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# Posterior Spinal Fusion With Multilevel Posterolateral Convex Disc Releases for the Treatment of Severe Thoracolumbar Scoliosis

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## ABSTRACT

**Background:** Severe, rigid thoracolumbar scoliosis presents a surgical challenge to achieve 3-dimensional correction, maximize distal motion segments, and avoid operative morbidity conferred by combined anterior-posterior approaches or 3-column osteotomies. We present a new approach for releasing these curves, using multilevel posterolateral convex disc release (PCDR) and posterior instrumented fusion.

**Methods:** There were 3 adults and 1 adolescent (mean age, 31.8 years; 2 females) with severe progressive thoracic and transforaminal lumbar (major) idiopathic scoliosis (IS) who were treated with 3-level PCDR, multiple posterior column osteotomies, and posterior instrumented thoracolumbar fusion with all–pedicle screw constructs.

**Results:** Restoration of global coronal and sagittal alignment was achieved for all patients (minimum 2-year follow-up). Lowest instrumented vertebra (LIV) was L4 in 2 patients and L3 in the remaining 2. All except 1 were fused to the lower end vertebra. Postoperatively, mean thoracolumbar curve was reduced from 77.3° (range, 69°–91°) to 21.8° (72%Δ), LIV tilt decreased from 26.8° to 8.3°, and LIV translation improved (2.5–1.2 cm; 58%Δ), whereas lumbar lordosis remained unchanged. Average central sacral vertical line shift measured via C7 sagittal vertical axis changed from 1.4 to –0.7 cm. There were no complications except for dysesthesias in the lower extremity on the side of the PCDR in 1 patient, which resolved after 3 months.

**Conclusions:** Severe thoracolumbar IS presents a surgical challenge to achieve 3-dimensional correction, minimize fusion levels, and avoid procedural morbidity. PCDR is a novel technique that may facilitate this correction with minimal procedure-related morbidity.

Lumbar Spine

Keywords: thoracolumbar scoliosis, new technique, posterolateral convex disc release, feasibility study

## INTRODUCTION

Surgical management of severe, rigid thoracolumbar scoliosis in the skeletally mature adolescent and adult presents a surgical challenge. A number of surgical approaches and techniques have been used for severe, rigid scoliosis, each with advantages and drawbacks, predominantly due to approach-related morbidity. Historically, combined anterior disc release with posterior fusion has been commonly used to address rigid thoracolumbar scoliosis. Despite the positive results surrounding the anterior approach both biomechanically and clinically,<sup>1–4</sup> this approach has fallen out of favor because of perceived or verified morbidity, including pulmonary function impairment, vascular injury, postoperative ileus, and the need for chest tubes, leading to prolonged hospitalization and possible abdominal hernia or pseudohernia.<sup>5</sup> These concerns have exhorted sur-

geons to champion the posterior-only approach as a means to obviate the potential morbidity.<sup>6–11</sup>

Although the posterior-alone approach does carry the advantage of evading potential pulmonary impairment and other morbidities, it may be associated with longer fusions and more distal lowest instrumented vertebrae compared with the anterior-only approach or combined approaches, leading to subsequent loss of distal motion segments, and may not result in adequate deformity correction.<sup>12–15</sup> Posterior-based osteotomies from posterior column osteotomies to pedicle subtraction osteotomy and, finally, to vertebral column resection may facilitate operative goals but are associated with significant complications, including neurologic injury, dural tears, and pseudarthrosis.<sup>16</sup>

The rationale for maintaining the maximal number of unfused motion segments below or

above is to maintain as much clinical motion as possible and also to minimize the transfer of stresses to the adjacent levels, which may accelerate the progression of disc degeneration.<sup>7,8,10,11,17-19</sup>

The purpose of the present study is to evaluate the feasibility of a novel technique we have developed for releasing rigid thoracolumbar curvature while avoiding the morbidity associated with anterior approaches or more advanced posterior osteotomies to facilitate curve correction and maximize remaining motion segments. We present the posterolateral convex disc release (PCDR): a multilevel anterior column-shortening technique performed via a transforaminal lumbar interbody fusion (TLIF) equivalent approach that creates substantial spinal flexibility for posterior reconstruction under a single anesthetic. Four illustrative cases are presented here, with an emphasis on indications and outcome.

## METHODS

Institutional Review Board approval from Mount Sinai Hospital was obtained for this retrospective study investigating the radiographic and clinical course of 4 patients with severe progressive thoracic and major thoracolumbar idiopathic scoliosis undergoing 3-level PCDR (T12-L3 or L1-L4), multiple posterior column osteotomies, and posterior instrumented thoracolumbar fusion with all-pedicle screw constructs.

