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REPUBLICATION

(54) **LATERAL RETRACTOR SYSTEM FOR
MINIMIZING MUSCLE DAMAGE IN SPINAL
SURGERY**

Publication Classification

(71) Applicant: **Edward Rustamzadeh**, San Jose, CA
(US)

(72) Inventor: **Edward Rustamzadeh**, San Jose, CA
(US)

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29/00 (2013.01); *A61N 1/00* (2013.01); *A61B*
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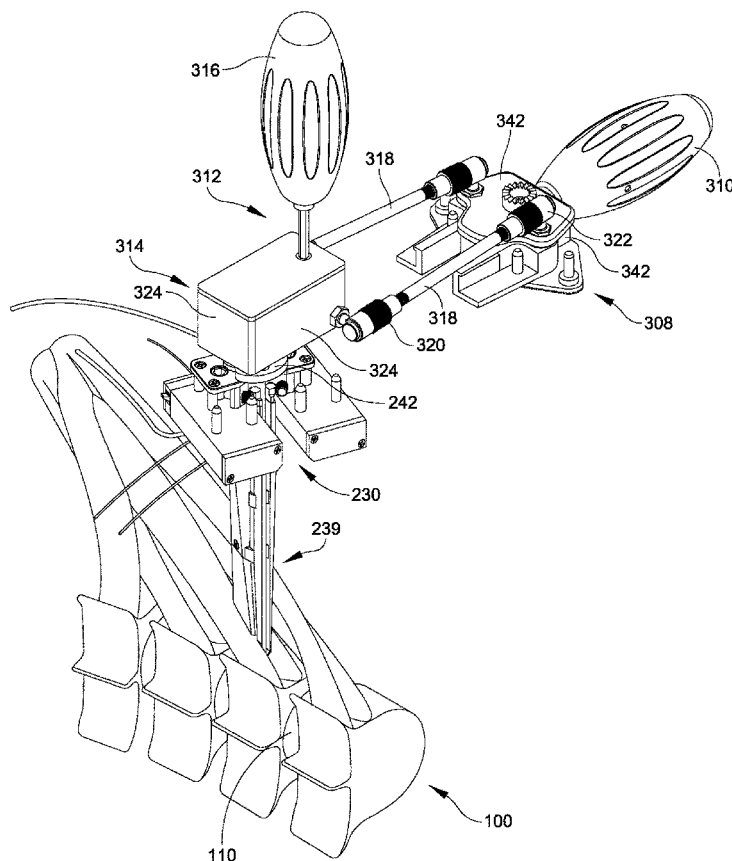
(65) US 2021/0145429 A1 May 20, 2021

Related U.S. Application Data

(60) Continuation-in-part of application No. 16/988,901, filed on Aug. 10, 2020, which is a continuation-in-part of application No. 16/533,368, filed on Aug. 6, 2019, now Pat. No. 10,799,230, which is a continuation of application No. 16/356,494, filed on Mar. 18, 2019, now Pat. No. 10,426,452, which is a division of application No. 16/273,322, filed on Feb. 12, 2019, now Pat. No. 10,363,023.

(57) **ABSTRACT**

A lateral retractor system for forming a pathway to a patient's intervertebral disc space includes a single dilator and a retractable dual-tapered-blade assembly. The dilator may feature a narrow rectangular body for insertion at an insertion orientation parallel to the fibers of the patient's psoas muscle, at an approximate 45-degree angle to the patient's spine. The retractable dual-tapered-blade assembly consists of only two blade subassemblies, each having a blade bordered by adjustable wings, along with built-in lighting and video capabilities. The dual-tapered-blade assembly may be passed over the single dilator at the insertion orientation and rotated approximately 45-50 degrees to a final rotated orientation parallel to the intervertebral disc space before the two blade subassemblies are retracted away from one another to create the surgical pathway, while simultaneously and continuously assessing for encroachment upon one or more nerve structures within 360-degrees of the instrument. Other embodiments are also disclosed.



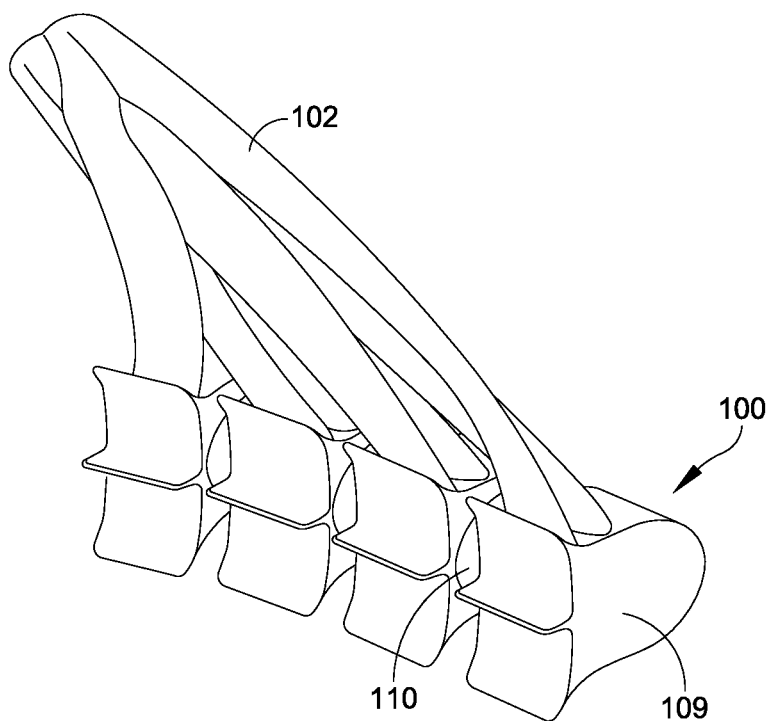


FIG. 1A

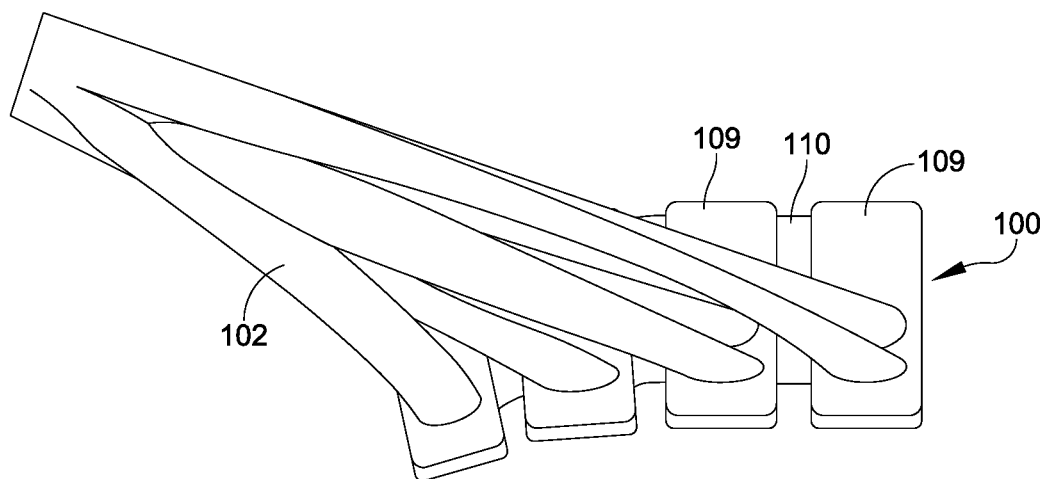


FIG. 1B

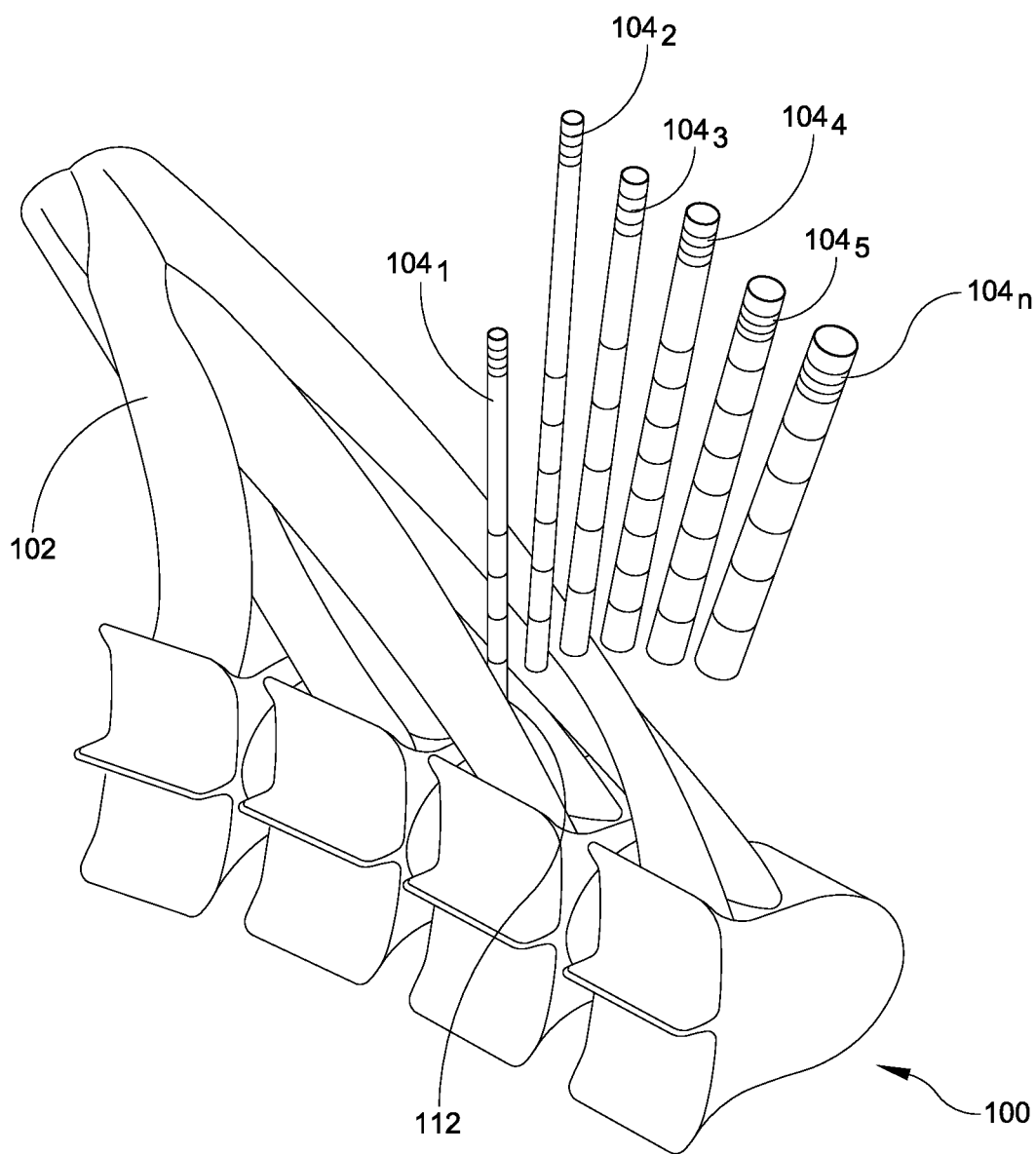


FIG. 2A
(PRIOR ART)

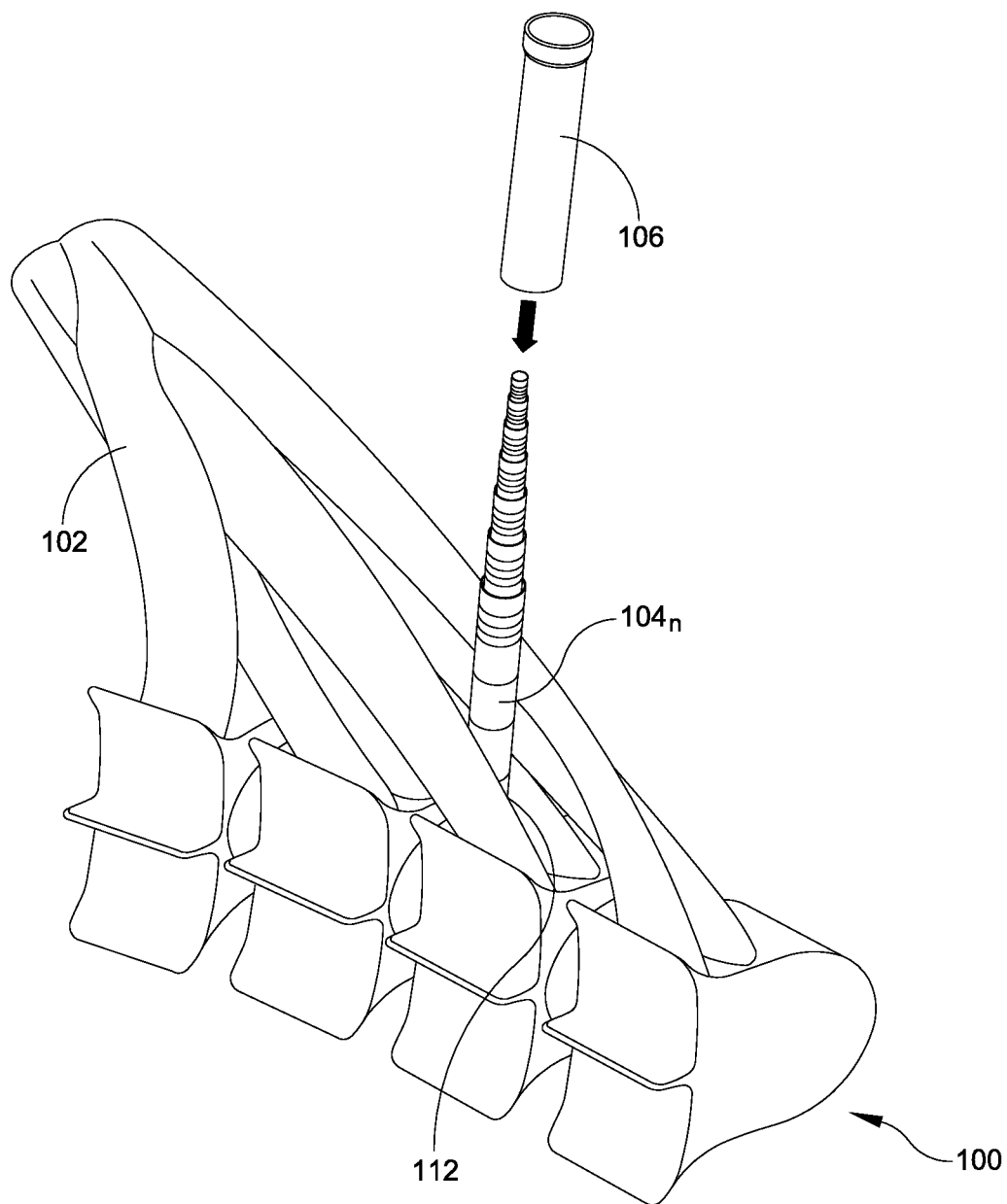


FIG. 2B
(PRIOR ART)

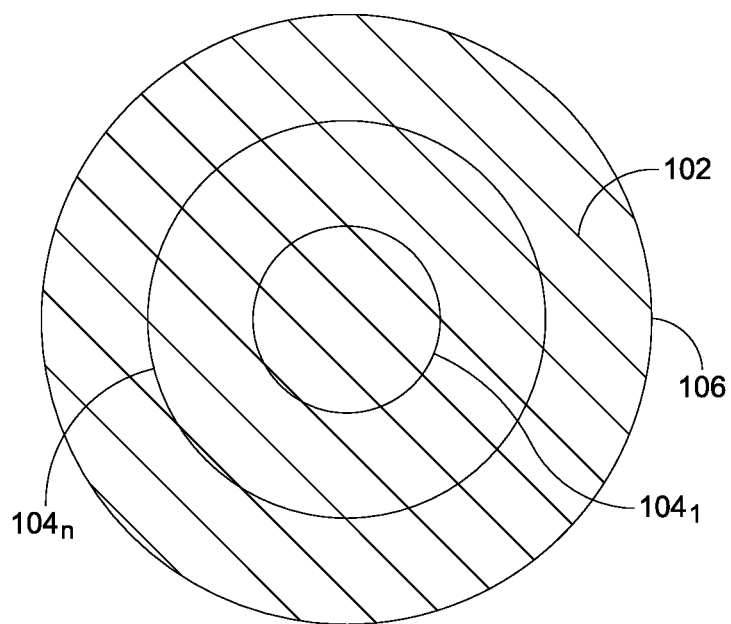


FIG. 3
(PRIOR ART)

