

# **EXHIBIT 15**

**TO THE DECLARATION OF BRIAN J. NISBET  
IN SUPPORT OF DEFENDANTS' MOTION  
FOR SUMMARY JUDGMENT OR, IN THE  
ALTERNATIVE, SUMMARY ADJUDICATION**



**OPERATIVE REPORT**

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<b>NAME:</b>	████████████████████	<b>MED REC #:</b>	████████████████
<b>Date of Operation:</b>	02/14/2017	<b>Room:</b>	EE2W 2105/A
<b>Dict Phys:</b>	NEVILLE ALLEYNE, MD	<b>Account #:</b>	████████████████
<b>Date of Birth:</b>	██████████████		

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**SURGEON:**  
Neville Alleyne, MD

**PREOPERATIVE DIAGNOSIS:**  
L2-3, L3-4, L4-5, and L5-S1 lumbar spinal stenosis with instability and scoliosis.

**POSTOPERATIVE DIAGNOSIS:**  
L2-3, L3-4, L4-5, and L5-S1 lumbar spinal stenosis with instability and scoliosis.

**PROCEDURE PERFORMED:**  
Part 1: XLIF L2-3, L3-4, L4-5.

**ASSISTANT:**  
Tommy D Hammonds, PA.

**ANESTHESIA:**  
General endotracheal anesthesia.

**ANESTHESIOLOGIST:**  
Dr. Ladan Farhoomandi, MD.

Somatosensory motor evoked potentials being performed by Ms. Christina Brady.

**PROCEDURE IN DETAIL:**  
The patient brought to the operating room, supine position. After successful general endotracheal anesthesia. Central line, A-line, Foley catheter, Venodyne boots, and somatosensory motor evoked potentials were placed. The patient was then meticulously placed onto the operating table in a lateral decubitus position with the right side up. All bony prominences well padded. Axillary roll was placed and the patient was then positioned for an XLIF and taped into position with a blanket roll on the anterior portion and posterior portion to keep her aligned. The bed was then flexed and appropriate AP and lateral x-rays were taken with fluoroscopy to obtain good end plates. Next the anterior longitudinal ligament, posterior longitudinal ligament, the 30 yard line and trajectory path were then marked at L4-5, L3-4, and L2-3. The wound was then prepped and draped in usual sterile fashion. The subcutaneous tissue was then infiltrated with 10 cc of Marcaine with epi. Incision was carried down through the skin down to the subcutaneous tissue. The fascia was then entered at L4-5 by using the Metz, blunt dissection down to the psoas. The surgeon's hand was then used to sweep and palpate the iliac crest, the TP as well as the disc space. The 1st dilator was placed and the thresholds were then checked and noted to be stable circumferentially, K-wire was then placed into the L4-5 30-yard line, followed by 2nd dilator which was tested and the retractor blades were then placed over the 2nd dilator and the lights were then inserted. The



Squadron retractor was then opened and locked into position and secured with the bed mount. This was followed by the placement of the shim under AP fluoro at L4-5 followed by an annulotomy that was made after the K-wire and the dilators were removed and the floor of the disk space was then tested circumferentially for any thresholds. 15 blade was used to make a rectangular incision in to the anulus on the right side followed by pituitary rongeur to remove disc material and annular debris followed by the 4, 6, and 8 trial which were inspected under AP and lateral fluoro, the 8 trial was then used, we used an 8 x 18 x 55 trial filled with DBM putty and BMP prior to placing are cage, the endplates were then scraped with the scrapper followed by the rasp. Pituitary rongeur was used to remove any further disc material and annular debris. The wound was then irrigated and suction dried and are 8 x 18 x 55 cage was then impacted with the impactor mallet. Intraoperative lateral x-ray confirmed our position. Because of the spondylolisthesis, care was taken to make sure where our posterior markers were, they were in good position and reduction of the spondylolisthesis was noted.

