

WITHDRAWN: Treatment for Lumbar Spinal Stenosis Secondary to Ligamentum Flavum Hypertrophy Using Percutaneous Endoscopy through Interlaminar Approach: A Retrospective Study

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EDITORIAL NOTE:

The full text of this preprint has been withdrawn by the authors while they make corrections to the work. Therefore, the authors do not wish this work to be cited as a reference. Questions should be directed to the corresponding author.

Abstract

Background: This paper is to describe percutaneous endoscopy in the treatment of lumbar spinal stenosis secondary to ligamentum flavum hypertrophy targeted. To investigate the efficacy and safety of percutaneous endoscopy in the treatment of this kind of lumbar spinal stenosis in elderly patients.

Method: A retrospective analysis of 40 elderly patients with lumbar spinal stenosis secondary to ligamentum flavum hypertrophy admitted between January 2016 and January 2018 was performed. According to different surgical methods, they were divided into two groups: the control group and the endoscopy group (interlaminar approach), 20 people per group. There were 9 males and 11 females in the control group; the age of patients was 65.65 ± 4.44 years, and the average disease duration was 4.55 ± 1.85 years. Besides, There were 10 males and 10 females in the endoscopy group; the age of patients was 67.30 ± 4.23 years, and the average disease duration was 4.95 ± 2.04 years. Collect and count surgical-related indicators, preoperative and postoperative radiologic findings, incision visual analogue scale (VAS), lumbar and leg pain VAS, lumbar Japanese Orthopaedic Association (JOA) and Oswestry disability index (ODI) scores of all patients.

Result: A series of surgical indicators (including the operation time, the quantity of bleeding and postoperative hospital stay) in the endoscopy group was significantly lower than that in the control group ($p < 0.05$). The incision VAS score in the endoscopy group was also significantly lower than that in the control group at each time after surgery ($p < 0.05$). Besides, compared with the control group, in the endoscopy group, the leg pain VAS score and lumbar ODI score after surgery were significantly decreased ($p < 0.05$). Compared with the control group, in the endoscopy group, the lumbar JOA score was significantly higher ($p < 0.05$).

Conclusion: Percutaneous endoscopic technique is a small trauma, quick recovery, safe and effective minimally invasive surgery for patients with lumbar spinal stenosis secondary to ligamentum flavum hypertrophy.

1. Background

Lumbar spinal stenosis is a common bone disease in the elderly and currently recognized by the North American Spine Society as “a clinical syndrome of the buttock or lower extremity pain, which may occur with or without back pain, associated with diminished space available for the neural and vascular elements in the lumbar spine.”(1). There are many causes of lumbar spinal stenosis, which can be divided into congenital and acquired. The latter is secondary to hypertrophy of soft tissue around the bone or (and) the intraspinal and the thickness of ligamentum flavum (LF) plays a major role in the pathogenesis of lumbar spinal stenosis (2-4). The LF covers the lateral and posterior walls of the spinal canal between the second cervical vertebra and the first sacral vertebra. It is composed of connective tissue and is thought to play an important role in establishing the internal stability of the spine, controlling intervertebral movement and maintaining a smooth surface of the posterior dural sac (5). Thickening or

hypertrophy of the LF to a certain extent can also lead to spinal stenosis, and further compression of the intraspinal nerve root or cauda equina, even in the absence of articular process hyperplasia or nucleus pulposus prolapse still can cause the corresponding neural symptoms. At the same time, due to the aging population in China, the incidence of lumbar spinal stenosis has increased significantly, seriously affects the quality of life of patients (6, 7). It often causes pain in the low back and legs, difficulty in walking, paruria and even paraplegia (8). Early patients are usually treated conservatively with NSAIDs, physical therapy, epidural injections, lifestyle improvements, and comprehensive rehabilitation (9, 10) and patients who fail to respond to conservative treatment should be treated with surgery (11, 12). Traditional surgical methods include laminectomy, hemilaminectomy, and lumbar interbody fusion, which focus on complete decompression with significant results. However, the above operative methods may affect the stability of the spine, meanwhile, extensive trauma, postoperative infection, poor wound healing, internal fixation loosening or breakage and other operative complications all make the application of this technology, especially for elderly patients, still have some certain limitations (13). In recent years, the surgical treatment for lumbar spinal stenosis in the elderly tends to be minimally invasive. It has obtained a good clinical result with the development of microsurgery and minimally invasive spine surgery technique. The concept of percutaneous endoscopic lumbar decompression was first proposed by Kambin in 1973 (14), and this kind of technology has gradually matured after continuous improvement of YESS technique and TESSYS technique. On the one hand, this kind of surgery is performed through the interlaminar space or intervertebral foramen, without damaging paravertebral muscles or ligaments or affecting the stability of the spine (15). On the other hand, the skin incisions are small, and the trauma to the patient is little. Besides, percutaneous endoscopic surgery does not affect rescue therapy after surgical failure. There are many studies on the curative effect analysis of spinal endoscopy in the treatment of lumbar spinal stenosis at present, but no studies aiming at lumbar spinal stenosis secondary to LF hypertrophy. This study aims to explore the efficacy and safety of percutaneous endoscopy in the treatment of lumbar spinal stenosis secondary to LF hypertrophy, thus for the application of this technique in this kind of diseases provides a reference.

2. Materials And Methods

2.1 Ethics statement

This retrospective study was approved by the Ethics Committee of The Affiliated Hospital of Hangzhou Normal University, China. Written informed consent was obtained from all patients.

2.2 Subjects

From January 2016 and January 2018, a total of 40 patients with lumbar spinal stenosis secondary to LF hypertrophy admitted to The Affiliated Hospital of Hangzhou Normal University were enrolled in this retrospective study. They were divided into two groups, including the control group, the endoscopy group (interlaminar approach). The demographic features of the patients are shown in Table 1.

Inclusion criteria: 1) Patients with negative preoperative routine iodine allergy test; 2) failed conservative therapy of at least 3 months or symptom aggravation to the extent of being intolerable; 3) the CT and MRI confirmed the lumbar spinal stenosis secondary to LF hypertrophy; 4) patients with radicular pain or intermittent claudication as the main symptom; 5) Patients diagnosed with single segment lumbar spinal stenosis as the main symptoms (L4/5 or L5/S1) (Figure 1).