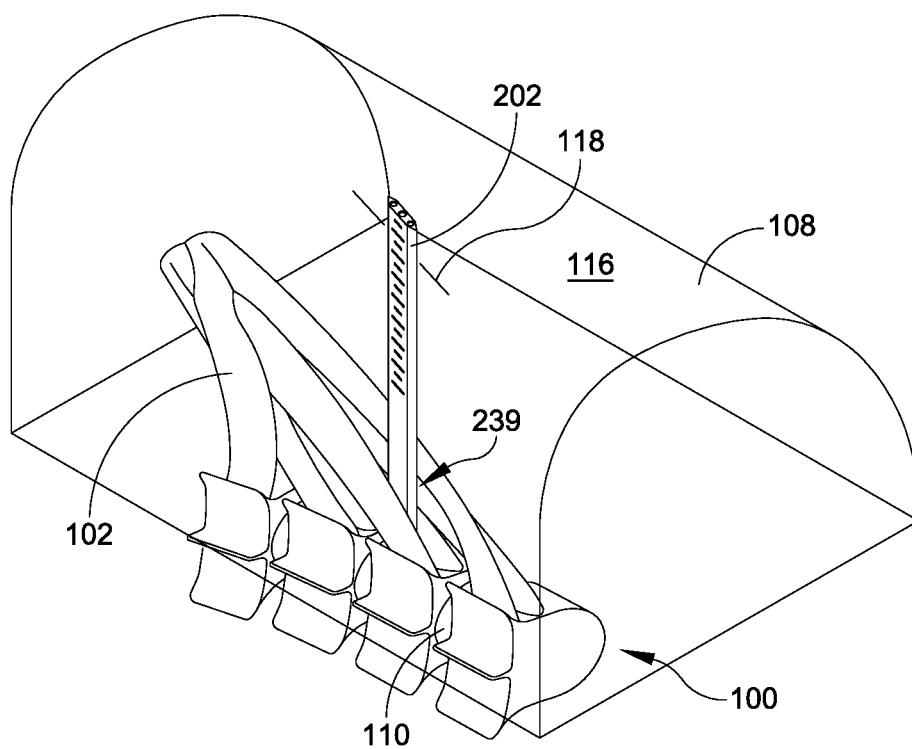


FIG. 4

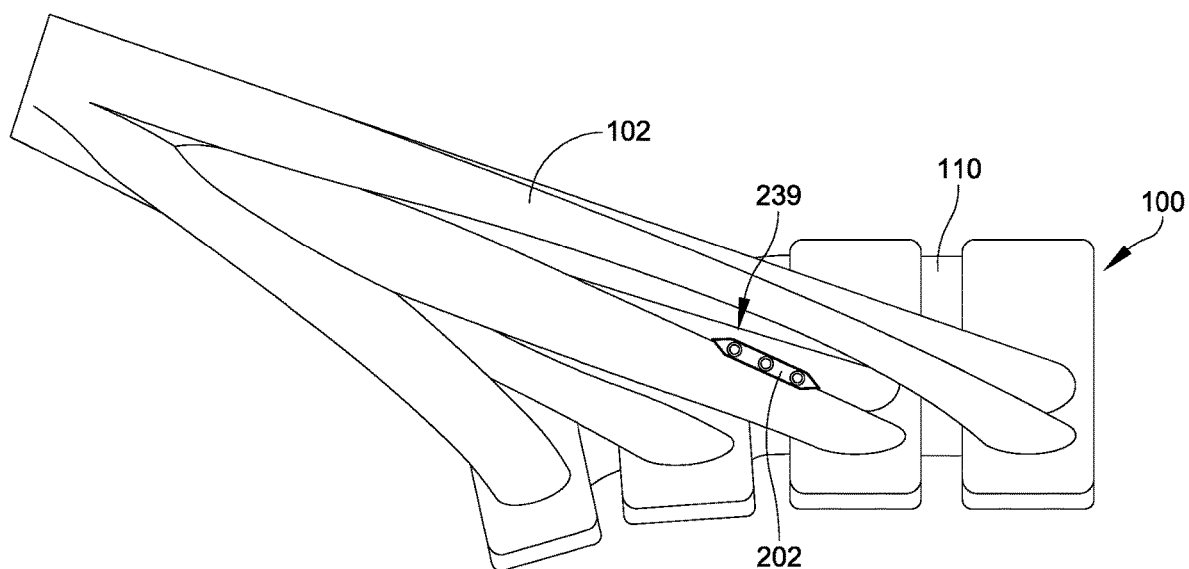


FIG. 5

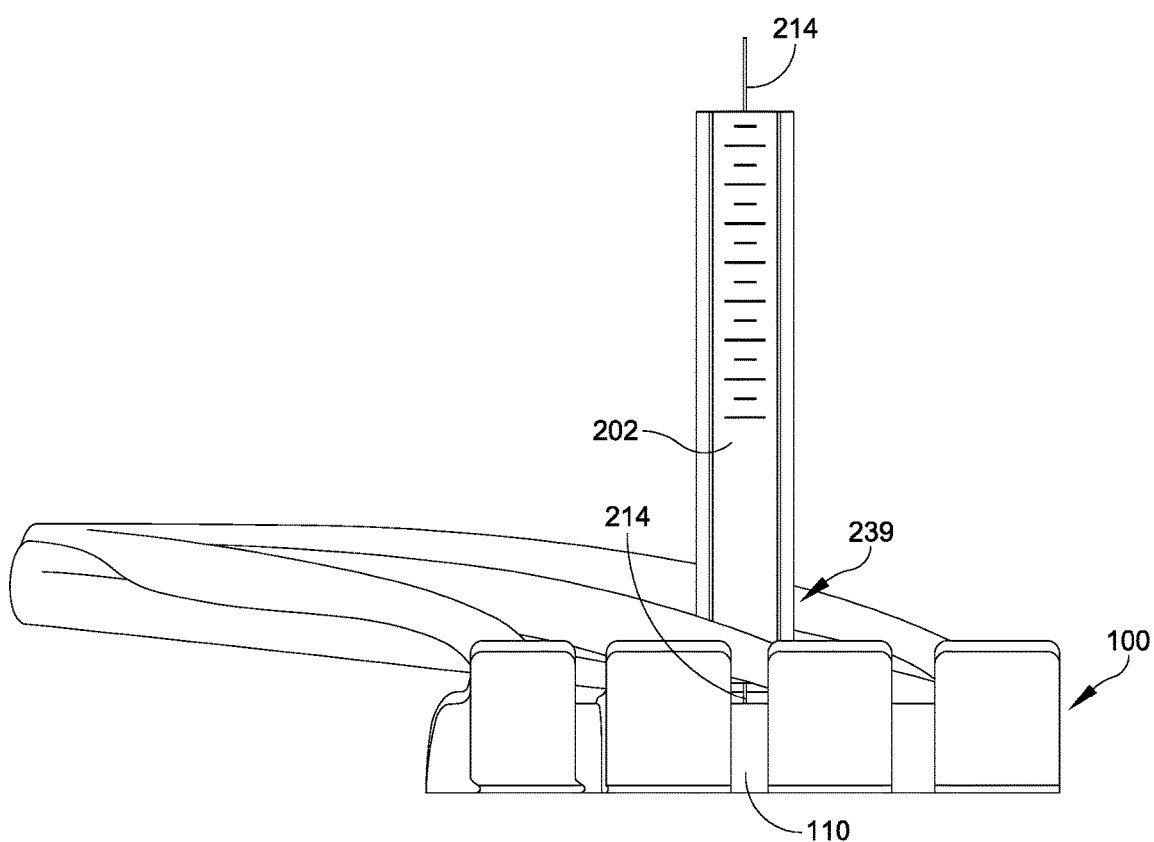


FIG. 6

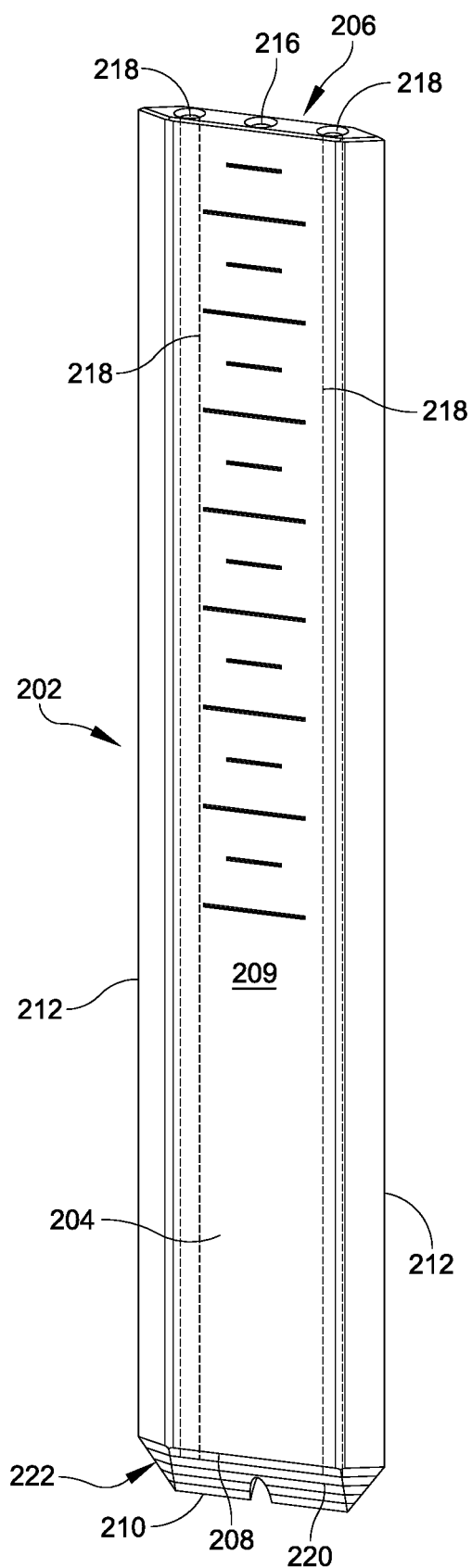


FIG. 7

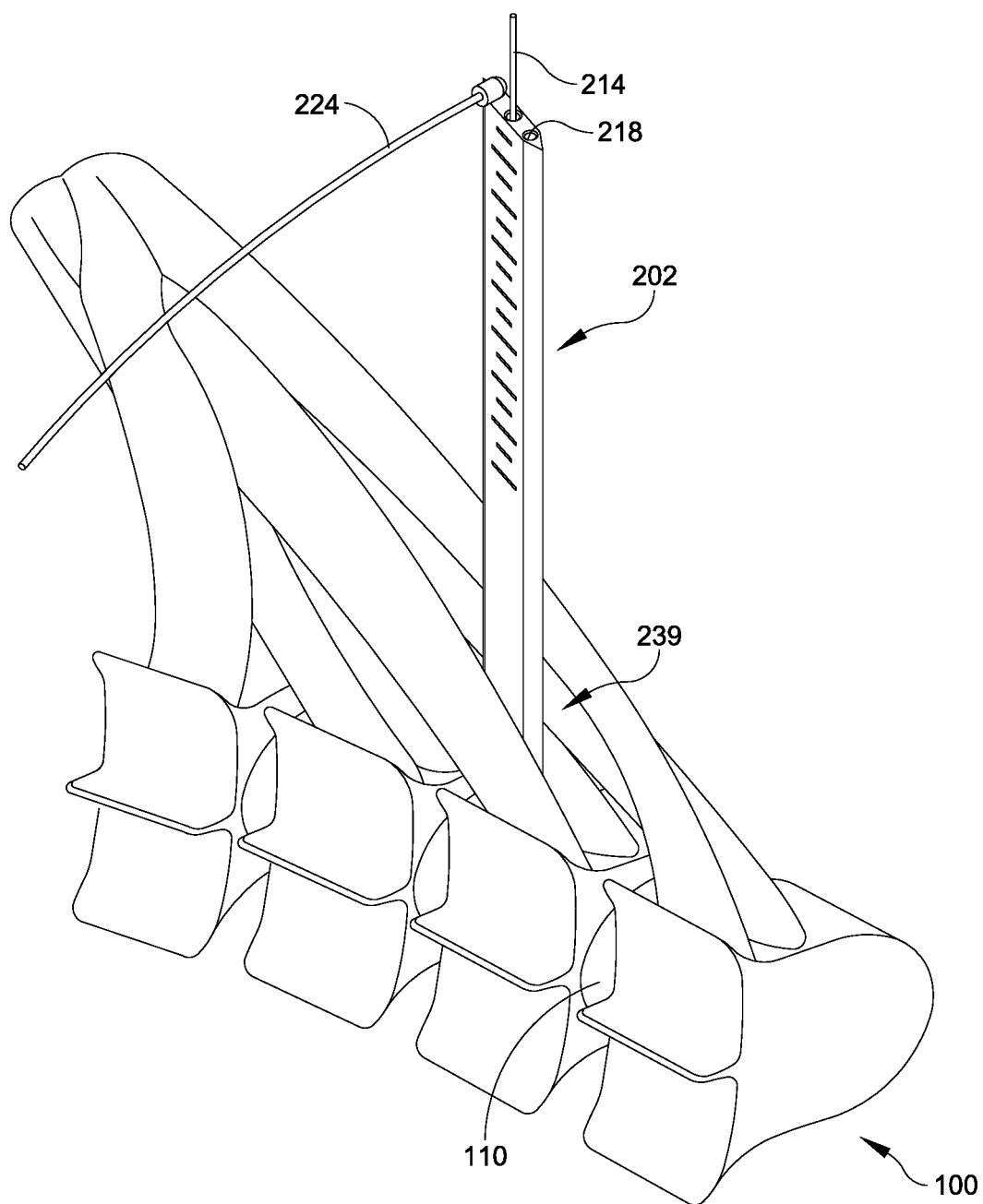


FIG. 8

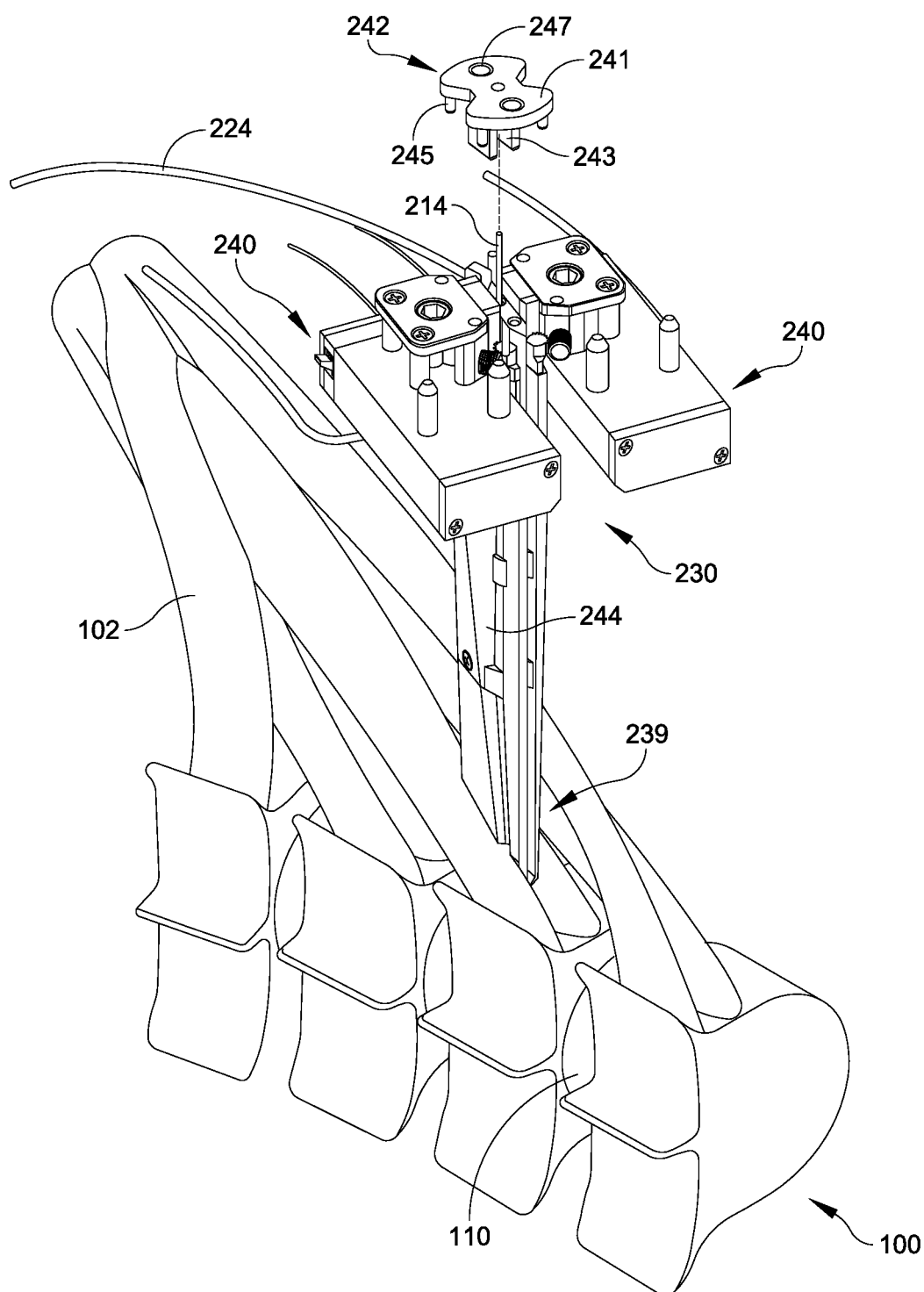


FIG. 9

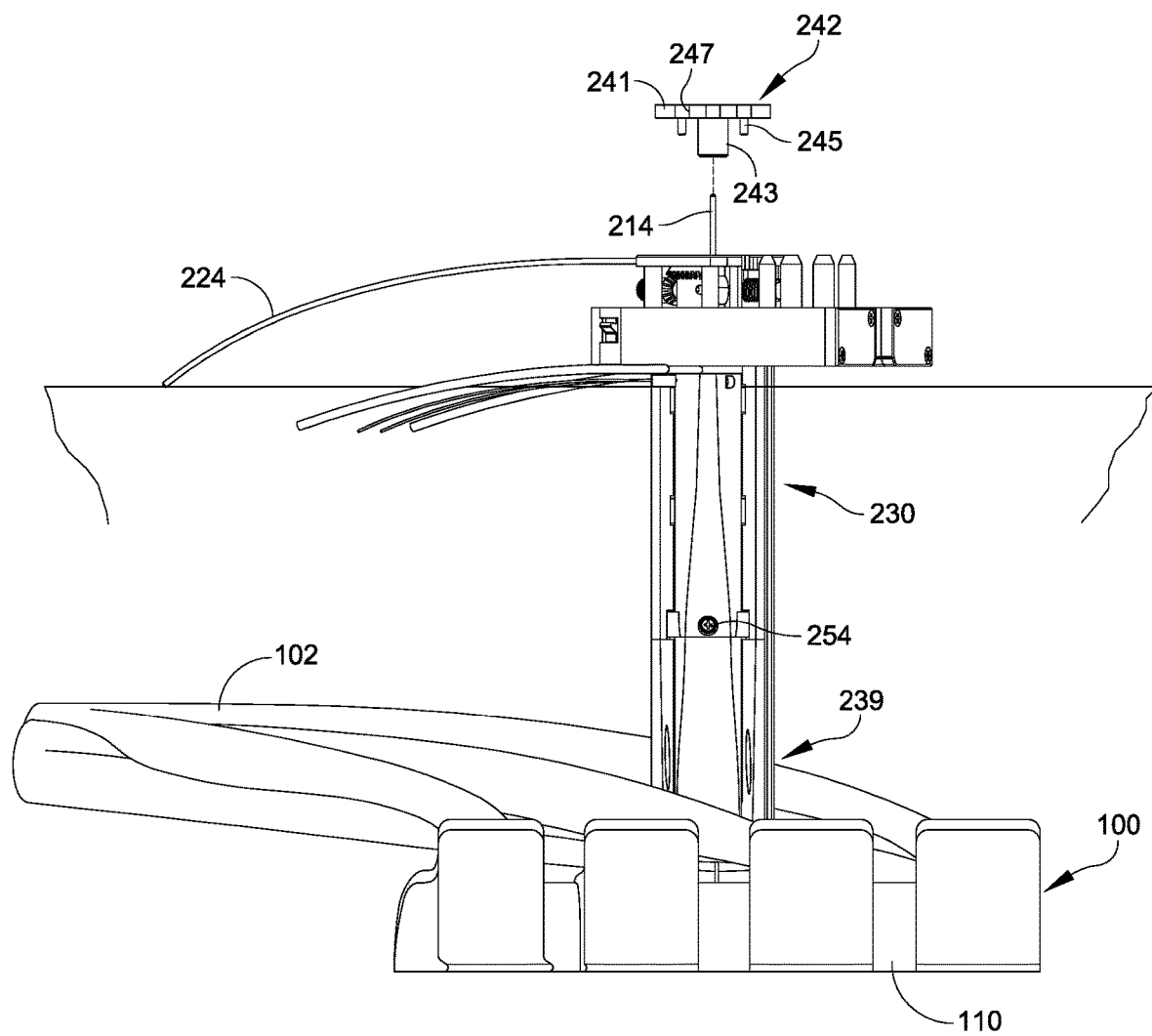


FIG. 10

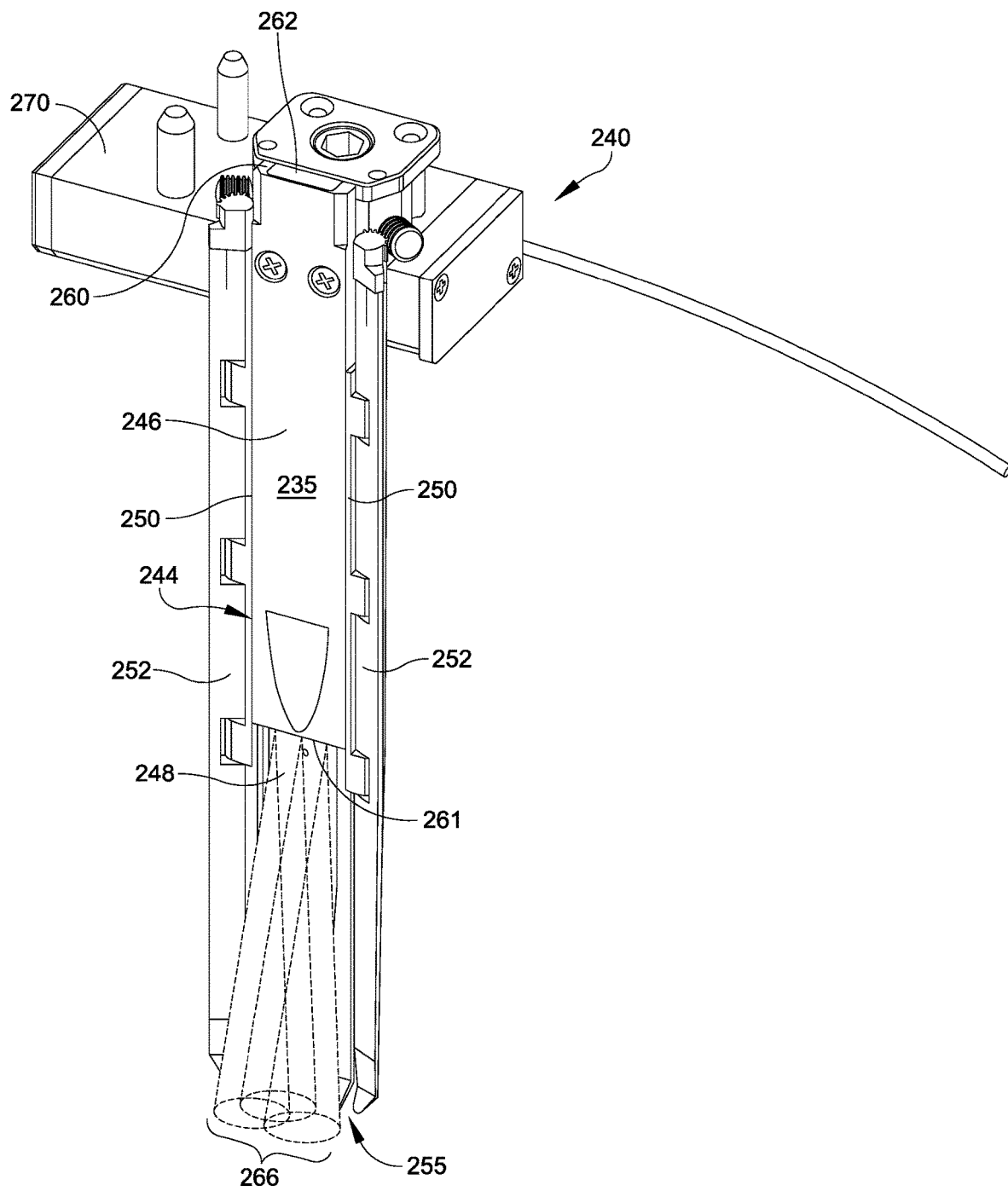
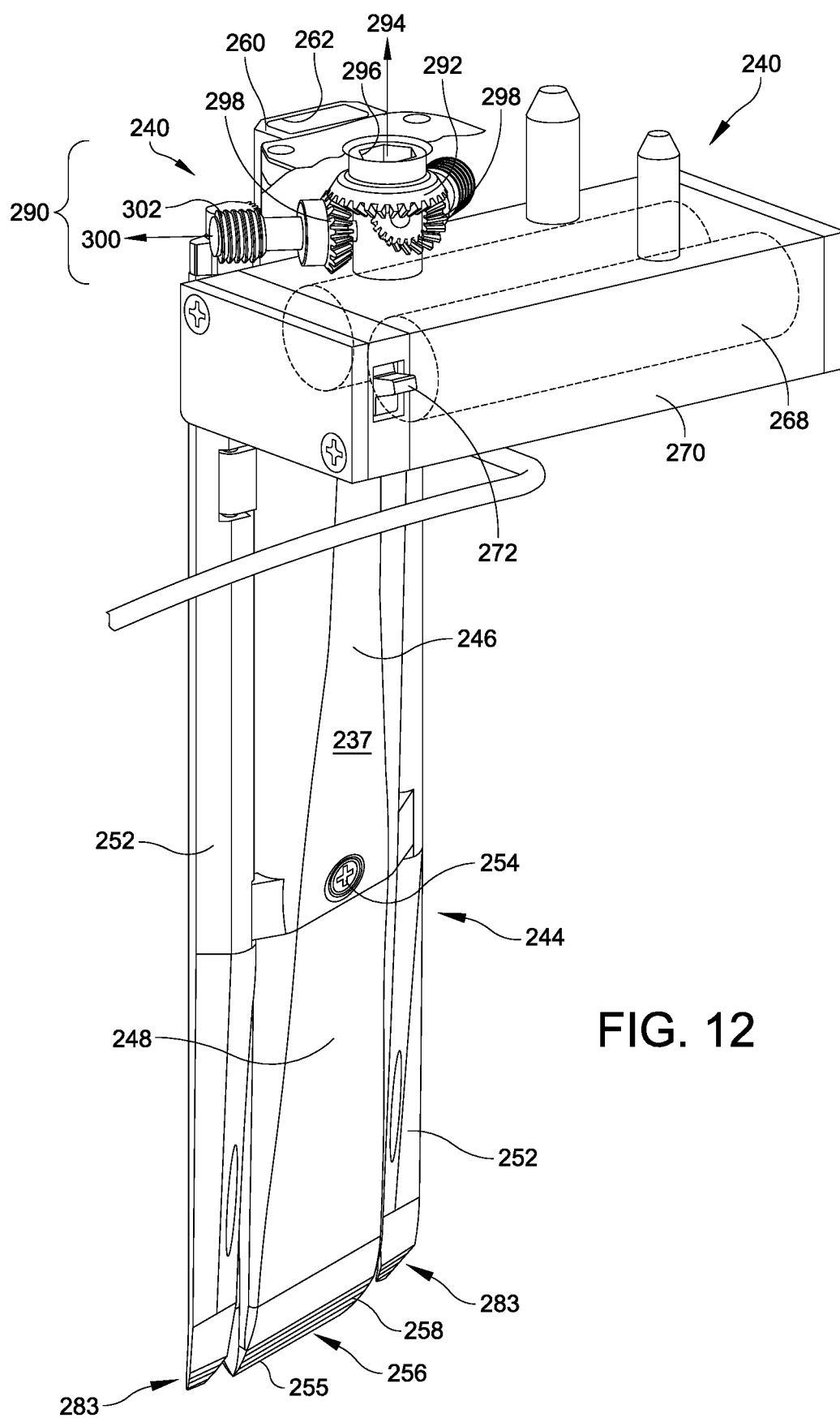
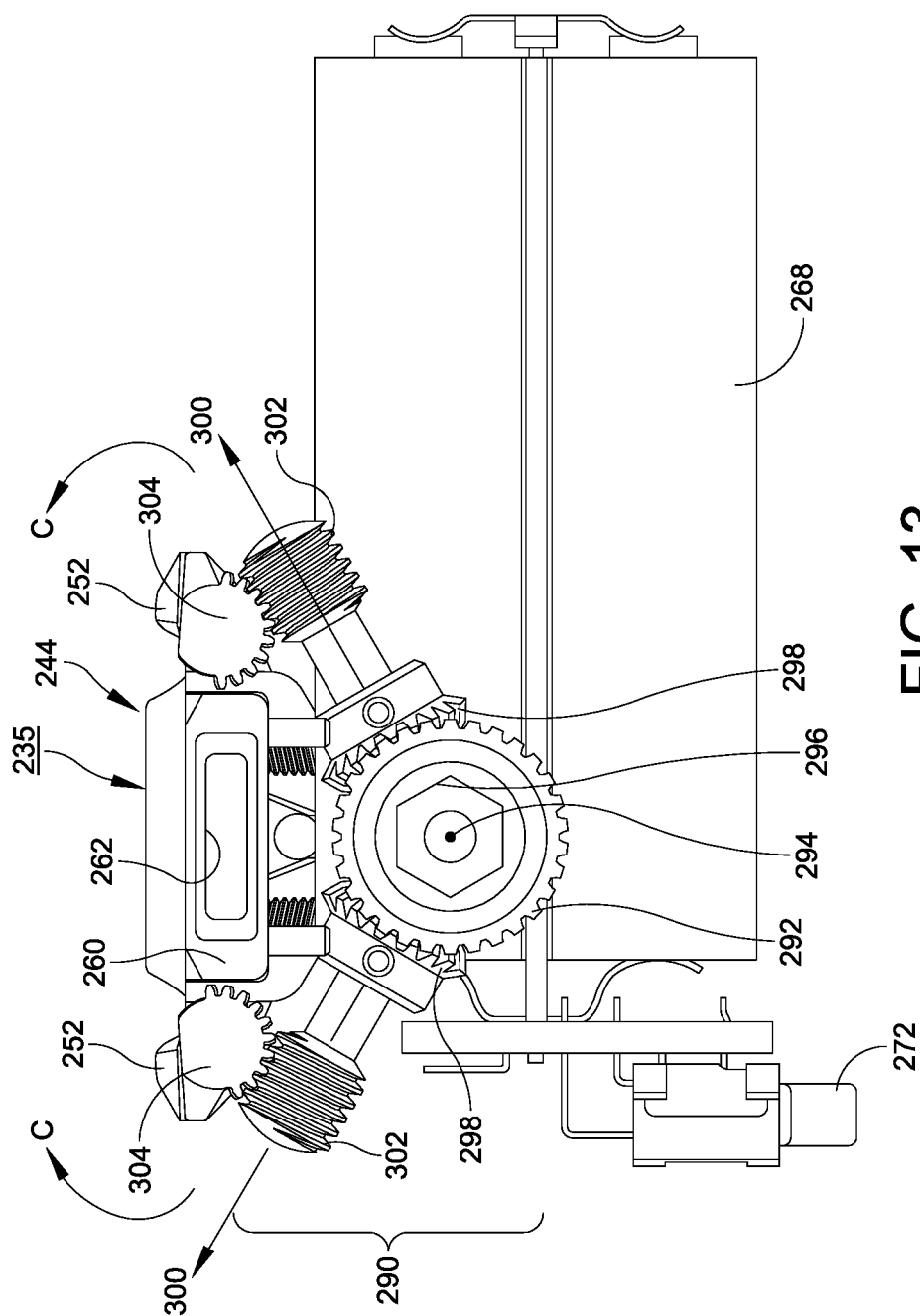


