

Thompson Techniques:
ADVANCED MIS ALIF ACCESS

"Thompson's Anterior Lumbar Ring System provides a simple, safe, and intuitive platform to achieve consistent midline spine exposure using minimal incision size while affording maximal exposure of the anterior spine."

- Jonathan E. Schoeff, MD, FACS



Jonathan E. Schoeff, MD, FACS

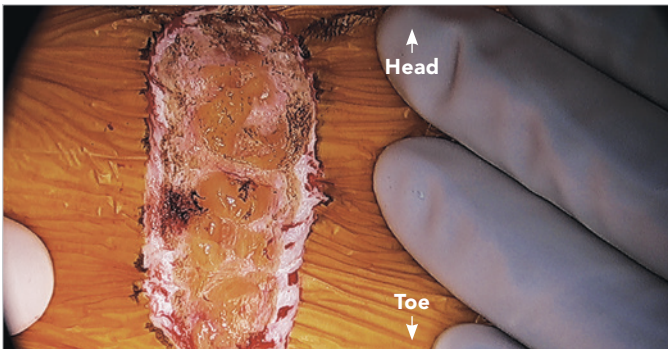
Dr. Schoeff is a board-certified general surgeon, who completed his residency training at the University of Cincinnati. His surgical practice in Denver, CO is dedicated to anterior spine exposure, including lumbar, thoracolumbar, thoracic, and complex revisional cervical. In this era of increasingly subspecialized care, his practice focus on spine exposure has allowed for significant advances in techniques, directed at minimally invasive approaches to the anterior spine.

As a thought leader, educator, and innovator, his understanding of the anterior spine space and the need for safe, effective, and efficient midline spine exposure provided a basis for collaboration with Thompson retractors, the market leader in surgical retractor design. This collaborative effort, which culminated in the Thompson Anterior Lumbar Ring System, represents a significant evolution of the traditional ring frame retractor, aimed at minimizing retractor footprint while maximizing spine exposure, all through small skin incisions with limited tissue trauma.

"In every way, shape, and form, Thompson Retractors are superior."

- Jonathan E. Schoeff, MD, FACS

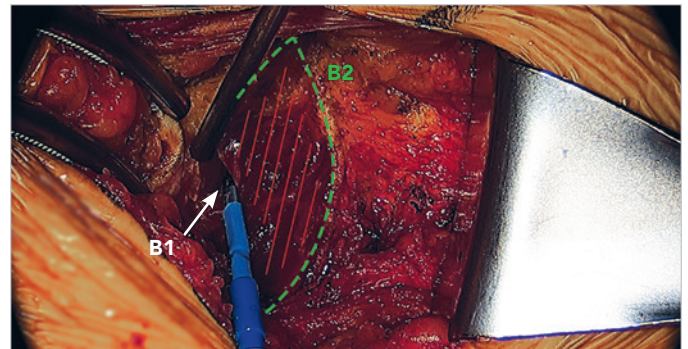
Advanced MIS Technique



Step A: Incision

A knife is used to make a skin incision, usually between 4-6cm in length. It is oriented transversely for the vast majority of single level L5/S1 fusions (bikini cut) and vertically for all fusions above L5 (L4/5, L3/4, etc.) or any multi-level fusions.

TIP: When a pre-existing scar exists, it is preferable to use for skin incision, regardless of orientation.



Step B: Incise Rectus Fascia (anterior rectus sheath)

For vertical skin incisions: Subcutaneous flaps are elevated and a paramedian (most commonly left sided) fascial incision is made with cautery.

For transverse skin incisions: A transverse fascial incision is made, followed by elevation of fascial flaps (Pfannestiel-type dissection).

B1: Exposed Rectus Abdominus

B2: Fascia

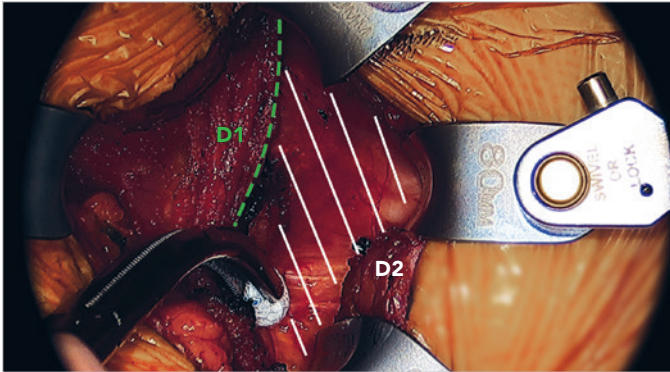


NOTICE

The Thompson Retractor is provided in a non-sterile condition. Reference the Thompson Retractor IFU for cleaning, sterilization, and care instructions, as well as additional warnings and cautions.

