Lumbar spine surgery positioning complications: a systematic review

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OBJECT There are a variety of surgical positions that provide optimal exposure of the dorsal lumbar spine. These include the prone, kneeling, knee-chest, knee-elbow, and lateral decubitus positions. All are positions that facilitate exposure of the spine. Each position, however, is associated with an array of unique complications that result from excessive pressure applied to the torso or extremities. The authors reviewed clinical studies reporting complications that arose from positioning of the patient during dorsal exposures of the lumbar spine.

METHODS MEDLINE, Scopus, and Web of Science database searches were performed to find clinical studies reporting complications associated with positioning during lumbar spine surgery. For articles meeting inclusion criteria, the following information was obtained: publication year, study design, sample size, age, operative time, type of surgery, surgical position, frame or table type, complications associated with positioning, time to first observed complication, long-term outcomes, and evidence-based recommendations for complication avoidance.

RESULTS Of 3898 articles retrieved from MEDLINE, Scopus, and Web of Science, 34 met inclusion criteria. Twenty-four studies reported complications associated with use of the prone position, and 7 studies investigated complications after knee-chest positioning. Complications associated with the knee-elbow, lateral decubitus, and supine positions were each reported by a single study. Vision loss was the most commonly reported complication for both prone and knee-chest positioning. Several other complications were reported, including conjunctival swelling, ischemic orbital compartment syndrome, nerve palsies, thromboembolic complications, pressure sores, lower extremity compartment syndrome, and shoulder dislocation, highlighting the assortment of possible complications following different surgical positions. For prone-position studies, there was a relationship between increased operation time and position complications. Only 3 prone-position studies reported complications following procedures of less than 120 minutes, 7 studies reported complications following mean operative times of 121–240 minutes, and 9 additional studies reported complications following mean operative times greater than 240 minutes. This relationship was not observed for knee-chest and other surgical positions.

CONCLUSIONS This work presents a systematic review of positioning-related complications following prone, knee-chest, and other positions used for lumbar spine surgery. Numerous evidence-based recommendations for avoidance of these potentially severe complications associated with intraoperative positioning are discussed. This investigation may serve as a framework to educate the surgical team and decrease rates of intraoperative positioning complications.

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KEY WORDS lumbar spine surgery; prone; knee-chest; positioning complications; systematic review

Exposure of the lumbar spine is achieved through a variety of intraoperative surgical positions.4 The prone, kneeling, knee-chest, knee-elbow, and lateral decubitus positions represent plausible positions that allow for exposure of the lumbar spine. However, each of these positions has an array of unique complications.4,9,11,14,28,30 These complications result from excessive pressure applied to ventral or lateral structures, causing potentially significant postoperative morbidity.4,9,11,14,15,22,23,31,33,39,47 While certain complications are transient, some result in permanent deficit and severe disability in patients undergoing lumbar spine surgery.7,11,15,23,28,32 Thus, surgeons must be
mindful of intraoperative patient positioning to relieve potentially harmful pressure upon susceptible structures.4

Complications related to positioning during lumbar spine surgery are typically analyzed from an institutional perspective.14,26,29,46 A systematic review of complications following the numerous positioning options for lumbar spine surgery has not been previously performed. The goal of the present study is to educate the surgical team on avoiding intraoperative positioning complications, thereby improving patient outcomes. We sought to identify reported complications following different intraoperative positions for lumbar spine surgery and offer evidence-based recommendations for prevention of these potentially serious complications.

Methods

Identification of Studies

A systematic review of the literature was conducted following Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) criteria.27 We conducted MEDLINE, Scopus, and Web of Science database searches with the following search algorithm: (“positioning” or “position”) and (“complications”) or (“prone position”) and (“complications”) or (“knee-chest” or “kneeling”) and (“complications”) or (“lateral” or “lateral decubitus”) and (“complications”) and (“lumbar” and (“spine” or “surgery”)). The search returned 3898 citations. The search period ended April 24, 2015.