FIG. 11





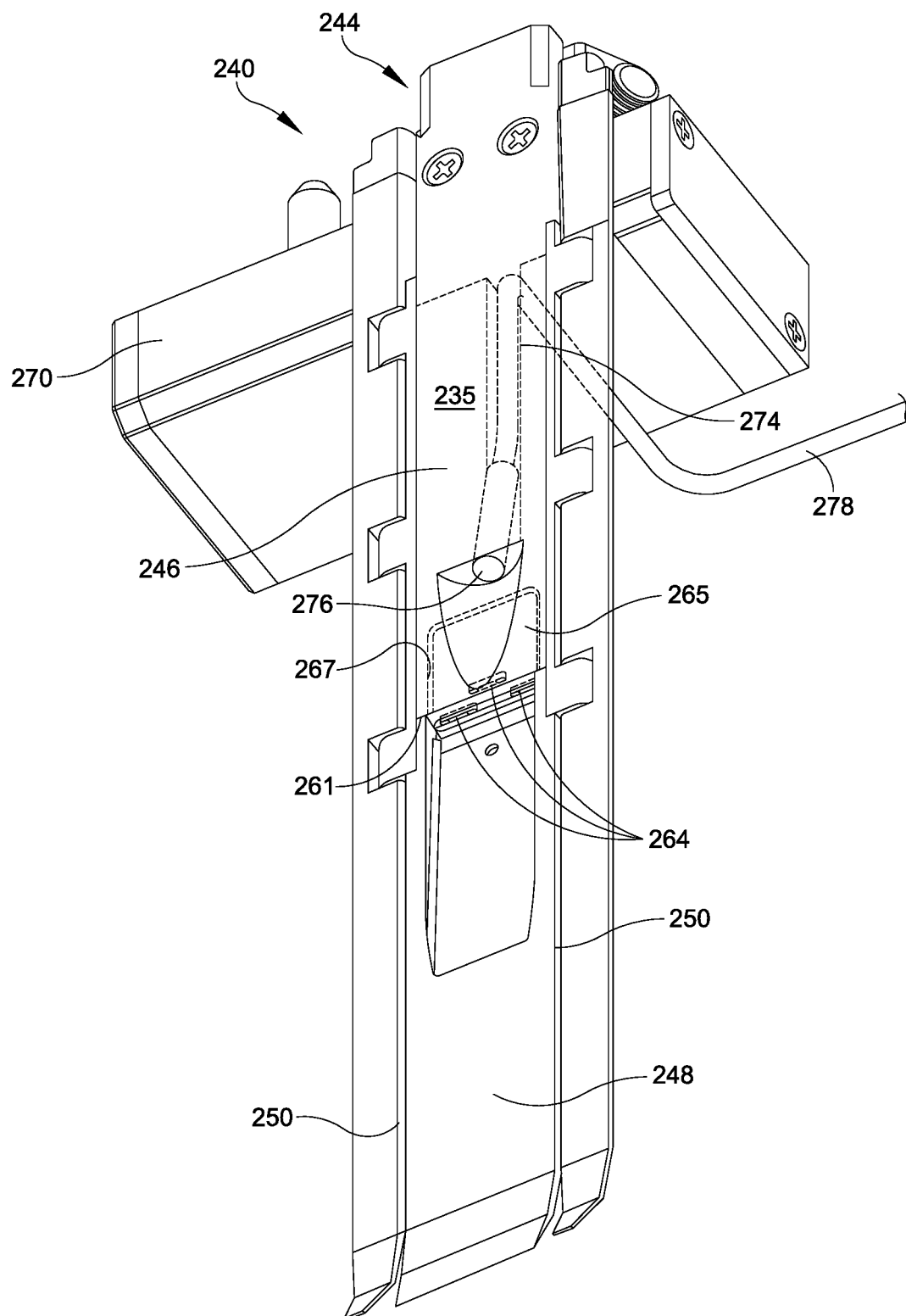


FIG. 14

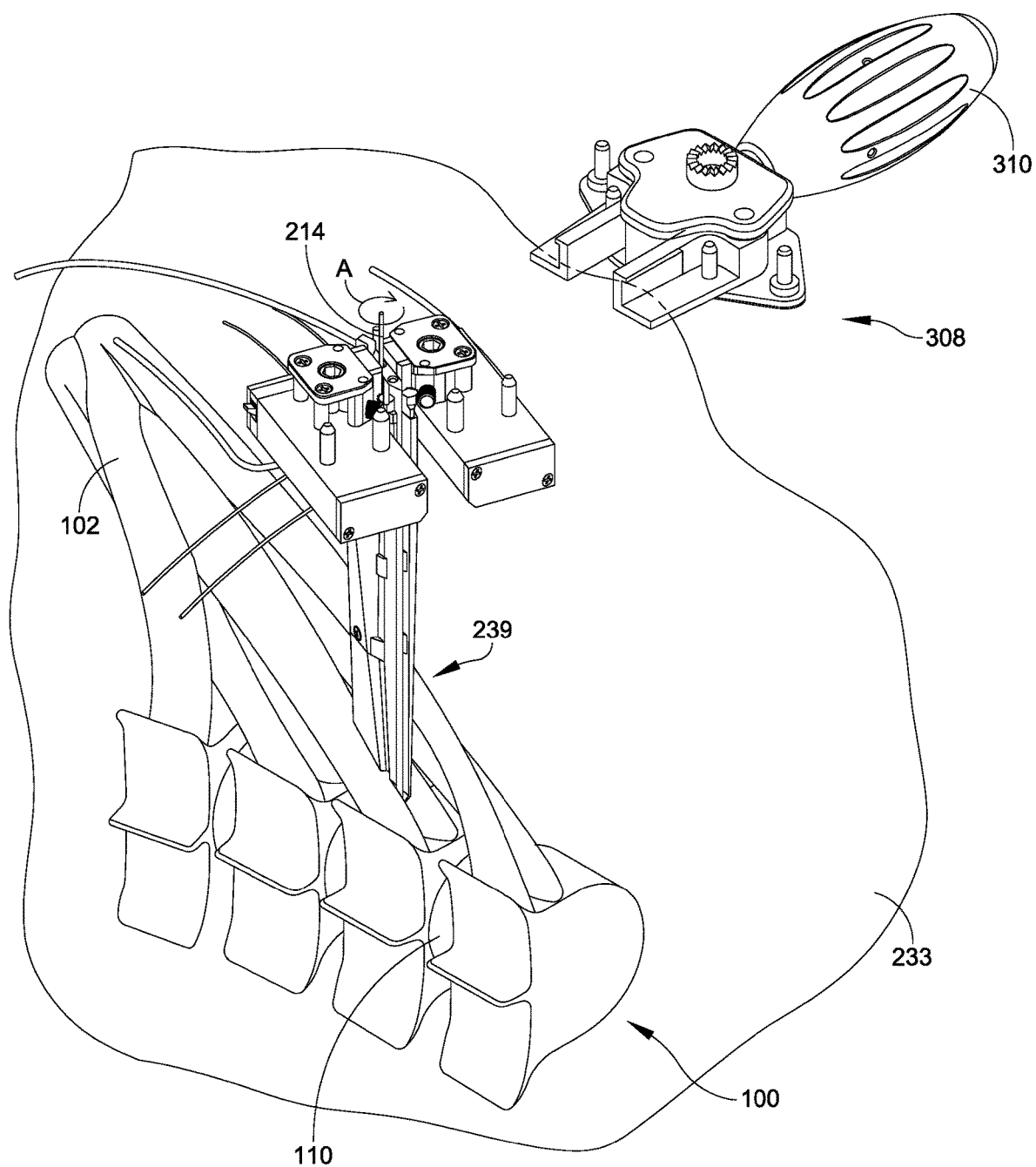


FIG. 15

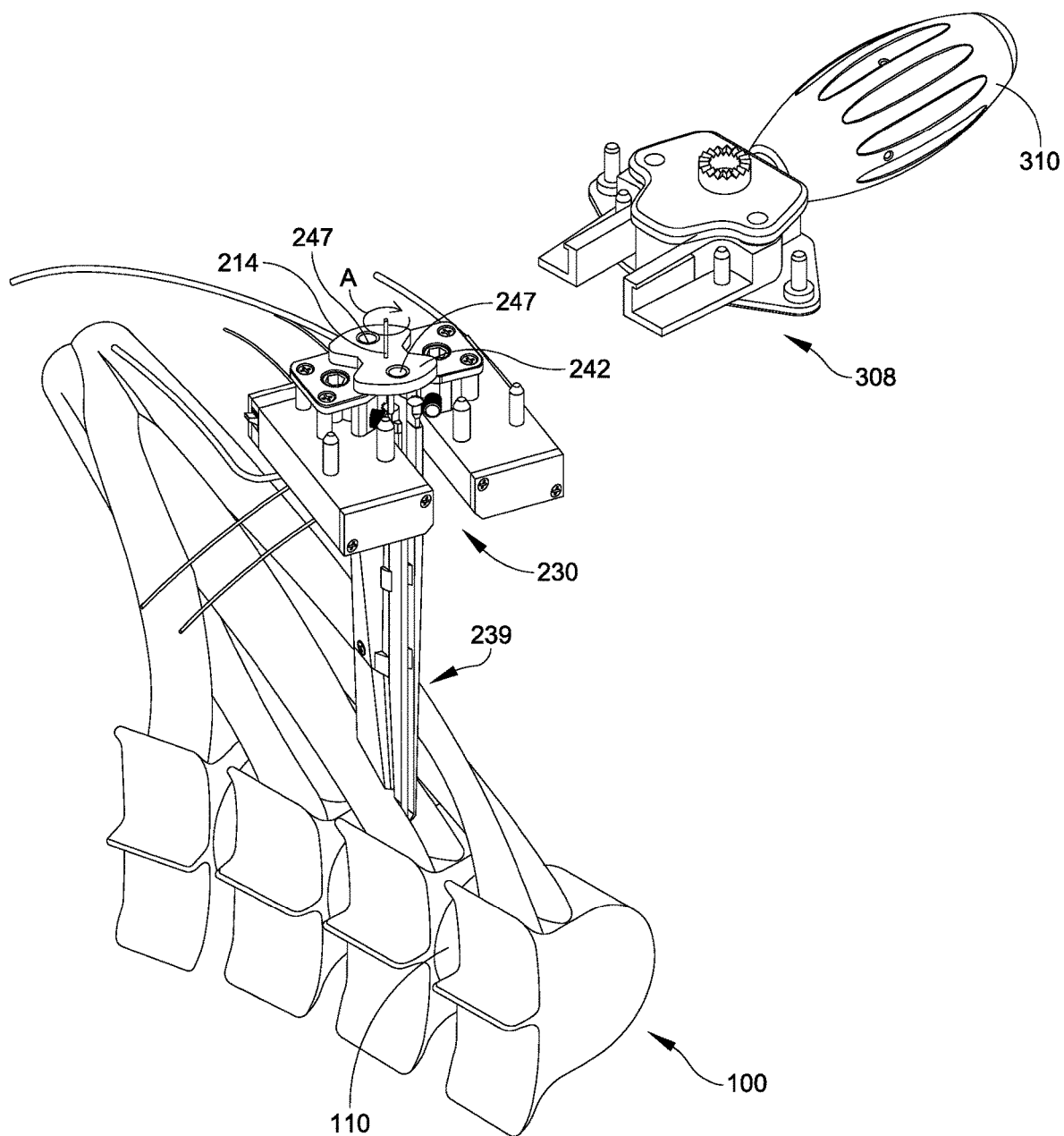


FIG. 16

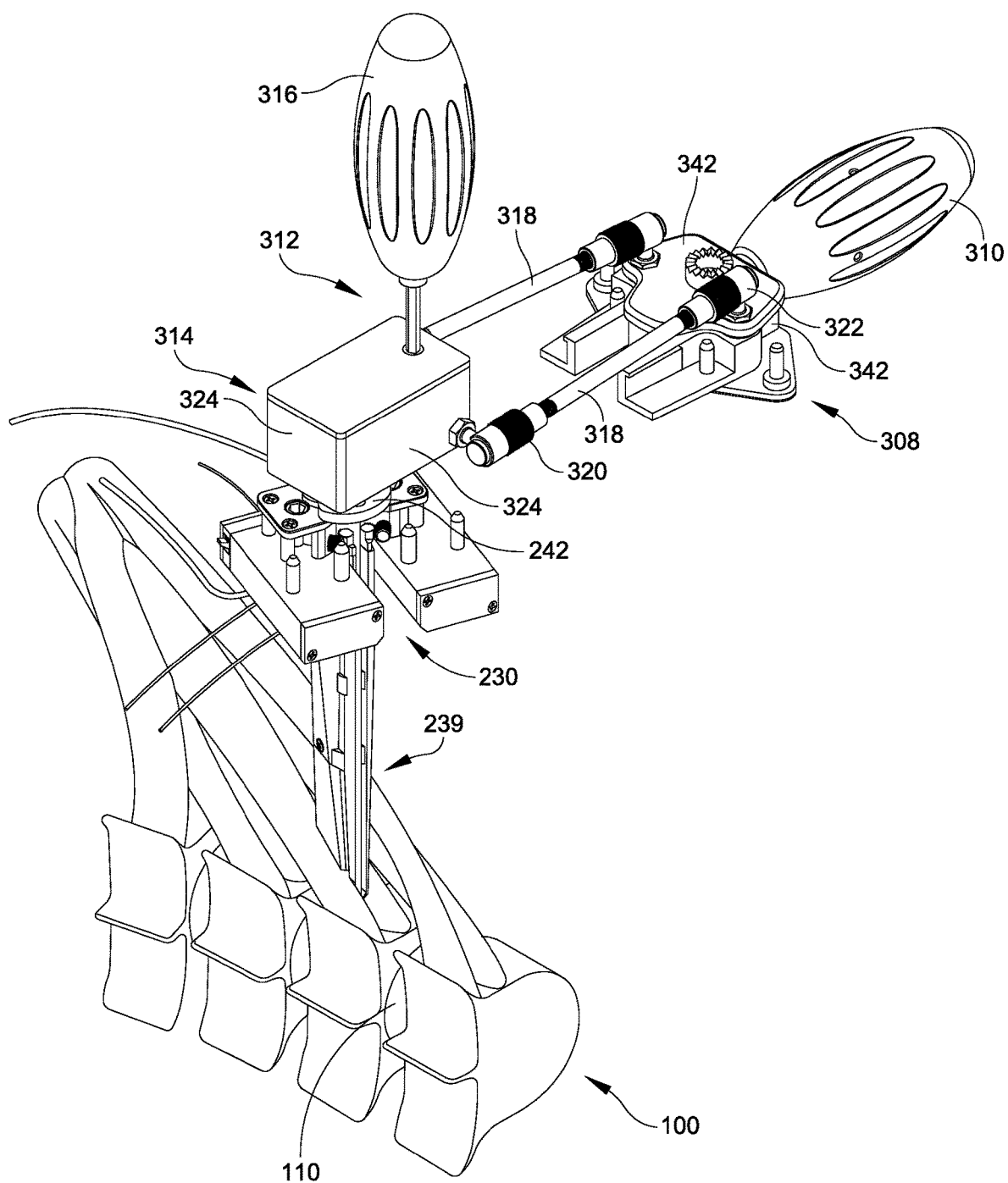


FIG. 17

FIG. 18

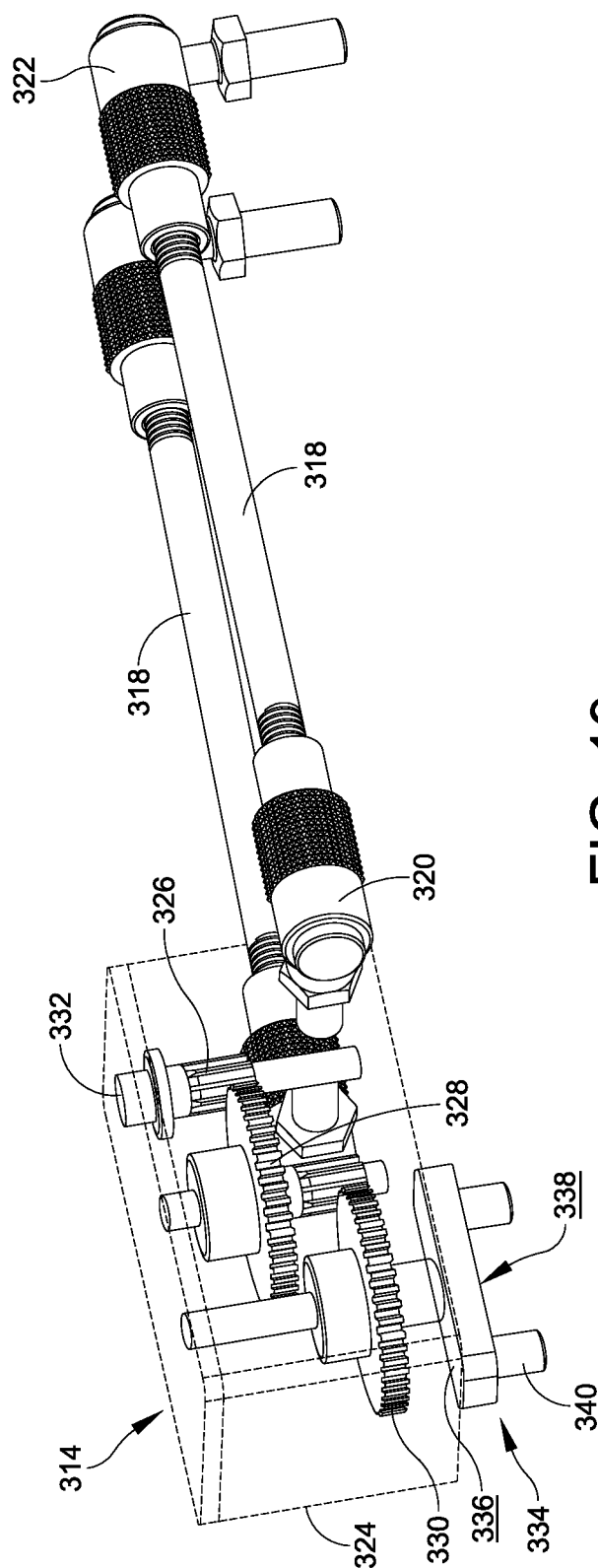


FIG. 20

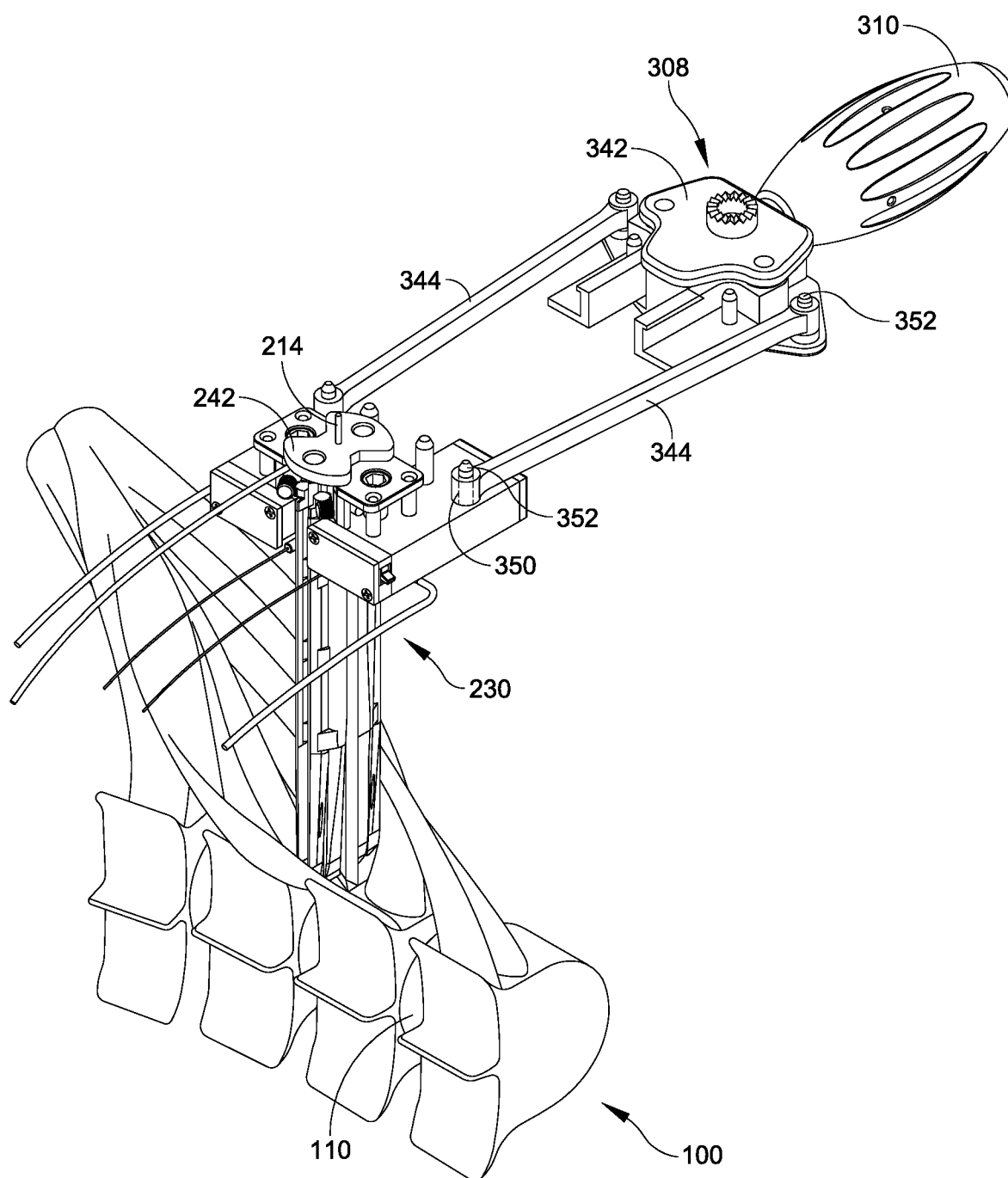