Radiographic and clinical data were obtained preoperatively, postoperatively, and at follow-up. The following radiographic parameters were measured by the same observer: coronal Cobb angles of the major thoracolumbar and minor structural thoracic curvatures, respectively; thoracic kyphosis, LIV tilt and translation, sagittal and coronal global alignment, and maximal correction (coronal curve flexibility) on preoperative side-bending films. Comparisons were made of the levels between the LIV and stable vertebrae, touched vertebrae, Cobb end vertebrae (CEV), and neutral vertebrae.

Total lumbar lordosis (LL) was measured from T12 to S1. Thoracolumbar sagittal alignment (TL) was measured from T10 to L2. Thoracic kyphosis was measured from T5 to T12. The C7 sagittal vertical axis (C7SVA, the horizontal distance between the C-7 plumb line and the posterosuperior corner of the S-1 vertebral body) was used to measure global sagittal alignment. The central sacral vertical line (CSVL, the horizontal distance

between the C-7 plumb line and the central sacral vertical line) was used to measure global coronal alignment. The LIV tilt was measured as the angle between the horizontal and a line parallel to the lower end plate of the LIV. The LIV translation was measured as the distance (in cm) from the center of the LIV to the CSVL. Preoperative neutral vertebra was defined as the most cephalad vertebra below the apex of the major curve whose pedicles are symmetrically located within the lateral borders of the vertebral body, and the stable vertebra (SV) was defined as the most cephalad vertebra at or immediately below the end vertebra (EV) of the major curve that is most closely bisected by the CSVL. Operative and perioperative outcomes, complications, and morbidity were retrospectively collected.

The PCDR technique performed essentially uses a TLIF approach on the convex side of the curve being corrected and including 3 discs to the level of the LIV. First, the posterior elements of the spine are exposed, prior to instrumentation, and a grade II osteotomy of the relevant spinal segment is performed.<sup>20</sup> This involves the resection of the inferior (medial) facets as well as the cephalad portion of the superior facet to the level of the pedicle as well as the ligamentum flavum at a given spinal segment.<sup>20</sup> After this osteotomy is performed the intervertebral disc is then accessed in a familiar TLIF approach in which the pars interarticularis is removed on the convexity. The exiting nerve root must be identified and avoided, and the spinal cord or cauda equina (traversing nerve root) should be protected with a retractor. This approach differs from the typical TLIF in that dissection around the anterolateral annulus to the midline is performed and a small ribbon malleable retractor is placed around the disc to protect the viscera and large blood vessels. The annulus can then be incised and nuclear material removed. In this technique 50% to 60% of the anterior annulus and corresponding nuclear material is removed. (Figure 1). Indications for this technique include severe, rigid thoracolumbar scoliosis with flexibility to greater than or equal to 35° correction on side bending, severe rotational deformity greater than 20° on inclinometer, and/or a desire to save a distal fusion level with rotational deformity of proposed lowest instrumented vertebrae greater or equal to Nash-Moe 2.

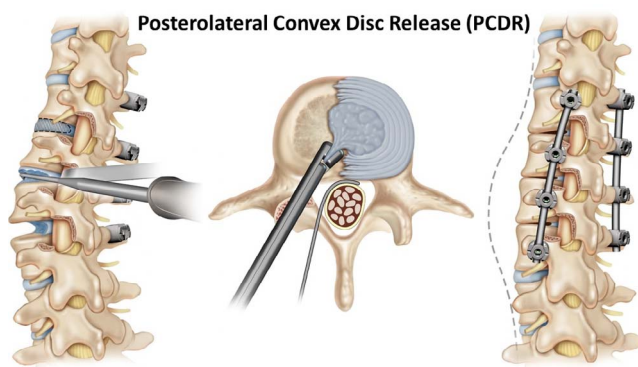


Figure 1. Illustration of PCDR technique.

## RESULTS

The case series included 4 patients (2 female, 2 male)—3 skeletally mature adults (2 female, 1 male) and 1 skeletally immature adolescent (male), with a mean age of 31.8 years and a mean of 2.3 years of follow-up. All patients had a diagnosis of thoracic and major thoracolumbar idiopathic scoliosis, and Lenke 6CN curves or their adult equivalents (Table 1).

