



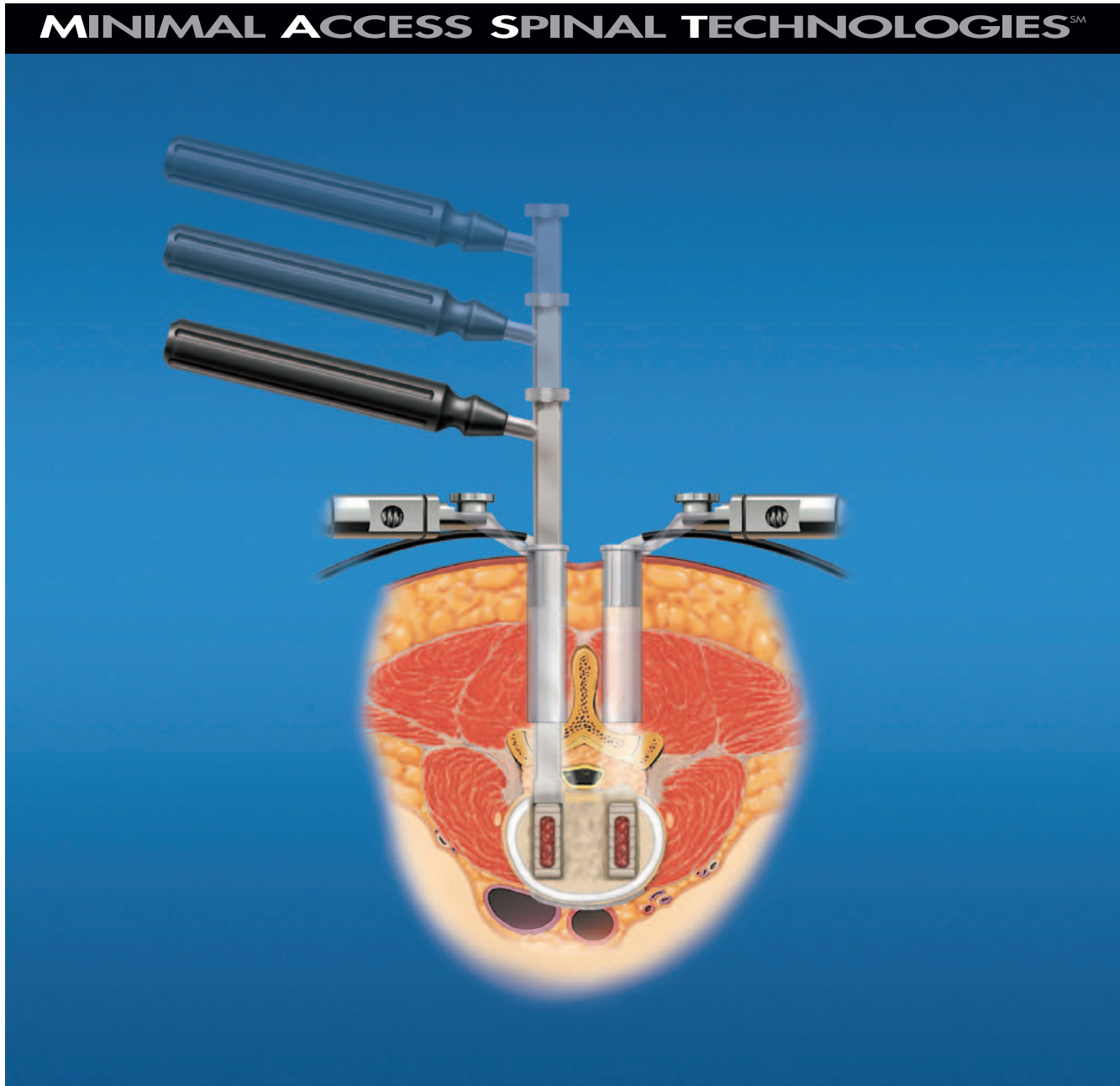
Medtronic

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Posterior Impacted Fusion Devices