FIG. 21

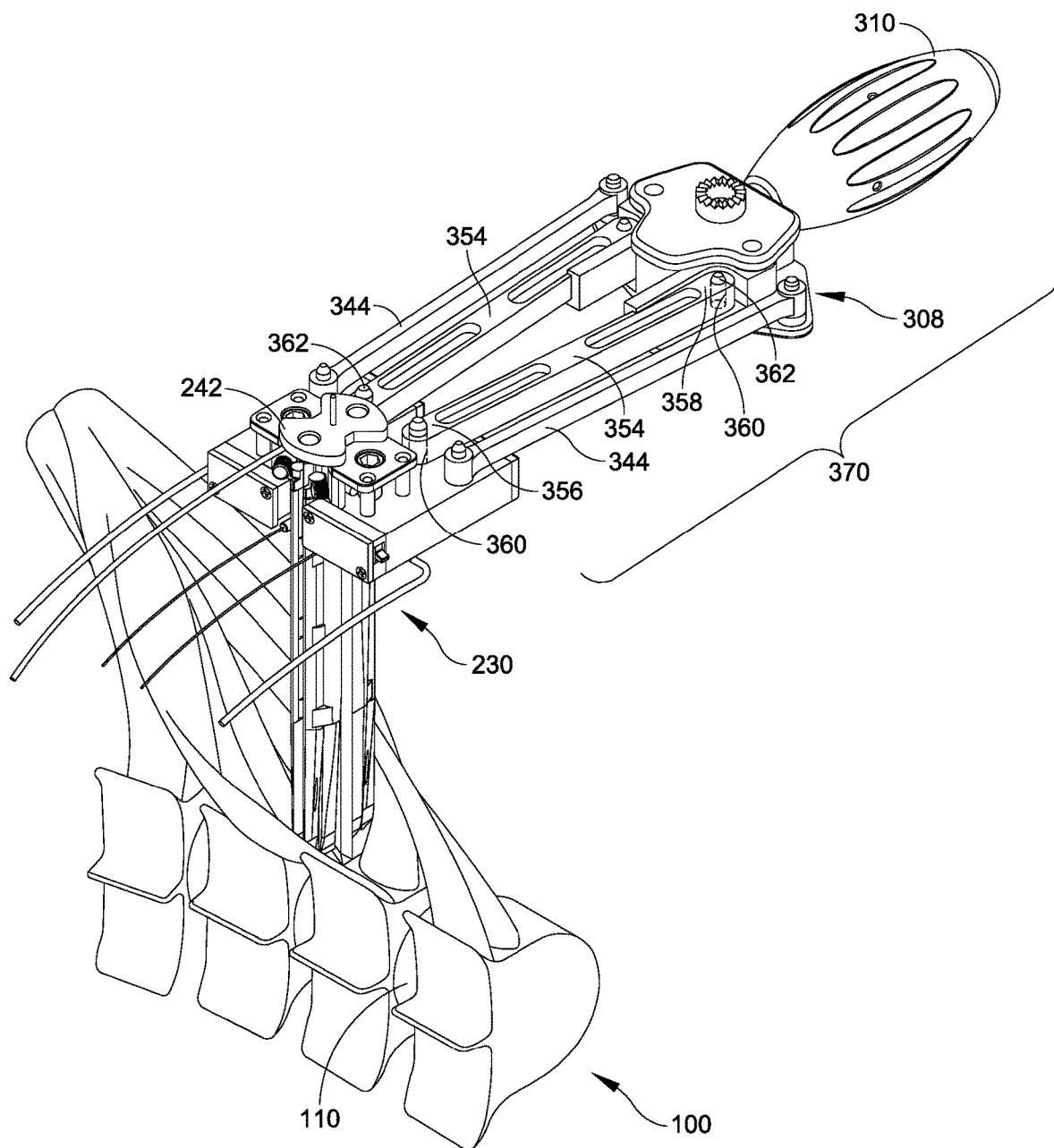


FIG. 22

FIG. 23

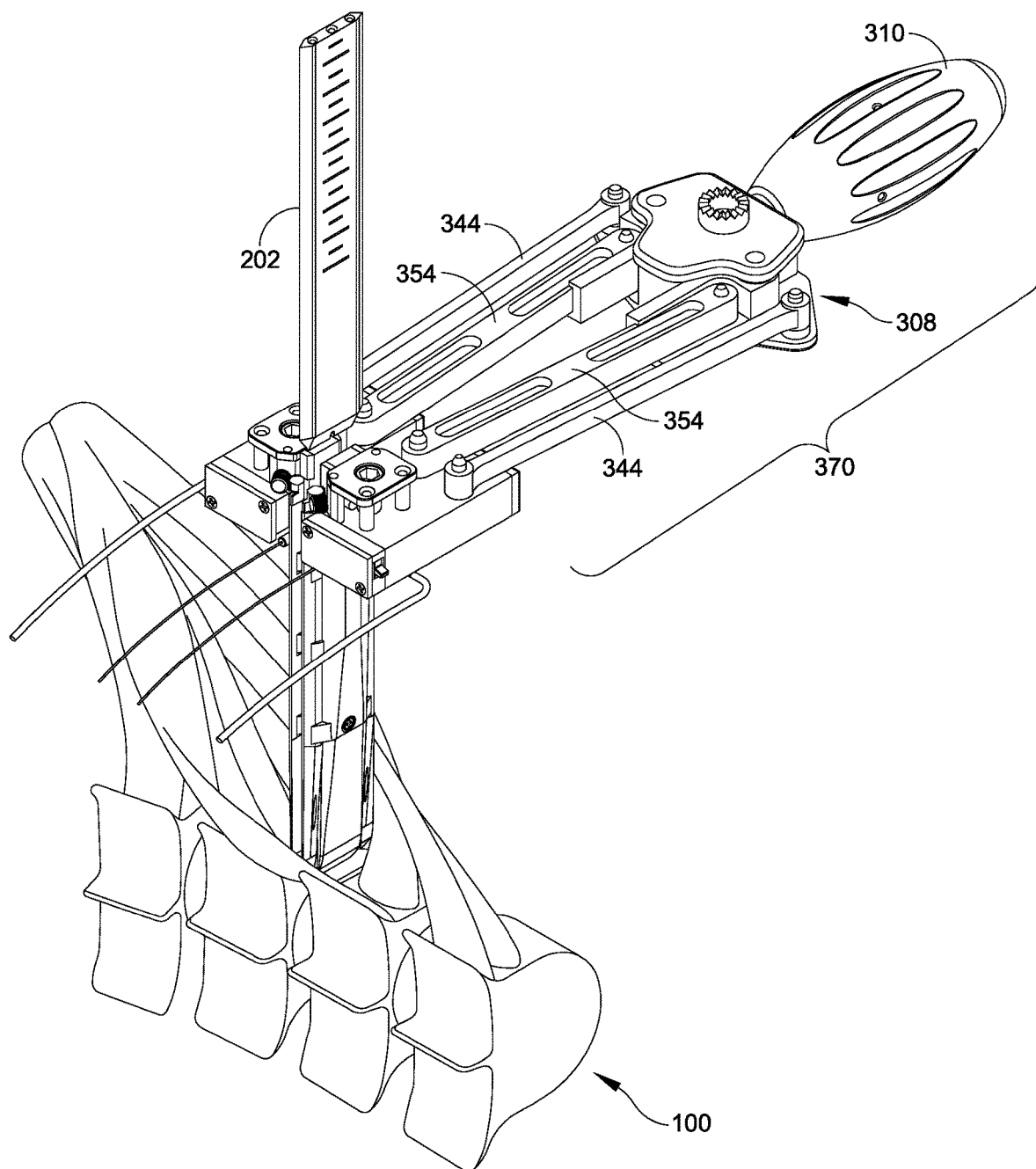


FIG. 24

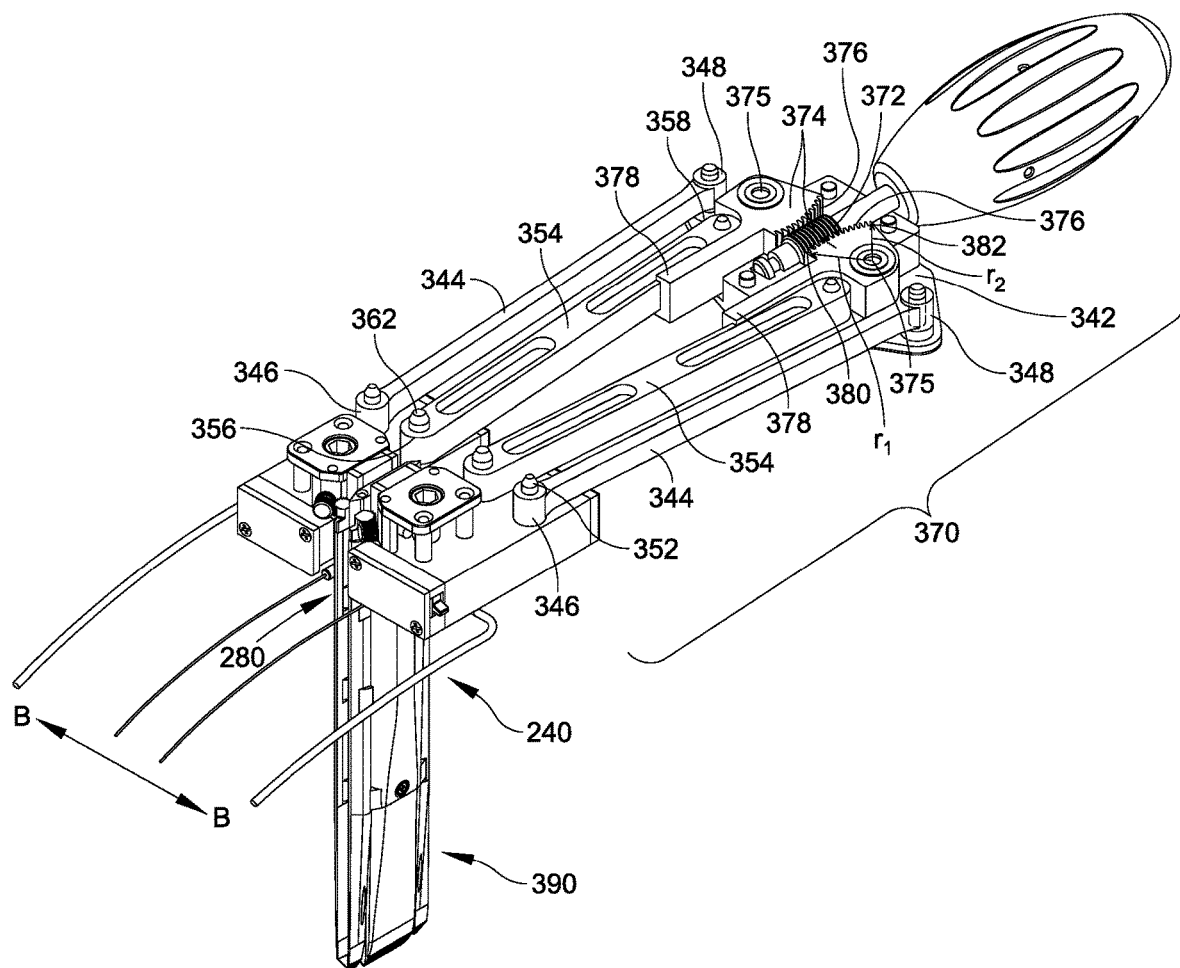


FIG. 25

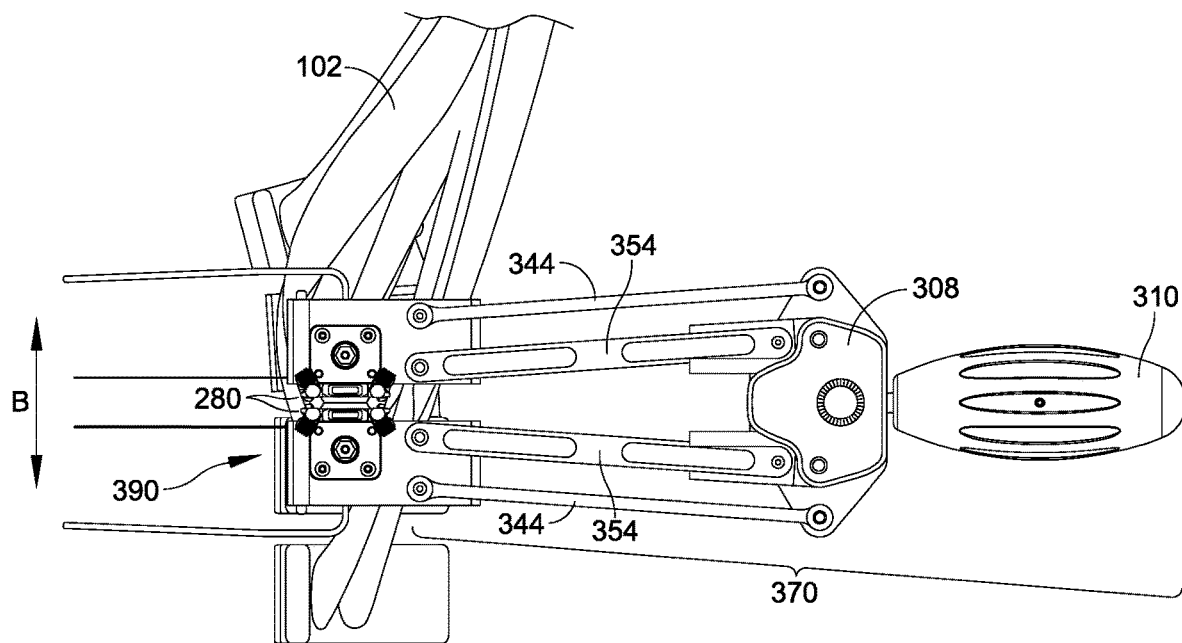


FIG. 26

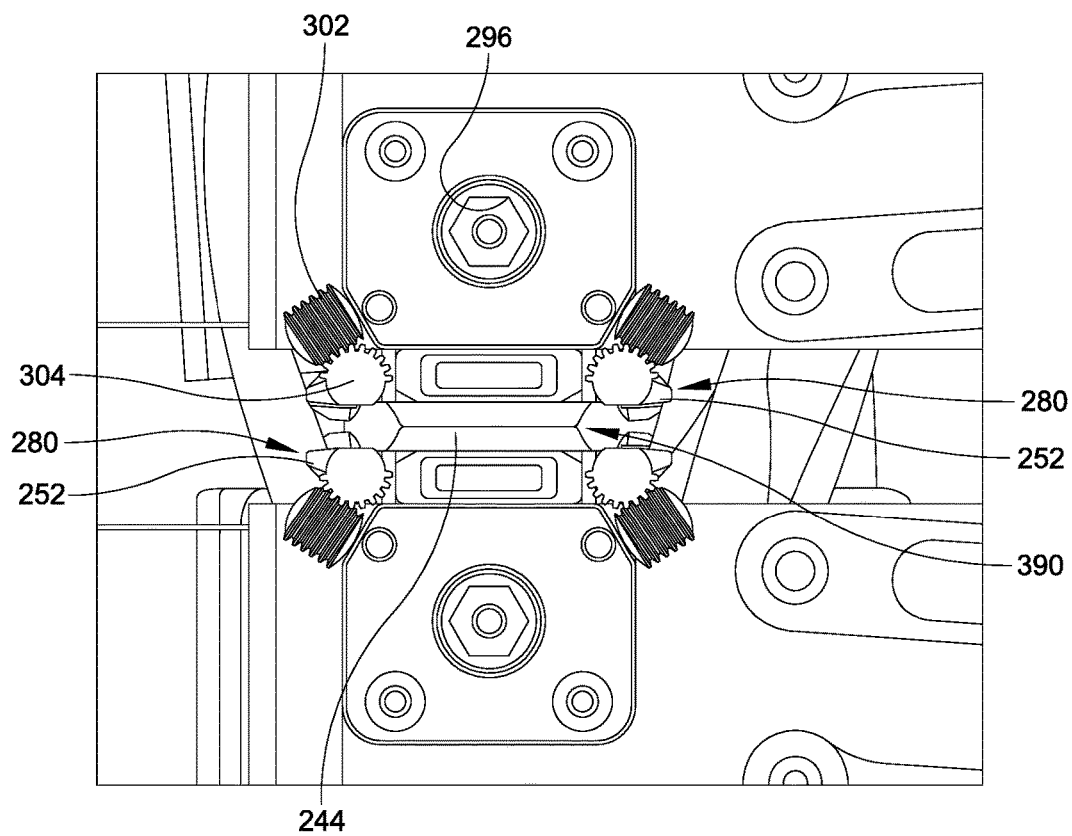
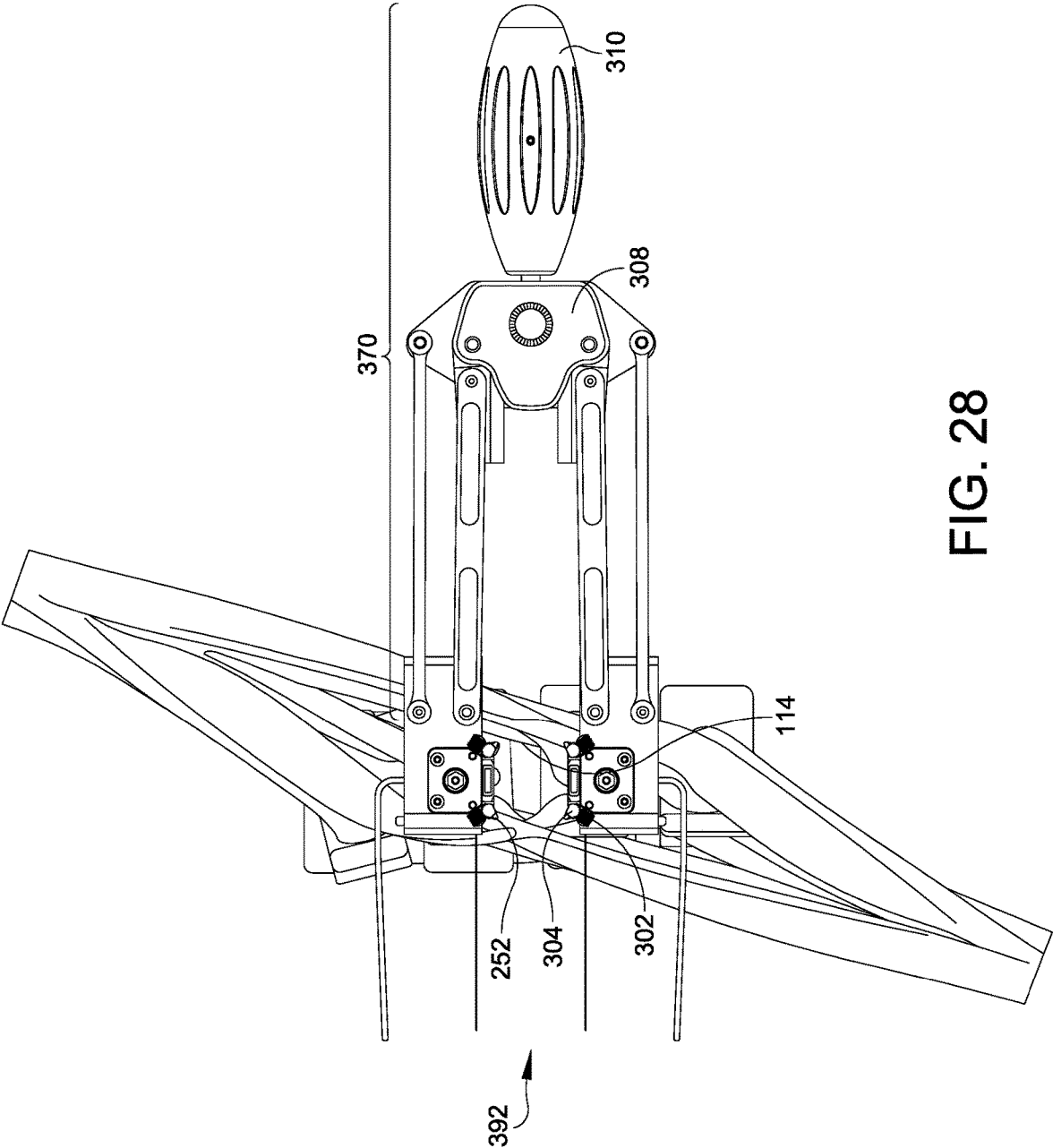


