



Patient Name: John Doe **MRN:** 1
Exam Date: 11/05/2002 **Case # :**
Surgeon: Daniel L. Bruning, MD **DOB :** 04/15/1942
Referring: Kimber Eubanks, MD
Procedure: Lumbar Provocative Manometric Discography L3-4, L4-5, L5-S1, under Fluoroscopic Guidance
Diagnosis: 724.2 BACK PAIN/LUMBAGO
722.52 DEGENERATIVE DISC DISEASE
722.1 HERNIATION/PROTRUSION OF LUMBAR DISC W/O MYELOPATHY
721.3 LUMBOSACRAL SPONDYLOLYSIS W/O MYELOPATHY

Indications: The patient was seen in consultation. Preprocedure conservative treatment including activity modification, physical therapy and non-steroidal anti-inflammatory drugs were utilized. Epidural steroids was also used and found to provide nontotal relief of axial back pain.

We are therefore going to be performing provocative manometric discography to see if we can identify the source of pain, rule out nonpainful discs suspicious of being pain sources, and to aid in determining the best course of treatment. Preoperative imaging and testing, including MRI and routine x-rays, were reviewed.

Informed Consent: The procedure was described in detail to the patient utilizing the spine model. The expected outcomes were explained to the patient including the risks inherent in the procedure including but not limited to infection, bleeding, nerve damage resulting in weakness or numbness, damage to adjacent organs, increase in pain or no decrease in pain. The patient willingly agreed to the procedure as planned.

Anesthesia: The patient remained alert and conversant throughout the entire procedure. Local anesthetic was also used for infiltration of tissues and skin.

Position: Prone Position

Skin Prep: Duraprep

Description of Procedure: An IV was started and 1 gm of Cephazolin was infused over 15". The patient was then taken to the fluoroscopy suite and placed in a prone position. Monitors were placed for Conscious Sedation. The back was prepped with Duraprep™ and draped in a sterile fashion. Strict aseptic technique was maintained throughout the procedure. The field was draped with sterile towels and the patient was draped in a full sterile laparoscopic sheet. Gloves, and barrier MOTI mask was worn. At this time, identification of the disc space was performed using fluoroscopic image intensification. 2% Xylocaine local skin infiltration was placed deeply using a 25 gauge 3 1/2" needle. Intra-discal access was then obtained using a right-sided extra-pedicular posterior lateral approach for the lumbar area. An 18 ga. 3 1/2" introducer needle was passed just lateral to the superior articular process to the outer annulus of the disc. Then, using a lateral view, a 6" 22 ga.



Procedure needle was passed through the introducer needle and negotiated into the central portion of the disc. Confirmation of central position of the needle tip was confirmed both lateral and AP. Each lumbar disc to be tested was approached in the same manner. The L5-S1 disc was unable to be approached from the right due to severe degeneration and bony bridge. The needles were placed with difficulty from the left in the normal manner.

Once all procedure needles were in place, provocative manometric injection was accomplished in the following manner. A Merit pressure syringe was filled with Omnipaque 300 containing Cephazolin 2.5 mg/cc. The syringe was attached to the procedure needle. Then in ½ cc increments, the dye/antibiotic solution was injected while observing and recording intradiscal pressures by the assistant present. The patient was awake and conversant throughout the entire procedure. They would then comment on the relative 0-10 scale level of pain and the familiarity of the elicited pain to their normal pain pattern. This was recorded for each level. Fluoroscopic pictures were recorded, needles were removed.

Findings:

L3-4: Degenerated inferior endplate with extravasation of dye into annulus.

NONPAINFUL

L4-5: Disc degeneration with annular disruption into annulus, NONPAINFUL

L5-S1: Severe disc degeneration with complete annular disruption. Dye extravasation into epidural space. Re-creation of left buttock pain familiar but this has only been felt by her in the last 2 days. No pain in low back in familiar area. NONPAINFUL.

Complications: None

Follow-Up: The patient will be discharged from the pain clinic to return to see his referring physician. Follow up by telephone will be made tomorrow. Discharge handout was given.

M.D.

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