Clinical Study

Endoscopic Transforaminal Thoracic Foraminotomy and Discectomy for the Treatment of Thoracic Disc Herniation

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Thoracic disc herniation is a relatively rare yet challenging-to-diagnose condition. Currently there is no universally accepted optimal surgical treatment for symptomatic thoracic disc herniation. Previously reported surgical approaches are often associated with high complication rates. Here we describe our minimally invasive technique of removing thoracic disc herniation, and report the primary results of a series of cases. Between January 2009 and March 2012, 13 patients with symptomatic thoracic disc herniation were treated with endoscopic thoracic foraminotomy and discectomy under local anesthesia. A bone shaver was used to undercut the facet and rib head for foraminotomy. Discectomy was achieved by using grasper, radiofrequency, and the Holmium-YAG laser. We analyzed the clinical outcomes of the patients using the visual analogue scale (VAS), MacNab classification, and Oswestry disability index (ODI). At the final follow up (mean: 17 months; range: 6–41 months), patient self-reported satisfactory rate was 76.9%. The mean VAS for mid back pain was improved from 9.1 to 4.2, and the mean ODI was improved from 61.0 to 43.8. One complication of postoperative spinal headache occurred during the surgery and the patient was successfully treated with epidural blood patch. No other complications were observed or reported during and after the surgery.

1. Introduction

Thoracic disc herniation is an uncommon condition. Although conservative treatment works well for many patients with thoracic disc herniation, surgical treatment is needed for patients suffering from myelopathy and/or neurological deficit caused by thoracic disc herniation. In the past decade, quite a few surgical procedures have been reported in the literature, and each of them has its own advantages and disadvantages [1–14]. Currently there is no universally accepted optimal surgical treatment for symptomatic thoracic disc herniation.

Minimally invasive spine surgery has proven safe and effective in treating lumbar and cervical herniations [15–24]. The advantages of minimally invasive techniques have compelled many physicians to explore the feasibility of using minimally invasive techniques in treating thoracic disc herniation, and a number of authors have reported encouraging primary results [14, 25–28]. Based on our extensive experience with treating lumbar and cervical disc herniation using minimally invasive techniques, we have developed an endoscopic transforaminal foraminotomy and discectomy technique for treating thoracic disc herniation. The purposes of this paper are to describe the technique and to report the results of a series of cases.

2. Materials and Methods

Between January 2009 and January 2012, 13 patients with symptomatic thoracic disc herniation were treated with percutaneous endoscopic thoracic foraminotomy and discectomy. The surgical procedures were performed under local anesthesia at our outpatient surgical center. All patients had soft thoracic disc herniation confirmed with magnetic resonance imaging (MRI). Symptoms related to the herniation were confirmed using discography. After a mean of 17 months of followup (range: 6–41 months), we analyzed the clinical
outcomes using the visual analogue scale (VAS), MacNab classification, and Oswestry disability index (ODI).

2.1. Diagnosis and Patient Selection. Considering that patients with thoracic disc herniation may have varied symptoms, some of which may be similar to symptoms of other medical conditions, we made the diagnosis by reviewing the patients’ medical history, performing physical examination, and analyzing radiographic findings. Patients qualified for our surgical procedure met the following criteria. First, the patient had middle back pain with or without radiation. Second, conservative pain treatments had failed to alleviate the pain. Third, magnetic resonance imaging (MRI) revealed soft thoracic disc herniation. And finally discography confirmed painful disc before the surgical procedure.

Patients with calcified discs or hard disc herniations were not treated with this procedure.

2.2. Tools. During the surgical procedure, a burr, a bone shaver, and the Holmium-YAG laser were used to undercut the facet and rib head for foraminotomy. Discectomy was achieved by using a grasper, radiofrequency, and the Holmium-YAG laser. The surgical procedures were performed with the assistance of an 8 mm (outer diameter) Wolf endoscope (Richard Wolf Medical Instruments Corporation, Vernon Hills, IL, USA).

2.3. Surgical Technique. The procedures were performed under local anesthesia with the patient in a prone position on a radiolucent table. The target disc was identified under fluoroscopic guidance (Figure 1(a)), and the entry point between the rib head and the facet (on oblique view) was marked on the skin (Figure 1(b)). Discography was performed to confirm the target disc and to help identify the location of the herniation. The 18 G needle inserted to perform discography was parallel to the upper endplate of the lower vertebral body (Figure 2). The tip of the needle reached posterior disc margin (on the lateral view) and was situated between midline and medial pedicle line (on the AP view). The surgical region was anesthetized with a combination of 0.5% lidocaine and epinephrine.