FIG. 27



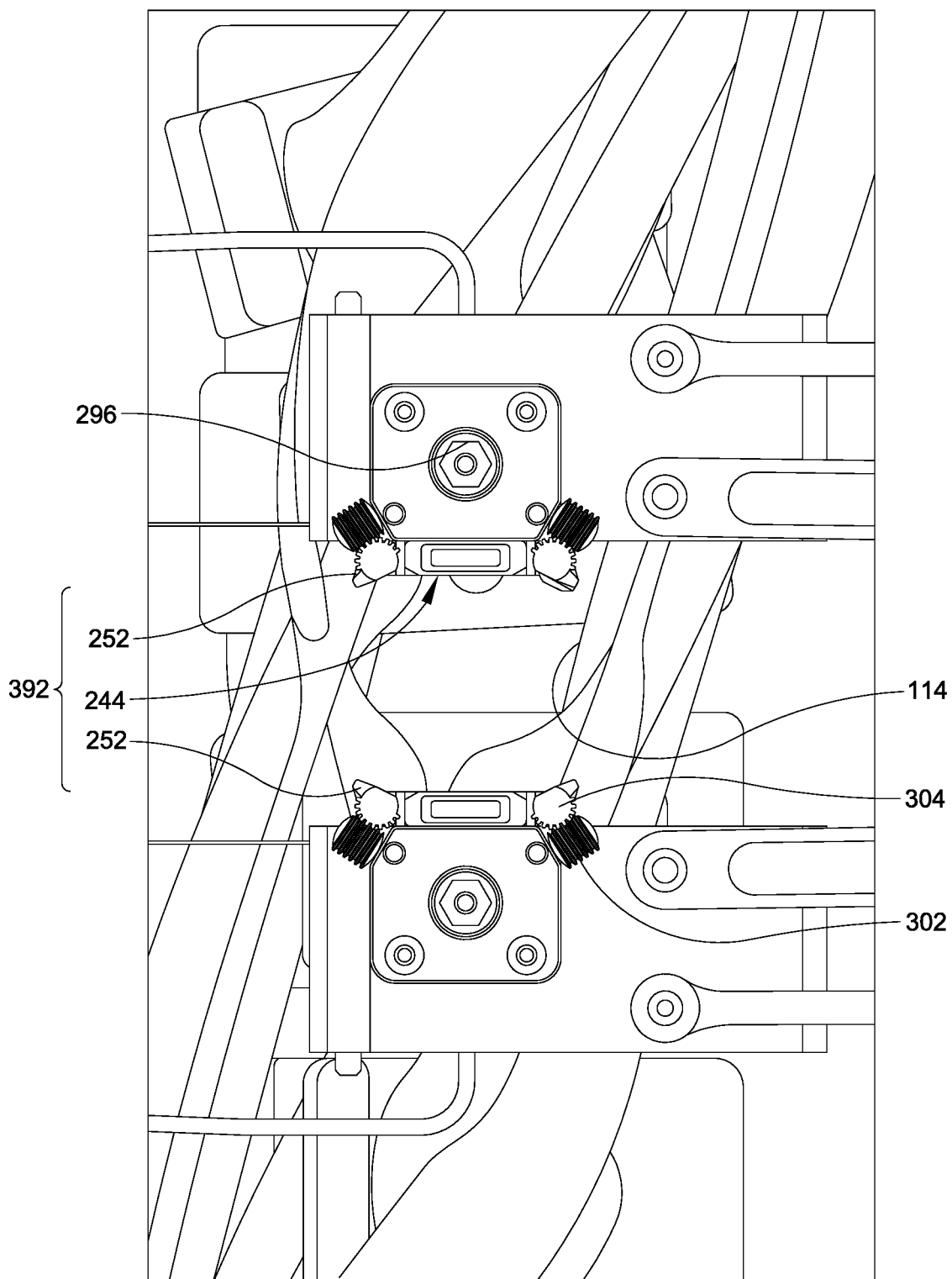


FIG. 29

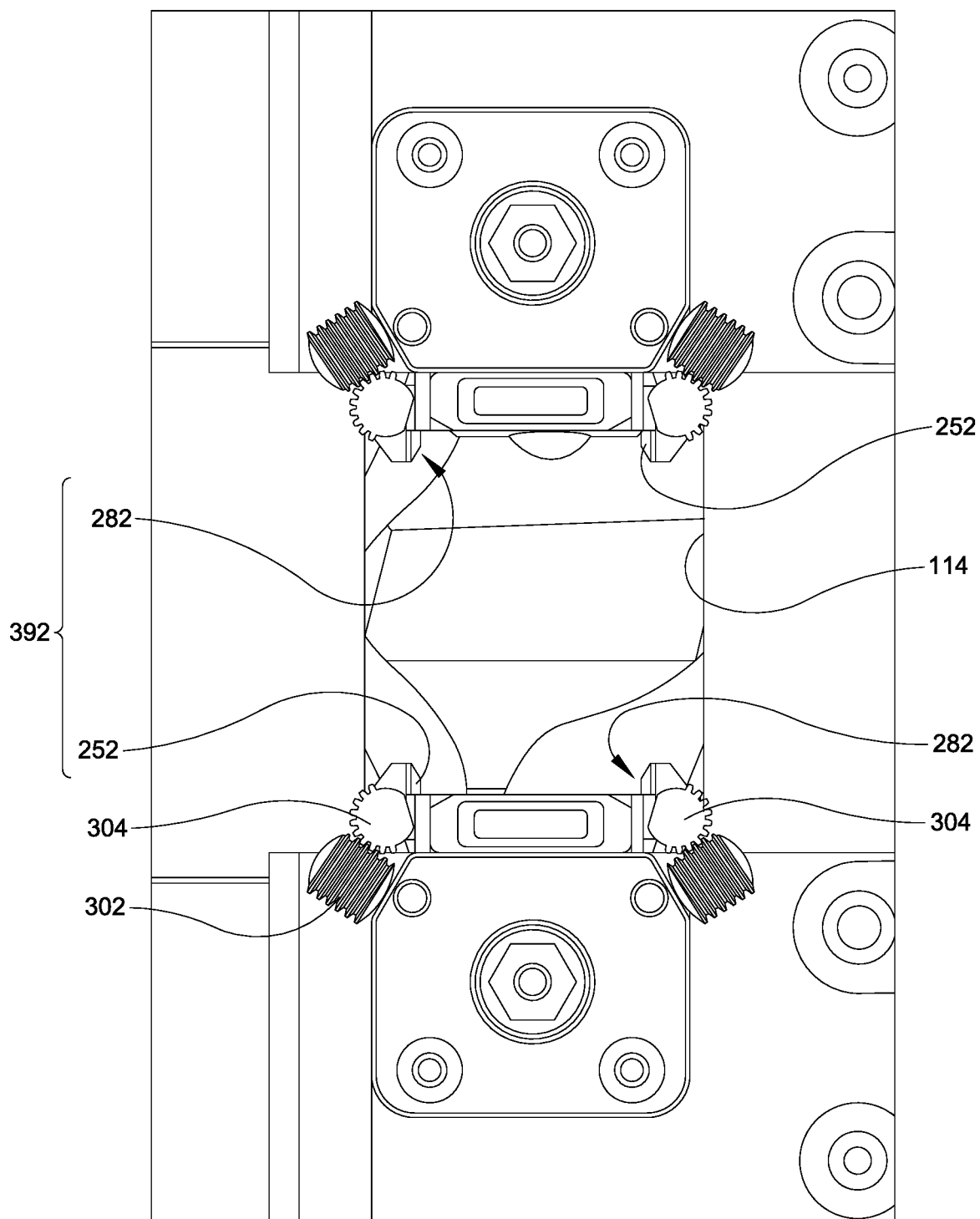


FIG. 30

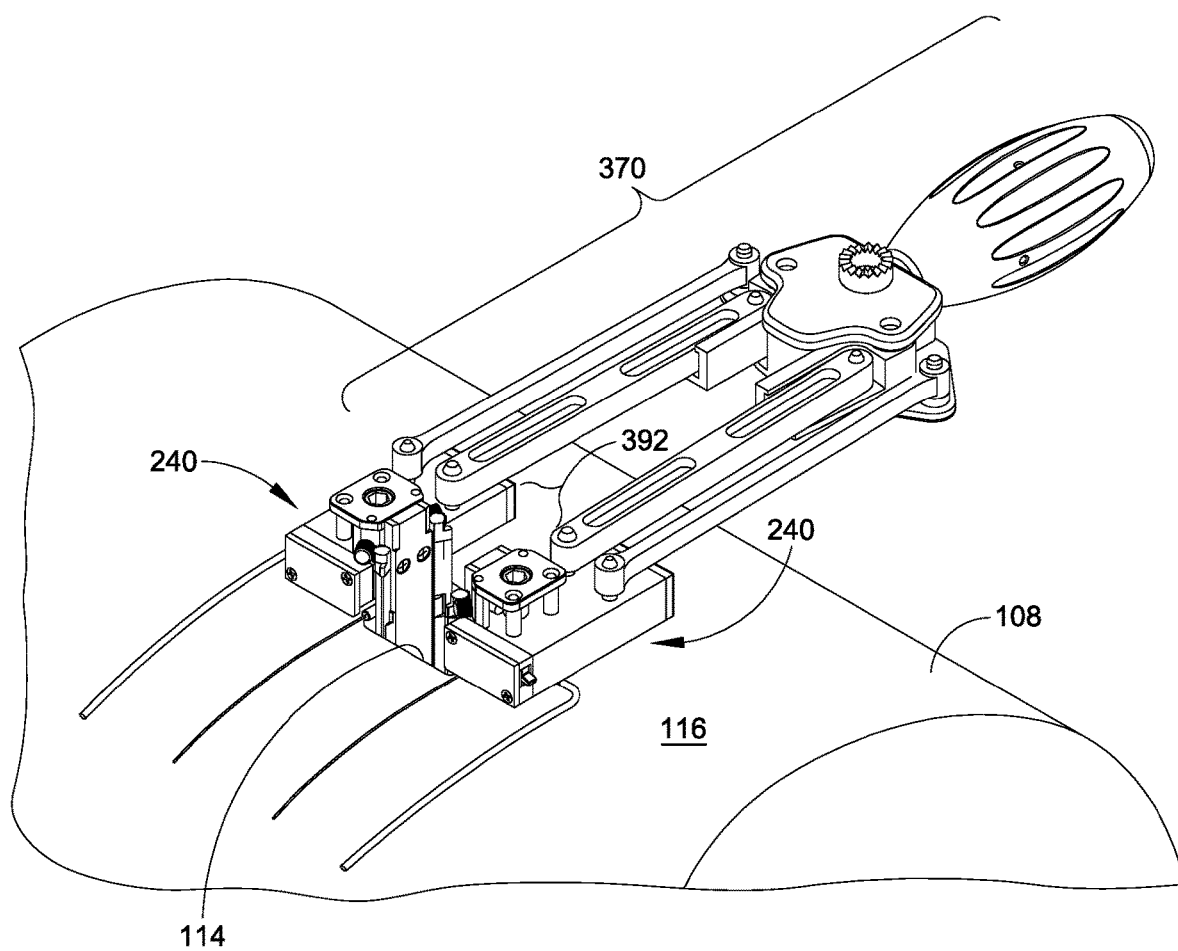


FIG. 31

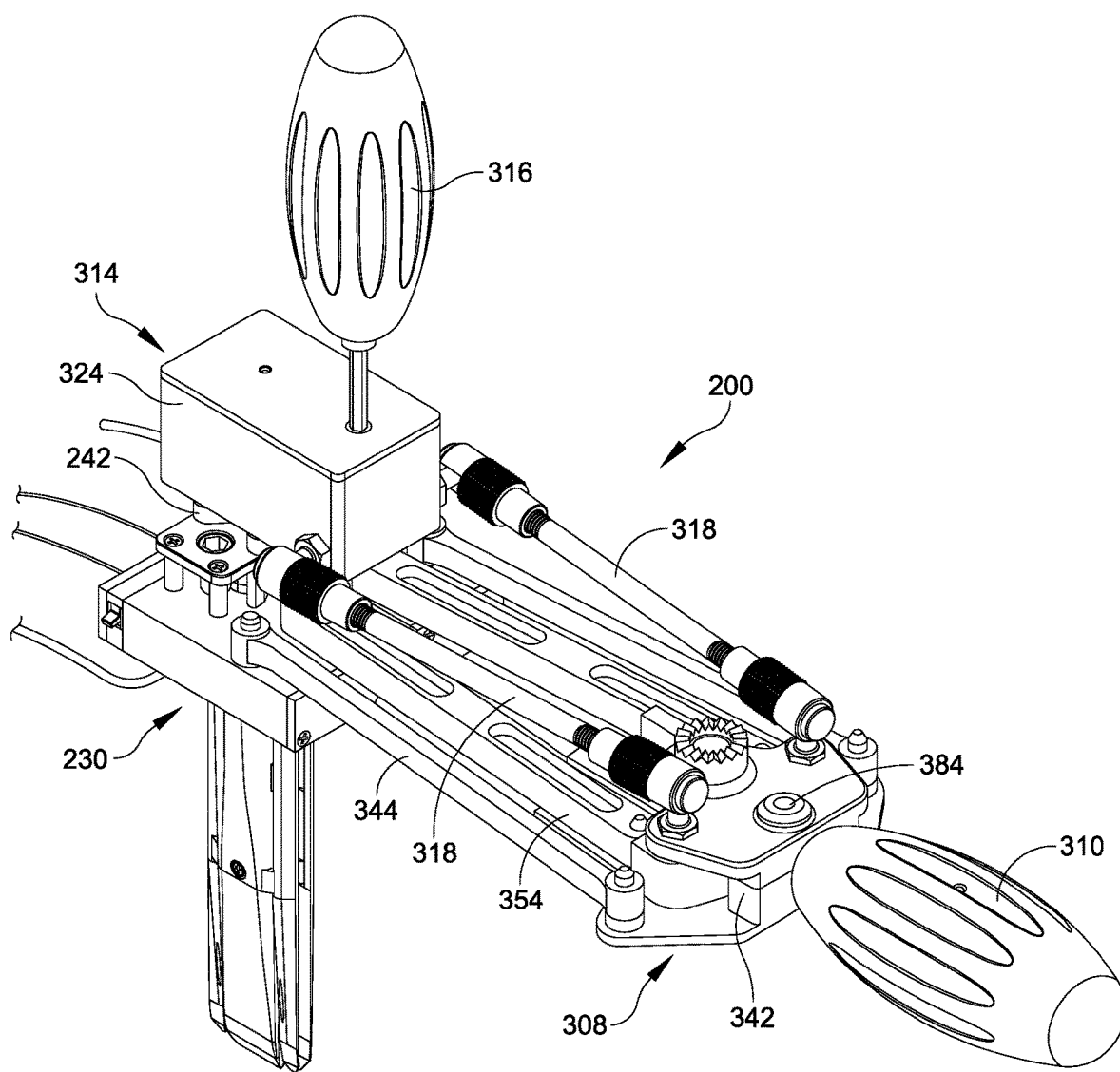


FIG. 32

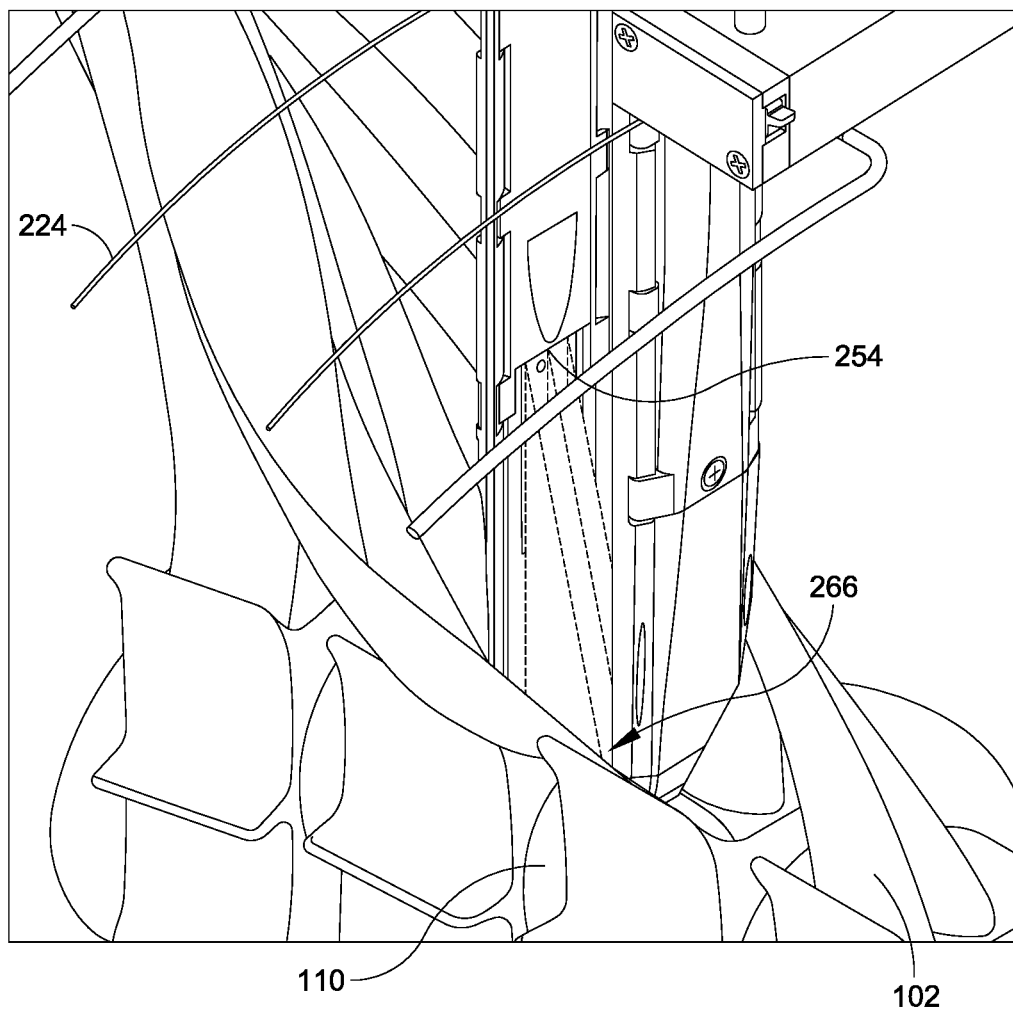


FIG. 33

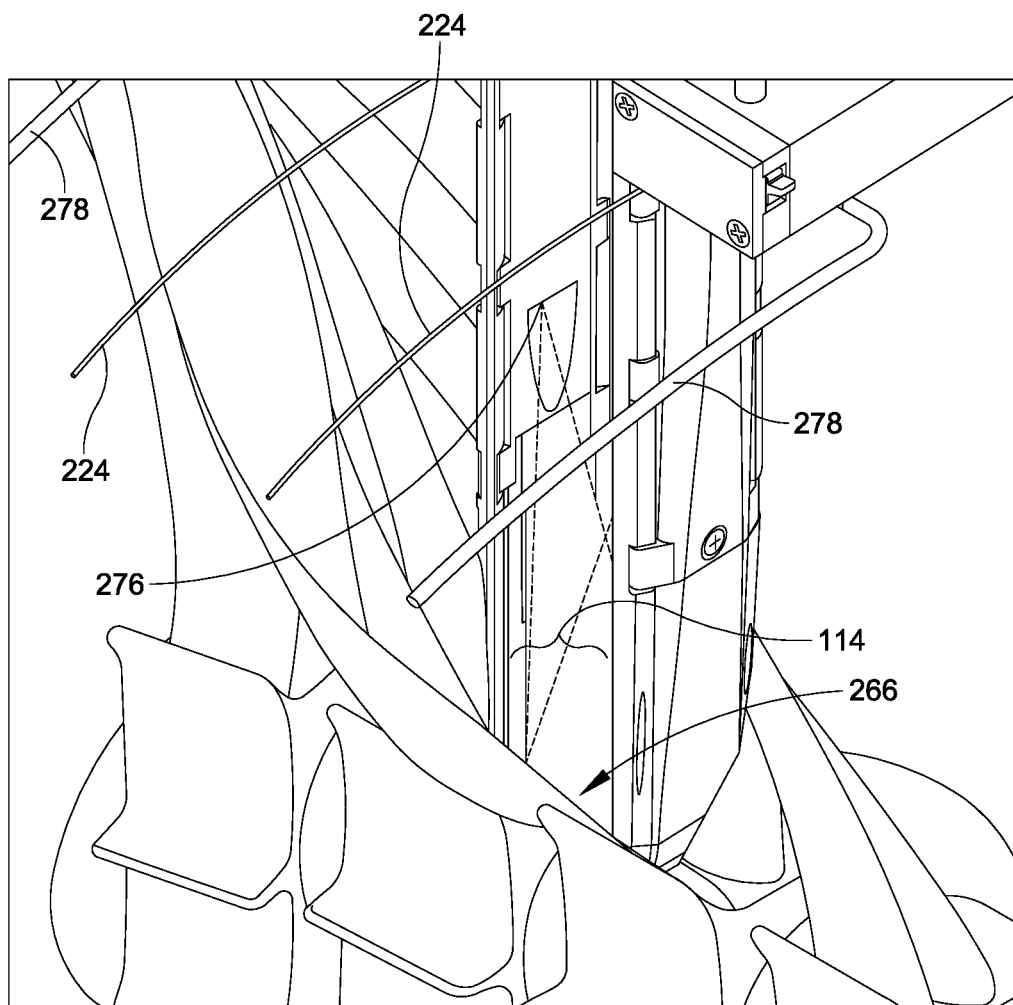


FIG. 34

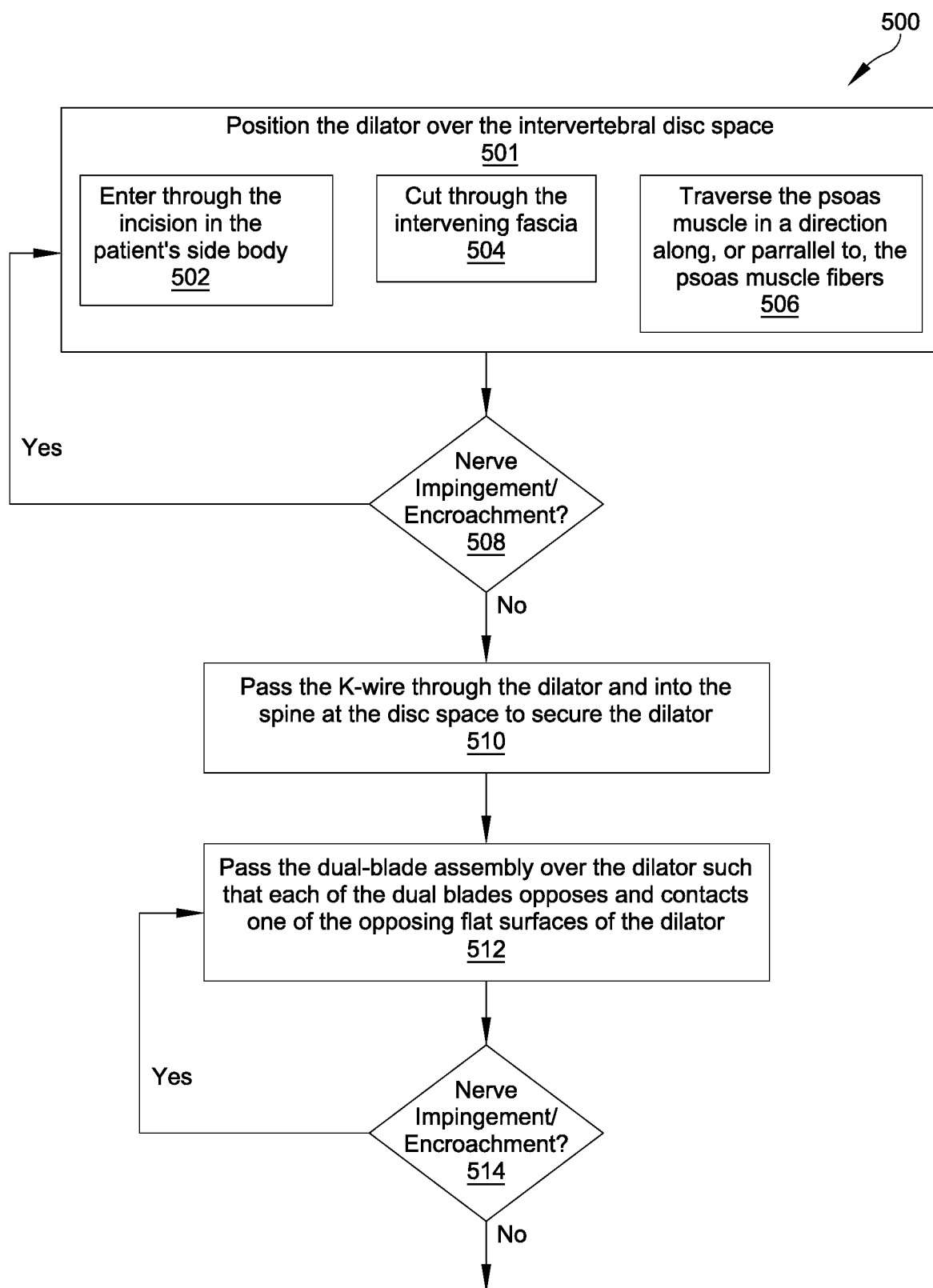


FIG. 35A

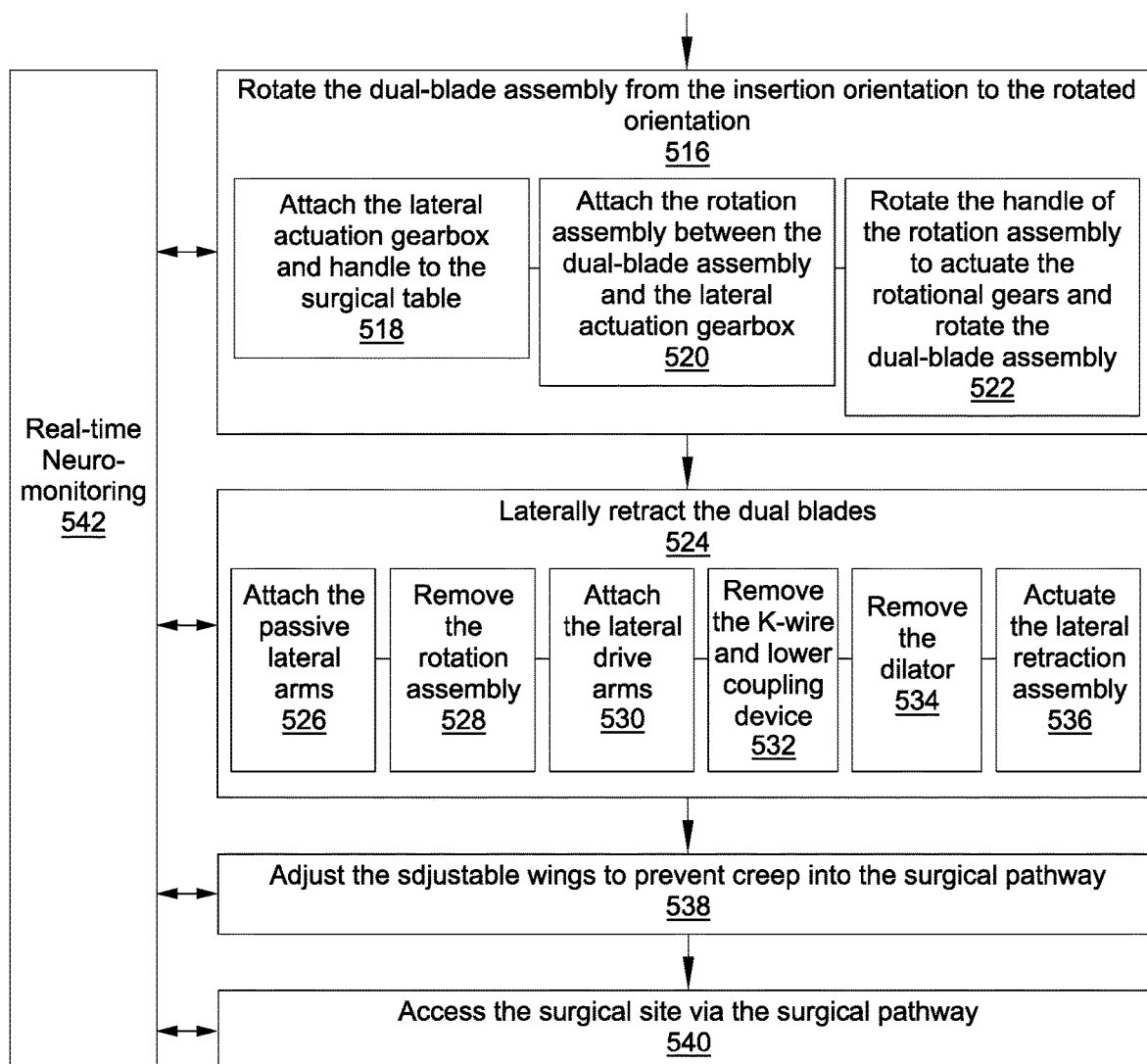


FIG. 35B

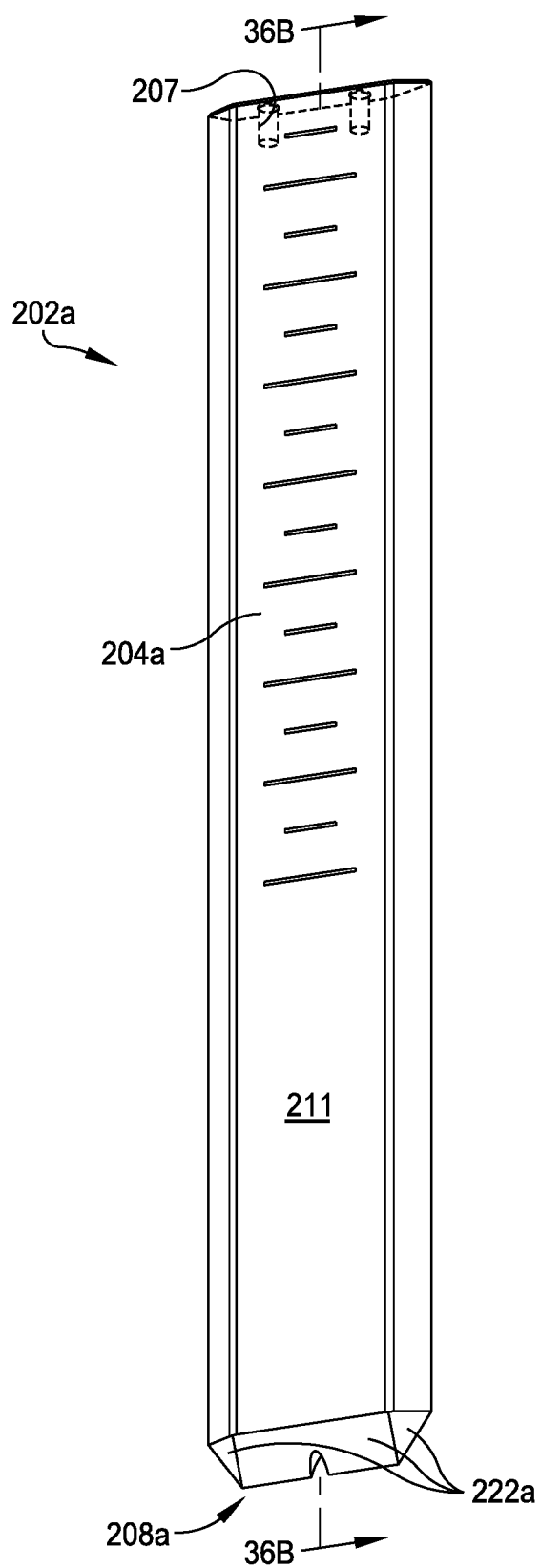


FIG. 36A

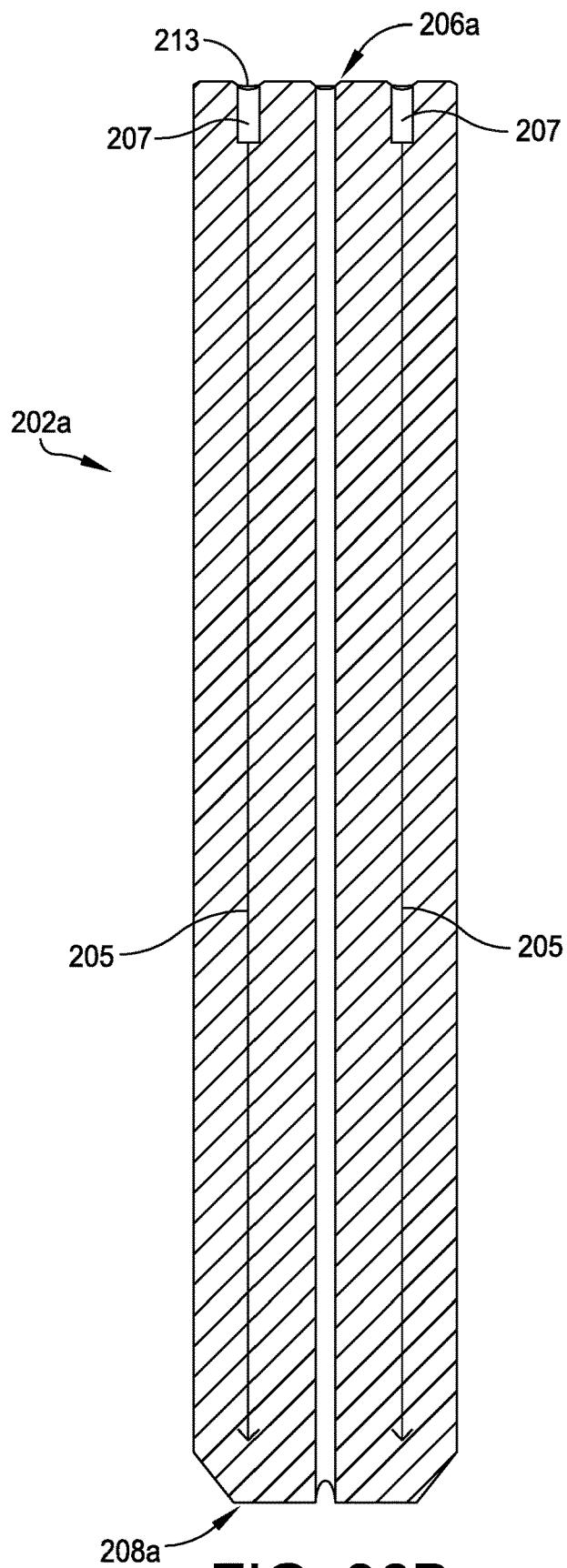


FIG. 36B

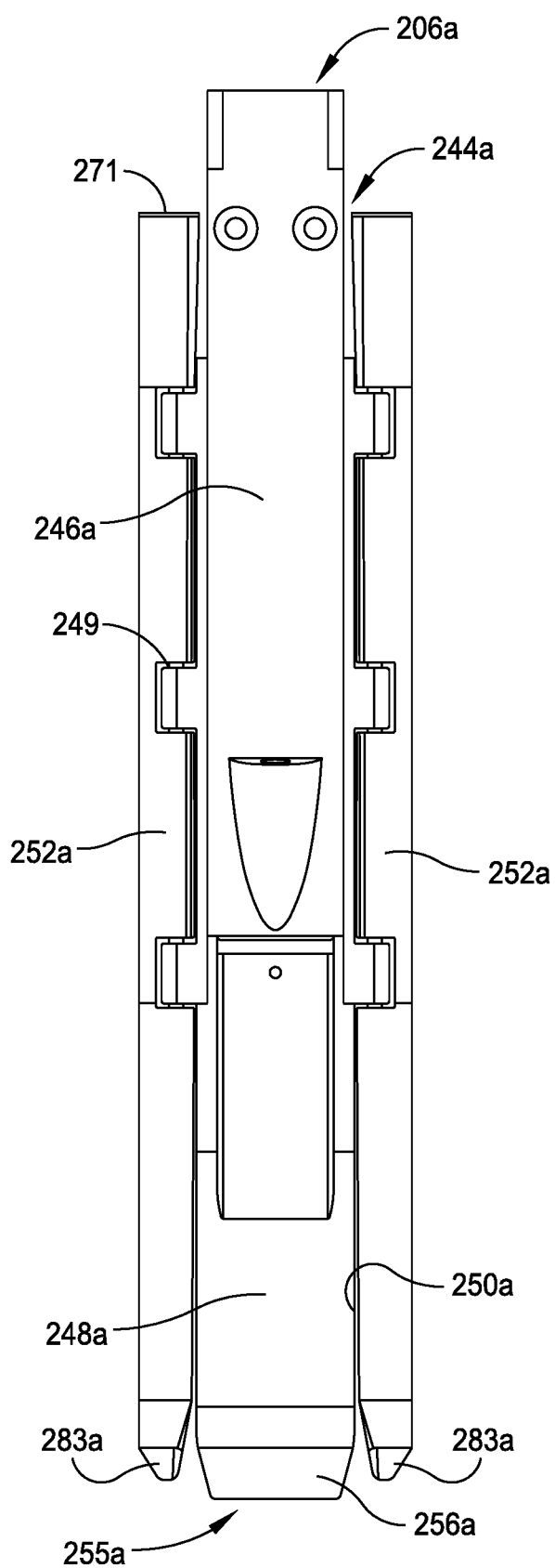


FIG. 37A

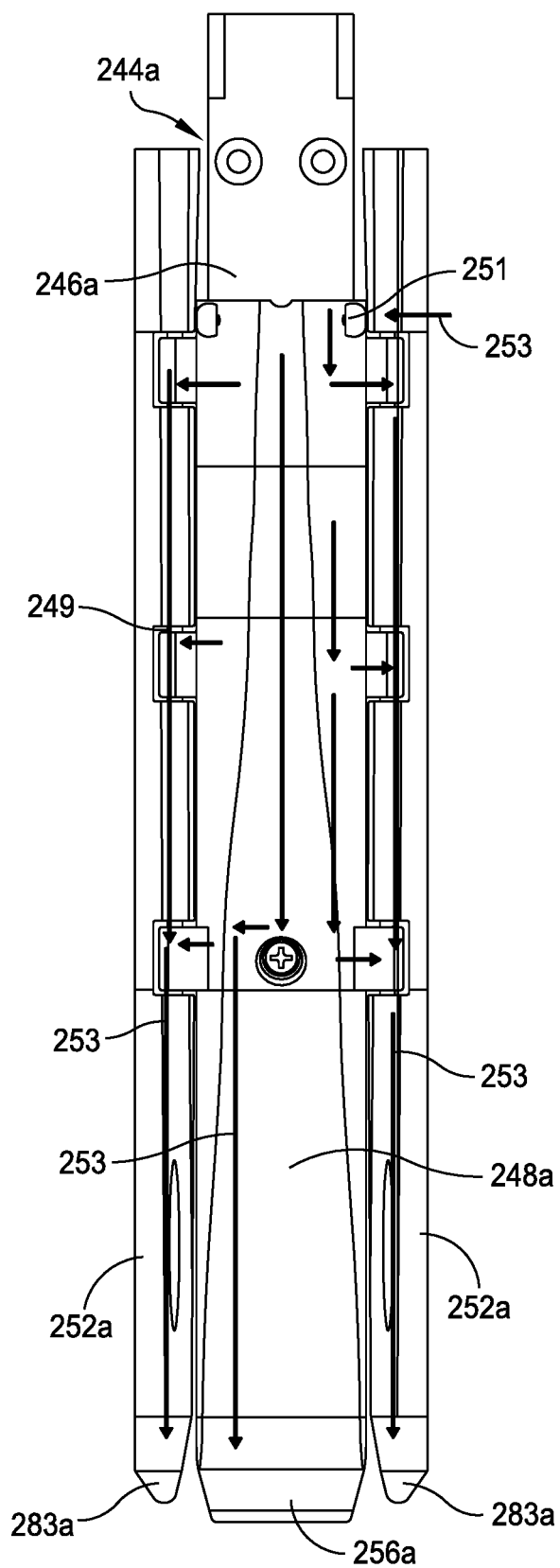


FIG. 37B

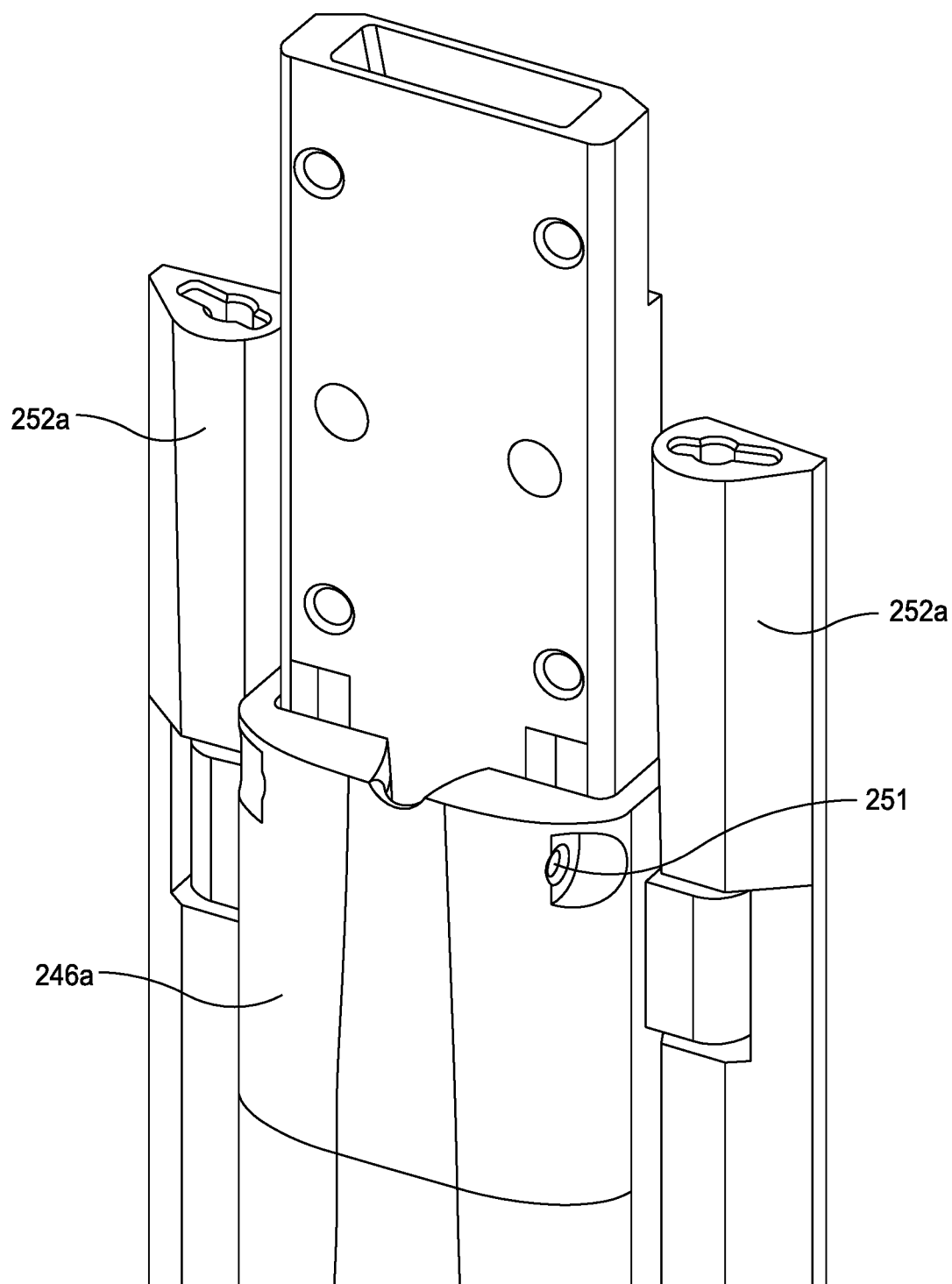


FIG. 37C

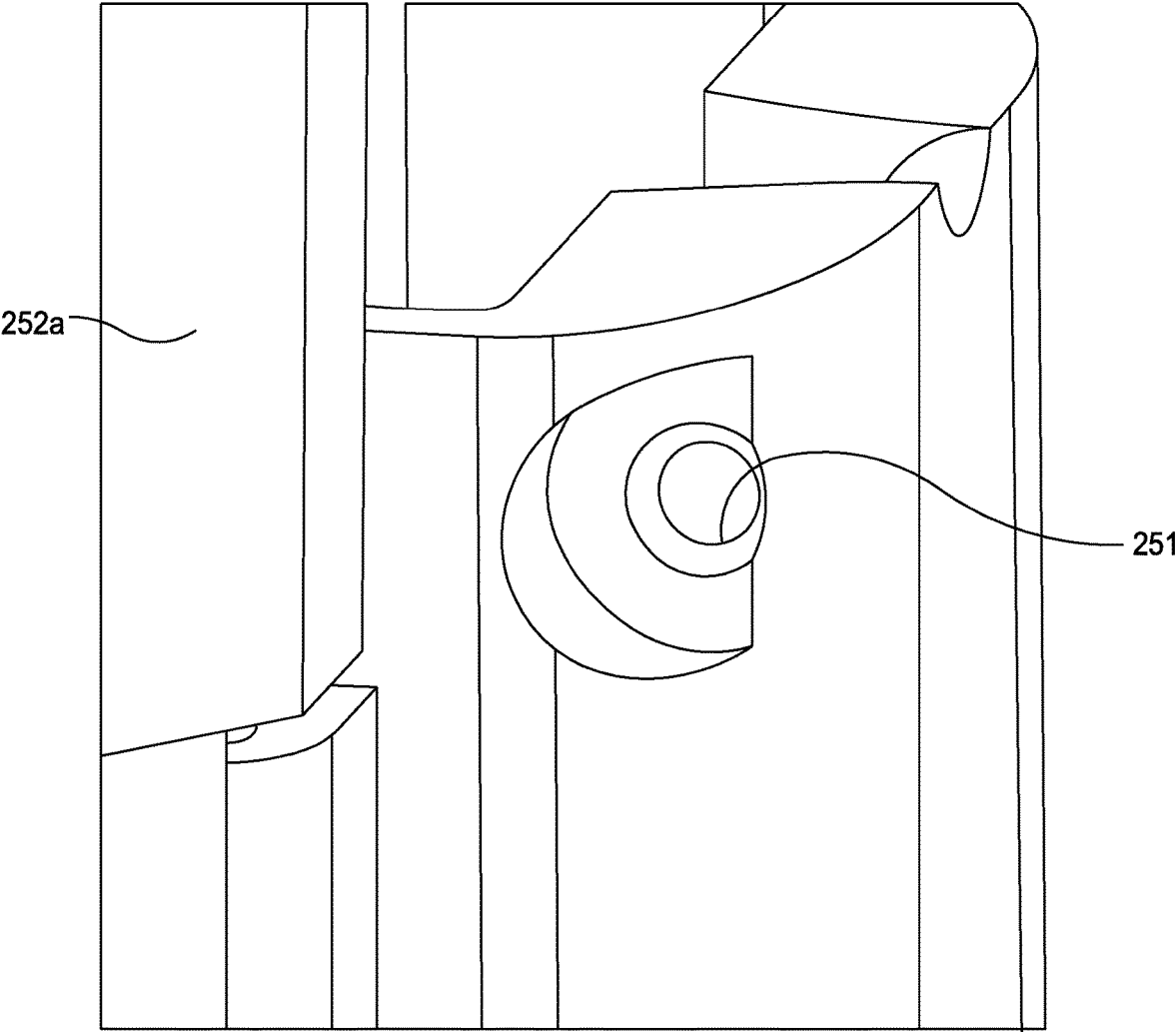


FIG. 37D

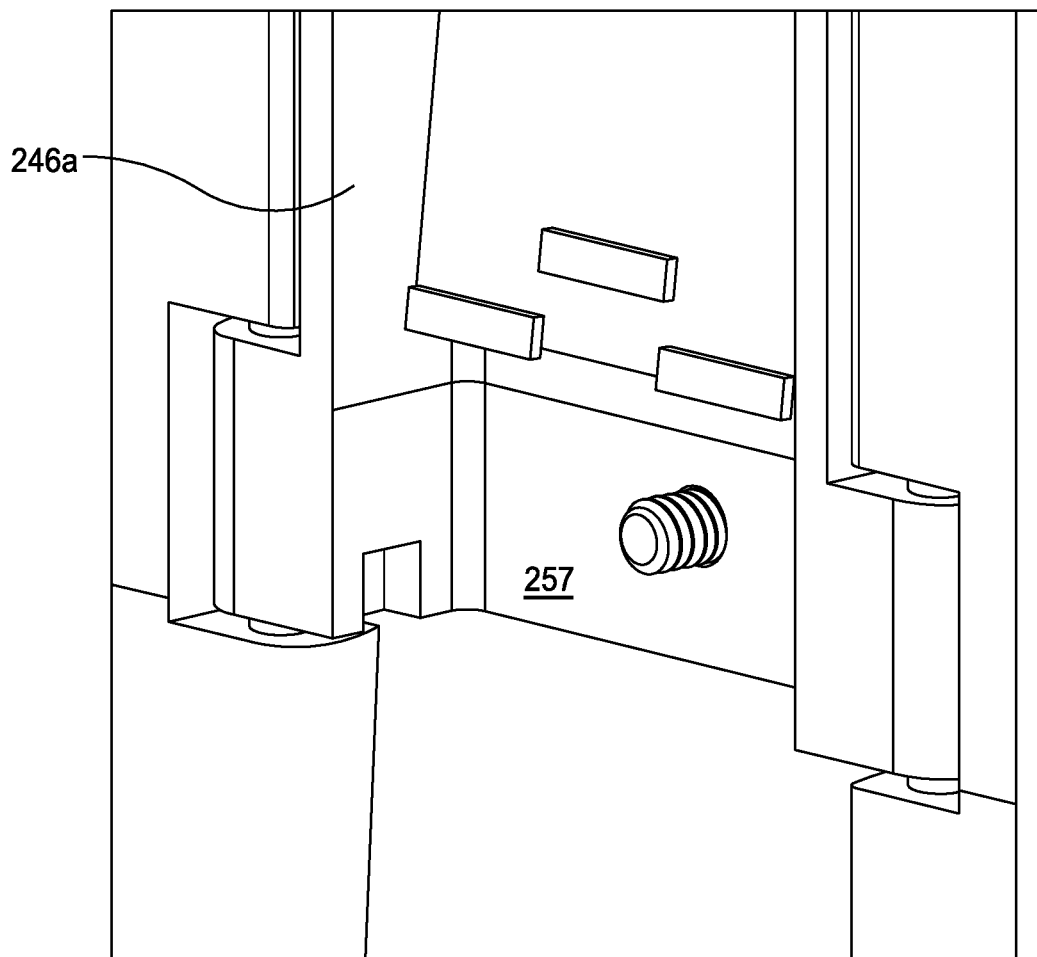


FIG. 37E

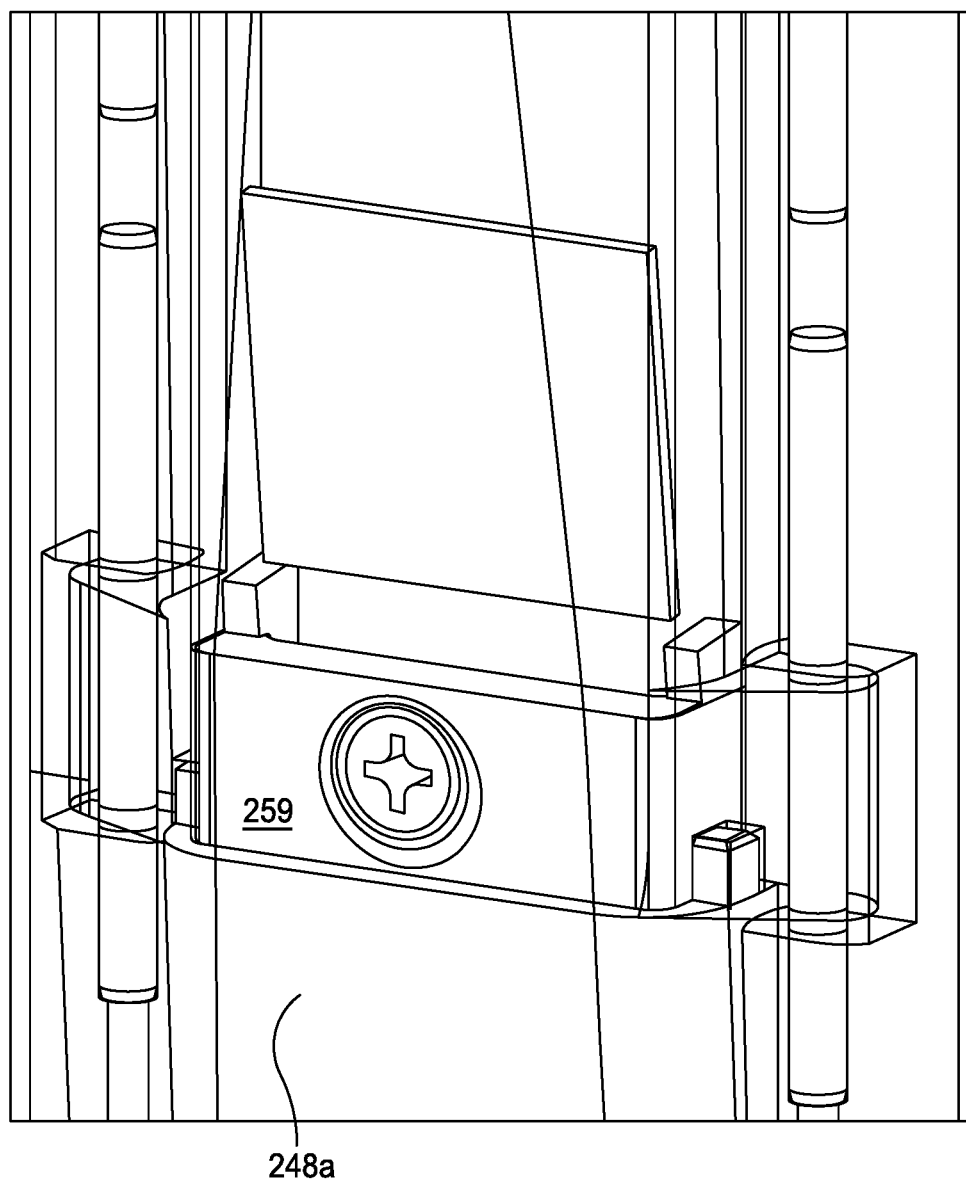


FIG. 37F

LATERAL RETRACTOR SYSTEM FOR MINIMIZING MUSCLE DAMAGE IN SPINAL SURGERY

REFERENCE TO PENDING PRIOR PATENT APPLICATIONS

[0001] This application is a continuation-in-part of pending prior U.S. patent application Ser. No. 16/988,901, filed Aug. 10, 2020 by Edward Rustamzadeh for “LATERAL RETRACTOR SYSTEM FOR MINIMIZING MUSCLE DAMAGE IN SPINAL SURGERY”, which is a continuation-in-part of prior U.S. patent application Ser. No. 16/533,368, filed Aug. 6, 2019 by Edward Rustamzadeh for “LATERAL RETRACTOR SYSTEM FOR MINIMIZING MUSCLE DAMAGE IN SPINAL SURGERY,” and issued as U.S. Pat. No. 10,799,230 on Oct. 13, 2020, which is a continuation of prior U.S. patent application Ser. No. 16/356,494, filed Mar. 18, 2019 by Edward Rustamzadeh for “LATERAL RETRACTOR SYSTEM FOR MINIMIZING MUSCLE DAMAGE IN SPINAL SURGERY” and issued as U.S. Pat. No. 10,426,452 on Oct. 1, 2019, which is a divisional of prior U.S. patent application Ser. No. 16/273,322, filed Feb. 12, 2019 by Edward Rustamzadeh for “LATERAL RETRACTOR SYSTEM FOR MINIMIZING MUSCLE DAMAGE IN SPINAL SURGERY” and issued as U.S. Pat. No. 10,363,023 on Jul. 30, 2019, all of which patent application is hereby incorporated by reference.

BACKGROUND

[0002] The spine is a flexible column formed of a plurality of bones called vertebrae. The vertebrae are hollow and piled one upon the other, forming a strong hollow column for support of the cranium and trunk. The hollow core of the spine houses and protects the nerves of the spinal cord. The different vertebrae are connected to one another by means of articular processes and intervertebral, fibrocartilaginous bodies, or spinal discs. Various spinal disorders may cause the spine to become misaligned, curved, and/or twisted or result in fractured and/or compressed vertebrae. It is often necessary to surgically correct these spinal disorders.

[0003] The spine includes seven cervical (neck) vertebrae, twelve thoracic (chest) vertebrae, five lumbar (lower back) vertebrae, and the fused vertebrae in the sacrum and coccyx that help to form the hip region. While the shapes of individual vertebrae differ among these regions, each is essentially a short hollow shaft containing the bundle of nerves known as the spinal cord. Individual nerves, such as those carrying messages to the arms or legs, enter and exit the spinal cord through gaps between vertebrae.

[0004] The spinal discs act as shock absorbers, cushioning the spine, and preventing individual bones from contacting each other. Discs also help to hold the vertebrae together. The weight of the upper body is transferred through the spine to the hips and the legs. The spine is held upright through the work of the back muscles, which are attached to the vertebrae.

[0005] A number of approaches, systems, and apparatuses have been devised to accomplish a variety of surgical interventions in association with the spine. These approaches enable a surgeon to place instrumentation and implantable apparatuses related to discectomy, laminectomy, spinal fusion, vertebral body replacement and other procedures intended to address pathologies of the spine. The

variety of surgical approaches to the spine have a number of advantages and drawbacks such that no one perfect approach exists. A surgeon often chooses one surgical approach to the spine from a multitude of options dependent on the relevant anatomy, pathology, and a comparison of the advantages and drawbacks of the variety of approaches relevant to a particular patient.

[0006] A common surgical approach to the spine is the lateral approach, which, in general, requires a surgeon to access the spine by creating a surgical pathway through the side of the patient's body through the psoas muscle to an intervertebral disc space where it is possible to dock onto the lateral lumbar disc. Variants of the lateral approach are commonly referred to as the “direct lateral” approach in association with the “DLIF” procedure, the “extreme lateral” approach in association with the “XLIF” procedure, and the “oblique lumbar” approach in association with the “OLIF” procedure.

