Lumbar microdiscectomy: a historical perspective and current technical considerations

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A historical review is presented of the original descriptions of lumbar discectomy, focusing on the evolution toward a less invasive surgical approach following the introduction of the operating microscope. From the initial work in Europe by Yasargil and Caspar to the popularization of microdiscectomy by Williams and Wilson in the United States, this procedure has successfully reduced operative time, surgical morbidity, and incision size while allowing patients to return to work faster. Emphasis is placed on the importance of a careful preoperative clinical and radiographic evaluation by identifying factors that may help in the prediction of a successful surgical outcome. A modification of the lumbar microdiscectomy technique is described including patient positioning in the lateral position as well as minimal disc space and nerve root manipulation. In their experience performing more than 3000 microdiscectomies, the authors have produced good-to-excellent clinical results in nearly 90% of patients, with the majority returning to work within 1 month. The complication rate of dural tears, discitis, or root injury has been less than 2%, with a reoperation rate of 5%. The authors believe that lumbar microdiscectomy remains the gold standard with which all other discectomy techniques must be compared.

KEY WORDS • lumbar spine • microdiscectomy • history

HISTORICAL PERSPECTIVE

The operative treatment of lumbar disc disease has challenged spine surgeons since the first reported case in 1929 by Dandy.14 In 1934, William J. Mixter, a neurosurgeon at Harvard College, and his orthopedic colleague, Joseph Barr, first elucidated the pathophysiology of the age-old curse often described as lumbago or sciatica.46 They reviewed and synthesized the case reports by Oppenheim, Goldthwait, Ellsberg, Bucy, Dandy, Petit-Daturlis, Schmorl, and others, added 11 cases of their own, thus providing the information substrate and the catalyst that would lead to the preoperative diagnosis and the surgical cure of millions of people with intractable pain. Far from minimally invasive, the lumbar discectomy technique described by Mixter and Barr involved an extensive removal of the lamina and offending ruptured disc through an intradural approach.24,46 Their technique was used during much of the Cold War era and underwent only subtle alteration until a less invasive microsurgical dissection was introduced in the late 1960s, which resulted in shortened hospital stays, less surgical morbidity, and a faster return to work for the patient.25,31,34,65,67,69,70 The first publications documenting the microsurgical discectomy procedure were in 1977: both Yasargil74 working in Switzerland and Caspar11 working in Germany reported their experience in applying the operating microscope to surgery for lumbar disc disease. During the following year, Wil-

Abbreviations used in this paper: CT = computerized tomography; HLD = herniated lumbar disc; LDH = lumbar disc herniation; MR = magnetic resonance; US = United States.
Preoperative Assessment

Before focusing on the intraoperative approach to microdiscectomy, a brief discussion of preoperative evaluation is warranted. The incidence of LDH peaks in patients between 24 and 45 years of age with the incidence leading to surgery occurring most often in patients in the 30- to 39-year-old range. A male predominance in the incidence of lumbar disc surgery ranges from 1.3:1 to 2:1 because discs in men undergo higher mechanical stress as well as inadequate nutrition due to longer nutrient diffusion pathways. Other risk factors for HLD include smoking, presence of narrower lumbar vertebral canal, sedentary occupations, prolonged motor vehicle driving, and operating vibrating machinery. Most surgeons initially manage patients with low-back pain and radicular symptoms with a trial of analgesic medications and physical therapy for several weeks before pursuing the option of costly radiographic studies and discussing surgical intervention because 90 to 95% of patients recover without surgery.

A careful preoperative history taking and physical examination are crucial in selecting appropriate surgical candidates. The duration of radicular symptoms as well as the presence of crossed Lasègue sign are important in the selection criteria, because patients with radiculopathy and sustained back pain for 6 months or more have more severe disc disease and poorer outcomes. Other clinical predictors of good outcome from surgery include: no preoperative comorbid conditions, no previous nonspinal surgery, the absence of a Workers’ compensation claim, younger age, presence of radicular distribution pain extending to the foot, positive straight-leg rising examination without back pain, and reflex asymmetry; each of these factors independently predicted a good outcome from lumbar discectomy.

Cerebrospinal fluid markers such as neurofilament and S100 proteins may provide additional data if needed to substantiate evidence of axonal and Schwann cell damage due to LDH compressing the nerve root.