After discography, a guiding wire was inserted through the needle, and a 10 mm skin incision was subsequently made. The needle was removed, and a sequential dilator was then inserted over the wire towards the posterolateral margin of the facet (Figure 3(a)). Once the tip of the dilator reached the surface of the annulus, the guiding wire was removed and the dilator was further inserted into the target foramen. A working cannula was then guided to the extraforaminal region over the dilator (Figure 3(b)). At this juncture, the dilator was removed and the endoscope was placed to assist with visualization.

Figure 1: The target disc was identified under fluoroscopic guidance (a), and the entry point between the rib head and the facet was marked on the skin (b).

Figure 2: Discography was performed to confirm the target disc and to help identify the location of the herniation; the needle was parallel to the upper endplate of the lower vertebral body.
To perform foraminotomy, we first tilted the cannula to expose the foraminal epidural space. We then used an Ellman radiofrequency probe (Ellman International, New York, USA) and a shaver to expose the facet medially and rib head laterally (Figure 4). The radiofrequency, as well as the Holmium-YAG laser, was used to remove scar tissue, when needed. A burr, bone shaver (Richard Wolf Medical Instruments Corporation, Vernon Hills, IL, USA), and the Holmium-YAG laser were used to undercut the facet and rib head, when necessary, to enlarge the foramen so the working cannula could be easily advanced to the inner foraminal zone. Once adequate foraminotomy was achieved, the inferior pedicle, disc, epidural space, and exiting spinal nerve root were exposed. Herniated disc material was then removed using a grasper, radiofrequency, and the laser (Figure 5). At the end of the procedure, free movement of the thecal sac was visible. After satisfactory decompression had been achieved, the endoscope was removed, and the wound was covered with a sterile strip.

3. Results

The treated disc levels included T5-6 (1), T6-7 (3), T7-8 (4), T8-9 (2), T9-10 (2), and T12-L1 (2). One patient had herniation at T6-7 and T7-8. The chief complaint of these patients was mid back pain with or without radiation (Table 1).

The patients (male: 7; female: 6; age: 40–69) were followed up for more than 6 months. At the final followup (mean: 17 months; range: 6–41 months), patient self-reported satisfactory rate (excellent and good results) was 76.9%. The mean VAS for mid back pain was improved from 9.1 to 4.2, and the mean ODI was improved from 61.0 to 43.8 (Table 1). The average operation time for each herniated disc was about 50 minutes. Blood loss during the surgery was minimal to none. Only one complication of postoperative spinal positional headache occurred and the patient was successfully treated with epidural blood patch. No other complications were observed or reported during or after the surgery. One patient
had recurrent thoracic disc herniation 8 months after the initial surgery. None of the patients experienced worsening of symptoms. When asked if they would undergo the same procedure again if needed in the future, 12 of the 13 patients said yes.

Adequate decompression of the spinal cord was confirmed by postoperative MRI (Figure 6).

4. Discussion

Surgical treatment for thoracic herniation has evolved from the posterior approach to posterolateral and anterior approaches and from open surgery to minimally invasive surgery. To reduce access-induced complications and to improve surgical outcomes, various surgical techniques have been developed over the years. The literature review shows that minimally invasive techniques assisted with endoscopic or microscopic visualization have gained tremendous popularity in recent years. An analysis of a national database showed that utilizing minimally invasive techniques to treat thoracic disc herniation has become a new trend [29]. Despite the advancement in surgical instruments and techniques, surgically treating thoracic herniation remains a challenge because of the anatomical characteristics of the thoracic spine. Currently there are still no universally agreed upon indications for surgery, and the optimal type of decompression method is still controversial. Until a gold standard treatment is established, surgeons worldwide will employ different surgical techniques to treat thoracic disc herniations. And the choice of the technique will be dependent on the surgeon’s training background, clinical experience, and personal preference.

Techniques using transforaminal approaches to treat thoracic disc herniation have a few advantages. The techniques generally need to remove only a small, lateral part of the facet joint to gain access for surgical and visualization instruments, and they generally do not require the resection of the unilateral facet joint and the caudal pedicle. Compared with posterior and anterior approaches, transforaminal approaches preserve postoperative spinal stability by avoiding resection
Table 1: Patient baseline characteristics and clinical outcomes.