Inclusion and Exclusion Criteria

Clinical studies performing any type of lumbar spine surgery, regardless of indication, were included in the study. To create a more homogeneous patient cohort, studies involving procedures across both the thoracic and lumbar spine were excluded. We imposed no restrictions on publication status. Animal, in vitro, biomechanical, and non–English language studies were excluded. Because of the limited amount of data, we included prospective and retrospective studies reporting complications associated with positioning during lumbar spine surgery.

Data Collection

Two reviewers (M.F.S. and V.Z.) independently conducted data extraction from the 34 included articles. The extracted data sets were compared to confirm accuracy. The level of evidence of the included articles was assessed using the Oxford Centre for Evidence Based Medicine Level of Evidence 2 classification system (http://www.cebm.net/cebm-levels-of-evidence/). Bias risk assessment was not performed for the individual studies in our review because most studies were retrospective case reports expressing strong inherent bias. The included studies are summarized in Tables 1, 2, and 3. From the eligible articles we obtained the following information: publication year, study design, sample size, sex, age, operative time, type of surgery, surgical position used, frame or table type, complications associated with positioning, time to first observed complication, long-term outcomes, and evidence-based recommendations for avoidance.

Results

Study Selection

Two reviewers (M.F.S. and V.Z.) evaluated the initial 3898 retrieved citations. After removing 2101 duplicates, the titles and abstracts of 1797 publications were screened.27 Studies that did not pertain to lumbar spine surgery and/or complications associated with intraoperative positioning were excluded. After excluding 1642 citations that did not meet the inclusion criteria, the full text of the remaining 155 articles was assessed. This resulted in 34 eligible articles being included in the final analysis (Fig. 1).

Study Characteristics

Of the 34 included studies in this review, 27 were case reports. The remaining studies included 2 randomized controlled trials and 1 prospective and 4 retrospective cohort studies. The year of publication ranged from 1973 to 2014. Study size ranged from 1 to 1111 patients. Twenty-four studies performed surgery in the prone position (Table 1), and 7 studies investigated complications following lumbar spine surgery in the knee-chest position (Table 2).1,5–7,9–11,13,15,18,19,21–26,28,29,32–34,36,37,39,40,42,46–48 Complications related to the knee-elbow, lateral decubitus, and supine positions were each reported by a single study (Table 3).14,30,31

Prone-Position Studies

Vision loss was the most commonly reported complication, with 11 case reports describing postoperative-onset vision loss. Three studies reported conjunctival swelling (chemosis) (Tables 1 and 4). A number of complications were reported by 2 studies in our review (i.e., cerebral infarction, ischemic orbital compartment syndrome, nerve palsies, and thromboembolic complications), showing the diversity of possible complications following prone positioning.

There was a positive correlation between increased operative time and the number of studies reporting complications related to the surgical position of the patient. Only 3 studies reported complications following procedures of less than 120 minutes, 7 studies reported complications following mean operative times of 121–240 minutes, and 9 additional studies reported complications following mean operative times of more than 240 minutes (Table 5). Vision loss and conjunctival swelling were reported across all operative time groups, whereas abdominal compartment syndrome, small bowel obstruction, acute angle-closure glaucoma, and nerve palsy were only witnessed in studies with mean operative durations of more than 240 minutes. The shortest operative time resulting in a postoperative positioning complication was 50 minutes, reported by Yilmaz and Kalemci,46 who described the development, in a single patient, of unilateral cortical blindness and concordant occipital infarction 2 hours after surgery.46

Knee-Chest Studies

There were significantly fewer studies reporting use of the knee-chest position relative to the prone position in this review (7 vs 24, respectively) (Tables 1 and 2). Acute renal failure, rhabdomyolysis, insecure endotracheal intu-
### TABLE 1. Prone-position studies identified by systematic review

