The most common forms of lumbar spondylolisthesis are 1) degenerative, from the facet and disc degeneration seen in the elderly; and 2) isthmic, from a pars fracture beginning at a younger age. Traditionally, spondylolisthesis due to pars defects is thought to be associated with mechanical instability and is therefore typically treated with fusion surgeries. The patient presented in this case, however, is an exception to this paradigm.

A 31-year-old man presented with a history of left radicular leg pain along the distribution of the sciatic nerve. He had a disc herniation at L5/S1 and bilateral pars defects with a Grade I spondylolisthesis. Dynamic radiographic studies did not show significant movement of L-5 over S-1. The patient did not desire to have a fusion. After induction of local anesthesia, the patient underwent an awake transforaminal endoscopic discectomy via the extraforaminal approach, with decompression of the L-5 and S-1 nerve roots. His preoperative pain resolved immediately, and he was discharged home the same day. His preoperative Oswestry Disability Index score was 74, and postoperatively it was noted to be 8. At 2-year follow-up he continued to be symptom free, and no radiographic progression of the listhesis was noted.

In this case preservation of stabilizing structures, including the supraspinous and interspinous ligaments and the facet capsule, may have reduced the likelihood of iatrogenic instability while at the same time achieving symptom control. This may be a reasonable option for select patient symptoms confined to lumbosacral radiculopathy.

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This approach is truly minimally invasive and minimizes disruption of the musculoskeletal structures, and thus is less likely to result in iatrogenic slip progression.

**Case Report**

**History and Examination**

The patient was a 31-year-old man who presented to clinic with a history of leg pain and mild back pain for more than 1 year. He was an avid basketball player, but his condition progressively worsened, to the point that he was unable to walk more than 10 feet before he had to rest. His leg pain was worse than the back pain by a 9:1 ratio. He had numbness over the gluteal area that extended down the back of his thigh to the knee. Preoperative visual analog scale (VAS) scores were 8–9 of 10. On examination the patient had some numbness in the foot, but no motor deficit was noted.

**Neuroimaging Findings**

Imaging revealed bilateral pars defects with Grade I spondylolisthesis at the L5–S1 level, with a disc herniation on the left compressing the S-1 nerve root. Dynamic flexion-extension radiographs of the lumbar spine showed minimal movement of L-5 over S-1 (Figs. 1–3). Extensive conservative management with NSAIDs, epidural injections, and physical therapy had failed in this patient over a period of 8 months. After an extensive discussion it was clear that because of his young age he would like to avoid a fusion surgery if possible.

**Operation**

The patient underwent a left-sided L5/S1 transforaminal endoscopic discectomy with intraoperative discography. The patient was positioned prone under monitored anesthesia care. Using fluoroscopy, the L5–S1 disc space was accessed through Kambin’s triangle using successive dilators and reamers through a 7-mm left flank incision. The herniated disc was removed and a foraminal enlargement was achieved with bone shavers, curettes, and endoscopic osteotomes.

**Postoperative Course**

The patient did well postoperatively and was discharged home 2 hours after surgery on the same day. His preoperative Oswestry Disability Index (ODI) score was 74, and this was reduced to 8. He continued to do well with regular follow-up. At 2 years after surgery he continued to be free from radicular and back pain, with a sustained ODI score of 8. His postoperative VAS scores were 1–2 of 10. His dynamic radiographs showed no increase in motion or slippage (Fig. 4).
endoscopic discectomy in pars defect and spondylolisthesis

Discussion

The vertebral column is maintained in a stable position by bony joints supported by muscles and ligaments. The stress and strain relationships with spinal ligaments are nonlinear and biphasic. There is a very low modulus of elasticity in the beginning and a very high modulus just before disintegrating. This implies that even with high strains there is less stress in the ligaments. This provides an optimum range of motion and absorbs a large amount of stress energy. Panjabi et al. showed that the maximum strain during flexion is on the supraspinous and interspinous ligament, with an intact pars in up to 18%. Also, ligamentum flavum provides additional support and biomechanical studies have shown that the failure strains have been 22%–80%. In a patient with spondylolisthesis from pars defects this stress on supraspinous and interspinous ligaments, ligamentum flavum, and anterior and posterior longitudinal ligaments is significantly increased, so that every structure is crucial for better load sharing.

With this understanding, we offered our 31-year-old patient the options of anterior lumbar interbody fusion, posterior instrumented fusion, microdiscectomy, and endoscopic transforaminal microdiscectomy. The patient was young and planned to have children in the future, which made the option of anterior lumbar interbody fusion less desirable because it can be associated with retrograde ejaculation. In addition, segmental fusion in a young patient might accelerate the need for possible additional fusions in the future from adjacent-level disease. Posterior interlaminar microdiscectomy would provide excellent symptomatic relief of radicular pain, but this comes at the cost of removal of the ligamentum flavum, medial facetectomy, and dissection of the paraspinal muscle, leading to worsening of the listhesis.

The long-term outcome in bilateral pars defects in athletes and young adults is often self-limited, with good healing and pain reduction in up to 80% of patients. However, some patients will remain symptomatic and require surgical intervention. Several treatment strategies can be used, and fusion surgery remains the standard choice. Although the results tend to be good, this outcome is not universal. In a subset of patients who had associated low-grade spondylolisthesis, minimal or no disc herniation, and age less than 20 years, direct pars repair might be favorable. Recently, minimally invasive surgery pars screw fixation techniques have been described by several groups of investigators. In their case series of 8 athletes, Gillis and colleagues demonstrated robust improvement of symptoms, which allowed a return to sport at their previous level in 6 of 8 patients. Not until 4 years later was lumbar fusion indicated in 1 patient.

In regard to our patient, because the symptoms clearly resulted from the significant disc herniation, we chose to undertake an incremental approach. It is most likely that this patient will ultimately require a fusion at the index site. However, given his unilateral radicular symptoms without back pain, his young age, the potential for an active lifestyle, and understanding of the treatment plan, we elected to perform the least morbidity-producing and least destabilizing operative intervention.

Conclusions

The preservation of critical structures and not the size of the incision defines the true essence of minimally invasive spine surgery. Microdiscectomy per se does not lead to instability of the spine but can contribute to worsening of existing spondylolisthesis. In this report we present a different option for treating a disc herniation in a patient with bilateral pars defect without fusion.
References


Disclosures

Dr. Wang is a consultant for DePuy Spine, Aesculap Spine, joimax, and K2M. He is a patent holder with DePuy Spine. Dr. Hofstetter is a consultant for Johnson & Johnson and for InVivo Therapeutics.

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