Advanced MIS Technique (Continued)

Step C: Set Up Ring Frame as shown in separate Anterior Lumbar Ring User Manual



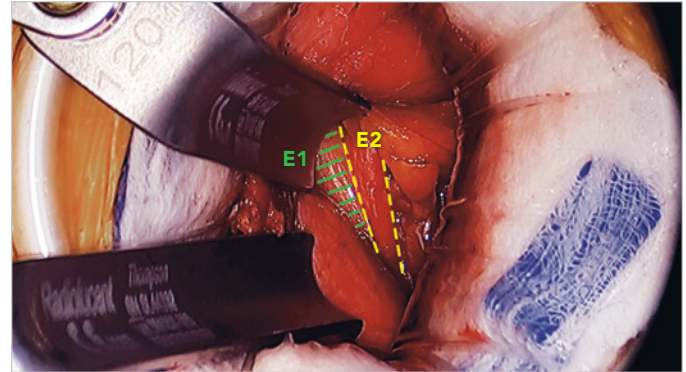
Step D: Mobilize and Retract Rectus

For vertical skin and fascial incisions: The midline attachments of the rectus abdominus muscle are released and the muscle is retracted laterally.

For transverse incisions: The muscle is mobilized in the midline. The muscle is then retracted laterally.

D1: Anterior Rectus Sheath

D2: Posterior Rectus Sheath



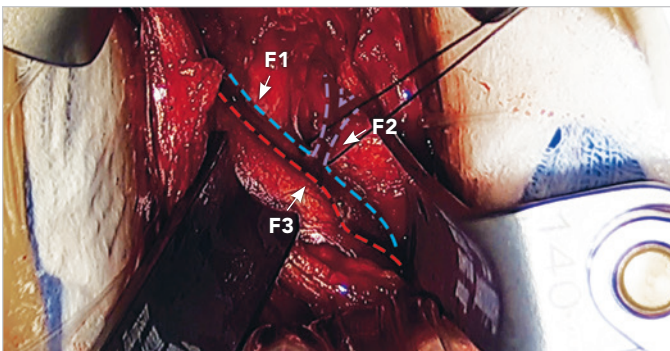
Step E: Mobilize Peritoneum and Ureter

The peritoneal sac is bluntly mobilized from the lateral abdominal wall and retracted medially.

The ureter is also identified, mobilized, and retracted along with the peritoneal sac.

E1: Peritoneum

E2: Ureter



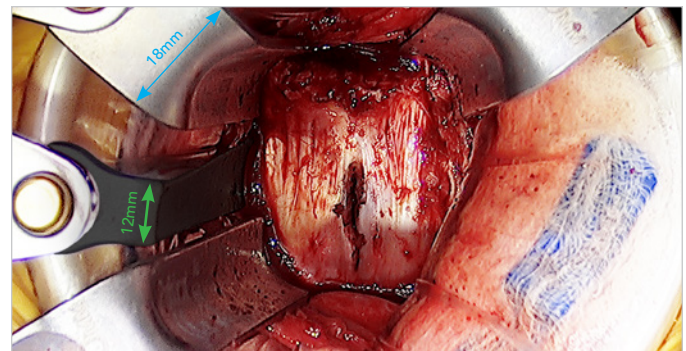
Step F: Mobilize and Retract Vessels

Vessels are mobilized and retracted. During exposure of L4/5 or above, dissection is typically performed along the lateral aspect of the vessels, while dissection of the L5/S1 space typically is performed medial to the iliac vessels. Segmental perforators are ligated.

F1: Left Common Iliac Vein

F2: Early branching ilio-lumbar vein with silk tie proximally

F3: Left Common Iliac Artery



Step G: Finalize Spine Exposure and Mark Midline

Retractors are placed to provide midline spine exposure. The midline of the spine/disc is identified using fluoroscopy and marked with cautery. The spine procedure is then performed.

Step H: Remove Retractor and Close Wound

Retractors are removed and the blood vessels, peritoneum, and ureter are allowed to return to their normal position. Reverse sequence of placement to check vasculature, then soft tissue structures. The wound is then closed using the surgeon's preferred method.

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