All patients underwent a 3-level PCDR (2 from T12–L3, and 2 from L1–L4), multiple posterior column osteotomies, and posterior instrumented thoracolumbar fusion with all-pedicle screw constructs (Figure 2 and Figure 3).

Restoration of global coronal and sagittal alignment was achieved for all 4 patients with a minimum of 2-year follow-up (Table 2). Lowest instrumented vertebra (LIV) was L4 in 2 of the adults and L3 in the other 2 patients. Three patients were fused to the distal CEV (LEV) or LEV-1. The last touched vertebra was L4 in 3 patients and L3 in 1 patient. The stable vertebra was deemed to be in L5 in all 4 patients. One patient with disc degeneration and subsequent laterolisthesis was

fused to 1 level below the LEV. This resulted in saving a level in 2 of the 4 patients.

After surgery, the mean thoracolumbar curve was reduced from 77.3° (SD, 9.9°) to 21.8° (SD, 4.9°), a 72% (SD, 6%) correction. The LIV tilt was decreased from 26.8° (SD, 9.0°) to 8.3° (SD, 1.5°), a 66% change. The LIV translation was also improved by a 58% decrease, from 2.5 cm (SD, 1 cm) to 1.2 cm (SD, 0.8 cm) (Table 3). The LL was maintained (57.0° vs 57.8°). The C7SVA changed from 1.4 cm (SD, 0.9 cm) to 0.7 cm (SD, 0.3 cm). Mean thoracolumbar clinical axial plane rotation measured via inclinometer improved from 25° to 6°.

The thoracic angle of trunk rotation (ATR) improved from 9.3° to 4.8° (SD, 3.8°), and the thoracolumbar ATR improved from 24.5° to 4° (SD, 3°).

There was 1 immediate postoperative complication. One patient experienced dysesthesias in the lower extremity ipsilateral to the side of the PCDR, which resolved completely after 3 months. There were no intraoperative complications: vascular injuries or dural tears. There were no long-term complications and no reoperations throughout the follow-up period.

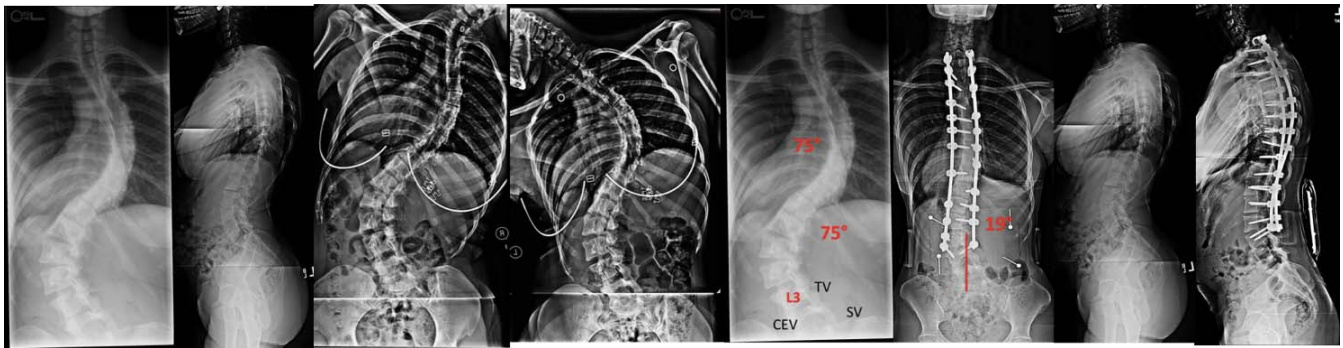
## DISCUSSION

The challenge the surgeon faces when addressing severe, rigid thoracolumbar scoliosis is to achieve a 3-dimensional correction while saving distal motion segments, leveling the LIV,<sup>21</sup> and avoiding approach-related morbidity. A number of techniques have been used to address severe, rigid scoliosis, including anterior disc release (or anterior discectomy) and posterior-based osteotomies with posterior instrumentation. Anterior discectomy has been shown to create greater axial instability that can

Table 1. Demographics and operative characteristics.

