

**Georgia Surgical Centers - North
2550 Windy Hill Rd. Suite 215
Marietta, Georgia 30067
(770) 850-8464
FAX (770) 850-9727**

Patient Name: XXXXX

Date: 05/25/05

Page 1 of 4

Type of Surgery:

1. Implantation of Left Octrode Spinal Cord Stimulator Lead
2. Implantation of Right Octrode Spinal Cord Stimulator Lead
3. Tunneling of Octrode Leads
4. Creation of RF Receiver Pocket
5. Implantation of RF Receiver

Surgeon: Robert E. Windsor, MD

Assistants: Maurice Bernaiche, DO

Pre-operative Diagnosis: 1. FBSS
2. Lumbar radiculopathy

Post-operative Diagnosis: Same

Type of Anesthesia: Conscious sedation and local anesthetic.

Blood Loss: None

Method of Surgery: The patient signed an informed consent form in the pre-op area after all risks and complications were explained and all questions were answered for the patient. An IV was started and IV fluids were initiated. IV fluid administration continued throughout the procedure. Blood pressure, heart rate, pulse oximetry, and electrocardiographic monitoring were monitored throughout the procedure. The patient's vital signs remained stable and the electrocardiogram demonstrated a normal sinus rhythm before, during, and after the procedure.

IV sedation appropriate to the procedure was administered by the physician/nurse and is accurately recorded in the nurse's documentation.

One gram of Ancef was administered before and after the procedure. The patient was prepped and draped in a sterile fashion in the prone position.

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Page 2 of 4

Implantation of left Octrode Spinal Cord Stimulator Lead

Under fluoroscopic visualization the lumbar spine was surveyed. After appropriate local anesthesia with 0.5% Bupivacaine with epinephrine and 1% Lidocaine with epinephrine via a 25G 1.5 inch needle, and a 25G 3.5 inch spinal needle for deeper tissues, a 14 gauge 4.5 inch Tuohy epidural needle was inserted into the L2-L1 epidural space using a left paramedian approach with loss of resistance technique. An octrode lead was then advanced up the posterior epidural space to the top of the T9 vertebra and slightly to the left of midline. Multiple positions and electrode montage were performed. At this point, the stimulator was activated using multiple electrode settings with a hand-held ANS stimulator. The patient received good low back and leg coverage. No abdominal or rib/sternal stimulation was noted by the patient. An AP spot film was obtained to record the final lead position after the needle was removed. At this point the needle was removed using a push-pull technique under direct fluoroscopic visualization making sure that the lead did not move. The spinal lead was anchored to the fascia using standard technique with 2-0 silk and lead anchor.

Implantation of Right Octrode Spinal Cord Stimulator Lead

Under fluoroscopic visualization the lumbar spine was surveyed. After appropriate local anesthesia with 0.5% Bupivacaine with epinephrine and 1% Lidocaine with epinephrine via a 25G 1.5 inch needle, and a 25G 3.5 inch spinal needle for deeper tissues, a 14 gauge 4.5 inch Tuohy epidural needle was inserted into the L2-L1 epidural space using a right paramedian approach with loss of resistance technique. An octrode lead was then advanced up the posterior epidural space to the top of the T9 vertebra and slightly to the right of midline. Multiple positions and electrode montage were performed. At this point, the stimulator was activated using multiple electrode settings with a hand-held ANS stimulator. The patient received good low back and leg coverage. No abdominal or rib/sternal stimulation was noted by the patient. An AP spot film was obtained to record the final lead position after the needle was removed. At this point the needle was removed using a push-pull technique under direct fluoroscopic visualization making sure that the lead did not move. The spinal lead was anchored to the fascia using standard technique with 2-0 silk and lead anchor.

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Page 3 of 4

Tunneling of Octrode Leads

A 3 cm vertical incision was made on the left paramedian thoracolumbar skin at the site of the Tuohy needles. A tunneling device was then passed from the caudal end of the paramedian incision to the superomedial aspect of the flank pocket. A carrying tip was then placed on the tunneling device and the octrode lead was then pulled back through.

Creation of RF Receiver Pocket

Following this, a 6 cm horizontal incision was made on the left gluteal skin below the level of his belt line and slightly lateral to the mid-gluteal line. A generous subcutaneous pocket was created using blunt dissection that was ~2 cm deep to the skin's surface. After it was completed, both it and the paramedian wound were copiously irrigated with Bacitracin solution.

Implantation of RF Receiver

The spinal ends of the octrode leads was then connected to the RF receiver. The plastic boots were ligated over their junctions and the pulse generator was placed in the pocket with lettering out. A quarter sized loop of lead was placed in the subcutaneous pocket at the caudal end of the paramedian incision and both incisions were closed with deep interrupted sutures of 2-0 Vicryl. The paramedian vertical incision was then further approximated using a running suture of 2-0 Vicryl. The skin was closed with skin staples. There was no stress on the skin edges or the leads upon closing.

Pre-needle removal A-P Spot Film: The spot film demonstrated that the octrode leads were slightly to the left and right of midline and at the midline with both lead electrodes positioned at the top of the T9.

Post-needle removal A-P Spot Film: The spot film demonstrated that the octrode leads were slightly to the left and right of midline and at the midline with both lead electrodes positioned at the top of the T9.

Complications: None

Disposition: 1. The patient was discharged to the recovery room in stable condition

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Page 4 of 4

2. Ciprofloxin 500 mg I po BID #14
3. Stimulator functioning and wound care were explained thoroughly
4. Retrial of stimulator in recovery area provided good coverage of the back, and both lower extremities.
5. The patient will follow up in 10 days for evaluation.

Surgeon: Robert E. Windsor, MD