Exclusion criteria:

1) The imaging examination indicated the multiple stenoses or lateral recess stenosis; 2) patients with lumbar spondylolisthesis; 3) patients with lumbar scoliosis greater than 20°; 4) patients with posterior longitudinal ligament ossification or severe lumbar disc herniation; 5) patients with severe osteoporosis, spinal tuberculosis, spinal infection, various tumors, or other diseases ;

2.3 Surgical methods

Traditional surgery: First, the patients were in the prone position and under general anesthesia. C-arm X-ray was used to locate the lesion, and the incision length of posterior median approach was 7-15 cm with the lesion as the center. Second, the paravertebral muscles were stripped to both sides of the spinous process to fully expose the spinous process, vertebral lamina and articular process of the lesion segment. Then, pedicle screw was screwed in after the screw position, direction and length were confirmed by C-arm X-ray, the spinous process and bilateral partial lamina of lesion segment was excised, the bilateral articular process were retained, and the hypertrophic LF was resected. Because all patients in the study had no significant lumbar disc herniation, none of them needed fusion. Finally, wash the incision, place the negative pressure drainage tube inside the incision, and close the incision in turn.

Percutaneous endoscopic technique: After the successful general anesthesia, the patients were placed in a prone position to keep the abdomen vacant and to create sufficient expansion in the laminae interval space, and the puncture point (the target interlaminar space) was preliminarily located and marked according to the positive and lateral radiographs of the lumbar spine and landmark of body surface preoperatively. After that, the locating needle was inserted at the puncture point to the articular process, and the surgical segment was confirmed under posterior-anterior radiographs after a routine disinfection procedure. Then a longitudinal incision of about 7mm was made on the lateral side of the spinous process to break through the deep fascia, and working cannula and trocar were rotated to the surface of the hypertrophic LF. Follows this, the trocar was removed after lateral perspective to determine the location of the cannula, and the endoscope was inserted through the working cannula until the interlaminar structures and hypertrophied LF were seen (Figure 2). Then, under the assistance of endoscope, part of the vertebral lamina and articular process was properly removed with the variable high-speed power bone drill and vertebral rongeur to fully expose the hypertrophic LF. These hypertrophic LF would be gradually removed from the stop with the tissue forceps, meanwhile, be careful with the adhesion between the hypertrophic LF and the dura mater and nerves until most of the hypertrophic LF is removed. After that, use a nerve hook to release the fiber hyperplasia and inflammatory vessels on the

surface of dural sac and nerve root so that the nerve structure can be decompressed sufficiently. Subsequently, the basal part of the spinous process plasty was performed through the bone drill to the contralateral LF, and the hypertrophic LF was treated with the same method as above. No compression in the nerve root and good self-pulsation indicated the completion of decompression (Figure 3). Finally, adequate hemostasis was achieved by radiofrequency coagulation, followed by removing the working cannula and suture the incision (Figure 4).

2.4 Postoperative treatment and rehabilitation management:

During the treatment, all patients received antibiotic prophylactic treatment and postoperative neurotrophic therapy. And patients in both groups were given non-steroidal anti-inflammatory drugs (NSAIDs) after surgery for postoperative early mobilization. On the second day after the surgery, the patients began to exercise with waist circumference, and strenuous exercise was not advocated. Besides, 1-2 weeks for bed rest mainly, and to resume daily activities and normal work after 3-4 weeks. Also, heavy physical activity, twisting and lifting heavy objects were avoided 12 weeks after the treatment. Finally, waist circumference should be worn when going out or getting up within 3 months after surgery; meanwhile, back muscle training should be performed to avoid lumbar muscle disuse.

2.5 Outcome measures:

MRI and CT were done on the second postoperative day after the surgery (Figure 5). The surgical indicators, including operation time, the quantity of bleeding and postoperative hospital stay were recorded in both groups. At 12h, 24h, 48h and 72h after the operation, the incision pain felt by the patients was evaluated using the visual analog scale (VAS). Besides, one day before the operation and one week, one month, three months, six months and one year after it, the leg pain of patients were evaluated using the VAS. Oswestry Disability Index (ODI) and the Japanese Orthopaedic Association (JOA) Score were recorded one day before the operation, one month, three months, six months, and one year after the operation.

2.6 Statistical analysis

Data were analyzed by SPSS 23.0 statistical analysis software (IBM Corporation, New York, NY), and the measurement data are presented as **S**. The paired t-test was used for self-matching groups. The difference between two groups was compared by the independent sample t-test. The Chi-square test was performed for the qualitative data. Statistical significance was set at P value less than 0.05.

3. Results

3.1 Comparison of patients' basic information between both groups

There were 9 males and 11 females in the control group; the age of patients was 65.65 ± 4.44 years, and the average disease duration was 4.55 ± 1.85 years. Besides, There were 10 males and 10 females in the endoscopy group; the age of patients was 67.30 ± 4.23 years, and the average disease duration was 4.95 ± 2.04 years. There was no significant difference between both groups on the patients' basic information (including age, gender and disease duration) ($p > 0.05$; Table 1).

3.2 Comparison of surgical indicators between both groups

The operation time, the quantity of bleeding and postoperative hospital stay in the control group were 92.90 ± 15.46 min, 194.30 ± 28.61 ml and 9.95 ± 1.96 days, respectively, and those in the endoscopy group were 59.95 ± 11.90 min, 13.55 ± 2.58 ml and 5.15 ± 1.31 days, respectively. Compared with the control group, these surgical indicators were significantly lower ($p < 0.05$; Table 2).

3.3 Comparison of incision VAS score between both groups

The incision VAS score in the control group at 12h, 24h, 48h and 72h after the operation were 8.10 ± 1.12 , 7.50 ± 1.19 , 5.85 ± 1.14 , 3.80 ± 1.28 points, respectively, and these in the endoscopy group were 4.25 ± 1.29 , 3.80 ± 1.20 , 2.85 ± 1.04 , 1.95 ± 1.05 points, respectively. It is not difficult to see that the incision VAS score in the endoscopy group was significantly lower than that in the control group at each time after surgery ($p < 0.05$; Figure 6).