<table>
<thead>
<tr>
<th>Authors &amp; Year</th>
<th>Study Design</th>
<th>Position</th>
<th>Sample Size</th>
<th>Mean Age (yrs)</th>
<th>Mean Op Time in Mins</th>
<th>Complications Presented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pirris &amp; Nottmeier, 2013</td>
<td>Case report</td>
<td>Prone</td>
<td>1</td>
<td>65</td>
<td>—</td>
<td>Diplopia, CN VI palsy, pneumocephalus</td>
</tr>
<tr>
<td>Yilmaz &amp; Kalemci, 2013</td>
<td>Case report</td>
<td>Prone</td>
<td>1</td>
<td>53</td>
<td>50</td>
<td>Vision loss, cerebral infarction (unilateral occipital)</td>
</tr>
<tr>
<td>Dahab et al., 2012</td>
<td>Case report</td>
<td>Prone</td>
<td>1</td>
<td>47</td>
<td>—</td>
<td>Lower-extremity compartment syndrome</td>
</tr>
<tr>
<td>Goni et al., 2012</td>
<td>Case report</td>
<td>Prone</td>
<td>1</td>
<td>38</td>
<td>105</td>
<td>Vision loss, cerebral infarction (bilateral occipital)</td>
</tr>
<tr>
<td>Minami et al., 2012</td>
<td>Case report</td>
<td>Prone</td>
<td>1</td>
<td>76</td>
<td>216</td>
<td>CVC-related venous thrombosis</td>
</tr>
<tr>
<td>Chae et al., 2011</td>
<td>Case report</td>
<td>Prone</td>
<td>1</td>
<td>22</td>
<td>210</td>
<td>Bite injury, cyanotic &amp; edematous protruding tongue</td>
</tr>
<tr>
<td>Shih et al., 2011</td>
<td>Case report</td>
<td>Prone</td>
<td>4</td>
<td>62</td>
<td>374</td>
<td>Abdominal compartment syndrome, small-bowel obstruction</td>
</tr>
<tr>
<td>Zimmerer et al., 2011</td>
<td>Case report</td>
<td>Prone</td>
<td>1</td>
<td>73</td>
<td>—</td>
<td>Vision loss</td>
</tr>
<tr>
<td>Singer &amp; Salim, 2010</td>
<td>Case report</td>
<td>Prone</td>
<td>1</td>
<td>68</td>
<td>&gt;300</td>
<td>Acute angle–closure glaucoma</td>
</tr>
<tr>
<td>Cho &amp; Lee, 2008</td>
<td>Case report</td>
<td>Prone</td>
<td>1</td>
<td>51</td>
<td>270</td>
<td>Entrapment neuropathy of lateral femoral cutaneous nerve</td>
</tr>
<tr>
<td>Mohammadi &amp; Hosseini, 2008</td>
<td>RCT</td>
<td>Prone</td>
<td>HN 70, HD 70</td>
<td>HN 58, HD 53</td>
<td>HN 101, HD 121</td>
<td>Chemosis</td>
</tr>
<tr>
<td>Reddy et al., 2008</td>
<td>Case report</td>
<td>Prone</td>
<td>1</td>
<td>55</td>
<td>270</td>
<td>Vision loss</td>
</tr>
<tr>
<td>Yu et al., 2008</td>
<td>Case report</td>
<td>Prone</td>
<td>1</td>
<td>68</td>
<td>240</td>
<td>Vision loss, ischemic orbital compartment syndrome</td>
</tr>
<tr>
<td>Jeon et al., 2007</td>
<td>RCT</td>
<td>Prone</td>
<td>HN 54, HD 54</td>
<td>HN 55, HD 55</td>
<td>HN 178, HN 197</td>
<td>Chemosis</td>
</tr>
<tr>
<td>Corso et al., 2006</td>
<td>Case report</td>
<td>Prone</td>
<td>1</td>
<td>58</td>
<td>330</td>
<td>Vision loss, chemosis</td>
</tr>
<tr>
<td>Leibovitch et al., 2006</td>
<td>Case report</td>
<td>Prone</td>
<td>1</td>
<td>80</td>
<td>480</td>
<td>Vision loss, ischemic orbital compartment syndrome</td>
</tr>
<tr>
<td>Morfedy et al., 2006</td>
<td>Case report</td>
<td>Prone</td>
<td>1</td>
<td>43</td>
<td>160</td>
<td>Acute bowel ischemia</td>
</tr>
<tr>
<td>Chalam &amp; Shah, 2005</td>
<td>Case report</td>
<td>Prone</td>
<td>1</td>
<td>55</td>
<td>690</td>
<td>Vision loss</td>
</tr>
<tr>
<td>Ali et al., 2003</td>
<td>Case report</td>
<td>Prone</td>
<td>1</td>
<td>57</td>
<td>—</td>
<td>Shoulder dislocation, ischemic limb due to arterial compression</td>
</tr>
<tr>
<td>Suzuki et al., 2001</td>
<td>Case report</td>
<td>Prone</td>
<td>1</td>
<td>73</td>
<td>—</td>
<td>Vision loss</td>
</tr>
<tr>
<td>Brandt et al., 1998</td>
<td>Case report</td>
<td>Prone</td>
<td>1</td>
<td>56</td>
<td>—</td>
<td>Fat embolism</td>
</tr>
<tr>
<td>Dilger et al., 1998</td>
<td>Case report</td>
<td>Prone</td>
<td>1</td>
<td>44</td>
<td>720</td>
<td>Vision loss</td>
</tr>
<tr>
<td>Lee et al., 1998</td>
<td>PCS</td>
<td>Prone</td>
<td>20</td>
<td>54</td>
<td>160</td>
<td>Pressure sores</td>
</tr>
<tr>
<td>Katz et al., 1994</td>
<td>Case report</td>
<td>Prone</td>
<td>4</td>
<td>54</td>
<td>480–540</td>
<td>Vision loss</td>
</tr>
</tbody>
</table>

