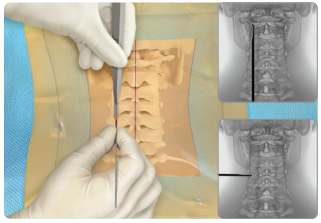
Cervical Foraminotomy and Discectomy

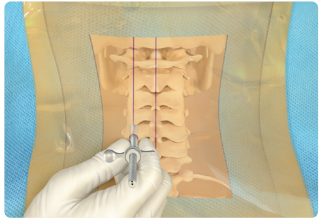
Quick Reference Guide



1

Midfacet Line

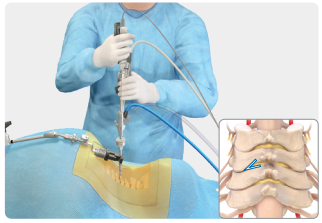
- Use AP fluoroscopy to identify and mark the midline and midfacet line



2

Access

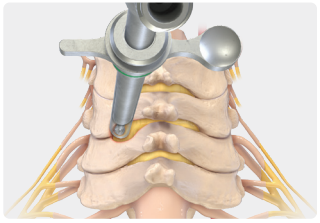
- Use a #11 or #15 blade to create an incision <1 cm in length; dilate through the musculature and fascia
- Dock on the posterior midfacet
- Insert the cannula with the bevel opening facing medially



3

Expose the “V”

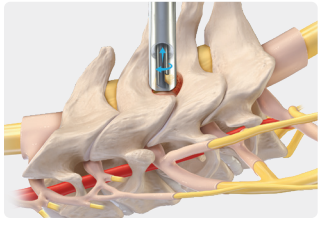
- Dissect, identify, and expose the cranial and caudal laminae and medial facet
- Define the “V” (lamina-facet junction)



4

Convert the “V” to a “U”

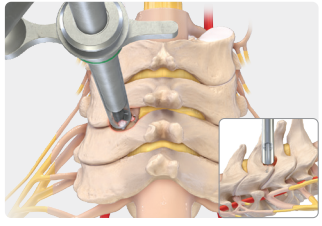
- Use a bur and Kerrison to undercut the cranial and caudal laminae and medial facet, converting the “V” to a “U”



5

Decompress

- Open the ligamentum flavum as needed
- Identify the exiting nerve and lateral boarder of the dura
- Decompress the foramen from pedicle to pedicle



6

Discectomy

- Stay lateral to the dura and use endoscopic graspers and instruments to access the disc space and remove herniated fragments
- Confirm decompression and mobilize the exiting nerve

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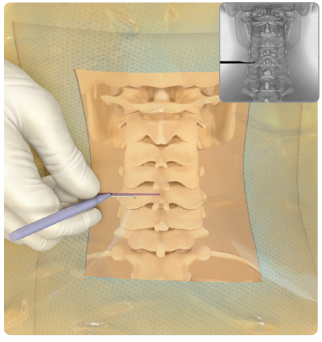
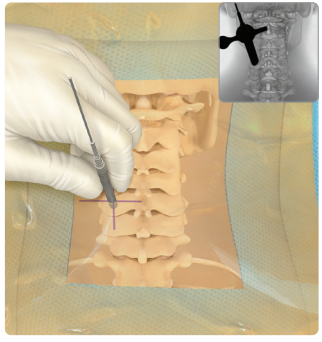
Cervical MBT

Quick Reference Guide



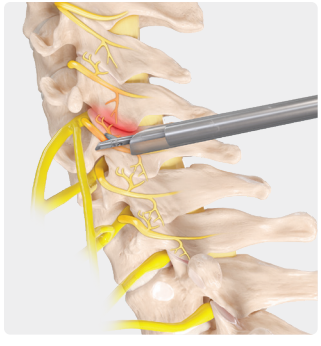
1

- Use AP and lateral fluoroscopy to confirm the level
- Use a switching stick or Penfield dissector to identify the midfacet docking point
- Mark this location