[0007] A common problem associated with the lateral surgical approach includes a significant risk of damage to the musculature surrounding the spine. FIGS. 1A-1B illustrates a partial view of a spine 100 comprised of sequential vertebrae 109, each separated by intervertebral disc space 110, with an attached psoas muscle group 102 (including the psoas minor and psoas major). As shown, the psoas muscle 102 runs generally in a cranial-caudal direction with muscle fibers attached diagonally or at an approximate 45-degree angle to the spine 100. FIGS. 2A-2B illustrate an exemplary lateral approach to the spine. In typical lateral approaches, after making an incision in the psoas muscle 102, the surgeon places a number of sequential circular dilators 104_{1-n}, each larger in diameter, on the desired pathway to the spine 100 through the psoas muscle 102 to dilate the surgical site radially away from the initial incision site or K-wire insertion point. This dilation process can lead to compression of muscle, nerves, and blood supplies adjacent to the vertebral body, which can lead to ipsilateral upper thigh pain, hip flexor weakness that causes difficulty in walking and/or stair climbing, and muscle atrophy that follows from muscle injury.

[0008] After the series of circular dilators are forced into the muscle tissue, a multi-bladed or tubular retractor apparatus 106 may be placed over the final dilator 104_n. The retractor is then retracted radially to separate the psoas muscle and other soft tissues. A common problem associated with this type of lateral procedure is that soft tissues, including the musculature and nerves surrounding the spine, become crushed and/or trapped near the distal end of the retractor's blades when the retractor is passed over the final dilator, a problem often referred to as “trappage,” graphically depicted in FIG. 3.

[0009] In order for the surgeon to clear the surgical pathway to the disc space, or to “see” the disc space, the surgeon must cauterize and cut the muscle that is caught inside the retractor, effectively performing a muscle biopsy each time the surgeon performs an XLIF, DLIF, OLIF procedure. Beyond undesired muscular damage to the patient, this approach requires additional effort for the surgeon to utilize a cautery or similar device to remove the trapped soft tissues from between the distal end of the retractor and the vertebral bodies prior to completing access to the spine.

[0010] Oftentimes the resulting damage and trauma to the soft tissue resulting from trappage and removal of psoas

muscle tissue with a cautery causes lasting problems for a patient. For instance, a patient who experiences trappage during surgery will often have ipsilateral upper thigh pain and leg weakness. Such pain and leg weakness occurs due to the linkage of the psoas to the lower body, as the psoas muscle connects to the femur. Thus, damage to the psoas will generally manifest in lower body discomfort, including pain and weakness in the leg.

[0011] Another problem associated with existing lateral surgical approaches to the spine is nerve damage. The lumbar plexus is a web of nerves (a nervous plexus) in the lumbar region of the body which forms part of the larger lumbosacral plexus. The lumbar plexus in particular is often damaged as a direct result of surgical intervention utilizing the lateral approach to the spine. The nerves associated with the lumbar plexus can experience indirect nerve injury as a result of over-dilation or over-retraction of apparatuses utilized to accomplish lateral access to the spine. They also can experience direct nerve injury as a result of direct trauma caused by impingement from the instrumentation utilized during the surgical intervention in association with the lateral approach to the spine, as in the case of trappage, discussed above. Such indirect and direct nerve damage can cause numbness in part or all of the leg and can lead to indirect muscle atrophy. A recent meta-analysis review of 24 published articles indicates that the lateral approach is associated with up to a 60.7% complication rate. Gammal, Isaac D, et. al, Systemic Review of Thigh Symptoms after Lateral Transpsoas Interbody Fusion for Adult Patients with Degenerative Lumbar Spine Disease, International Journal of Spine Surgery 9:62 (2015). The review further found that the retractors resulted in 43% psoas muscle pain, 30.8% psoas muscle weakness, and 23.9% nerve or plexus injury due to the inherently flawed design of existing commercially available retractors.