CN = cranial nerve; CVC = central venous catheter; HD = head down; HN = head neutral; PCS = prospective cohort study; RCT = randomized controlled trial; — = no data.

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### TABLE 2. Knee-chest position studies identified in this systematic review

<table>
<thead>
<tr>
<th>Authors &amp; Year</th>
<th>Study Design</th>
<th>Position</th>
<th>Sample Size</th>
<th>Mean Age (yrs)</th>
<th>Mean Op Time in Mins</th>
<th>Complications Presented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quraishi et al., 2012</td>
<td>Case report</td>
<td>Knee-chest</td>
<td>1</td>
<td>44</td>
<td>600</td>
<td>Vision loss, CN VI palsy</td>
</tr>
<tr>
<td>Rudolph et al., 2011</td>
<td>Case report</td>
<td>Knee-chest</td>
<td>1</td>
<td>65</td>
<td>240</td>
<td>Gluteal compartment syndrome, rhabdomyolysis, renal failure</td>
</tr>
<tr>
<td>Nicol et al., 2009</td>
<td>RCS</td>
<td>Knee-chest</td>
<td>1111</td>
<td>—</td>
<td>49,* 128†</td>
<td>Thromboembolic events</td>
</tr>
<tr>
<td>Moriano-Béjar et al., 2008</td>
<td>Case report</td>
<td>Knee-chest</td>
<td>1</td>
<td>56</td>
<td>450</td>
<td>Lower-extremity compartment syndrome, rhabdomyolysis, renal failure</td>
</tr>
<tr>
<td>Roth et al., 2007</td>
<td>Case report</td>
<td>Knee-chest</td>
<td>1</td>
<td>53</td>
<td>—</td>
<td>Vision loss</td>
</tr>
<tr>
<td>Langmayr et al., 1996</td>
<td>Case report</td>
<td>Knee-chest</td>
<td>1</td>
<td>33</td>
<td>60</td>
<td>Quadriplegia, vision loss, cerebral infarction</td>
</tr>
<tr>
<td>Alexander, 1973</td>
<td>RCS</td>
<td>Knee-chest</td>
<td>151</td>
<td>—</td>
<td>—</td>
<td>Insecure endotracheal tube, DVT, femoral vein thrombosis</td>
</tr>
</tbody>
</table>

RCS = retrospective cohort study.