3.4 Comparison of leg pain VAS score between both groups

Before surgery, the leg pain score in the control group and endoscopy group were 8.05 ± 1.15 and 8.15 ± 1.18 points, respectively, with no significant difference between them ($p > 0.05$). After surgery, the leg pain VAS score was gradually decreasing in both groups. Meanwhile, the leg pain VAS score in the control group on one week, one month, three months, six months and one year after the operation were 4.25 ± 1.07 , 3.85 ± 1.04 , 3.30 ± 1.22 , 2.90 ± 1.21 , 2.80 ± 1.20 points, respectively, and these in the endoscopy group were 3.05 ± 1.10 , 2.05 ± 0.94 , 2.00 ± 0.97 , 1.9 ± 0.94 , 1.75 ± 1.21 points, respectively. Thus, the leg pain VAS score in the endoscopy group was significantly lower than that in the control group at each time after surgery ($p < 0.05$; Figure 7).

3.5 Comparison of lumbar ODI and JOA score between both groups

Before surgery, no matter the lumbar ODI score or the lumbar JOA score, there are no significant differences between the control group and the endoscopy group ($p > 0.05$). After surgery, on the one hand, the lumbar JOA score was gradually increasing in both groups; on the other hand, the lumbar ODI score was gradually decreasing in both groups. Also, the lumbar JOA score in the endoscopy group was significantly higher than that in the control group at each time after surgery, and the lumbar ODI score in the endoscopy group was significantly lower than that in the control group at each time after surgery (all $p < 0.05$; Figure 8 and Figure 9).

3.6 Complications

There were no significant intraoperative or postoperative complications in both groups (including dural or neural injury, cerebrospinal fluid leakage, infection, bedsore and so on). Follow-up at one year showed no recurrence, lumbar instability or other symptoms in both groups.

4. Discussion

In recent years, with the improvement of medical condition and living standard, there are more and more older adults, and the number of patients with LSS is also increasing gradually. LSS refers to various forms of the spinal canal, neural canal and intervertebral foramen stenosis, which would compress dural sac, spinal cord or nerve root, and result in the corresponding nerve dysfunction. Intermittent lameness is a typical symptom. According to the anatomical classification, LSS can be divided into the following three types: central type, foraminal type and lateral recess type (16). Meanwhile, the vertebral canal can be divided into four walls: the anterior wall is the vertebral body, intervertebral disc and posterior longitudinal ligament, the posterior wall is the vertebral lamina, articular process and most of LF, and the bilateral walls are pedicle, intervertebral foramen and part of LF. And the focus of this study is the patients with LSS secondary to hypertrophy of LF.

The LF is composed of a large number of elastic fibers, which are nearly vertical, starting at the lower edge of the upper vertebral arch and ending at the superior edge of the next vertebral arch. LF consists of both superficial and deep components. The superficial component of the LF inserts onto the superior edge, and the posterosuperior surface of the caudal lamina, and the deep LF inserts for a variable distance onto the anterosuperior surface of the caudal lamina (17, 18). When the spine is tilted or bent, the LF extends and the tension increases; on the contrary, when the spine is in a neutral position, the LF contracts and normally does not form wrinkles. However, it can cause degeneration, hyperplasia and hypertrophy of LF based on repeated indirect injury and chronic strain; then the LF would squeeze the nerves and cause a local circulatory disturbance. Some studies had suggested that the degree of hypertrophy of LF is positively correlated with chronic low back pain, and it is difficult to relieve (19). In addition, LSS secondary to LF hypertrophy is common in the elderly, and most of them are located in L4/5 level (20-22), which is also consistent with the lesion segments of the patients in this study.

Conservative treatment is often the first choice for such patients, including bed rest, physiotherapy, traction, medication and acupuncture (23-25). The above treatments are symptomatic, but for elderly patients with LSS, the lesions are mostly caused by degeneration of the tissue around the nerve root, and will not be cured by these treatments. At present, there is no enough evidence to recommend any particular type of non-operative treatment for LSS, and most conservative treatments are based on expert advice and treatment experience. Moreover, many studies also revealed that a variety of conservative treatments have limited effects and are prone to relapse (26-31). Therefore, most patients who have failed to respond to conservative management will still choose surgery.

In the past few decades, lumbar interbody fusion has been considered as the standard procedure for the treatment of LSS. Still, the surgical trauma was great, accomplished by the destruction of bone,

increasing the risk of postoperative intervertebral instability (32). Compared with minimally invasive surgery, patients with traditional open surgery showed a longer time of lying in bed, and the incidence of complications was significantly higher, such as pulmonary infection, symptomatic deep venous thrombosis, urinary tract infection and so on (33, 34). More importantly, most of the patients were elderly patients; the above complications would have a greater negative impact. Besides, the normal biomechanics of the spine was changed after fusion, which always limited the movement of the surgical segment and increased the movement and load of the adjacent segment. Thus this type of surgery often caused adjacent segment degeneration, including disc degeneration, spondylolisthesis, adjacent vertebrae fracture and so on (35, 36). In the long run, such surgery often leads to the limitation of lumbar movement and even long-term low back pain due to the loss of the active segment of the patients (37).

Nowadays, the expectation of elderly patients for surgical treatment is not only for relieving pain but also for quick postoperative recovery so that they can be able to return quickly to normal life. As a result, minimally invasive spine surgery technique emerged as the times require (38, 39). The initial indications of minimally invasive spine surgery were limited to lumbar disc herniation, and various types of LSS were contraindications at that time. However, after that, as surgical techniques and instruments improve, the operative indications have gradually extended, and LSS has become one of that. Ahn pointed out that different approaches should be used for different types of LSS: the interlaminar approach is suitable for central canal stenosis to be decompressed thoroughly, lateral recess stenosis can be operated by interlaminar or transforaminal approach, and transforaminal approach can be used for foraminal stenosis (40). In addition, several reports have shown that transforaminal approach is often used in LSS, while interlaminar approach is used in this study for the following reasons: 1) In this study, these patients with LSS were mainly caused by the hypertrophy of LF, and most of the LF was located in the posterior wall of the vertebral canal, so the interlaminar approach was more suitable than the transforaminal approach to decompress the spinal canal; 2) Most of the hypertrophy of ligamentum flavum is at the L4/5 level, and the diseased segments of the patients in this study are at L4/5 or L5/S1, the operation of the transforaminal approach is more difficult because of the influence of the iliac crest; 3) The anatomy of interlaminar approach is closer to that of open surgery, which is more convenient for operation, and reduce the risk of inadvertent iatrogenic injury.