At L3-4 in the similar fashion, through the same opening the 1st dilator was placed and checked for threshold, K-wire was then placed at the 30 yard line and the 2nd dilator circumferentially tested and the retractor blades were then inserted. Once this was accomplished, the light was then turned on and the dilators were opened up with a Squadron retractor which was then locked to the bed mount and secured after the Squadron retractor blades were opened. The floor of the disc space was then tested and noted to have adequate threshold. The shim was then placed uneventfully followed by the annulotomy at L3-4 followed by pituitary rongeur to remove disc material and annular debris, followed by the 4, 6, 8, and 10 trials. The 10 x 18 x 55 trial was felt to be snug. Once this was removed and checked under AP and lateral fluoro, it was noted be in good position. This was followed by the scraper rasp disc space irrigation and the implant was then placed from Alphatec using the \_\_\_\_\_ impacted with the impactor mallet noted to be in good position and our attention was then taken to L2-3. In a similar fashion, at L2-3 through a separate incision skin incision was made. Subcutaneous tissue was visualized followed by the blunt dissection using the Metzenbaum scissors to the psoas at L2-3. The first dilator was placed and thresholds were tested, noted be adequate, K-wire was then introduced into the L2-3 disk space followed by the 2nd dilator which was checked circumferentially followed by the Squadron retractor blades being placed with the retractor uneventfully at L2-3 and opened after it was secured to the bed mount. Once this was accomplished, the 1st and 2nd dilators were removed, K-wire was left in place. The floor of the disc space was then tested circumferentially for adequate thresholds. The shim was then introduced at L2-3, secured, followed by the annulotomy which was done with a 15 blade followed by straight pituitary rongeur followed by the scraper and 4, 6, and 8 trials which were checked under AP and lateral fluoro, noted to have good threshold, once they were reintroduced, the 8 was felt to be adequate, we used an 8 x 18 x 50 filled with BMP and DBM putty. Impacted with the impactor mallet. Prior to doing this, the disc space at L2-3 was scraped, rasped, and further disc debris was removed followed by disc space irrigation and suctioning of that disk space. With the cage now in place L2-3 intraoperative AP and lateral fluoro confirmed the position and orientation at all 3 levels. The Floseal was then placed into each one of these openings and followed by lyophilized vancomycin. Fascia was closed with 1 Vicryl followed by the deep subcutaneous tissue with the 2-0 Vicryl for both incisions. The incisions were then stapled. Dermabond and an Ioban dressing was then applied. Sponge and needle count were correct x2. The patient tolerated the procedure well. At no time were there any alterations in somatosensory and motor evoked potentials. Total blood loss

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about 50 cc for \_\_\_\_\_ combined 3 levels and at no time were there any alterations in somatosensory or motor evoked potentials. The 2nd part will be dictated after the patient is \_\_\_\_\_.

NEVILLE ALLEYNE, MD

NA

D: 2017-02-14 10:58:00

T: 02/14/2017 20:29:54

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Confirmation No.: 20366483

DICTATED BY:NEVILLE ALLEYNE, MD

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Scripps Memorial Hospital  
Encinitas

29820E

**OPERATIVE REPORT**

<b>NAME:</b>	████████████████████	<b>MED REC #:</b>	████████████████████
Date of Operation:	02/14/2017	Room:	EDISC
Dict Phys:	NEVILLE ALLEYNE, MD	Account #:	████████████████████
Date of Birth:	████████████████████		

**SURGEON:**  
Neville Alleyne, MD

**PREOPERATIVE DIAGNOSES:**

1. L2-L2, L3-L4, L4-L5, L5-S1 decompressive laminectomy.
2. Bilateral medial facetectomies at L2 to S1.
3. Bilateral foraminotomies at L2 to S1.
4. K2M instrumentation T10 to S2.
5. Bilateral lateral fusion at T9 to S2.

**ASSISTANT:**  
Mr. Tommy Hammonds.

**ANESTHESIA:**  
General endotracheal anesthesia.

**ANESTHESIOLOGIST:**  
Dr. Ladan Farhoomand. Somatosensory and motor evoked potentials being performed by Ms. Christine Brady.

**PROCEDURE IN DETAIL:**

The patient was brought to the operating room, supine position after successful general endotracheal anesthesia. Foley catheter had already been in place. Central line and A-line were already in place. The patient was taken from an excellent position and positioned on the operating table in Jackson frame for the posterior procedure. Care was taken moving the cervical spines so as to not cause a cervical spine injury. All bony prominences were well padded. The upper extremities at 90:90 with padding under the axilla to prevent brachial plexopathy. Final position was then approved by Anesthesia.

The patient was then prepped and draped in the usual sterile fashion. The subcutaneous tissue from T10 to S2 was infiltrated with 1: 500,000 epinephrine solution. Incision was carried down to the fascia. Fascia was then incised down to the spinolaminar junction further dissection out to the tips of the transverse process was accomplished using a Cobb and electrocautery dissection. Next, the supraspinous and interspinous ligaments at \_\_\_\_\_ were then removed. Next, the pins were placed into the T8 spinous process and one pin at the posterior superior iliac spine on the right and the other on the left. The \_\_\_\_\_ was then assembled and the Mazor Renaissance robot was then called for.

With the assembly of the \_\_\_\_\_, the AP and oblique registrations were then taken in the thoracic and

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