* Laminotomy, decompression, and disc enucleation procedures.
† Posterolateral spinal fusion, with or without decompression or pedicle fixation.
bation, and quadriplegia were only reported among studies using the knee-chest position. Furthermore, vision loss was only reported by 3 studies (Table 4). There was no correlation found between increased operative time and the number of studies reporting complications, but this may have been due to the limited number of studies reporting complications related to this operative approach. Lower-extremity compartment syndrome, acute

![PRISMA flow diagram for selection of studies based on inclusion criteria during systematic review.](image)

**TABLE 3. Miscellaneous position studies identified in this systematic review**

<table>
<thead>
<tr>
<th>Authors &amp; Year</th>
<th>Study Design</th>
<th>Position</th>
<th>Sample Size</th>
<th>Mean Age (yrs)</th>
<th>Mean Op Time in Mins</th>
<th>Complications Presented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Osler et al., 2014</td>
<td>RCS</td>
<td>Supine</td>
<td>263</td>
<td>50</td>
<td>—</td>
<td>Pressure sores</td>
</tr>
<tr>
<td>Papastefanou et al., 1994</td>
<td>Case report</td>
<td>Lat decubitus*</td>
<td>2</td>
<td>55.5</td>
<td>—</td>
<td>Femoral nerve palsy</td>
</tr>
<tr>
<td>Eie et al., 1983</td>
<td>RCS</td>
<td>Knee-elbow</td>
<td>943</td>
<td>—</td>
<td>—</td>
<td>Upper-extremity paresis (mechanical pressure on brachial plexus)</td>
</tr>
</tbody>
</table>

* Retroperitoneal flank approach.
rhabdomyolysis, and acute renal failure were only reported among studies with mean operative times of more than 120 minutes, while thromboembolic complications, cerebral infarction, and vision loss were observed following shorter operation durations (Table 5). Langmayr et al. reported the progressive development of quadriplegia in 1 patient during the early postoperative period; it was the most significant neurological deficit following lumbar spine surgery found in our review. This occurred following a 60-minute procedure and was associated with extreme rotation or hyperextension of the head in the knee-chest position.

**Miscellaneous Position Studies**

Nerve palsies and pressure sores were identified in 3 studies reporting miscellaneous lumbar surgery positions (Tables 3 and 4). This group consisted of knee-elbow, lateral decubitus, and supine positions (Table 4). Vision loss was not reported among these studies, but the number of studies was markedly limited.

**Discussion**

This study represents the most comprehensive systematic literature review of positioning complications following lumbar spine surgery. We analyzed complications associated with the prone, knee-chest, and other miscellaneous intraoperative positions. Many studies within our review offered evidence-based recommendations for avoidance of these position-related complications. The most common and significant complications identified among the included studies in our review are presented below, along with prevention guidelines.

**Vision Loss**

Vision loss is an extremely rare complication, with reported incidences of 0.003% to 0.0008% for nonocular surgeries, and 3.09 per 10,000 for spinal fusion procedures. While the incidence of postoperative vision loss has not been investigated solely following lumbar spine surgery, it was the most commonly reported complication associated with intraoperative positioning during our review. Onset of vision loss can occur during the postoperative period and may present with decreased visual acuity, lack of light perception, ophthalmoplegia, and/or ptosis. These symptoms arise following ischemic optic neuropathy, central artery occlusion, ischemic orbital compartment syndrome, or occipital cerebral infarction. These findings can occur unilaterally or bilaterally.

Persistent visual loss is reported in a number of cases. Leibovitch et al. reported a persistent deficit through 4 months of follow-up, with no improvement in light perception, ptosis, or ophthalmoplegia. Conversely, rapid recovery of vision within 48 hours of vision loss has been reported. Although the possibility exists for recovery, it is not always complete or symmetric. Chalam et al. reported the partial resolution of bilateral visual loss, with 1 eye exhibiting detection of hand motion and the other revealing persistent loss of light perception at 1-year follow-up.

Prevention of postoperative vision loss is critical. The pathogenesis of this significant deficit is thought to arise from venous flow obstruction caused by applied external pressure during the operation, consequently resulting in increased orbital venous and intraocular pressure. Several risk factors are associated with this, including prolonged operative time, high-volume infusion, intraoperative anemia, and hypotension. When these risk factors are combined with applied ventral pressure to the head, a head-down position, or extreme rotation of the head to one side during prone positioning, they may result in loss of vision due to compromised blood flow to the optic nerve.