<table>
<thead>
<tr>
<th>Case number</th>
<th>Age</th>
<th>Sex</th>
<th>Level</th>
<th>Main symptoms</th>
<th>Follow-up (M)</th>
<th>Pre-VAS</th>
<th>Post-VAS</th>
<th>Pre-ODI</th>
<th>Post-ODI</th>
<th>MacNab</th>
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<tbody>
<tr>
<td>1</td>
<td>59</td>
<td>F</td>
<td>T12-L1</td>
<td>Low back and mid back pain, leg pain</td>
<td>33.5</td>
<td>10</td>
<td>5</td>
<td>42</td>
<td>52</td>
<td>Good</td>
</tr>
<tr>
<td>2</td>
<td>43</td>
<td>F</td>
<td>T9-10</td>
<td>Mid back pain</td>
<td>32.5</td>
<td>10</td>
<td>7</td>
<td>56</td>
<td>88</td>
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</tr>
<tr>
<td>3</td>
<td>40</td>
<td>M</td>
<td>T9-10 (R)/T9-10 (L)</td>
<td>Mid back pain</td>
<td>18</td>
<td>10</td>
<td>2</td>
<td>42</td>
<td>12</td>
<td>Excellent</td>
</tr>
<tr>
<td>4</td>
<td>56</td>
<td>F</td>
<td>T6-7</td>
<td>Mid back pain</td>
<td>13</td>
<td>7</td>
<td>4</td>
<td>60</td>
<td>52</td>
<td>Good</td>
</tr>
<tr>
<td>5</td>
<td>48</td>
<td>F</td>
<td>T6-7</td>
<td>Mid back pain</td>
<td>13</td>
<td>9</td>
<td>0</td>
<td>66</td>
<td>6</td>
<td>Excellent</td>
</tr>
<tr>
<td>6</td>
<td>52</td>
<td>M</td>
<td>T8-9</td>
<td>Mid back pain, upper back pain</td>
<td>13</td>
<td>10</td>
<td>5</td>
<td>92</td>
<td>62</td>
<td>Good</td>
</tr>
<tr>
<td>7</td>
<td>57</td>
<td>F</td>
<td>T5-6</td>
<td>Mid back pain, low back pain, and neck pain</td>
<td>12</td>
<td>10</td>
<td>9</td>
<td>70</td>
<td>58</td>
<td>Good</td>
</tr>
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<td>8</td>
<td>69</td>
<td>F</td>
<td>T7-8</td>
<td>Mid back pain, right chest pain</td>
<td>11.5</td>
<td>9</td>
<td>6</td>
<td>58</td>
<td>54</td>
<td>Poor</td>
</tr>
<tr>
<td>9</td>
<td>48</td>
<td>M</td>
<td>T7-8</td>
<td>Mid back pain, right chest pain radiates to abdomen</td>
<td>6.5</td>
<td>9</td>
<td>5</td>
<td>60</td>
<td>66</td>
<td>Excellent</td>
</tr>
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<td>10</td>
<td>32</td>
<td>M</td>
<td>T8-9</td>
<td>Mid back pain radiates to shoulder blade</td>
<td>6</td>
<td>6</td>
<td>4</td>
<td>36</td>
<td>18</td>
<td>Good</td>
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<tr>
<td>11</td>
<td>59</td>
<td>M</td>
<td>T6-7, T7-8</td>
<td>Mid back pain radiates to chest</td>
<td>15</td>
<td>10</td>
<td>6</td>
<td>62</td>
<td>54</td>
<td>Fair</td>
</tr>
<tr>
<td>12</td>
<td>54</td>
<td>M</td>
<td>T12-L1</td>
<td>Mid back pain</td>
<td>41</td>
<td>8</td>
<td>1</td>
<td>78</td>
<td>32</td>
<td>Excellent</td>
</tr>
<tr>
<td>13</td>
<td>51</td>
<td>M</td>
<td>T7-8</td>
<td>Mid back pain radiates to left side chest and rib</td>
<td>6</td>
<td>10</td>
<td>1</td>
<td>70</td>
<td>16</td>
<td>Excellent</td>
</tr>
</tbody>
</table>

VAS: visual analog scale, ODI: Oswestry Disability Index, Pre: preoperative, Post: postoperative.
Figure 6: Preoperative MRI images of a T8-9 disc herniation compressing the spinal cord, which caused the patient to have mid back pain radiating to the shoulder blade ((a) and (b)). Postoperative MRI images showing removal of the extruded disc material ((c) and (d)).

traditional open spine surgery, or thoracotomy. Because the thoracic spinal cord is highly susceptible to injury due to the anatomical nature of the thoracic spine, our technique requires the surgeon to have great surgical skills and considerable amount of experience with endoscopic surgery.

5. Conclusions
For carefully selected patients, endoscopic transforaminal thoracic discectomy and foraminotomy is a safe and effective treatment option for symptomatic soft thoracic disc herniation.

Conflict of Interests
The authors have no conflict of interests or financial ties to disclose.

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References


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