Compared with traditional surgery, the advantages of spinal endoscopy are as follows:

In the process of resecting the ligamentum flavum, only 1~2mm of the upper and lower lamina was removed to maintain spinal stability (41, 42). What's more, in this study, unilateral approach with bilateral decompression was adopted to better maintain the overall stability and provide advantages to the patient in postoperative rehabilitation. It is not difficult to see that patients in the endoscopy group have significantly better scores after surgery, including VAS, ODI and JOA score; b) We had accurate positioning during the surgery so that we could have a definite object in view and make decompression more effective; c) The operative vision was presented on the screen and magnified to several times. Therefore, the nerve would be exposed more clearly for more accurate decompression. d) The minimally invasive surgery could effectively reduce local scar tissue, thereby reducing the probability of iatrogenic

LSS occurrence after the operation (43). e) The continuous perfusion of normal saline during the operation, on the one hand, the water pressure could play the role of local hemostasis and reduce the bleeding volume during the operation effectively, on the other hand, it also played an important role in ensuring a clear field of vision in the process of operation, thus improving the efficiency of operation and reducing the time of operation. It is clear from this study that the endoscopy group was lower than the control group, whether the operation time or the quantity of bleeding.

Although there were no obvious complications in both groups of patients in this study, it did not mean that percutaneous endoscopic decompression would not lead to the occurrence of various complications, such as dural rupture, subdural hematoma, nerve root injury, infection and other complications all might happen (44, 45). According to this research, our experience of achieving better surgical outcomes and effectively guarding against related complications could be concluded as follows. Because the operating space of minimally invasive surgery was relatively small, the operation plan should be made carefully before operation according to the patient's medical history, symptoms, physical examination and various imaging data to ensure the same therapeutic effect as open surgery. Besides that, the incision location was identified by the relative position of the hypertrophic LF and the adjacent vertebral lamina and articular process to avoid unnecessary bone and soft tissue injury. Except for the adequate preoperative preparation, the limited operative space also suggested that we need to operate meticulously, stop bleeding timely and keep the clear operative field, especially in the process of stripping the nerve root or dural sac from the surrounding tissue. Moreover, the process of entering the working cannula should be done in a step-by-step manner. More specifically, before the contralateral decompression, we should ensure that the ipsilateral decompression is completed and the operative field is clear, then tilt the cannula as far as possible, properly remove the basal part of the spinous process so that the cannula can enter the contralateral spinal canal and continue contralateral decompression, and attention should also be paid to the protection of ipsilateral nerve and dural sac during contralateral decompression. Another phase that requires caution is adequate decompression; it requires us to actively deal with other pathological changes that cause LSS such as herniated or free disc and the osteophyte formation of the articulated facet when we remove the hypertrophic LF during the operation. Lastly, the original intention of minimally invasive surgery is safe, effective, less bed rest time and quick recovery, which is in line with the concept of enhanced recovery after surgery (ERAS). Therefore, we gave all patients NSAIDs for analgesia and encouraged patients to get out of bed and walk at the bedside on the first postoperative day, which was not only conducive to postoperative recovery but also helped to reduce the occurrence of postoperative complications.

Despite these promising results, questions remain. First, this study was a retrospective study, and the number of patients in this study was small. Secondly, the follow-up time of this study is not long enough, and the long-term effect remains to be observed. Therefore, larger, prospective, randomized controlled studies with longer treatment periods are our next-step research direction to confirm the results.

5. Conclusion

This retrospective study shows that percutaneous endoscopic technique can be used for the treatment of lumbar spinal stenosis secondary to ligamentum flavum hypertrophy. Furthermore, the operation method has a significant short-term effect and has the advantages of small trauma, quick recovery, safe and effective.

Abbreviations

Lumbar spinal stenosis (LSS); Ligamentum flavum (LF)

Declarations

Ethics approval and consent to participate:

This study was conducted at the Hangzhou Normal University Affiliated Hospital, and permission was obtained from the hospital's Ethics Committee. The authors had to obtain patient consent before enrolling participants in this study.

Consent for publication:

Not applicable.

Availability of data and materials:

The data and materials might be obtained from the corresponding author upon request.

Competing interests:

The authors declare that they have no competing interests.

Funding:

Not applicable.

Authors' contributions:

Y.Liu, Y.Qi and X.Gu contributed to the conception and design of the study, performance of the experiments, data analysis and acquisition, and manuscript writing. D.Diaty and G.Zheng designed the study and analyzed the data. X.Shen and S.Lin contributed to the data acquisition. J.Chen and Y.Song edited the manuscript. All authors read and approved the final manuscript.

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References

1. Tomkins-Lane C, Melloh M, Lurie J, et al. ISSLS Prize Winner: Consensus on the Clinical Diagnosis of Lumbar Spinal Stenosis: Results of an International Delphi Study. *Spine*. 2016;41(15):1239–46.
2. Kim YU, Kong YG, Lee J, et al. Clinical symptoms of lumbar spinal stenosis associated with morphological parameters on magnetic resonance images. *European spine journal: official publication of the European Spine Society, the European Spinal Deformity Society, and the European Section of the Cervical. Spine Research Society*. 2015;24(10):2236–43.
3. Yoshiiwa T, Miyazaki M, Kawano M, Ikeda S, Tsumura H. Analysis of the Relationship between Hypertrophy of the Ligamentum Flavum and Lumbar Segmental Motion with Aging Process. *Asian spine journal*. 2016;10(3):528–35.
4. Benditz A, Sprenger S, Rauch L, et al. Increased pain and sensory hyperinnervation of the ligamentum flavum in patients with lumbar spinal stenosis. *Journal of orthopaedic research: official publication of the Orthopaedic Research Society*. 2019;37(3):737–43.
5. Safak AA, Is M, Sevinc O, et al. The thickness of the ligamentum flavum in relation to age and gender. *Clinical anatomy (New York, NY)*. 2010;23(1):79–83.
6. Nandi J, Chowdhery A. A Randomized Controlled Clinical Trial to Determine the Effectiveness of Caudal Epidural Steroid Injection in Lumbosacral Sciatica. *Journal of clinical diagnostic research: JCDR*. 2017;11(2):RC04–8.
7. Yokosuka J, Oshima Y, Kaneko T, et al. Advantages and disadvantages of posterolateral approach for percutaneous endoscopic lumbar discectomy. *Journal of spine surgery (Hong Kong)*. 2016;2(3):158–66.
8. Ahn Y, Lee SH, Park WM, et al. Percutaneous endoscopic lumbar discectomy for recurrent disc herniation: surgical technique, outcome, and prognostic factors of 43 consecutive cases. *Spine*. 2004;29(16):E326-32.
9. Lurie J, Tomkins-Lane C. Management of lumbar spinal stenosis. *BMJ*. 2016;352:h6234.
10. Inoue G, Miyagi M, Takaso M. Surgical and nonsurgical treatments for lumbar spinal stenosis. *European journal of orthopaedic surgery traumatology: orthopedie traumatologie*. 2016;26(7):695–704.
11. Weinstein JN, Lurie JD, Tosteson TD, et al. Surgical versus nonoperative treatment for lumbar disc herniation: four-year results for the Spine Patient Outcomes Research Trial (SPORT). *Spine*. 2008;33(25):2789–800.
12. Seavey JG, Balazs GC, Steelman T, et al. The effect of preoperative lumbar epidural corticosteroid injection on postoperative infection rate in patients undergoing single-level lumbar decompression. *The spine journal: official journal of the North American Spine Society*. 2017;17(9):1209–14.
13. Lee JC, Kim Y, Soh JW, Shin BJ. Risk factors of adjacent segment disease requiring surgery after lumbar spinal fusion: comparison of posterior lumbar interbody fusion and posterolateral fusion. *Spine*. 2014;39(5):E339-45.
14. Minamide A, Yoshida M, Iwahashi H, et al. Minimally invasive decompression surgery for lumbar spinal stenosis with degenerative scoliosis: Predictive factors of radiographic and clinical outcomes.