For proper protection of the eyes, correct positioning must be confirmed at multiple time points before and during the operation to prevent improper shifting of the head. Quraishi et al. suggested that high-risk patients, including those with expected prolonged operative time and/or substantial blood loss, should be positioned so the head lies at or above the level of the heart, in a neutral forward position, and intraoperative eye swelling and pressure should be checked consistently. As well, the use of...
of a head frame may be indicated to substantially reduce direct pressure to the eyes.33 Fewer published reports exist regarding postoperative vision loss following the knee-chest position compared with the prone position, but Roth et al.36 reported the onset of vision loss even with the use of a foam headrest and goggles covering the eyes. This emphasizes the highly variable and inconsistent onset of postoperative vision loss, even with the proper implementation and use of preventive measures. No matter the setting, immediate ophthalmological evaluation is necessary to increase the necessity for the head to lie level with or above the rest of the body to avoid gravity-induced venous stasis and fluid collection.14 This can be achieved with the use of various headrests (i.e., cushion, foam headrest, horseshoe head rest, or head frame), but a head frame may be best because it avoids compression of periorbital structures, which may increase the risk of venous stasis.26,36

**Quadriplegia**

Langmayr et al.21 reported a case of progressive quadriplegia development following surgery in the knee-chest position. This occurred in a 33-year-old male patient undergoing a 60-minute operation.21 Following the procedure, the patient complained of lower extremity paralysis, which then progressed to quadriplegia.21 MRI identified a hypointense lesion in the upper cervical spinal cord, which correlated to the patient’s symptomatology.21 No embolic source was found and the authors believed it was caused by extreme rotation or hyperextension of the head in the knee-chest position.21 Loss of tone in the cervical musculature during surgery, resulting in increased cord compression in patients with preexisting cervical stenosis, systemic embolism, and/or primary vertebral artery embolism due to occlusion and subsequent stasis of arterial blood flow, was theorized.16,21 Most likely, extreme rotation, flexion, or extension of the neck, and resultant stretching of the cervical cord produced impaired blood flow along the carotid and/or vertebral arteries.21 Therefore, while avoidance of applied pressure to ventral structures of the head is key for prevention of postoperative vision loss and periorbital swelling, extreme rotation or hyperextension of the neck must be circumvented because of potential impairment of blood flow to the spinal cord and cerebral hemispheres.16,21 Neck and head position must be checked at multiple points by the surgeon and anesthesiologist to ensure prevention of this severe, life-threatening complication.

**Bite Injury**

Chae et al.6 reported the unusual intraoperative discovery of a bite injury, producing a cyanotic, edematous, protruding tongue. Rocuronium, a skeletal muscle relaxant,
was administered for emergent decompression and reposi-
tion of the tongue, leading to restoration of the blood sup-
ply, reduction of edema, and, ultimately, resulting in no
long-term tongue complications.\textsuperscript{5,6} The authors attributed
this intraoperative injury to inadequate preoperative intra-
oral care and intraoperative wake-up test.\textsuperscript{6} With extensive
concentration placed on securing proper ventilation, the
prospect of tongue protrusion was inadvertently missed.\textsuperscript{6}
When pressure is applied to the neck, there may be tongue
displacement and decreased venous return, resulting in an
edematous, enlarged tongue.\textsuperscript{6} However, with a neutral head
position, neck pressure is reduced, minimizing the risk for
intraoperative tongue displacement and swelling, thereby
decreasing bite injuries.\textsuperscript{6} Bite blockers, if used, should be
short and soft to prevent traumatic injury to the tongue and
teeth, but should be sufficient enough to prevent significant
intraoral cavity volume reduction.\textsuperscript{6}

