

Why might a doctor recommend spine surgery?

What is disc degeneration?

What is lumbar interbody fusion?

How is fusion performed?

What are the treatment options for fusion?

What is lateral access spine surgery?

What is eXtreme Lateral Interbody Fusion (XLIF®)?

Is XLIF a widely adopted surgical technique?

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How many surgeons are trained to perform the XLIF surgery?

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Why might a doctor recommend spine surgery?

There are a number of reasons why a doctor might recommend spine surgery. In general, surgery is performed to eliminate instability or nerve compression in the back due to degenerated discs and/or facet joints. Disc degeneration results in a lack of proper spacing between the discs, which can cause severe and debilitating pain. Other conditions that might require surgery are the slippage of one vertebra over another or a change in the normal curvature of the spine – including scoliosis and other extreme curvatures of the spine.

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What is disc degeneration?

As we age, our intervertebral discs lose water content and become less able to hold the loads applied to them. This aging process is normal, but in some people, it can cause back or leg pain due to loss of disc height and impingement of nerves. Many people suffer a compromised quality of life due to disc degeneration. Spinal surgery can reduce motion between the vertebrae, correct alignment, and restore proper disc height, alleviating pain. During the procedure, the surgeon removes most of the disc between the two vertebrae that are to be stabilized and implants a spacer to restore correct spinal alignment. The surgeon also implants bone-forming cells that bridge the space between the vertebrae and allow the bone to grow together. Increased stability and restoration of disc height often result in significant pain relief.

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What is lumbar interbody fusion?

Lumbar interbody fusion is a surgical technique that attempts to eliminate instability in the back. Instability can be due to degenerated discs and/or facet joints that cause unnatural motion and pain, loss of height of the disc space between the vertebrae that causes pinching of the spinal nerves exiting the spinal canal, slippage of one vertebra over another, and/or change in the normal curvature of the spine.

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How is fusion performed?

Fusion is accomplished by fusing the vertebrae together to reduce their motion. Fusing the vertebrae together requires removal of most of the intervertebral disc (or discs if more than one level is identified for fusion), preparation of the adjacent ends of the vertebrae (endplates) to clear the soft tissue, implantation of an intervertebral spacer to restore disc height and spinal alignment (for nerve root decompression) and to carry the loads of the torso, and packing the vertebrae with bone-forming cells that will bridge the space and fuse the joint. In some cases, the instability is severe enough that further augmentation of the fusion is required by placing screws and plates or rods into the vertebrae to hold them together.

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What are the treatment options for fusion?

In most cases, some attempt is made at conservative treatment before fusion is recommended. If fusion surgery is warranted, there are several techniques for approaching the spine to perform the fusion, defined mainly by the direction of the approach. Three of the most traditional approaches to spinal fusion include:

Posterior Lumbar Interbody Fusion (PLIF)

In a PLIF procedure, the spine is approached from the back of the body, allowing for direct access to problematic nerves and potential placement of screws and rods in addition to the intervertebral fusion through one approach. The muscles lying over the spine are opened and spread from the middle out to both sides. Some vertebral bone is removed, relieving pressure on the nerves and providing access to the intervertebral disc. Traditionally, this approach requires significant muscle, bone and ligament dissection and/or disruption, which can sometimes lead to pain and desensitization of the back muscles after surgery.

Transforaminal Lumbar Interbody Fusion (TLIF)

A traditional TLIF procedure is essentially a modification of a PLIF procedure where the muscle is dissected from the middle out to the side, but only on one side instead of from the middle out to both sides (as in PLIF) sparing trauma to the opposite side.

Anterior Lumbar Interbody Fusion (ALIF)

In an ALIF procedure, the spine is approached from the front of the body. Spine surgeons and general surgeons often work together to safely expose the front of the spine either by going through the abdomen or by retracting it under the skin. This approach spares trauma to the back muscles, but requires delicate manipulation of major blood vessels that lie in front of the spine.

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What is lateral access spine surgery?