- Journal of orthopaedic science: official journal of the Japanese Orthopaedic Association. 2017;22(3):377–83.
15. Lawrence MM, Hayek SM. Minimally invasive lumbar decompression: a treatment for lumbar spinal stenosis. *Curr Opin Anaesthesiol.* 2013;26(5):573–9.
 16. Kim HS, Paudel B, Jang JS, et al. Percutaneous Full Endoscopic Bilateral Lumbar Decompression of Spinal Stenosis Through Uniportal-Contralateral Approach: Techniques and Preliminary Results. *World neurosurgery.* 2017;103:201–9.
 17. Winkler PA, Zausinger S, Milz S, et al. Morphometric studies of the ligamentum flavum: a correlative microanatomical and MRI study of the lumbar spine. *Zentralbl Neurochir.* 2007;68(4):200–4.
 18. Olszewski AD, Yaszemski MJ, White AA. The anatomy of the human lumbar ligamentum flavum. New observations and their surgical importance. *Spine.* 1996;21(20):2307–12.
 19. Munns JJ, Lee JY, Espinoza AA, Orías, et al. Ligamentum flavum hypertrophy in asymptomatic and chronic low back pain subjects. *PloS one.* 2015;10(5):e0128321.
 20. Sairyo K, Biyani A, Goel V, et al. Pathomechanism of ligamentum flavum hypertrophy: a multidisciplinary investigation based on clinical, biomechanical, histologic, and biologic assessments. *Spine.* 2005;30(23):2649–56.
 21. Yabe Y, Hagiwara Y, Ando A, et al. Chondrogenic and fibrotic process in the ligamentum flavum of patients with lumbar spinal canal stenosis. *Spine.* 2015;40(7):429–35.
 22. Kosaka H, Sairyo K, Biyani A, et al. Pathomechanism of loss of elasticity and hypertrophy of lumbar ligamentum flavum in elderly patients with lumbar spinal canal stenosis. *Spine.* 2007;32(25):2805–11.
 23. Ma XL, Zhao XW, Ma JX, et al. Effectiveness of surgery versus conservative treatment for lumbar spinal stenosis: A system review and meta-analysis of randomized controlled trials. *International journal of surgery (London England).* 2017;44:329–38.
 24. Tsubosaka M, Kaneyama S, Yano T, et al. The factors of deterioration in long-term clinical course of lumbar spinal canal stenosis after successful conservative treatment. *J Orthop Surg Res.* 2018;13(1):239.
 25. Zaina F, Tomkins-Lane C, Carragee E, Negrini S. Surgical versus non-surgical treatment for lumbar spinal stenosis. *The Cochrane database of systematic reviews.* 2016(1):CD010264.
 26. Ammendolia C, Stuber KJ, Rok E, et al. Nonoperative treatment for lumbar spinal stenosis with neurogenic claudication. *The Cochrane database of systematic reviews.* 2013(8):CD010712.
 27. Schneider M, Ammendolia C, Murphy D, et al. Comparison of non-surgical treatment methods for patients with lumbar spinal stenosis: protocol for a randomized controlled trial. *Chiropractic manual therapies.* 2014;22:19.
 28. Ammendolia C, Stuber K, de Bruin LK, et al. Nonoperative treatment of lumbar spinal stenosis with neurogenic claudication: a systematic review. *Spine.* 2012;37(10):E609-16.