|                           | Patient                                 |                    |  |  | Mean   |
|---------------------------|---|--------------------|--|--|--------|
|                           | 1                                       | 2                  | 3                                      | 4  |        |
| Sex                       | M                                       | M                  | F                                      | F  | 50% F  |
| Age, y                    | 17                                      | 37                 | 28                                     | 45   | 32     |
| Skeletal maturity         | Immature                                | Mature             | Mature                                 | Mature   |        |
| Lenke                     | 6CN                                     | 6CN                | 6CN                                    | 6CN  |        |
| Follow-up, y              | 2                                       | 2.2                | 2                                      | 3.1  | 2.3    |
| No. of levels fused       | 13                                      | 14                 | 14                                     | 14   | 13.75  |
| Operative time, min       | 360                                     | 340                | NC                                     | 345  | 348.33 |
| EBL, cc                   | 3000                                    | 1220               | 800                                    | 800  | 1455   |
| Need for transfusion, Y/N | Y (1500 cell saver/<br>3 units of PRBC) | N (610 cell saver) | Y (385 cell saver/<br>2 units of PRBC) | Y (355 cell saver/1 unit of<br>designated blood) | NA     |
| Complications, Y/N        | N                                       | N                  | N                                      | N  | N      |

Abbreviations: NC, not collected; EBL, Estimated Blood Loss; PRBC, Packed Red Blood Cells; NA, not applicable.



**Figure 2.** A 28-year-old female patient underwent posterior spinal fusion with posterior column osteotomies and PCDR T12 to L3 with excellent clinical outcomes at 1 year of follow-up. Fusion to touched vertebrae, 1 level cephalad to the CEV.

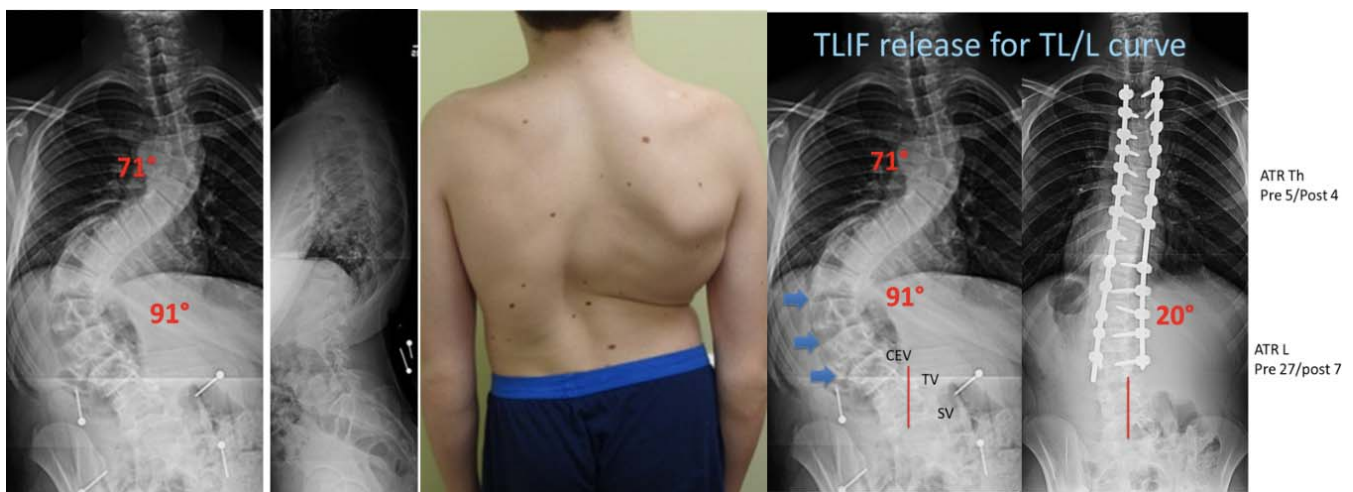
be used to derotate the spine when biomechanically compared to posterior releases.<sup>22</sup>

Use of anterior approaches for scoliosis either as stand-alone procedures or in combination with posterior surgery has declined because of associated pulmonary or other approach-related morbidity. Anterior stand-alone procedures for thoracolumbar curvatures have been associated with shorter fusions and more cephalad LIV than posterior procedures.<sup>12,23–25</sup> Matched comparisons between anterior and posterior approaches in Lenke 5C curves demonstrated equivalent curve correction and reduced hospital stays with the posterior approach versus anterior fusion in moderate thoracolumbar scoliosis.<sup>26</sup> Posterior approaches have been reported to achieve results at least equivalent to those of combined approaches in severe, rigid thoracic scoliosis.<sup>8,27</sup> However, posterior constructs may be associated with more distal fusion that can increase the rate of adjacent segment degeneration, with fusion to L4 associated with a 27% risk of

developing degeneration at 10 years.<sup>21</sup> Criteria for fusion to L3 versus L4 with standard techniques were suggested by Erdem et al.<sup>28</sup>

In this case series of patients with severe rigid thoracolumbar scoliosis, we used a novel technique involving a posterolateral convex disc release followed by posterior instrumentation. PCDR allows for an improved release compared with posterior-only releases and perhaps approaches the benefits of an anterior disc release through a posterolateral approach similar to that used for a TLIF. The increased flexibility attainable through PCDR theoretically can allow for shorter fusion constructs and sparing of distal motion segments as well as improved coronal, sagittal, and axial plane correction, while also avoiding anterior approach-related morbidity.

