indications and the associated risks.,The risk of the procedure discussed include infection, bleeding, allergic reaction, dural puncture, headache, nerve injuries, spinal cord injury, and cardiovascular and CNS side effects with possible of vascular entry of medications. I also informed the patient of potential side effects or reactions to the medications potentially used during the procedure including sedatives, narcotics, nonionic contrast agents, anesthetics, and corticosteroids.,The patient was informed both verbally and in writing. The patient understood the informed consent and desired to have the procedure performed.,PROCEDURE: , Oxygen saturation and vital signs were monitored continuously throughout the procedure. The patient remained awake throughout the procedure in order to interact and give feedback. The X-ray technician was supervised and instructed to operate the fluoroscopy machine.,The patient was placed in the prone position on the treatment table with a pillow under the lower abdomen to reduce the natural lumbar lordosis. The skin over and surrounding the treatment area was cleaned with betadine. The area was covered with sterile drapes, leaving a small window opening for needle placement. Fluoroscopy was used to identify the boney landmarks of the facet joints and the planned needle approach. The skin, subcutaneous tissue, and muscle within the planned

approach were anesthetized with 1 % lidocaine.,With fluoroscopy, a *** spinal needle was gently guided into the superior-anterior neuroforamin lateral to the mid-pedicular line at ***. Multiple fluoroscopic views were used to ensure proper needle placement. Approximately *** of non-ionic contrast agent was injected into the joint under real time fluoroscopic observation. Correct needle placement was confirmed by production of an appropriate epidurogram and radiculogram without concurrent vascular dye pattern. Finally the treatment solution, consisting of *** was injected.,All injected medications were preservative free. Sterile techniques were used throughout the procedure.,COMPLICATIONS: ,None. No complications.,The patient tolerated the procedure well and was sent to the recovery room in good condition.,DISCUSSION: , Post-procedure vital signs and oximetry were stable. The patient was discharged with instructions to ice the injection site as needed for 15-20 minutes as frequently as twice per hour for the next day and to avoid aggressive activities for 1 day. The patient was told to resume all medications. The patient was told to be in relative rest for 1 day but then could resume all normal activities.,The patient was instructed to seek immediate medical attention for shortness of breath, chest pain, fever, chills, increased pain, weakness, sensory or motor changes, or changes in bowel or bladder function.,Follow up appointment was made in approximately 1 week.