29. Peng K, Chen L, Peng J, Xing F, Xiang Z. Effects of calcitonin on lumbar spinal stenosis: a systematic review and meta-analysis. *Int J Clin Exp Med*. 2015;8(2):2536–44.
30. Macedo LG, Hum A, Kuleba L, et al. Physical therapy interventions for degenerative lumbar spinal stenosis: a systematic review. *Physical therapy*. 2013;93(12):1646–60.
31. Burgstaller JM, Porchet F, Steurer J, Wertli MM. Arguments for the choice of surgical treatments in patients with lumbar spinal stenosis - a systematic appraisal of randomized controlled trials. *BMC Musculoskelet Disord*. 2015;16:96.
32. Guo S, Sun J, Tang G. Clinical study of bilateral decompression via vertebral lamina fenestration for lumbar interbody fusion in the treatment of lower lumbar instability. *Experimental therapeutic medicine*. 2013;5(3):922–6.
33. Park Y, Seok SO, Lee SB, Ha JW. Minimally Invasive Lumbar Spinal Fusion Is More Effective Than Open Fusion: A Meta-Analysis. *Yonsei Med J*. 2018;59(4):524–38.
34. Wong AP, Smith ZA, Stadler JA, et al. Minimally invasive transforaminal lumbar interbody fusion (MI-TLIF): surgical technique, long-term 4-year prospective outcomes, and complications compared with an open TLIF cohort. *Neurosurg Clin North Am*. 2014;25(2):279–304.
35. Zhang C, Berven SH, Fortin M, Weber MH. Adjacent Segment Degeneration Versus Disease After Lumbar Spine Fusion for Degenerative Pathology: A Systematic Review With Meta-Analysis of the Literature. *Clinical spine surgery*. 2016;29(1):21–9.
36. Ekman P, Möller H, Shalabi A, Yu YX, Hedlund R. A prospective randomised study on the long-term effect of lumbar fusion on adjacent disc degeneration. *European spine journal: official publication of the European Spine Society, the European Spinal Deformity Society, and the European Section of the Cervical. Spine Research Society*. 2009;18(8):1175–86.
37. Glassman SD, Carreon LY, Ghogawala Z, et al. Benefit of Transforaminal Lumbar Interbody Fusion vs Posterolateral Spinal Fusion in Lumbar Spine Disorders: A Propensity-Matched Analysis From the National Neurosurgical Quality and Outcomes Database Registry. *Neurosurgery*. 2016;79(3):397–405.
38. Becker HJ, Nauer S, Porchet F, et al. A novel use of the Spine Tango registry to evaluate selection bias in patient recruitment into clinical studies: an analysis of patients participating in the Lumbar Spinal Stenosis Outcome Study (LSOS). *European spine journal: official publication of the European Spine Society, the European Spinal Deformity Society, and the European Section of the Cervical. Spine Research Society*. 2017;26(2):441–9.
39. Hirsch C, Breque C, Ragot S, et al. Biomechanical study of dynamic changes in L4-L5 foramen surface area in flexion and extension after implantation of four interspinous process devices. *Orthopaedics & traumatology, surgery & research: OTSR*. 2015;101(2):215-9.
40. Y Ahn. Percutaneous endoscopic decompression for lumbar spinal stenosis. *Expert Rev Med Dev*. 2014;11(6):605–16.
41. Hamasaki T, Tanaka N, Kim J, et al. Biomechanical assessment of minimally invasive decompression for lumbar spinal canal stenosis: a cadaver study. *J Spin Disord Tech*.

2009;22(7):486–91.

42. Bresnahan L, Fessler RG, Natarajan RN. Evaluation of change in muscle activity as a result of posterior lumbar spine surgery using a dynamic modeling system. *Spine*. 2010;35(16):E761-7.
43. Strömquist F, Jönsson B, Strömquist B. Dural lesions in decompression for lumbar spinal stenosis: incidence, risk factors and effect on outcome. *European spine journal: official publication of the European Spine Society, the European Spinal Deformity Society, and the European Section of the Cervical. Spine Research Society*. 2012;21(5):825–8.
44. Komp M, Hahn P, Oezdemir S, et al. Bilateral spinal decompression of lumbar central stenosis with the full-endoscopic interlaminar versus microsurgical laminotomy technique: a prospective, randomized, controlled study. *Pain Physician*. 2015;18(1):61–70.
45. Xie TH, Zeng JC, Li ZH, et al. Complications of Lumbar Disc Herniation Following Full-endoscopic Interlaminar Lumbar Discectomy: A Large, Single-Center, Retrospective Study. *Pain Physician*. 2017;20(3):E379-E87.

Tables

Table 1. Comparison of patients' basic information between both groups

	Control group	Endoscopy group
Case (n)	20	20
Male (n)	10	9
Female (n)	10	11
Age (year)	65.65±4.44	67.30±4.23
Average disease duration	4.55±1.85	4.95±2.04
L ₄₋₅ (n)	13	14
L ₅ .S ₁ (n)	7	6

Table 2. Comparison of surgical indicators between both groups

	Control group	Endoscopy group
Operation time (min)	92.90±15.46	59.95±11.90*
the quantity of bleeding (ml)	194.30±28.61	13.55±2.58*
postoperative hospital stay(d)	9.95±1.96	5.15±1.31*

Note: *P<0.05 compared with the control group.

Figures



(a)



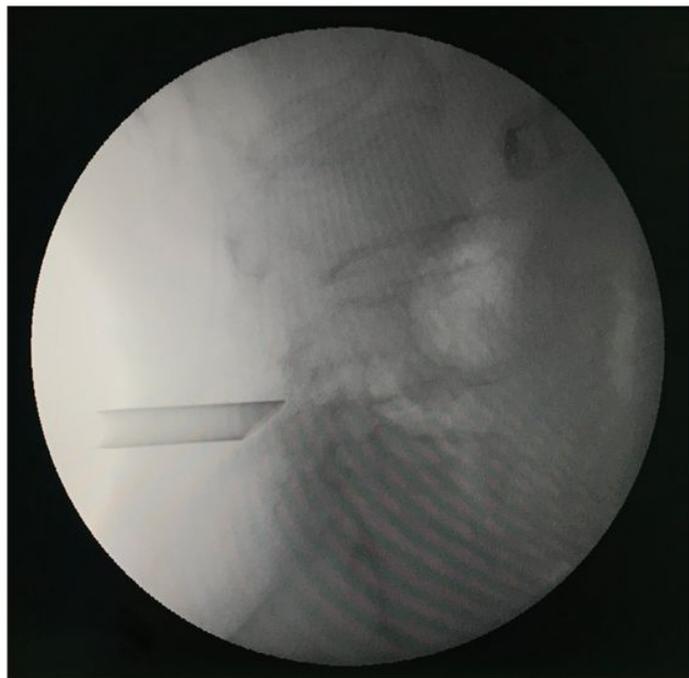
(b)

Figure 1

Preoperative imaging examinations of a case. (a): Preoperative lumbar anteroposterior X-ray. (b): Preoperative T2-weighted lumbar spinal magnetic resonance image demonstrating spinal cord compression at level L4-5 (arrows).