\textbf{Shoulder Dislocation}

Ali et al.\textsuperscript{2} reported the recurrence of shoulder disloca-
tion in a patient undergoing lumbar spine fusion in the
prone position following trauma. The patient’s shoulders
and elbows were abducted to 90° and flexed, respectively,
with both arms supported by an arm cushion and board.\textsuperscript{2}
During the procedure, arterial blood pressure waveforms
were lost, resulting in unilateral arm paleness, which was
concerning for recurrent anterior shoulder dislocation.\textsuperscript{2}
Ultimately, the patient suffered from an ischemic limb,
secondary to axillary artery compression by shoulder
dislocation.\textsuperscript{2} Fortunately, recognition of arterial-catheter
waveform abnormalities allowed for early detection and
prevention of potential compartment syndrome, rhabdo-
myolysis, and possible subsequent renal failure.\textsuperscript{2} Reduction
of the dislocation, confirmation of restored arterial blood
pressure, and additional support of the injured extremity
allowed for continuation of the spine procedure without
further complications.\textsuperscript{2} This study highlights the necessity
of consistent monitoring of arterial waveforms to properly
maintain perfusion of extremities during lumbar spine
surgery, especially following trauma.\textsuperscript{2} The arm position in
this study is routinely used because of improved catheter
and monitor access. However, this may predispose patients
to shoulder dislocation, and consequent brachial plexus in-
jury and arterial impingement.\textsuperscript{2,3,12,41} The authors suggested
an alternative position in patients with prior history or
increased risk of shoulder dislocation: arms placed lateral
relative to the chest, with adducted shoulders, extended el-
bows, and pronated forearms.\textsuperscript{2} Along with improved and
less extreme positioning of extremities, continual inspec-
tion of peripheral pulses, capillary refill, skin tone, oxime-
try, and arterial-catheter waveforms should greatly reduce
the risk of ischemic limb complications.\textsuperscript{2,6,12,13,28}

\textbf{Compartment Syndrome}

Compartment syndromes are rare but are representative
of extreme complications that are possible following long-
term operations lasting longer than 2 to 4 hours.\textsuperscript{3,12,37} The
cause of increased compartmental pressures following surgery is not always apparent and may occur even with
careful positioning and attention to areas under pressure.\textsuperscript{21}
Lower-extremity compartment syndrome was reported in
3 studies in our review—Dahab et al.,\textsuperscript{11} Rudolph et al.,\textsuperscript{37}
and Moriano-Béjar et al.\textsuperscript{28}—encompassing bilateral glu-
teal, anterior thigh, and anterior leg compartments. Com-
partment syndrome location was clearly related to areas of
pressure applied during intraoperative positioning. Prone
positioning used in Dahab et al.\textsuperscript{11} resulted in an anterior
thigh syndrome, whereas Rudolph et al.\textsuperscript{37} and Moriano-
Béjar et al.\textsuperscript{28} reported gluteal and anterior leg compart-
ment syndromes, respectively, because of applied pressure
in the knee-chest position. Hip flexion in the knee-chest
position may predispose patients to increased gluteal com-
partment pressure, reducing pelvic perfusion.\textsuperscript{37} Although
positioning plays a role, the syndrome’s etiology is likely
related to multiple factors, including obesity, operative
time, positioning, and intraoperative hypotension.\textsuperscript{27} To
avoid lower-extremity compartment syndrome, Rudolph et al.\textsuperscript{37}
suggested obese patients with risk factors for pro-
longed surgery time might benefit from being placed in
the prone position, but noted that this position offers its
own unique set of possible complications, such as abdomi-
nal and visceral ischemia, which are also associated with
gluteal compartment syndrome. Ultimately, because of
the ambiguity found between different positions and the
development of compartment syndrome, it is important
that surgeons do not confuse postoperative symptoms of
extremity ischemia with preoperative deficits associated
with the patient’s lumbar pathology.\textsuperscript{28}

\textbf{Pressure Sores}

Operations with a duration of more than 3 hours in-
crease the risk of pressure sore development.\textsuperscript{22} Use of some
frames, such as the Relton-Hall frame, produce increased
pressure at specific points where the patient’s body rests.\textsuperscript{22}
In morbidly obese patients or any patient with increased
risk of developing pressure ulcers, careful frame selection
should be considered. Certain frames such as the Wilson,
Andrews, Jackson, and longitudinal bolster tables accom-
modate proper lumbar spine exposure with reduced com-
pression of ventral structures.\textsuperscript{12,13} Use of pillows and careful
positioning of the abdomen and extremities diminish these
pressure points as well.\textsuperscript{4,12} The risk and consequences of
developing pressure sores is important. This review high-
lights the need for future studies comparing the relative
risk of pressure sores following the use of various tables
and frames.

