Utilization of lateral anterior lumbar interbody fusion for revision of failed prior TLIF: illustrative case

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BACKGROUND The use of the lateral decubitus approach for L5–S1 anterior lumbar interbody fusion (LALIF) is a recent advancement capable of facilitating single-position surgery, revision operations, and anterior column reconstruction. To the authors' knowledge, this is the first description of the use of LALIF at L5–S1 for failed prior transforaminal lumbar interbody fusion (TLIF) and anterior column reconstruction. Using an illustrative case, the authors discuss their experience using LALIF at L5–S1 for the revision of pseudoarthrosis and TLIF failure.

OBSERVATIONS The patient had prior attempted L2 to S1 fusion with TLIF but suffered from hardware failure and pseudoarthrosis at the L5–S1 level. LALIF was used to facilitate same-position revision at L5–S1 in addition to further anterior column revision and reconstruction by lateral lumbar interbody fusion at the L1–2 level. Robotic posterior T10–S2 fusion was then added to provide stability to the construct and address the patient's scoliotic deformity. No complications were noted, and the patient was followed until 1 year after the operation with a favorable clinical and radiological result.

LESSONS Revision of a prior failed L5–S1 TLIF with an LALIF approach has technical challenges but may be advantageous for single position anterior column reconstruction under certain conditions.

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KEYWORDS revision spine surgery; spinal instrumentation; TLIF; ALIF

Revision spinal surgery is uniquely challenging, and patients are often affected by pseudarthrosis, infection, hardware complications, and deformity. An anterior approach to the spine in the form of anterior lumbar interbody fusion (ALIF) is an effective, safe, and widely used tool for segmental lordosis correction and indirect decompression. Its advantages include access via a virgin corridor in case of previous posterior spine surgery, the ability to resect the anterior longitudinal ligament to restore lordosis, and the insertion of a large-footprint interbody cage to promote fusion, especially in the setting of prior pseudoarthrosis.

Its more recent variation, lateral anterior lumbar interbody fusion (LALIF), which is performed using the anterolateral retroperitoneal approach in lateral decubitus position, has been successfully used in select circumstances. The LALIF approach is a true L5–S1 anterior approach to the disc space in the lateral position. It facilitates single-position surgery, including both anterior and posterior column reconstruction and, as a result, increases operative efficacy and efficiency.

Although this technique is increasingly used by surgeons for various reasons, to the best of our knowledge it has not been described to salvage previous posterior interbody fusion. The challenges associated with vessel dissection from the anterior approach in the lateral position are even greater in the setting of prior posterior interbody surgery given some degree of anterior inflammation and scarring associated with even a posterior interbody technique. We report the case of a patient with prior extensive lumbar surgery and sagittal deformity in which LALIF was safely applied to successfully address

ABBREVIATIONS ALIF = anterior lumbar interbody fusion; LALIF = lateral anterior lumbar interbody fusion; LL = lumbar lordosis; LLIF = lateral lumbar interbody fusion; PM = pelvic mismatch; PT = pelvic tilt; SS = sacral slope; TLIF = transforaminal lumbar interbody fusion.

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The common iliac vein was a limitation due to prior scarring associated with pseudoarthrosis caused by the TLIF cage. With the assistance of a vascular surgeon, we opted for single-position anterior column reconstruction surgery in an anatomy on prior lumbar spine magnetic resonance imaging (Fig. 2), anterior column with an anterolateral approach. Based on vascular posterior decompression and fusion, we planned to address the deformity proximal to the prior construct. Lastly, the patient was placed prone on the Jackson table to correct her scoliosis and maximize LL, verified using intraoperative fluoroscopy. Retractors were placed in a standard fashion, and the discectomy was completed. Care was taken to note the right iliac vein, which was gravity dependent and had a propensity for falling into the operative corridor. The previous interbody cage, which was found to be highly mobile, was removed in one piece. Of note, we did encounter metallosis in the area secondary to the pseudoarthrosis. Aerobic, anaerobic, and fungal cultures of the implant were all negative. A new, appropriately sized hyperlordotic titanium cage with autograft and allograft was placed with a single retaining screw.

With the patient in the same position on the table, we then performed a standard lateral lumbar interbody fusion (LLIF) via transpsoas approach at L1–2 to address the deformity proximal to the prior construct. Lastly, the patient was placed prone on the Jackson table to correct her scoliosis and maximize LL, verified using intraoperative fluoroscopy. We subsequently removed all prior instrumentation and placed new posterior spinal instrumentation from T10 to S1 as well as S2 alar-iliac screws to achieve rigid circumferential fusion and reduce the chances of repeated nonunion. The first stage of the surgery was completed in 2.5 hours, which included anterior exposure and closure. Blood lost during this stage was 100 mL, and the total length of hospital stay was 5 days.

There were no complications intraoperatively or in the immediate postoperative period. The patient did very well, with complete resolution of her lower extremity symptoms and significant improvement in back pain. At the 1-year follow-up clinic visit, she was pain-free, did not use any pain medications, had resumed her daily routine, and could walk without the aid of any assistive devices. At the 6-month postoperative interval, there was evidence of intact hardware, correction of spinal deformity, and satisfactory fusion on radiographs (Fig. 3 and Table 1). Her spinopelvic parameters at the 1-year follow-up were LL 49°, PM 11°, PT 28°, SS 30°, and C7-SVA of 2 cm. The Cobb angle in the coronal plane was 4°.