MINIMAL ACCESS SPINAL TECHNOLOGIESSM



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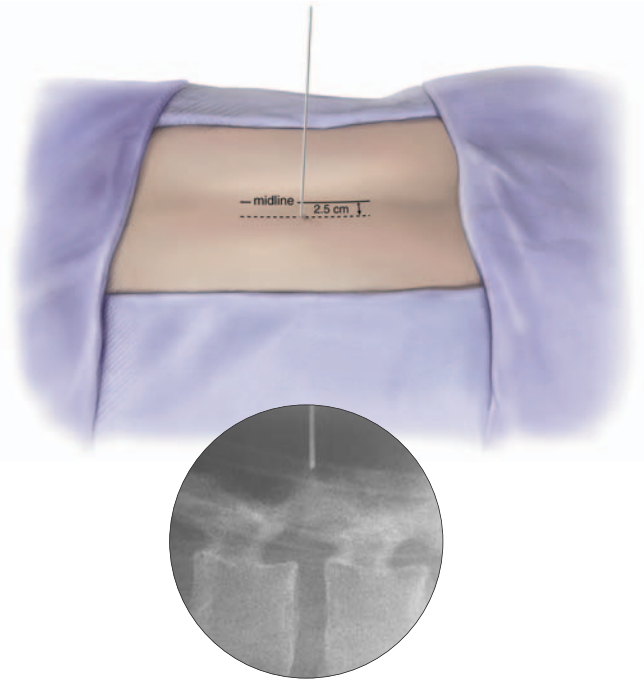
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Preoperative Planning

Spinal needle is placed into paraspinal musculature 2-2.5cm off of midline at the appropriate level confirmed using lateral fluoroscopy.

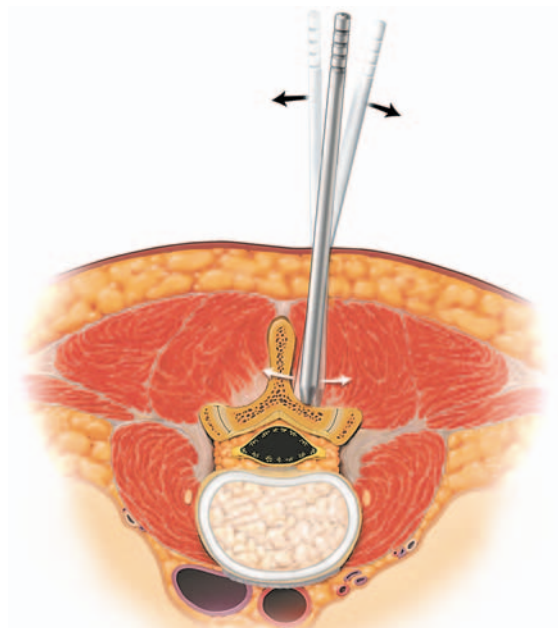
- The spinal needle is removed and a vertical incision is made at the puncture site.
- The Guidewire is placed through the incision and directed toward the inferior aspect of superior lamina under lateral fluoroscopy.



Dilation/Tubular Retraction

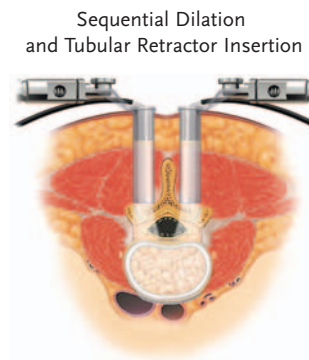
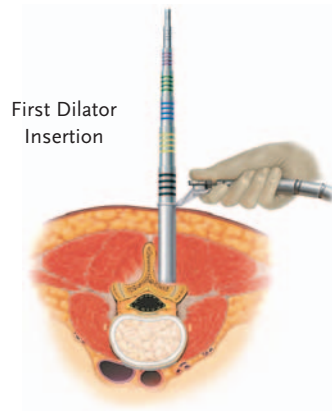
Insert initial cannulated soft tissue Dilator over the Guidewire. Once the fascia is penetrated, remove the Guidewire and advance the Dilator down to the inferior edge of superior lamina. Confirm the placement of initial Dilator using lateral fluoroscopy.

- Use the initial Dilator to palpate the lamina in both the coronal and sagittal planes.
- The tip of the Dilator is used to sweep the paraspinal musculature off the laminar edge.
- This maneuver affirms coronal placement and expedites soft tissue removal.
- The second, third, fourth and fifth Dilators are placed over the initial Dilator down to the lamina.



Tubular Retraction Insertion

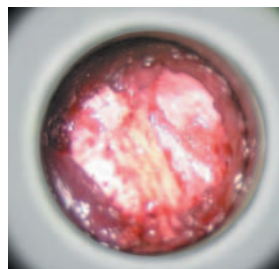
- The Flexible Arm is attached to the Tubular Retractor.
- The Tubular Retractor is placed over the sequential Dilators, docking on the lamina.
- It is important to always apply downward pressure while adjusting the Flexible Arm.
- Repeat muscle dilation and place the second Working Channel on the opposite side.
- Fluoroscopy is used to confirm appropriate positioning.



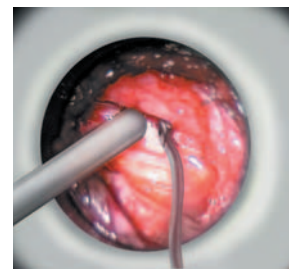
Discectomy

- A conventional discectomy is performed by incising the annulus with a 15-scalpel blade lateral to the dural sac.
- This is done bilaterally and then soft fragments from the intradiscal space or extruded fragments are removed with Disc Rongeurs in a conventional fashion.