\textbf{Thromboembolic Complications}

Nicol et al.\textsuperscript{29} suggested that intraoperative positioning
plays a crucial role in the rate of deep vein thrombosis
(DVT) and pulmonary embolism (PE) development fol-
lowing lumbar spine surgery. There is substantial varia-
tion in reported rates of thromboembolic complications
following spine surgery, with some reports as high as 12%,
and some as low as 0.3%.\textsuperscript{3,5,39} Nicol et al. reported a 0.27% rate
of thrombotic complications, with no further reduc-
tion in reported rates of thromboembolic complications,
with some reports as high as 12%, and some as low as 0.3%.\textsuperscript{3,5,39} Nicol et al. reported a 0.27% rate of thrombotic complications, with no further reduc-
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tion in reported rates of thromboembolic complications,
tioning with rates of thrombosis, but proper distribution of weight and avoidance of acute joint flexion may contribute to reduced DVT and PE incidence.1,24,29

Minami et al.24 further postulated that particular neck positions during lumbar spine surgery in the prone position might result in venous kinking. The patient in their case report was placed in a slightly flexed-neck position which, in combination with the presence of a central venous catheter in the internal jugular vein, potentially contributed to venous stasis and thrombosis.24 A head-neutral position to avoid venous kinking, and use of subclavian venous catheterization, reduces the risk of venous stasis and subsequent thrombotic events.24 Thus, patient positioning during lumbar spine surgery is intricately associated with thromboembolic complication rates, once again supporting the necessity of proper positioning and consistent checking throughout the procedure.

Peripheral Nerve Palsies

Damage to peripheral nerves and subsequent neurological deficit were reported following prone, knee-elbow, and lateral decubitus positioning.9,14,31 Cho and Lee9 reported entrapment neuropathy of the lateral femoral cutaneous nerve at the level of the anterior superior iliac spine (ASIS) following instrumented, posterior lumbar interbody fusion. Postoperatively, the patient complained of unilateral, anterior thigh paresthesia, but no muscle weakness.9 No concurrent lumbar radiculopathy was diagnosed following electrodiagnostic testing.9 The sensory deficit was associated with placement of the pelvic bolster under the ASIS during prone-position surgical technique.9 This complication was witnessed following an operative time of 270 minutes.9 Increased operative time is a clear risk factor during lumbar spine surgery, because of excessive pressure applied to peripheral nerve locations. Eie et al.14 reported the onset of transient right-arm paresis because of pressure applied to the brachial plexus during intraoperative knee-elbow positioning. Papastefanou et al.31 reported compressive neuropathy of the femoral nerve associated with the lateral decubitus position during anterior lumbar interbody fusion. The authors, following anatomical study, stated that immobility of the lumbar spine from a prior fusion, combined with hip extension during the procedure, resulted in constriction of the femoral nerve.31 Compressive injury resulting in postoperative neurological deficits is a potential complication following multiple positions for lumbar spine surgery. To avoid postoperative neurological deficit, surgeons must remain vigilant for excessive intraoperative pressure near key peripheral nerve locations.

Limitations

Most studies in our review were retrospective case reports, preventing us from calculating pooled complication rates. Furthermore, it is very likely that severe complications, like quadriplegia, are underreported. In addition, while stratification of complications by table and frame type would decrease heterogeneity among studies and reveal inherent differences, the primary literature is varied and does not routinely differentiate in reporting operative procedures. This review highlights the need for future studies comparing the relative risk of various lumbar spine surgery positions, tables, and frames on the incidence of postoperative complications.

Conclusions

This work presents a systematic review of positioning complications following prone, knee-chest, and other positions used for lumbar spine surgery. Heterogeneity among reporting likely reflects the real-world practice and conceptualization of complications by surgeons. Vision loss was the most commonly reported complication following both prone and knee-chest positioning. We discuss numerous evidence-based recommendations for avoidance of potentially severe complications associated with intraoperative positioning. Such an investigation should serve as a framework to provide education to the surgeon and decrease the rates of position-related complications in patients.

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