For a patient with persistent radiculopathy suggestive of LDH, neuroimaging evaluation is necessary to determine if nerve root compression by a herniated disc corresponds to the clinical condition. Magnetic resonance imaging has replaced CT and myelography as the initial test of choice for several reasons. Almost all significant technical advances are initially met with skepticism if not active resistance. This was certainly the case with the operating microscope and, in particular, with its application to microsurgery of the lumbar disc. The small incision, diminished muscle trauma, and manipulation of neural structures allowed by a magnified view into the disc space under coaxial illumination has softened this resistance, and the majority of neurosurgeons now use the operating microscope to perform lumbar disc surgery. Over the past decade, lumbar microdiscectomy has become an outpatient procedure with success rates equal to those found in initial microdiscectomy studies.

Fig. 1. Axial (left) and sagittal (right) T2-weighted MR images of an L4–5 paramedian herniation of the nucleus pulposus through a ruptured anulus fibrosus.
were randomized into a continued conservative therapy group and a surgically managed group showed short-term success with 90% satisfaction in the surgically managed group compared with 66% satisfaction in the conservative therapy group at 1 year; however, this difference lost statistical significance at 4 years with 80% compared with 68% patient satisfaction, respectively.67 Shvat, et al.53 reviewed the cases of 55 male truck drivers following 3 months of conservative therapy to treat acute HLD. They found no significant difference in outcome or costs between continuing conservative therapy compared with surgery; however, the conservatively treated group did miss 18.5 more weeks of work over a 5-year period than those who underwent surgery. The anatomical continuity of the anulus fibrosis following disc herniation helps to predict surgical success because patients with an extruded disc fragment through the ruptured anulus have better clinical outcomes at 2 years compared with patients with contained herniation or disc disease.64 There is a clear advantage to surgical treatment when patients are seeking immediate relief of pain and a faster return-to-work time.

**SURGICAL TECHNIQUE**

The surgical approach is similar, with a few modifications, to that described by Yasargil,74 Caspar,11 and Williams.69,70 Patients are placed in a slightly flexed lateral decubitus position, with the affected side up and the surgeon seated (Fig. 2). Fluoroscopic or radiographic confirmation of the correct interspace is obtained with a radiopaque skin marker. Prophylactic intravenously administered antibiotics are given in one dose at least 30 minutes prior to the skin incision. A 15- to 25-mm skin incision is made just lateral to the appropriate spinous processes; the lumbodorsal fascia is incised 2 mm from its insertion and a subperiosteal dissection exposes the inferior third of the lamina above the ligamentum flavum, the medial facet, and the upper portion of the inferior lamina. A Williams retractor, either 1 or 2 cm wide and 5 to 7 cm long, maintains the exposure. At this point, a second radiograph may be obtained.

The operating microscope with a 300-mm objective is then brought into use. A low-profile, angled, high-speed drill with a 4- to 5-mm coarse diamond bit is used to thin the inferior lamina, medial facet, and superior lamina surrounding the interspace. A small curette is used to detach the ligamentum flavum directly over the nerve root inferolaterally and a 2-mm angled Kerrison rongeurs is used to begin the simultaneous bone removal over the nerve root and then laterally and superiorly to detach the ligamentum flavum and obtain a minimal medial facetectomy and achieve removal of the thinned inferior bone of the superior lamina. One-, two-, and three-millimeter rongeurs are used to remove the ligamentum flavum as needed but the medial portion is usually preserved so that it still overlies the nerve root.

The remainder of the operation is performed in the standard fashion. Epidural veins are coagulated with low-setting bipolar forceps. The disc is palpated with a blunt Penfield dissector or right angle nerve hook, and the nerve root is retracted using a blunt suction tip. Free fragments are removed from the epidural space, and the posterior longitudinal ligament is incised and nuclear material is removed in the standard fashion (Fig 2, lower left). After thorough superior, medial, and inferior exploration, a foraminotomy is completed; the fascia is closed with two to three sutures and the skin is closed with a subcutaneous stitch. Steri strips and an adhesive bandage are applied to the wound (Fig 2, lower right).

Patients are urged to begin ambulating immediately and are discharged within 24 hours, either the same day or the following morning, in 95% of the cases. Most patients have returned to work within 1 month after microsurgery for an extruded fragment; these results have not changed significantly since our earlier report.43 The mean operating time is usually 30 to 60 minutes. Approximately 90% of patients obtain good-to-excellent pain relief.