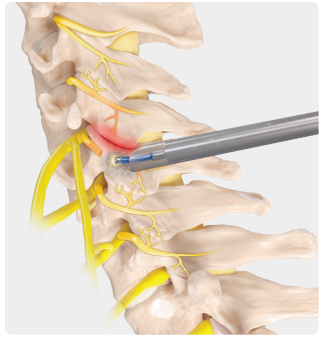
2

- Insert the needle at the marked location and dock on the midfacet
- Make an incision with a #11 blade; remove the inner stylet, insert the guidewire, and remove the spinal needle while maintaining guidewire position
- Insert the switching stick or sequential dilators over the guidewire and confirm the bony landmark
- Insert the cannula with the bevel oriented medially



3

- Clear soft tissue with the FlexTip RF probe and endoscopic instrumentation, working lateral/ventral from the docking point to identify the medial branch nerve
- Limit excessive lateral/ventral advancement to protect the exiting and lateral branch nerves
- Transect the medial branch nerve with a scissor punch, hook scissor, or FlexTip RF probe



4

- Using the FlexTip RF probe, ablate the nerve ends and fully denude the facet wall medial to lateral
- Repeat for the adjacent-level medial branch to ensure full facet joint denervation

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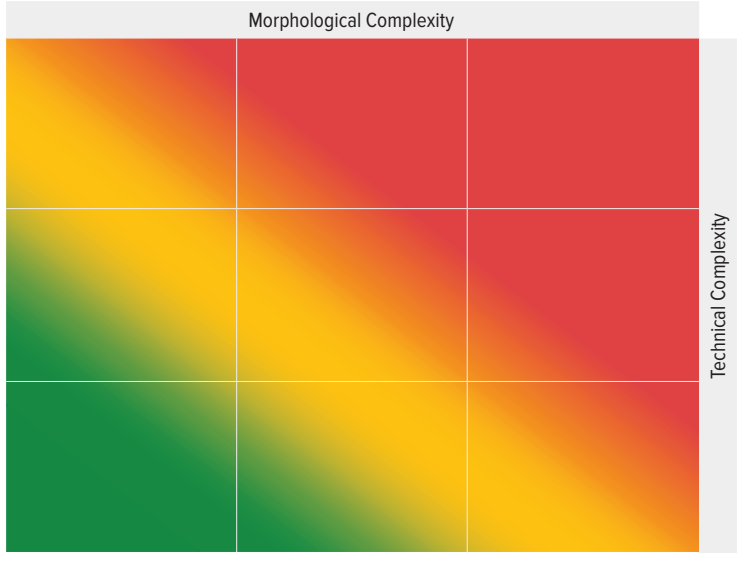
Complexity of Endoscopic Spine Procedures

Quick Reference Card

View the full presentation



- **PECCD** (Posterior Endoscopic Cervical Central Decompression)
- **TETD** (Transforaminal Endoscopic Thoracic Discectomy)
- **TE-ULBD** (Thoracic Endoscopic Unilateral Laminotomy for Bilateral Decompression)
- **Endoscopic Fusion**

- **PECF** (Posterior Endoscopic Cervical Foraminotomy)
- **EELD** (Extraforaminal Endoscopic Lumbar Discectomy)
- **TE-LRD** (Transforaminal Endoscopic Lateral Recess Decompression)
- **ICELF** (Interlaminar Contralateral Endoscopic Lumbar Foraminotomy)
- **LE-ULBD** (Lumbar Endoscopic Unilateral Laminotomy for Bilateral Decompression)
- **TELF** (Transforaminal Endoscopic Lumbar Foraminotomy)

- **IELD** (Interlaminar Endoscopic Lumbar Discectomy)
- **TELD** (Transforaminal Endoscopic Lumbar Discectomy)
- **IE-LRD** (Interlaminar Endoscopic Lateral Recess Decompression)
- **MBT** (Medial Branch Transection)

>1b = c (eg, deformity [b] + degeneration [b] = c)

- Easy access (eg, interlaminar L5-S1)
- Soft disc herniation

- Level-specific difficulty (eg, transforaminal L5-S1)
- Relevant deformity/ spondylolisthesis
- Severe degeneration
- Calcified disc herniation
- Osteodiscal stenosis

- Potential danger to critical structures (eg, vertebral artery looping)
- Scarring (eg, revision at the same side)

Reference
Farshad M, et al. *N Am Spine Soc J.* 2025;22:100603. doi:10.1016/j.xnsj.2025.100603.

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