Lateral access spine surgery is a safe and reproducible means of addressing certain spine disorders with an approach from the side of the patient, as opposed to an approach from the back or the front. A lateral approach is made safe with the use of nerve monitoring technology.

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What is eXtreme Lateral Interbody Fusion (XLIF)?

In an XLIF procedure, the spine is approached from the side of the body. The patient is positioned on the surgical table on his side. Two small incisions are made: one directly over the side of the waist (through which most of the procedure is performed), and the other slightly behind the first, toward the back muscles (through which the surgeon's finger safely guides the approach).

Frequently Asked Questions: eXtreme Lateral Interbody Fusion (XLIF®)



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Is XLIF a widely adopted surgical technique?

Until now, widespread acceptance of minimally invasive techniques has evaded spine surgery. The primary reason for this was the inherent difficulty introducing new technologies while attempting to achieve the same surgical objectives as conventional surgery. The XLIF surgical technique is different, however, because it incorporates two systems developed by NuVasive®: the MaXcess® System and the NVJJB™ System.

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The MaXcess® System provides customized maximum surgical access while minimizing the soft tissue disruption that often occurs during open surgery. The MaXcess System allows the fundamentals of conventional surgical techniques to be achieved, while eliminating the unfamiliar requirements of operating coaxially through tubular portals. Additionally, since there are no adjunctive visualization tools (e.g., endoscope, monitor), the MaXcess System enables direct illuminated visualization of the patient's anatomy through conventional methods.

The NVJJB™ System is another important technology that enables safety and reproducibility during minimally disruptive techniques. This system is the only surgeon-driven technology that provides dynamic, discrete information about nerve location and condition. In the XLIF technique, NVJJB™/M5® is used to enable a safe trajectory past the nerves in the psoas muscle by communicating nerve proximity and directional information. This enables the surgeon to locate and avoid the lumbar plexus while accessing the disc. NVJJB/M5 is the only nerve avoidance system that has demonstrated safety and reproducibility during a lateral transpsoas technique.

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What are the key advantages to the XLIF technique?

The XLIF approach does not require dissection or retraction of the sensitive back muscles, bones, ligaments, or nerves and allows for more complete disc removal and implant insertion as compared with traditional posterior procedures. Nor does lateral access require the delicate abdominal exposure or present the same risk of vascular injury as traditional anterior approaches. As a result, operating time is often reduced, patient blood loss is minimized, and recovery time is significantly shorter.

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Are there any disadvantages to the XLIF surgical technique?

The primary disadvantage of the XLIF approach is the inability to directly address problems with nerves toward the back of the spine, which would require a second procedure, if necessary. In postoperative studies, thigh discomfort was routine, and slight lateral thigh numbness is rare. However, both symptoms resolved completely within four to six weeks. Some patients may experience some soreness at the surgical incision and/or pain or weakness when lifting the thigh immediately after surgery.

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What can a patient expect after XLIF surgery?

Most patients stay in the recovery room from one to three hours after surgery. Once the anesthesiologist feels that the patient is doing well, he will be returned to his room in the hospital. It is normal for incision wounds to be sore immediately after surgery. The nursing staff will regularly check vital signs and ensure there is no problem with either the wound or nerve function in the patient's legs. Generally, most patients are able to get up and walk around the evening after surgery. Most XLIF patients are discharged from the hospital the day following surgery. The physician will discuss with the patient any appropriate medications, as well as a prescribed program of activities.

Generally, fusion patients are seen again in the physician's office about ten days to two weeks after surgery. After the initial follow-up, a patient will need to visit with his doctor at various intervals (up to two years or more) to assess fusion progress.

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How many surgeons are trained to perform the XLIF surgery?

NuVasive® has a comprehensive training program focused on recruiting the top surgeons around the world to perform the XLIF technique.

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NuVasive is a medical device company focused on the design, development and marketing of products for the surgical treatment of spine disorders. The company's product portfolio is focused on applications in the over \$3.6 billion U.S. spine fusion market. The company's current principal product offering includes a minimally disruptive surgical platform called Maximum Access Surgery, or MAS™, as well as a growing offering of cervical and motion preservation products.

