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MAGNETIC RESONANCE IMAGING

RADIOLOGY ASSOCIATES
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X-RAY ASSOCIATES
OF NEW MEXICO, P.C.

RADIOLOGY REPORT

Pa _____ Exam Date 12-9-92

File # R16943 Referring Doctor(s) _____ Location AIC

MRI OF THE LUMBAR SPINE:

Comparison is made with an exam from 3-27-92. Multiple T1 and dual echo T2 weighted sagittal and axial sequences of the lumbar spine were obtained. Additional sagittal and axial T1 weighted images were performed, prior to and following administration of intravenous gadolinium. The patient, again, demonstrates evidence of a lower lumbar fusion. In the interval, he has had a left laminectomy at the L4 level. There is a large fluid collection originating from the laminectomy defect in an epidural location, extending dorsal to the neural canal, consistent with a fairly large pseudomeningocele. A small collection of epidural fluid is located in the left lateral recess at the L4 level and is possibly producing pressure upon the exiting nerve root. The previously described disc herniation at the L3-4 level is again noted and is essentially unchanged. Also, at the L4-5 level, a central broad disc protrusion is again noted and is unchanged. I do not identify any significant contrast enhancement on the post gadolinium images to suggest significant epidural fibrosis. The lumbar vertebral bodies demonstrate inhomogeneous marrow, consistent with degenerative change. Dr. aware of these findings.

IMPRESSION:
Postoperative changes of a left laminectomy at the L4 level, with development of a fairly extensive pseudomeningocele. A portion of the epidural fluid is contained within the left lateral recess at the L4 level. No significant interval change in the previously described disc abnormalities at the L3-4 and L4-5 levels. No significant epidural fibrosis.

724.4

, MD

RAV/blm
EXAM DATE: 12-9-92
DICTATED DATE: 12-9-92
TRANSCRIBED DATE: 12-9-92
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DISCHARGE SUMMARY

FINAL DIAGNOSIS:
Pseudomeningocele, secondary to lumbar laminectomy.

PROCEDURE DONE:
Laminectomy wound revision, with closure of pseudomeningocele.

SUMMARY:
This patient underwent lumbar decompression by in August, with relief of his presenting symptoms. After a couple of weeks he began to develop a different pain, lower down, more towards the left, a pain that has persisted until the present time and limited his ability to get up and about. There were no neurological findings to go along with it, but an MRI scan showed a large collection of spinal fluid issuing from the surgical area, extending into the tissues on the left-hand side, reaching to the level of the deep fascia. The patient did have tenderness to pressure on that. When we did that, he had radiating pain on the left.

At the time of surgery, the wound was revised. A pseudomeningocele was identified and excised after closing its connection with the dural sac with running Surgiloid sutures, and then application of fibrin glue.

The patient was drained for a couple of days and kept on bed rest, then allowed upwards, which he has been able to do with relief of the preoperative complaints, and a sense of well being.

He is discharged on Toradol.

TRANSCRIBED: 12/31/92
9244

ADMITTED: 12/18/92

DISCHARGED: 12/22/92

REPORT: DISCHARGE SUMMARY

At that point we used reverse Trendelenburg as well as increased pressure in the airway to see whether there was leakage and there wasn't. Nonetheless, I opted to reinforce this situation by creating fibrin blue with single donor cryoprecipitate and the appropriate thrombin and calcium. That sealed the entire laminectomy wound. Hemovac was then brought on the surface of the laminas, placed through a stab wound in the muscles. Closure was done with interrupted 0 Vicryl deep and 2-0 subcutaneously and with stitches.

Blood loss estimated at 60 ml. The patient tolerated the procedure well. Sponge and cottonoid counts were correct.

DICTATED: 12/18/92
TRANSCRIBED: 12/23/92
JOB: 8649

ADMITTED: 12/18/92

DISCHARGED:

REPORT: OPERATIVE REPORT

OPERATIVE REPORT

DATE OF OPERATION: 12/18/9/2

PREOPERATIVE DIAGNOSIS: Pseudomeningocele following lumbar laminectomy.

POSTOPERATIVE DIAGNOSIS: Pseudomeningocele following lumbar laminectomy.

PROCEDURE PERFORMED: Repair of pseudomeningocele with wound revision.

ANESTHESIA: General anesthesia with intubation was used and was satisfactory.