[0012] One existing method of neuromonitoring involves the insertion of a number of epidural electrodes into the lumbar plexus. Stimulation of the electrodes is used to trigger a response in the patient's nerve structures, and the resulting evoked potentials correspond to the neural activities of the nerve structures near the recording electrodes. The potentials may be recorded to detect reactions in the nervous system that may indicate a problem, including some type of impingement or encroachment of an instrument upon the nerve structures during a procedure. This method, while providing information relating to a change in the behavior of the nerve structures nearby the inserted electrodes, does not directly correlate to a change in the behavior of the nerve structures in response to a nearby surgical instrument such as a dilator or a retractor, and is therefore not optimal for identifying impingement from the instrumentation utilized during the surgical intervention.

[0013] In addition, existing dilators oftentimes incorporate a vertical wire conductor that extends through the outer wall of the dilator parallel to the longitudinal axis of the apparatus, terminating in a pinpoint electrode at the distal end of the apparatus. The electrode may stimulate nearby nerve structures to assess for any impingement upon nerve or plexus. Because the vertical wire provides only a pinpoint electrode, the surgeon must manually rotate the apparatus through 360 degrees to perform a full range of neuromonitoring for impingement upon all of the adjacent neurological structures surrounding the device: the front and the back, superior and inferior. This additional step is cumbersome

and presents challenges in achieving thorough neuromonitoring. Moreover, because existing dilators with pinpoint electrodes require the surgeon to rotate the dilators to achieve neuromonitoring in 360 degrees, the dilators cannot perform a full range of monitoring once they are affixed. After fixation, only pinpoint monitoring is provided, and existing devices cannot provide continuous, real-time neuromonitoring throughout the procedure.

[0014] Existing retractor systems also present challenges in terms of illumination and require a separate light source that attaches to the top of the retractor. This separate device is cumbersome, physically interfering and disruptive, and the limited ability to position the light source oftentimes means that light reflects off of the retractor blades before returning to the surgeons eyes, which leads to suboptimal visualization of the surgical area.

[0015] Existing retractor systems also lack ease of adjustability and are not designed with an eye toward ergonomic use by the surgeon, who is forced to hunch over the retractor apparatus during the course of the procedure to direct the surgical equipment as desired.

SUMMARY

[0016] This Summary is provided to introduce a selection of concepts in a simplified form that are further described below in the Detailed Description. This Summary is not intended to identify key aspects or essential aspects of the claimed subject matter. Moreover, this Summary is not intended for use as an aid in determining the scope of the claimed subject matter.

[0017] One embodiment provides a lateral retractor system for forming a lateral retractor system for forming a surgical pathway through a plurality of psoas muscle fibers to a patient's intervertebral disc space, comprising a dilator including a conductive body extending between a proximal end and a distal end; a first nonconductive layer disposed upon an outer surface of the conductive body; a first active neuromonitoring tip protruding from the distal end of the conductive body to a leading distal edge configured for insertion into the intervertebral disc space; and a first conductive electrical pathway extending from a first conductive input surface at the proximal end of the conductive body, through the conductive body, and to the first active neuromonitoring tip such that an electrical signal applied to the first conductive input surface causes the first active neuromonitoring tip to simultaneously and continuously stimulate one or more nerve structures located adjacent to any portion of a circumference of the distal end of the conductive body to assess for an encroachment of the dilator upon the one or more of the nerve structures.

[0018] Another embodiment provides a dilation system for minimizing damage to a patient's psoas muscle fibers when forming a surgical pathway to an intervertebral disc space of the patient's spine, the dilation system having a dilator including a conductive body portion extending between a proximal end and distal end; a nonconductive layer disposed upon the conductive body portion; and a conductive neuromonitoring portion extending distally from the distal end of the conductive body portion to a leading distal edge configured for insertion between the patient's psoas muscle fibers, wherein when an electrical dilator stimulus is applied to the proximal end of the conductive body portion, the electrical dilator stimulus propagates through the conductive body portion to the conductive

neuromonitoring portion such that the conductive neuromonitoring portion simultaneously stimulates one or more nerve structures located adjacent to any point about a circumference of the conductive neuromonitoring portion.