Although the effects of various releases, including discectomy, facetectomy, and rib head resections, have been investigated in cadavers in the thoracic spine, the amount of curve correction achievable



**Figure 3.** A 17-year-old male patient underwent posterior spinal fusion with posterior column osteotomies and PCDR T12 to L3 with excellent clinical outcomes at 2 years of follow-up. Fusion to CEV, 1 level cephalad to the touched vertebrae.

**Table 2.** Changes in radiographic parameters.

|   | 17 y/M  | 37 y/M  | 28 y/F  | 45 y/F  | Mean        | SD         |
|---|---------|---------|---------|---------|-------------|------------|
| Preoperative main thoracic, ° (% flexibility) | 71 (24) | 44 (16) | 71 (25) | 48 (25) | 58.5 (22.5) | 14.5 (4.4) |
| Postoperative main thoracic, ° (% correction) | 27 (62) | 20 (55) | 15 (79) | 18 (63) | 20 (64.8)   | 5.1 (10.1) |
| Preoperative thoracolumbar, ° (% flexibility) | 91 (20) | 78 (33) | 71 (38) | 69 (31) | 77.3 (30.5) | 9.9 (7.6)  |
| Postoperative thoracolumbar, ° (% correction) | 20 (78) | 29 (63) | 20 (72) | 18 (74) | 21.8 (71.8) | 4.9 (6.3)  |
| Preoperative lordosis, °                      | 58      | 40      | 71      | 59      | 57          | 12.78      |
| Postoperative lordosis, °                     | 52      | 48      | 68      | 63      | 57.8        | 9.32       |
| CEV   | L3      | L3      | L4      | L4      |             |            |
| Touched vertebra                              | L4      | L4      | L3      | L4      |             |            |
| Stable vertebra                               | L5      | L5      | L5      | L5      |             |            |
| LIV   | L3      | L4      | L3      | L4      |             |            |
| Distal fusion level saved                     | Yes     |         | Yes     |         |             |            |

with unilateral facetectomy and discectomy in multiple levels in the thoracolumbar spine has yet to be established.<sup>29</sup> Anterior disc release has been shown to significantly increase flexibility and decrease spinal stiffness in cadaveric and animal models.<sup>30–31</sup>

PCDR was able to restore global coronal and sagittal alignment for all 4 patients in this case series at most recent follow-up, with minimal complications. Correction of the major curvature from a mean of 77.3° to 21.8° (approximately 71.8%) was achieved using PCDR. This is comparable to the range of coronal correction achieved by standard anterior and posterior fusions reported in the current literature from 32% to 85%.<sup>24,32–34</sup> PCDR can be considered an intermediate release for moderately severe curvatures that do not require 3-column osteotomies or a formal anterior release. PCDR has the potential to preserve a distal level, as reported in some anterior procedures, and improves coronal imbalance by 52%.<sup>35–36</sup> A distal fusion level was saved in 2 of our 4 patients: one fused cephalad to the CEV and the other one cephalad of the touched and stable vertebrae. One patient was fused 1 level caudal to the CEV because of the presence of disc degeneration at the intervertebral disc caudal to the CEV. LIV tilt was improved from a preoperative mean of 26.8° to postoperative mean 8.3°, LIV

translation from 2.5 to 1.2 cm. No significant complications lasting beyond 3 months occurred.

Reducing the number of fused levels maximizes spinal flexibility and distributes stress across more distal lumbar motion segments, potentially diminishing adjacent segment disc degeneration.<sup>10</sup> Minimizing the loss of lumbar motion can theoretically reduce the risk of lumbar degeneration or pain. Several biomechanical studies have shown that posterior spinal fusion constructs for thoracolumbar deformity that extend to the lumbar spine can increase the rate of adjacent segment deformity and late back pain.<sup>7,21,37,38</sup> In this series, the LIV was L3 in 2 patients and L4 in 2 patients. A distal vertebral level was saved in the 28-year-old patient with an LIV of L3 and a CEV of L4. Ideally, fusion constructs should avoid extension beyond L3 to avoid an increased risk of disc degeneration, assuming the remaining unfused caudal motion segments are healthy preoperatively.<sup>21</sup> Ten-year disc degeneration in AIS has been reported, and an LIV of L4, disc wedging caudad to the LIV  $\geq 5$ , and LIV translation  $\geq 2$  cm were found to be risk factors for disc degeneration.<sup>21</sup> In the current PCDR series, LIV translation was adequately reduced, although LIV tilt was slightly greater than the targeted goal of 5° or less. In this case series we showed initial clinical feasibility for this procedure to be able to