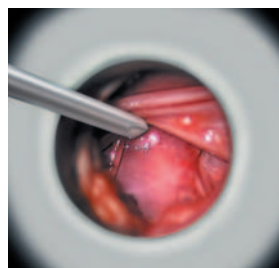
The main goal of this step is to remove extruded fragments, to decompress neural elements, and to provide entry to the disc space for distraction with minimal or no nerve root retraction. If there is significant disc space collapse, a complete discectomy may not be possible until disc space distraction is accomplished.



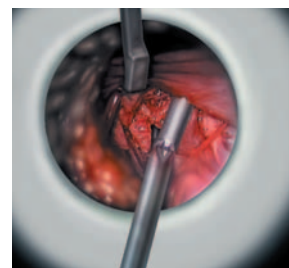
Soft Tissue Removal



Ligamentum Flavum Removal



Nerve Root Retraction

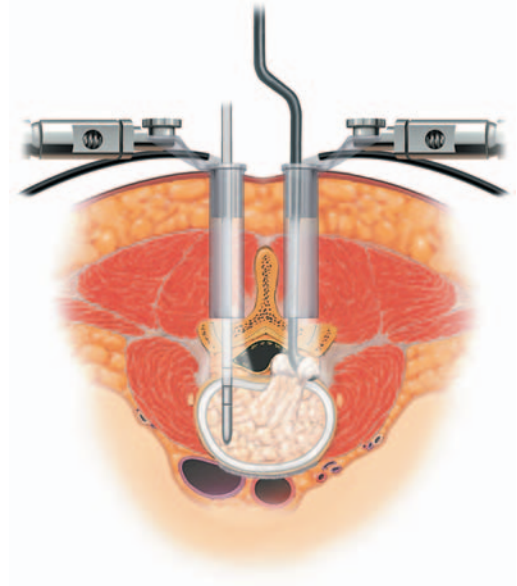
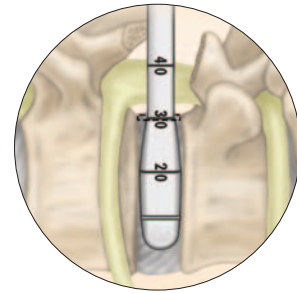


Discectomy

Disc Space Distraction

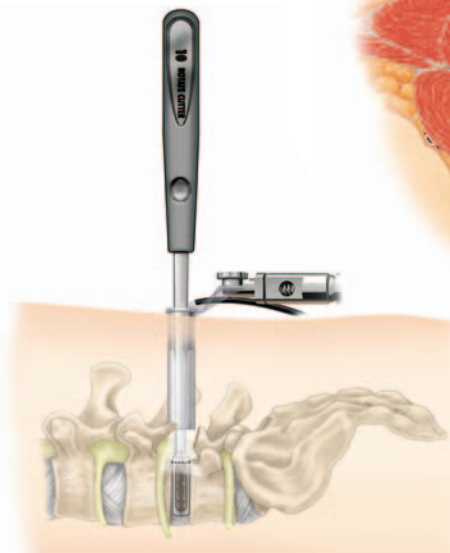
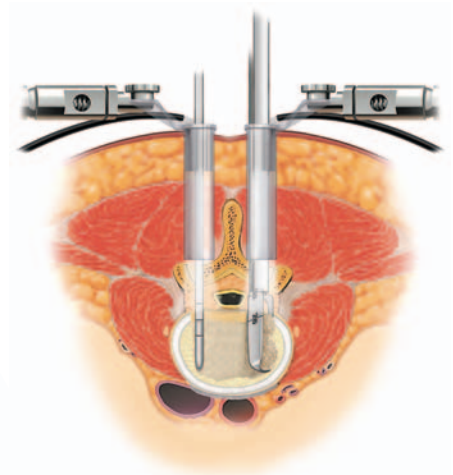
The disc space is sequentially distracted until original disc space height is obtained and normal foraminal opening is restored.

- Insert the Distractor with the T-handle attached, with the flat surface parallel to the endplates.
- Rotate the Distractor 90 degrees to distract the space and remove the T-handle.
- Sequentially insert Distractors from side to side until the desired height is obtained.
- The largest Distractor is left in the disc space in the distracted position while continued disc space preparation is performed.



Disc Space Preparation - Rotate Cutter

- The smallest Rotate Cutter is inserted into the disc space with the cutting blades parallel to the dural sac.
- The Rotate Cutter is rotated once or twice at a depth of 20mm to remove osteophytes at the dorsal endplate. Removing osteophytes facilitates placement of the Cutting Chisel later in the procedure.
- The Rotate Cutter is then inserted up to a depth of 30mm and rotated to remove residual intradiscal material.



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