Discussion

Observations

Over the last two decades, ALIF has been consistently gaining popularity among spine surgeons and has been shown to lead to significant indirect decompression, comparable or even better patient outcomes, and faster return to mobility and function when compared to posterior approaches. The use of LALIF, a modification of the ALIF approach, has shown promising results, especially in obese patients.
or patients with previous abdominal surgery.6 The lateral patient positioning facilitates exposure by taking advantage of gravity to retract abdominal contents away from the surgical site.6,7 There is evidence in the literature that using the anterior-lateral corridor to the spine results in less pain, better cosmesis, reduced postoperative ileus, and similar deformity correction and outcomes compared to surgery in the supine position.4,6,9,10 From a technical perspective, LALIF offers all the benefits of an anterior approach to the spine, even in the presence of posterior instrumentation.1,2,4,5,14,15,18

As demonstrated by our case, LALIF can also be used for removal of a previously implanted interbody cage in case of pseudarthrosis. The LALIF technique can provide a safe passage by avoiding scar tissue from prior posterior surgery and potential complications associated with revision spine surgery via a posterior approach.1 Although combined ALIF and LLIF have been described in supine position, it may still require turning the patient to the prone position for posterior instrumentation to achieve a circumferential fusion.19 LALIF increases operating room efficiency by facilitating single-position surgery, especially when fusion at multiple lumbar levels is required.6,7,9,10,18 It also enables direct visualization of neural, visceral, and vascular structures, which makes it safer compared to oblique and lateral approaches. Posterior instrumentation, if required, can also be achieved in the same setting, thus reducing operative and anesthesia time, operating room service, and the risks involved with repositioning an anesthetized patient with a potentially unstable spine.6,8–10 Similar to other reports, we planned to instrument down to the pelvis with the use of the Mazor X Surgical Robot. This, along with surgeon comfort, was the reasoning behind performing the instrumentation in prone position in this case.6

**Lessons**

One limitation that we have often faced is mobilization of the great vessels, especially the bilateral iliac veins. Vascular injury is an important and potentially dangerous complication reported in anterior lumbar spine approaches, occurring in 2%–24% patients.1,4,13,15,16,18,20 Specific attention needs to be paid to the vascular anatomy, particularly the sacral veins, which may need to be ligated and divided as has been well described.1,11,12,16,25 At first, surgeons may not be familiar with performing ALIF in the lateral position, but for vascular and neurosurgeons, who work frequently as a team, these challenges can be overcome, providing LALIF as a safe, effective, and potentially advantageous alternative to standard ALIF surgery in appropriate cases.6,15,16,19

Revision of a prior failed L2–S1 fusion construct with pseudarthrosis at L5–S1 after TLIF with LALIF at L5–S1 and LLIF at L1–2 is feasible and was performed in this case without complications and with a favorable 1-year result. Single-position anterior column reconstruction may be considered as a potentially advantageous technique in appropriately selected cases to facilitate operative efficacy and efficiency.

**References**


**TABLE 1. Comparison of pre- and postoperative spino-pelvic parameters**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Preop</th>
<th>1-yr Postop</th>
</tr>
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<tbody>
<tr>
<td>C7-sagittal vertical axis</td>
<td>+6 cm</td>
<td>+2 cm</td>
</tr>
<tr>
<td>PT</td>
<td>32°</td>
<td>28°</td>
</tr>
<tr>
<td>Pelvic incidence</td>
<td>55°</td>
<td>60°</td>
</tr>
<tr>
<td>LL (T12–S1)</td>
<td>55°</td>
<td>49°</td>
</tr>
<tr>
<td>PM</td>
<td>19°</td>
<td>11°</td>
</tr>
<tr>
<td>SS</td>
<td>23°</td>
<td>30°</td>
</tr>
<tr>
<td>Coronal Cobb angle</td>
<td>22°</td>
<td>4°</td>
</tr>
</tbody>
</table>


Disclosures
Dr. Chandra reported personal fees from Nuvasive Inc. outside the submitted work. Dr. Cheng reported personal fees from Nuvasive Inc., Globus Medical, Spine Wave, Notogen, SpinalCyte, Surgalign, Spine Innovations, and Cytoflectics outside the submitted work. Dr. Veeravagu reported personal fees from Nuvasive Inc. and Medtronic while conducting the study and personal fees from Osteocentric outside the submitted work. No other disclosures were reported.

Author Contributions
Conception and design: Haider, Chandra, Cheng, Stienen, Veeravagu. Acquisition of data: Haider, Cheng, Veeravagu. Analysis and interpretation of data: Haider, Wagner, Stienen, Veeravagu. Drafting the article: Haider, Wagner, Cheng, Veeravagu. Critically revising the article: all authors. Reviewed submitted version of manuscript: Haider, Cheng, Stienen, Veeravagu. Approved the final version of the manuscript on behalf of all authors: Haider. Statistical analysis: Haider. Administrative/technical/material support: Haider, Cheng. Study supervision: Stienen.

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