**Table 3.** Changes in measurements.

|                                     | 17 y/M | 37 y/M | 28 y/F | 45 y/F | Mean | SD  |
|-------------------------------------|--------|--------|--------|--------|------|-----|
| Coronal imbalance preoperative, cm  | 0.97   | 2.7    | 1.09   | 0.85   | 1.4  | 0.9 |
| Coronal imbalance postoperative, cm | 0.27   | 0.67   | 0.94   | 0.8    | 0.67 | 0.3 |
| LIV tilt                            | 37     | 28     | 27     | 15     | 26.8 | 9.0 |
| LIV tilt                            | 7      | 10     | 9      | 7      | 8.3  | 1.5 |
| LIV translation preoperative        | 3.75   | 2.7    | 2.41   | 1.19   | 2.5  | 1.1 |
| LIV translation postoperative       | 1.4    | 1.53   | 1.76   | 0      | 1.2  | 0.8 |
| Thoracic ATR preoperative           | 5      | NC     | 18     | 5      | 9.3  | 7.5 |
| Thoracic ATR postoperative          | 6      | 4      | 9      | 0      | 4.8  | 3.8 |
| Thoracolumbar ATR preoperative      | 27     | 30     | 15     | 26     | 24.5 | 6.6 |
| Thoracolumbar ATR postoperative     | 6      | 2      | 1      | 7      | 4    | 3.0 |

Abbreviation: NC, not collected.

save a distal fusion level compared with other techniques. However, because of the limited cases evaluated, we have not shown an ability to routinely save a distal fusion level, and this would require further study with a larger cohort and more extensive follow-up to determine whether long-term outcomes are comparable to those of other techniques.

PCDR has low morbidity in the milieu of techniques to release the spine. A posterior corridor is used, taking advantage of the rotation of the vertebral segment, which delivers the lateral disc and the anterior longitudinal ligament more posteriorly along the convexity of the curvature. At the same time, the spinal cord and/or cauda equina deviate toward the concavity and further away from the operative field. There are potential risks involved with PCDR. Complications were minimal in our series. One patient did experience dysesthesias in the lower extremity on the side of the PCDR, which resolved completely after 2 months and was likely related to irritation of the dorsal root ganglion of an operated segment. Potential drawbacks of this approach include incomplete restoration of lordosis compared with anterior approaches with the use of a structural graft. We have not used this technique to add structural grafts or synthetic structural support, although that could be performed, particularly at the caudal end of the construct to preserve lordosis and stability of the distal segment pedicular fixation. Lumbar lordosis was well maintained in our patients. Other potential complications include durotomy or injury to either viscera or anterior blood vessels when performing the discectomy. The exiting foraminal nerve root is at potential risk, particularly as the root descends and traverses the disc space. We have used a retractor for the exiting and traversing nerve root and a small ribbon malleable retractor to protect the viscera during the release, and this is an area ripe for further development of instruments to facilitate this approach.

In conclusion, severe, rigid thoracolumbar scoliosis may be a challenge to treat in order to achieve optimal 3-dimensional correction while minimizing fusion levels and avoiding procedural morbidity. PCDR is a novel technique that may facilitate this correction with minimal procedure-related morbidity. PCDR appears to be effective as an adjunct procedure to achieve 3-dimensional correction of the thoracolumbar spine without the associated

approach-related morbidity of anterior approaches, using a very familiar TLIF approach to achieve disc release. In this series, the procedure was effective in restoring coronal, axial, and sagittal alignment, and it may facilitate saving a distal fusion level in some cases without the addition of a separate anterior exposure. Clinical results have been excellent, with presumed improved correction compared with posterior-only approaches. Further study of this technique is required, including cadaveric biomechanical studies to compare the release to other approaches, development of improved retractors to prevent injury to exiting nerve roots, development of this approach in the thoracic spine, and future studies comparing this technique with a control group without PCDR or with anterior or lateral approaches.

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