SPINAL CORD STIMULATOR

PRE-PROCEDURE DIAGNOSIS:
1) __**A**__

POST-PROCEDURE DIAGNOSIS: Same as above

PROCEDURE:
1) Insertion of spinal cord stimulator leads x 2
2) Initial programming of device
3) Fluoroscopic needle guidance

PHYSICIAN:

ASSISTANT: None

LOCAL ANESTHETIC INJECTED: 7 mL of 1% lidocaine per needle site.

MEDICATIONS INJECTED: None

SEDATION MEDICATIONS: __**B**__

ESTIMATED BLOOD LOSS: None

COMPLICATIONS: None

Time-out was taken to identify the correct patient, procedure and side prior to starting the procedure.

TECHNIQUE: The patient was positioned prone on the fluoroscopy table. The patient was prepped and draped in the usual sterile fashion using DuraPrep and a fenestrated drape. Routine vital sign monitors were applied and anesthesia was initiated. The patient remained conversant throughout the procedure.

The area to be injected was determined using fluoroscopy. Local anesthetic was given by raising a skin wheal and going down to the hub of a 27-gauge 1.25-inch needle. The 25-gauge 3.5-inch needle was used to anesthetize down to just short of the ligamentum flavum to be entered. A 14-gauge Tuohy needle was then advanced to contact the right __**C**__ lamina. It was walked off in a superior medial direction until it entered the epidural space using loss of resistance to saline and air. The Boston Scientific spinal cord stimulator lead was advanced through the Tuohy needle and directed to rest the tip at the __**D**__. The same procedure was repeated in detail for the left side to insert a second lead

within the epidural space to reside adjacent to the first lead. The patient was allowed to fully awaken from anesthesia. Testing was carried out by the device representative under the guidance of Dr. Christopher Faubel. Once the leads were assured to be in the correct position and coverage of stimulation was sufficient per the patient and the rep, the needles were withdrawn leaving the leads in place and were then secured to the patient's skin using Stay-Fix adhesive bandages and Tegaderm. The patient's back was cleaned. The patient was allowed to fully recover from anesthesia and taken to the recovery room in good position.

The procedure was completed without complications and was tolerated well. The patient was monitored after the procedure. Final stimulation programming and testing of the device was done in the recovery room by the device representative. The patient (or responsible party) was given post-procedure and discharge instructions to follow at home. The patient was discharged in stable condition. A follow-up appointment was made.

Pre-procedure pain score: 9/10

Post-procedure pain score: 0/10

Notes: Talk about relief since last injection, or any interim events if you haven't seen them in clinic since the last injection, or improved function examples. Maybe mention a particular positioning change for that patient or that they were especially sensitive to the lidocaine sticks. Add anything that will help you on your next injections.