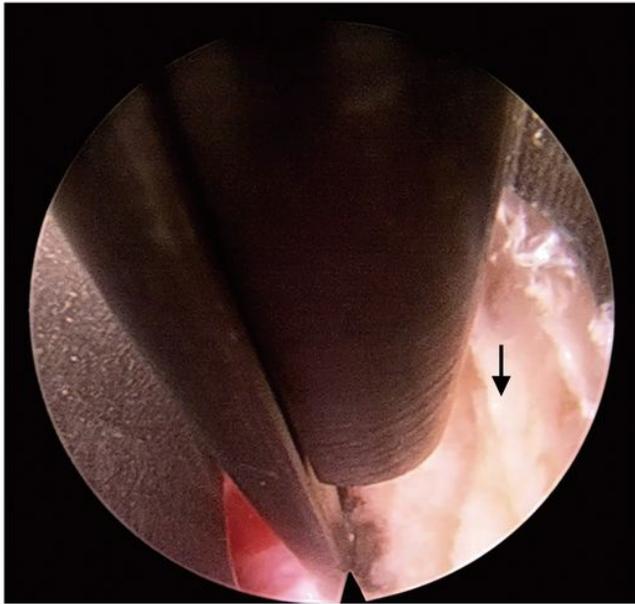
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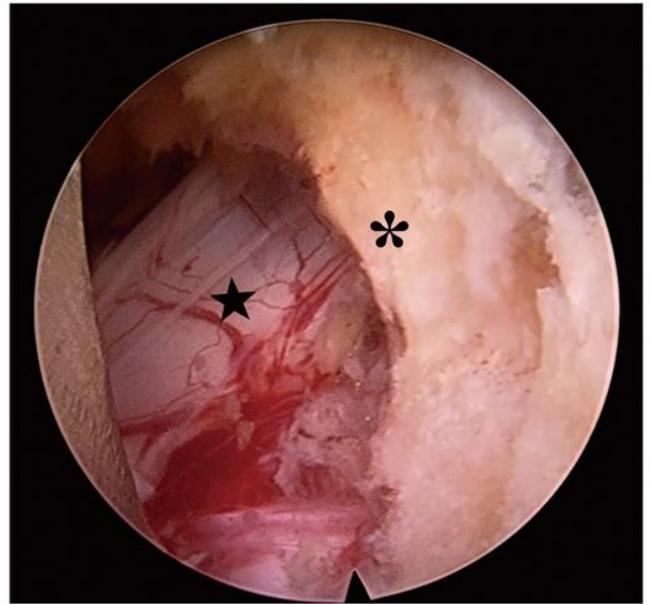
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Figure 2

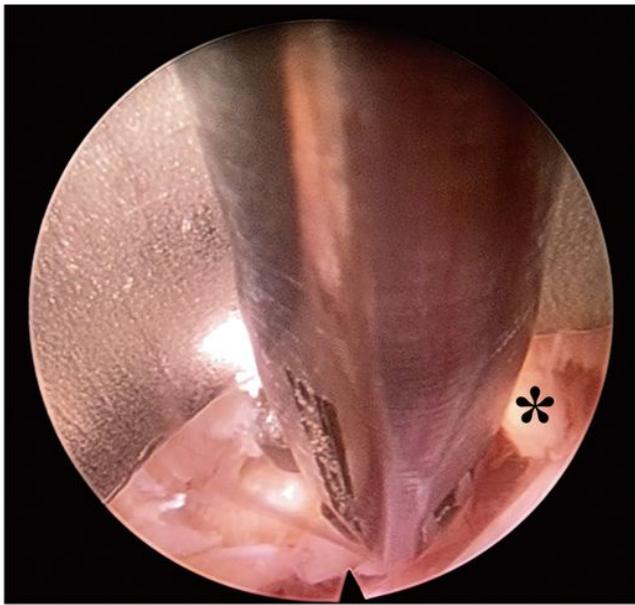
The localization of working cannula. (a), (b):Radiography showing the working cannula has successfully reached the operation area at L4-5 level.



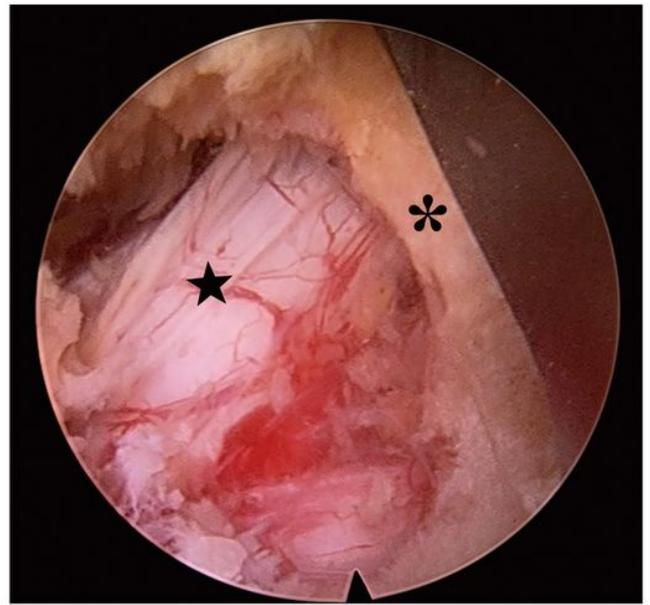
(a)



(b)



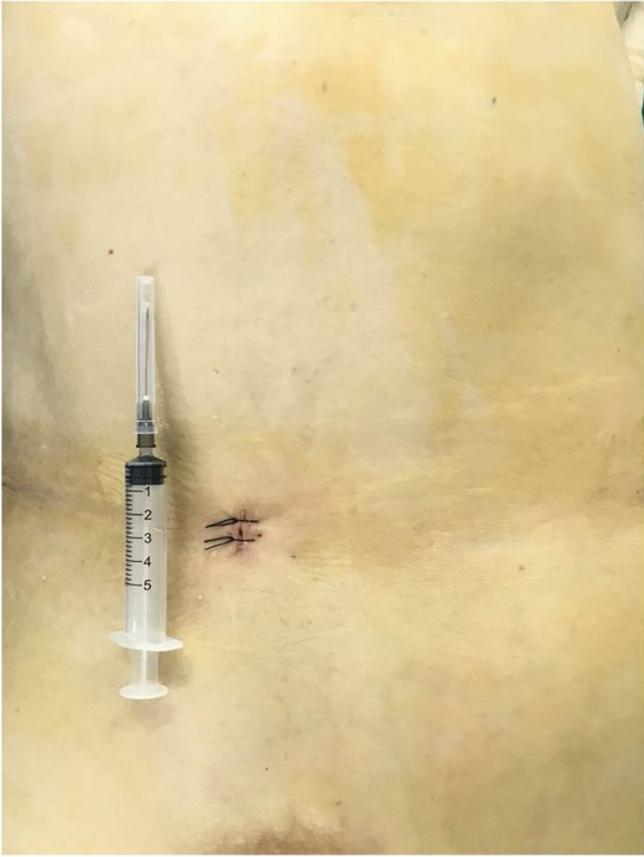
(c)