DESCRIPTION OF PROCEDURE: The patient was on the Cloward frame, properly padded. The knees and shoulders were properly elevated. Betadine prep was done and the patient was sterilely draped. We reopened the previous surgical incision, carried it down to the level of the tips of the spines. The fascia was started to be dissected from the left hand side. Clear spinal fluid came out and was cultured. I opened it more widely and found myself looking into a big cavity lined with epithelial lining, the bottom of which was the dura with a wrench, thorough which a nuchal of nerve roots protruded. I was able to protect these and easily put them back inside the dural sac with a piece of Gelfoam and they stayed there. They were not incarcerated. I then dissected the meningocele sac away laterally. It would not come off from the spinous processes medially. I therefore then liberated the dura all around from underneath the bone so that there would be slack in it and then a suture with locking stitches of 4-0 Surgiloid.

ADMITTED: 12/18/92

DISCHARGED:

REPORT: OPERATIVE REPORT

PREOPERATIVE HISTORY AND PHYSICAL

is being readmitted for further surgery to his back. He had surgery in August by for some disc problems and lumbar stenosis. During this time, he did have a slight dural tear that was repaired. There was never any open spinal fluid leakage following this. The patient seemed to do all right for a couple of weeks after surgery, but after that, he developed a complaint different from the one that he had prior to surgery. This is a pain felt low down in the buttock area, worse on the left, without radiating sciatica. There has been no localized numbness. The patient has found that lying down tends to make him more comfortable and has spent a lot of time lying down, but even that way, he is not free of some discomfort.

Recently, an MRI scan was done which showed fluid collection coming from the dural region into the tissues on the left side. This has been diagnosis as a pseudomeningocele. The patient has had no evidence of fevers, chills, redness or events suggesting that there is an infection present.

PAST MEDICAL HISTORY: Unchanged. He denies any significant illnesses or allergies to drugs.

PHYSICAL EXAMINATION: The patient is a tall, thin individual who moves about slowly and who seems to be fairly straight forward. Blood pressure is 105/70.

HEENT: Unremarkable.

The patient has herniorrhaphy incisions.

The heart is regular.

Significantly, he has a little fullness to palpation to the left and below the area of his lumbar incision. When I press on that sharply, he gets a radiating sensation down his legs.

ADMITTED:

DISCHARGED:

December 28, 1992

Staples were removed. The incision is healing properly. The patient has limited his activities at my direction but when up exhibits no headache and has had a vast improvement in the symptoms that were plaguing him prior to this last surgery. He is not free of some soreness felt low in the sacroiliac area. He is able to stand up straight without making an effort. For now, we are going to put him on Ibuprofen 800 three times a day and let him gradually pick up steam, see him once more in 2 weeks and perhaps make some recommendations for a more structured rehab program.

January 14, 1993

This patient has no longer had any problems standing up. Unfortunately, he noticed that when he sits after a very short time his buttocks begin to hurt and that goes down to the back of the legs. That is unlike the pain that he had before his second operation. He is not tender over the ischial bursas. He has no problem lying down and he has very little discomfort up walking which is something he could not do before closure of the meningocele. It is very likely that this individual is quite deconditioned seeing his body habitus and after his more recent operation by started out well but then had to cut down activities for a couple of months before he got fixed again. That would have deconditioned him further. He should start on his program of exercises and perhaps should have a more concerted program of physical therapy briefly again. I will ask him to check with Dr. on this matter.

December 15, 1992

This patient is referred by who operated on him on August 27, 1992 for disk problems and "lumbar stenosis". The patient did have a slight dural tear that was repaired. The patient never had any spinal fluid leak after that and did all right for the first two weeks after the surgery. Had mostly low back pain which was eased by the surgery. Then he began to have his present symptom which is not just truly lumbar but is felt in the buttocks area, worse on the left. There is no numbness there. This has been persistent and has forced him to stay down most of the time which he can do because he is retired. He has not lost any strength or feeling. His legs do not bother him. There has been no chills or fever or anything suggesting an infection. MRI scan that was done at Dr. request recently demonstrates a fluid collection adjacent as well as dorsal to the dura on the left side. It has the appearance of a pseudomeningocele and has the same signal intensity as spinal fluid.

Outside of that, the patient's health continues to be well. He does not acknowledge any medical problems, allergies or the like.

The patient is a very tall individual who moves about slowly. He does not exaggerate. His lumbar incision is well healed but there is a slight fullness to palpation to the left of it low down. Percussion over here produces pain to radiate down the left leg. There is some restriction of leg raising on the left. There is no heat or redness over this. The patient has a diminished right knee jerk and diminished to absent bilateral ankle jerks. That dates from surgeries done in 1959 and 1982 when his back was first invaded. Also has incisions for herniorrhaphy. Blood pressure was 105/70. Heart was regular. He is tall and lean of build.

Chances are this man has a pseudomeningocele that will need to be repaired. There is a very remote possibility that this be infected and I have so informed the patient. Preparations for surgery have been made.