**MANAGEMENT OF COMPLICATIONS AND RECURRENCES**

The incidence of complications in our series involving more than 2500 procedures such as dural tears, nerve root injury, and discitis is less than 1.5%. Cerebrospinal fluid leak and subsequent pseudomeningocele can be prevented by immediate recognition of a dural tear and primary repair with application of tissue glue or a dural substitute as needed. One of the least common yet extremely painful complications of lumbar disc surgery is discitis, which can be divided into two types.22 Septic discitis can be distinguished by the presence of fever, leukocytosis, positive bacteriological cultures, or histological features on biopsy.
as well as by an increase in erythrocyte sedimentation and C-reactive protein. Sterile or aseptic discitis is thought to be due to chemical irritation and inflammation of the cartilaginous endplates of the vertebrae and does not result in wound infection, fever, or positive cultures and laboratory results. Wilson and Harbaugh\(^7\) reported that this occurred in 2.3\% of cases and blamed it on the rongeurs flaking off pieces of cartilage during radical disc removal. The two entities need to be distinguished because septic discitis requires antibiotic therapy whereas aseptic discitis can be treated with rest and physical therapy. Case reports of great vessel or retroperitoneal injuries exist, and immediate laparotomy with fluid and blood replacement is required if this occurs.\(^2,5,7\) We have not encountered such a complication and no death has occurred in more than 2500 operations.

Whether to remove just the extruded fragment, as advocated by Williams,\(^7\) or to remove more aggressively the nuclear material of the disc has been a heated point of discussion among those using the microsurgical approach; our reoperation rate was 5\% in this series. The conservative surgical approach advocated by Williams, in which only the protruding disc fragment is removed rather than performing the more extensive discectomy initially, produced a recurrence rate of 9\%, whereas he reported a recurrence rate of only 5.5\% in his later series.\(^6,7,8\) He concluded that the spontaneous reherniation rate was only 1.9\%, because two thirds of the total reherniations were due to new lumbar trauma.\(^6\) The work of Wilson and Harbaugh\(^7\) who used a more aggressive discectomy to remove the entire disc material in hopes of preventing reherniation produced only a slightly lower recurrence rate of 4\%. A drawback applying to this technique was an increased risk of postoperative discitis and back pain, possibly due to greater irritation of the vertebral endplates.\(^6\) Results pooled from nine different series show a 3.7\% recurrence rate in cases involving more extensive disc excision, compared with a 7\% rate after limited disc removal.\(^4\) Striffeler, et al.,\(^62\) provided conflicting evidence: their comparison of Williams’ conservative microsurgical discectomy with the technique reported by Caspar revealed no significant difference between the two groups in reoperation rates due to recurrence. Their finding\(^6\) is substantiated by another retrospective review in which no increase was reported in reherniation or reoperation rates when disc fragment excision alone was compared with discectomy and endplate curettage.\(^6\) These results suggest a more extensive removal of disc material involving curettage of the vertebral endplates causes increased risk of anular penetration and subsequent abdominal structure injury as well as greater postoperative back pain while offering little advantage in preventing recurrence.

Dealing with reherniation or return of sciatica symptoms can be one of the most difficult tasks faced by those performing lumbar spine surgery. The incidence of repeated surgery for recurrence ranges from 1.7 to 8\%.\(^2,6,30,49,54,59,63,71\) Reports vary greatly as to how successful repeated microdiscectomy can be as 44 to 100\% of patients are able to return to work and 56 to 88\% have relief of their sciatica.\(^2,7,7,50,59\) The time interval between the initial procedure and recurrence of symptoms is an important predictor of success in reoperative procedures because patients with sciatica that recurs at least 1 year after the first operation have better outcomes, with success rates comparable to those of primary microsurgical lumbar discectomy.\(^27,51,31\) The surgical findings during repeated surgery for recurrent sciatica are also important in predicting outcome; the presence of scar formation and lack of definitive reherniation results in less satisfactory outcomes.\(^19\) Based on the previous discussion and our excellent results, we will only remove the free disc fragment if it is massive and the extruded disc material is the clear source of root compression. If the herniation is still contained or contiguous with the disc space, we routinely aggressively remove the nuclear material. To reduce perineural fibrosis we preserve, as much as possible, the epidural fat and ligamentum flavum over the nerve root.

**CONCLUSIONS**

Lumbar discectomy as the surgical treatment of the HLD has certainly evolved since the initial reports of this disease entity more than 70 years ago. We have not focused on outcome measurements as that will be discussed in another article in this issue; however, we continue to have good-to-excellent patient satisfaction and successful functional outcomes in approximately 90\% of our nearly 3000 procedures. We could not have achieved this rate of success without careful preoperative evaluation correlating clinical symptoms and signs to neuroimaging abnormalities. The extent of disc removal must be based on a case-by-case decision regarding the intraoperative appearance of the LDH. When a large free disc fragment is compressing the nerve root, we believe removal of the offending fragment alone minimizes the risk of serious complications without compromising pain relief or increasing recurrence rates. With extensive personal experience performing thousands of microdiscectomies and after investigating and using almost all percutaneous and standard operative techniques, we believe that the microsurgical approach for lumbar discectomy remains the gold standard against which all other procedures must be compared.

**References**

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