(d)

Figure 3

Endoscopic views of the surgical procedure. (a): Part of the vertebral lamina and articular process were properly removed with the rongeur to fully expose the hypertrophic LF. (b): Ipsilateral decompression. (c): Hypertrophic LF is gradually removed with the tissue forceps. (d): Contralateral decompression. (pentagrams mean nerve, arrow head means lamina, * ligamentum flavum)



(a)



(b)

Figure 4

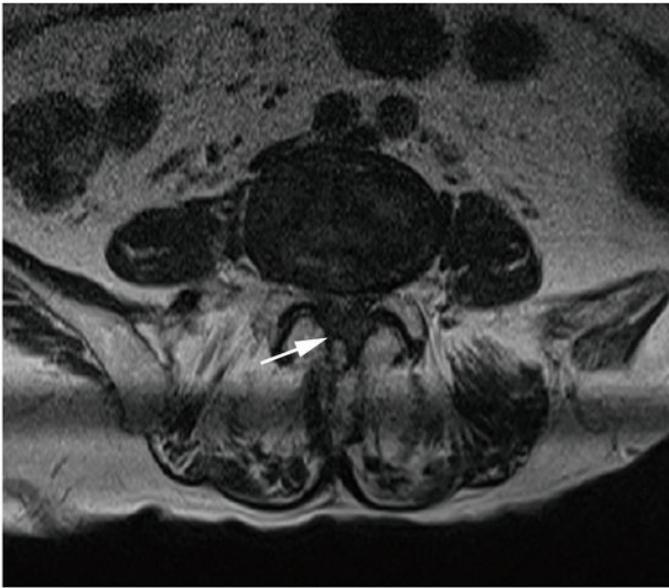
Postoperative wound and specimen. (a): Postoperative wound (b): Ligamentum flavum tissue specimen is removed during surgery.



(a)



(b)



(c)



(d)

Figure 5

The preoperative and postoperative images of a case. (a), (c): Preoperative CT (a) and MRI (c) images showing bilateral hypertrophic LF at the L4-5 level (arrows). (b), (d): Postoperative CT (b) and MRI (d) images showing full bilateral posterior spinal canal decompression at the L4-5 level after the surgery.

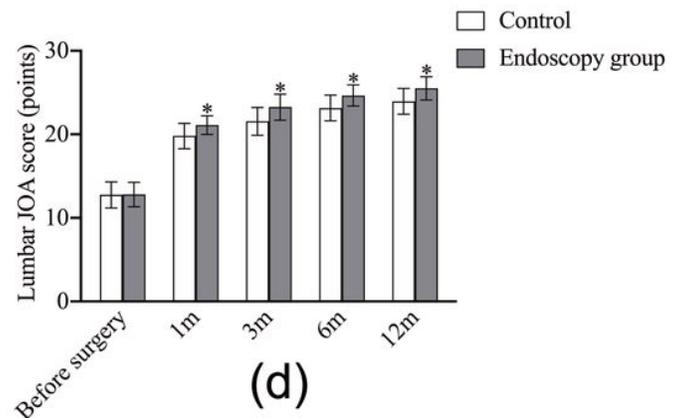
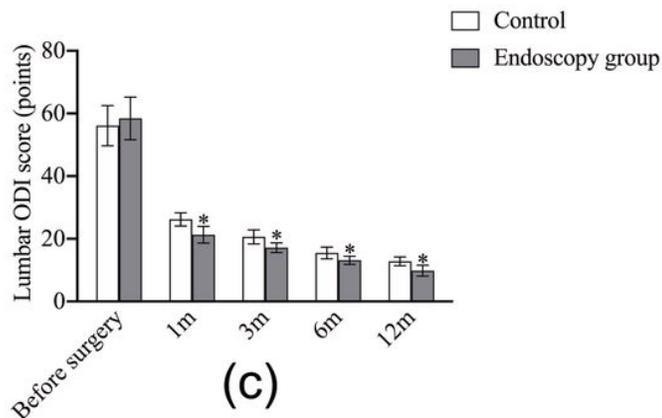
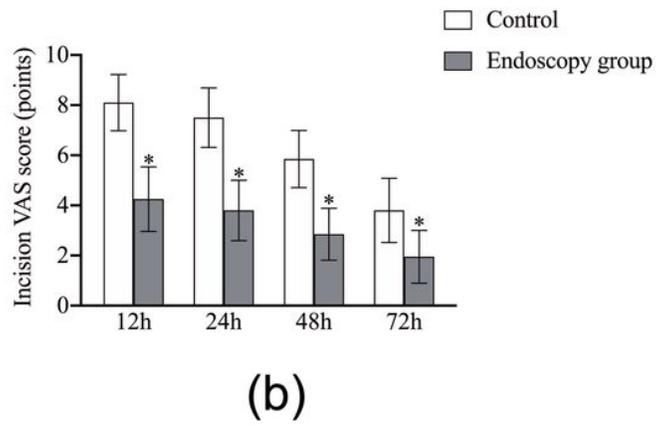
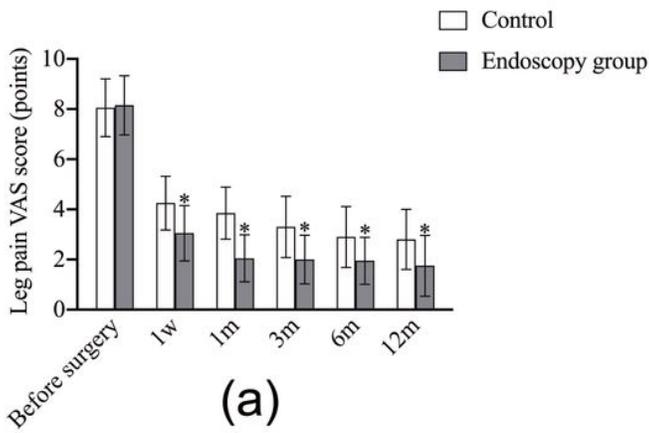


Figure 6

Pre and postoperative various clinical scores. (a): Leg pain VAS score of two groups before operation and at different time points postoperation. (b): Incision VAS score of two groups at different time points postoperation. (c): Lumbar ODI score of two groups before operation and at different time points postoperation. (d): Lumbar JOA score of two groups before operation and at different time points postoperation. (Note: *Compared with the control group, $p < 0.05$)