

# Georgia Surgical Centers - South

(404) 366-5652

## **Atypical Facial Pain Type of Surgery:**

1. Insertion of left infraorbital stimulator lead
2. Tunneling of left infraorbital nerve stimulator lead
3. Subcutaneous pocket creation
4. Internalization of internal pulse generator

**Surgeon:** Robert Windsor, MD

**Assistant:** Seneca Storm, MD

## **Pre-operative Diagnosis:**

1. Atypical facial pain
2. Trigeminal nerve injury

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

## **Insertion of Left Infraorbital Octrode Stimulator Lead**

The patient was prepped and draped in the supine position with his head rotated to the right. The patient's head was taped in place and his skin was covered with Ioban. The temporal artery and marked on the Ioban with a sterile marker. The skin 1.5 cm anterior to the temporal artery on the zygomatic arch was infiltrated with local anesthetic and a 2 cm horizontal incision was created. A 15 G Touhey needle was advanced along the zygomatic arch to 3-4 mm medial to a point 1 cm caudal to the orbit at the 6 o'clock position to the orbit. At this point an Octrode peripheral nerve stimulating lead was placed within the needle and the needle was removed using a push-pull method taking care not to dislodge the lead. The lead was then anchored in place using two drain stitches with 2-0 Neurolon. A series of stab wounds were created on a path superior,

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posterior, and finally caudal along the left anterior cervical spine. The lead was tunneled along the path utilizing a drain stitch using 2-0 Neurolon at the first three incisions.

### **Subcutaneous Pocket Creation**

A six centimeter horizontal incision was made approximately 5-7 cm caudal to the clavicle in the mid clavicular line. The pocket was made approximately 2 cm deep large enough to accommodate the IPG. The pocket was copiously irrigated with Bacitracin solution.

### **Internalization of Pulse Generator**

The lead was tunneled into the cephalad aspect of the pocket. The lead was connected to the IPG using standard technique. The strain relief was ligated onto the IPG/lead junction. The IPG was inserted into the pocket with the lettering out and the redundant lead was gently placed deep to the IPG. The pocket was closed with 2-0 Vicryl and the skin was closed with skin staples. The stab wounds were closed with 1-2 skin staples.

### **Spot Film**

A spot film was obtained with his cervical spine in the neutral posture. The Octrode lead was visualized 1-2 cm caudal to the orbit with the distal lead caudal to the medial edge of the orbit.

**Complications:** None

### **Disposition:**

1. The patient was discharged to the recovery room in stable condition
2. The ANS representative will program the patient in the recovery room.
3. Call for any problems or concerns
4. Keflex
5. Pain medication
6. The patient will follow up in five days for trial stimulator removal.

**Surgeon:** Robert Windsor, MD