[0019] Yet another embodiment provides retraction system for forming a surgical pathway through a patient's psoas muscle to the patient's intervertebral disc space, comprising a dilator for traversing a plurality of fibers of the patient's psoas muscle, the dilator having a dilator body portion and a dilator neuromonitoring portion extending distally from the dilator body portion; a retractor having retractable blades configured to pass over the dilator, each of the retractable blades having a blade body portion and a blade neuromonitoring portion extending distally from the blade body portion, wherein the dilator and each of the blades are conductive such that an electrical dilator stimulus applied to the dilator body portion propagates to the dilator neuromonitoring portion and an electrical blade stimulus applied to the blade body portion of each of the retractable blades propagates to each of the blade neuromonitoring portions to simultaneously and continuously stimulate one or more nerve structures located adjacent to any portion of a circumference of the dilator neuromonitoring portion and any portion of a circumference of each of the blade neuromonitoring portions to assess for an encroachment of the dilator and the dual-blade retractor upon the one or more of the nerve structures; and an insulative dilator nonconductive layer disposed upon the dilator body portion, and an insulative blade nonconductive layer disposed upon each of the blade body portions.

[0020] Other embodiments are also disclosed.

[0021] Additional objects, advantages and novel features of the technology will be set forth in part in the description which follows, and in part will become more apparent to those skilled in the art upon examination of the following, or may be learned from practice of the technology.

BRIEF DESCRIPTION OF THE DRAWINGS

[0022] Non-limiting and non-exhaustive embodiments of the present invention, including the preferred embodiment, are described with reference to the following figures, wherein like reference numerals refer to like parts throughout the various views unless otherwise specified. Illustrative embodiments of the invention are illustrated in the drawings, in which:

[0023] FIGS. 1A-1B illustrate perspective and top partial views, respectively, of a patient's spine comprised of sequential vertebrae, each separated by an intervertebral disc space, with an attached psoas muscle group;

[0024] FIGS. 2A-2B illustrate perspective views of a prior art retraction system including a series of increasing-diameter dilators and a circular lateral retractor, as inserted into the spine of FIGS. 1A-1B;

[0025] FIG. 3 illustrates a bottom-plan view of the prior art dilators and lateral retractor of FIGS. 2A-2B, as inserted into the psoas muscle and trapping the muscle fibers;

[0026] FIGS. 4-6 illustrate respective perspective, top, and front views of one embodiment of a rectangular dilator, as inserted at an insertion orientation through a patient's side body and through the psoas muscle over the intervertebral disc space of FIGS. 1A-1B;

[0027] FIG. 7 illustrates a perspective view of the rectangular dilator of FIGS. 4-6;

[0028] FIG. 8 illustrates a perspective view of the rectangular dilator of FIGS. 4-6, as inserted at the insertion orientation through the psoas muscle over the intervertebral disc space and having a monitor cable coupled with a conducting wire in electronic communication a neuromonitoring tip of the dilator;

[0029] FIGS. 9-10 illustrate perspective and side views, respectively, of one embodiment of a dual-blade assembly passed over the inserted dilator of FIGS. 4-8 in the insertion orientation;

[0030] FIGS. 11-14 illustrate left-perspective, right-perspective, top-plan, and left-bottom-perspective views, respectively, of one embodiment of a blade subassembly of the dual-blade assembly of FIGS. 9-10;

[0031] FIG. 15 illustrates a perspective view of the dual-blade assembly of FIGS. 9-10 installed in the insertion orientation, without a lower coupling device and disposed upon a surgical table in preparation for connection with a lateral retraction gearbox;

[0032] FIG. 16 illustrates a perspective view of the dual-blade assembly of FIGS. 9-10 including a lower coupling device attaching two of the blade subassemblies of FIGS. 11-14, in preparation for connection with the lateral retraction gearbox of FIG. 15;

[0033] FIG. 17 illustrates a perspective view of the dual-blade assembly of FIG. 16 in the insertion orientation, connected to the lateral retraction gearbox of FIGS. 15-16 via one embodiment of a rotation assembly;

[0034] FIG. 18 illustrates a perspective view of the connected dual-blade assembly, lateral retraction gearbox, and rotation assembly of FIG. 17, with the dual-blade assembly rotated to a final rotated orientation via the rotation assembly;

[0035] FIG. 19 illustrates a perspective view of one embodiment of a rotation gearbox and connecting rods of the rotation assembly of FIGS. 17-18;

[0036] FIG. 20 illustrates a perspective view of the connected dual-blade assembly, lateral retraction gearbox, and rotation assembly of FIGS. 17-18, with a handle of the rotation assembly removed and an embodiment of a pair of opposing passive lateral arms coupled between the dual-blade assembly and the lateral retraction gearbox;

[0037] FIG. 21 illustrates the assembly of FIG. 20, with a gearbox of the rotation assembly removed;

[0038] FIG. 22 illustrates a perspective view of the assembly of FIG. 21, with one embodiment of a pair of opposing lateral drive arms coupled between the dual-blade assembly and the lateral retraction gearbox;

[0039] FIG. 23 illustrates a perspective view of the assembly of FIG. 22, with a K-wire and a lower coupling device removed from the dual-blade assembly to an exploded position;

[0040] FIG. 24 illustrates a perspective view of the assembly of FIG. 23, with the dilator of FIGS. 4-8 removed to an exploded position;

[0041] FIG. 25 illustrates a perspective view of the assembly of FIG. 24, with a housing of the lateral actuation gearbox removed to reveal one embodiment of a lateral retraction gear chain operating within the housing;

[0042] FIGS. 26-27 illustrate top views of two adjacent blade subassemblies of FIGS. 11-14 coupled with one embodiment of a lateral retraction assembly and in a closed blade position;

[0043] FIGS. 28-30 illustrate top views of the two blade subassemblies coupled with the lateral retraction assembly of FIGS. 26-27 in a retracted blade position;

[0044] FIG. 31 illustrates a perspective view of the two blade subassemblies coupled with the lateral retraction assembly in the retracted blade position of FIG. 30, as inserted through the patient's side body;

[0045] FIG. 32 illustrates a perspective view of one embodiment of a fully assembled lateral retraction system;

[0046] FIG. 33 illustrates a perspective view of a surgical area illuminated using LEDs built into one embodiment of the lateral retraction system of FIG. 32;

[0047] FIG. 34 illustrates a perspective view of an image area covered by a video camera incorporated within one embodiment of the lateral retraction system of FIG. 32;

[0048] FIGS. 35A-35B provide a flowchart depicting an exemplary method of creating a surgical pathway to the patient's spine using the assemblies and systems of FIGS. 4-34

[0049] FIGS. 36A-36B illustrate perspective and cross-sectional views of another embodiment of a planar dilator featuring non-wired, continuous, and simultaneous neuromonitoring about 360-degrees of a circumference of the dilator; and

[0050] FIGS. 37A-37F illustrate respective front, rear, partial-rear-perspective, partial-side-perspective, unassembled partial-rear perspective, and assembled partial-rear perspective views of one embodiment of a blade and adjustable wings for incorporation into the blade subassembly of FIGS. 11-18, featuring non-wired, continuous, and simultaneous neuromonitoring about 360-degrees of a circumference of the blade and the adjustable wings.

DETAILED DESCRIPTION

[0051] Embodiments are described more fully below in sufficient detail to enable those skilled in the art to practice the system and method. However, embodiments may be implemented in many different forms and should not be construed as being limited to the embodiments set forth herein. The following detailed description is, therefore, not to be taken in a limiting sense.

[0052] This disclosure details a system and method of use for a lateral approach to creating a minimally invasive surgical pathway through a patient's side body and psoas muscle 102 to the intervertebral disc space 110 of the spine 100. Embodiments may include a lateral retractor system having a flat, narrow dilator having a body that tapers to a distal edge. The dilator inserted in a diagonal orientation that is parallel to the angled fibers of the psoas muscle and anchored into the disc space 110 via a K-wire. The dilator may be used in conjunction with a dual-blade lateral retractor that may be placed in a corresponding diagonal orientation over the flat, narrow dilator before the entire system is rotated approximately 45-50 degrees to the horizontal, or until the dilator and the lateral retractor are parallel with the disc space 110, as shown and discussed in FIGS. 17-18 below. Once the system is rotated, the dilator may be removed and the dual blades of the lateral retractor may be laterally separated to push the muscle fibers away and to complete the surgical pathway in a manner that minimizes entrapment of, impingement upon, and/or damage to the patient's muscle fibers and nerve structures. Because the dilator is narrow or flat in shape, which allows the dilator to be placed in its insertion orientation parallel to the muscle

fibers and then rotated to its final rotated orientation parallel to the disc space, the system functions with a single element or component dilator, rather than requiring placement of a series of sequentially larger circular dilators, as discussed in the Background section above.

[0053] Both the dilator and the lateral retractor may incorporate real-time, 360 degree neuromonitoring through stimulated horizontal wiring positioned on the external sides/surfaces of each of the distal dilator tip and the distal ends of the blades of the lateral retractor, enabling real-time and continuous neuromonitoring throughout the procedure from front to back and superior to inferior. Embodiments of the lateral retractor system may also incorporate built-in LED lighting for superior surgical visualization, as well as micro-video capabilities that enable the system to be operated in the most ergonomic and efficient fashion.

[0054] Turning to exemplary embodiments, FIGS. 4-34 and 35A-35B generally illustrate a method of using embodiments of a disclosed lateral retractor system 200 (FIG. 32) to employ a lateral surgical approach to clear a surgical pathway 114 to a patient's spinal disc space 110. Specifically and in one embodiment, FIGS. 4-34 detail a number of steps in which exemplary devices are in use to create the surgical pathway 114 through the side of a patient's body 108, through the psoas muscle 102, and to the intervertebral disc space 110, while FIGS. 35A-35B provide a flowchart depicting an exemplary method 500 of creating the surgical pathway 114 through the side of the patient's body 108 through the psoas muscle 102 to the disc space 110.

[0055] Employing fluoroscopy imaging technology, a dilator 202 may be placed over/adjacent to the intervertebral disc space 110 (FIG. 35A, 501). Specifically, and referring to FIGS. 4-7, the dilator 202 may enter through an incision 118 in the patient's side body 108 (FIG. 35A, 502), cut through any intervening fascia (FIG. 35A, 504), and then traverse the psoas muscle 102 in a direction, or at an insertion orientation 239, that is "along," or parallel to the muscle fibers of the psoas muscle 102, and diagonal to, or angled at approximately 45 degrees to, the patient's spine 100 (FIG. 35A, 506). The psoas muscle 102 may be accessed via the side of the patient's body 108 such that the dilator 202 protrudes from a lateral surface 116 of the patient's body 108 when inserted to full depth at the spinal column 100.

[0056] FIG. 7 illustrates a perspective view of one embodiment of the dilator 202. In this embodiment, the dilator 202 may feature a flat, narrow body 204 having opposing flat surfaces 209 that extend between a proximal end 206 for positioning at the lateral surface 116 of the patient's side body 108 (FIG. 4) and a distal end 208 for positioning adjacent the patient's spine 100. The longitudinal sides of the narrow body 204 of the dilator 202 may taper to opposing longitudinal edges 212, and the distal end 208 of the dilator 202 may taper to a distal edge 210 capable of cutting through the patient's fascia and traversing the fibers of the psoas muscle 102 in the parallel manner described above. As a result, the dilator 202 separates, rather than crushes, the fibers of the psoas muscle 102 as it traverses through the psoas muscle 102 to the spine 100, as shown in FIGS. 4-6 and 8.

[0057] The dilator 202 may also include a K-wire access aperture 216 that extends longitudinally through the body 204 of the dilator 202. In addition, conducting wires 218 may extend longitudinally through each side of the body 204 of the dilator 202. At the distal end 208 of the dilator 202,

the conducting wires **218** may be in electronic communication with a set of horizontal neurosensing wires **220** that are integrated or built into each side of the tapered distal end **208** of the dilator **202**. At the proximal end **206** of the dilator, the conducting wires **218** may be in electronic communication with a monitoring cable **224**, shown in FIG. 8, which may be configured to conduct an electronic stimulus through the conducting wires **218** to the horizontal neurosensing wires **220**, forming an active neuromonitoring tip **222** about an entirety of the distal end **208** of the dilator **202**.

[0058] Impingement of the active monitoring tip **222** upon, or alternatively, encroachment of the active monitoring tip **222** in close proximity to nerve structures located along the patient's spine **100** may stimulate those nerve structures that are nearby or adjacent to the active monitoring tip **222**. The voltage of the applied electronic stimulus may be adjusted as necessary and/or required to stimulate nerve structures within a defined distance of the active monitoring tip **222**. This applied stimulus causes the nerve structure(s) to fire and generate a responsive signal, which may in turn be conducted from the active monitoring tip **222**, through the conducting wires **218**, and to the monitoring cable(s) **224** in electronic communication with one or both of the conducting wires **218** at the proximal end **206** of the dilator **202**, as shown in FIG. 8, thereby translating the neurosensing stimulation of the active monitoring tip **222** by the nearby nerve structure(s) to external monitoring equipment (not shown) via the monitoring cable **224** and determining, in real time and with 360 degrees of monitoring range or field of view about the distal end **208** of the dilator **202**, a possibility of nerve or plexus injury as the dilator **202** is inserted (FIG. 35A, 508).

[0059] Embodiments of the dilator **202** and its components may be formed of any appropriate conductive or nonconductive, autoclavable or otherwise sterilizable metal or plastic. In addition, the body **204** of the dilator **202** may have any appropriate length to accommodate the patient's size, shape, and/or physiology. In one embodiment, the dilator **202** may be provided in a variety of lengths, allowing the surgeon to select in real-time the appropriate length for the patient.

[0060] Once the distal edge **210** of the dilator **202** is positioned at the spine **100** in the insertion orientation **239** that is parallel to the fibers of the psoas muscle **102** and spanning the disc space **110** diagonally at an approximate 45-degree angle, a K-wire **214** may be passed longitudinally through the access aperture **216** of the dilator **202** and into the spine **100** at the disc space **110** (FIG. 35A, 510), both stabilizing and securing the position of the dilator **202**, as shown in FIGS. 6 and 8. Because of the active monitoring tip **222**, the full range of monitoring—front to back and superior to inferior—may continue after the dilator **202** is fixed via the k-wire **214**. Unlike previous devices featuring pinpoint electrodes that require manual rotation to perform 360 degrees of monitoring, the active monitoring tip **222** remains active and provides a geometry capable of monitoring in 360 degrees during every stage of its insertion and use during a procedure.

[0061] Referring to FIGS. 9-10, after securing the K-wire **214** (FIG. 35A, 510) into the disc space **110** of the spine **100** such that the dilator **202** is stabilized, secured, and providing continuous neuromonitoring, a dual-blade assembly **230** of a dual-blade lateral retractor system **200** (FIG. 32) may be passed over or introduced at the insertion orientation **239**

alongside the dilator **202** such that each blade **244** of the dual-blade assembly **230** opposes and contacts one of the opposing flat surfaces **209** of the dilator **202** to further minimize damage to nerve structures and muscle fibers (FIG. 35A, 512).

[0062] As shown in FIGS. 9-10, the dual-blade assembly **230** may include two opposing and identical blade subassemblies **240** coupled to one another via a lower coupling device **242** configured to snap or press fit into receiving structures formed within each of the blade subassemblies **240**. The lower coupling device **242** may include a platform **241** having a plurality of protrusions extending from a bottom of the platform **241** that are sized to be received by each of the blade subassemblies **240**. The protrusions may include two opposing rectangular protrusions **243** and four opposing circular protrusions **245**, each for insertion into a corresponding one of the blade subassemblies **240**. The lower coupling device **242** may also include two circular receivers **247** formed within a top of the platform **241** and configured to receive components of additional functional assemblies that stack above the blade assembly **230**, as detailed further below.

[0063] FIGS. 11-13 illustrate front-perspective, rear-perspective, and top-plan views of one exemplary embodiment of the blade subassembly **240**, respectively. In this embodiment, the blade subassembly **240** may include a blade **244** having a planar inner surface **235** that faces the opposing blade **244** of the dual-blade assembly **230** (FIGS. 9-10), an outer surface **237**, a proximal blade portion **246**, a detachable distal blade portion **248**, and opposing longitudinal edges **250** that extend between a proximal end **260** of the proximal blade portion **246** and a distal end **255** of the distal blade portion **248**. Opposing adjustable wings **252** may be hingedly coupled with each of the opposing longitudinal edges **250**, as detailed further below.

[0064] Turning to the blade **244**, the detachable distal portion **248** may be a disposable, single-use insert of any appropriate length to accommodate the patient's size or physiology. In one embodiment, a plurality of detachable distal portions **248** may be provided in a peel pack (not shown), where each of the distal portions **248** contained within the peel pack feature a different length to accommodate a variety patient sizes and/or physiologies, which results in a variety of distances to traverse between the lateral surface **118** of the patient's body **108** and the spine **100**. During use, the surgeon may select the detachable distal blade portion **248** with the appropriate length before attaching the select distal blade portion **248** to the reusable and sterilizable proximal portion **246** of the blade **244**. The detachable distal portion **248** may attach to the reusable proximal portion **246** in any appropriate manner including, for example, a snap-fit of mating components or, as shown in FIG. 12, via an attachment screw **254** or another appropriate threaded fastener.

[0065] In one embodiment, the distal end **255** of the distal portion **248** of the blade **244** may form an active monitoring tip **256** similar to the active monitoring tip **222** of the dilator **202**. In this regard, horizontal neurosensing wires **258** may be incorporated or built into the outer surface **237** of the blade **244** at the active monitoring tip **256**. The horizontal neurosensing wires **258** may detect any impingement or encroachment upon nerve or plexus, and the resulting stimulus may be conducted through conducting wires embedded longitudinally in the blade, and through a monitoring cable

for reporting to external equipment. Via the active monitoring tip 256 of each of the distal blade portions 248 of the blades 244, continuous real-time neuromonitoring may be performed to prevent nerve or plexus injury when the blade assembly 230 is inserted over the dilator 202 (FIG. 35A, 512, 514), as well as when the blade assembly 230 is rotated (FIG. 35A, 516) and/or laterally separated or retracted (FIG. 35A, 524), as discussed below. Unlike existing systems, neuromonitoring over a full 360-degree monitoring range may continue throughout the procedure.

[0066] The sterilizable and reusable proximal blade portion 246 may include a number of unique features that aid the surgeon. In one embodiment, the proximal end 260 of the proximal blade portion 246 may form a generally rectangular receiver 262 configured to receive one of the rectangular protrusions 243 of the lower coupling device 242 (FIGS. 9-10), which is adapted to temporarily couple the dual, opposing blade subassemblies 240 to one another during insertion and assist in rotating the blade subassemblies 240 from the insertion orientation 239 to a final, rotated orientation, as discussed below in relation to FIGS. 17-18.

[0067] In addition, and referring to FIGS. 11-14, one or more light emitting diode (LED) lights 264 may be built into the proximal blade portion 246. As shown in FIGS. 11 and 14 and in this embodiment, three LED lights 264 may be positioned adjacent to the inner surface 235 of a distal end 261 of the proximal blade portion 246, such that the LED lights 264 illuminate a surgical area 266, as shown in FIG. 11. In one embodiment shown in FIG. 14, the LED lights 264 may be mounted to a printed circuit board (PCB) 265 housed within a PCB chamber 267 formed within the proximal blade portion 246 of the blade 244. The PCB 265 may incorporate control or interface circuitry that is, in turn, electrically coupled with a power source and a switch 272. In this embodiment, the power source may be one or more lithium ion batteries 268 housed within a battery housing 270 that is affixed in any appropriate manner to the outer surface 237 of the blade 244, as shown in FIGS. 11-13. The switch 272 may be electrically coupled between the batteries 268 and the PCB 265/LED lights 264, such that the switch 272 is configurable to control the lights 264 as necessary and/or desired by the surgeon. For example, the switch may be operated to illuminate a single one of the LED lights 264, a pair of the lights 264, or all of the LED lights 264 depending on the applicable light requirements and/or requisite run times.

[0068] Built-in lighting on the inner surfaces 235 of the blades 244 provides more accurate visualization for the surgeon due to the proximity of the light emitting source to the surgical field 266. The built-in lighting also eliminates the need for an external extension cord for lighting purposes, and prevents light projected from a separately attached light source, which is often attached to a proximal end of the apparatus, from reflecting off the blades and into the surgeon's eyes during operation.

[0069] The blade 244 may also include video capability to provide ergonomic operation for the surgeon. Specifically, and in one embodiment shown in FIG. 14, an interior of the proximal blade portion 246 may form a camera receiver channel 274 into which a video camera 276 (e.g., a commercially available micro-video camera) may be fed or positioned to provide a clear view of the surgical field 266. Images captured by the video camera 276 may be transmitted to one or more external monitors (e.g., flat screen

television monitors) (not shown) via a video output 278 electronically coupled between the video camera 276 and the monitor(s). In one embodiment, the video camera 276/video output 278 may employ wireless technology such as, for example, a Bluetooth, Zigbee, Wi-Fi or another appropriate transmitter or transceiver to communicate with the external monitoring devices. This video capability enables the surgeon to view his or her work within the surgical field 266 inside the dual-blade assembly 230 on the external monitors, and relieves the surgeon of the need to look straight down the assembly throughout the course of the procedure being performed.

[0070] As discussed above, each of the longitudinal edges 250 of the blade 244 may hingedly couple with an adjustable wing 252, as shown in FIGS. 11-14. As detailed below in relation to FIGS. 25-31, the adjustable wings 252 may be rotated or adjusted through 90 degrees relative to the inner surface 235 of the blade 244—from an open position 280 that is parallel with the blade 244 (FIGS. 25-27) to a closed position 282 that is perpendicular to the blade 244 (FIG. 30), and any position therebetween (FIGS. 28-29). This adjustment from the open position 280 to the closed position 282 essentially sections off the muscle surrounding the dual-blade assembly 230 as the blades 244 are separated or retracted away from one another, thereby preventing any “creep” of the muscle between the blades during retraction and enabling the dual-blade assembly 230 to accomplish what has previously required additional blades (e.g., multiple blades beyond two, a circular or radial blade configuration) to complete.

[0071] FIGS. 12-13 illustrate a perspective view of the blade subassembly 240 and a top view of the blade subassembly 240 with the battery housing 270 removed, respectively. Specifically, FIGS. 12-13 detail an exemplary actuation assembly 290 for the adjustable wings 252 on each blade 244. In this embodiment, the actuation assembly 290 may include a central miter gear 292 positioned horizontally such that a center axis 294 defined by the central miter gear 292 runs parallel to the blade 244. A top of the central miter gear 292 may form a hexagonal socket 296 configured to receive an actuating hex key (not shown), which may take the form of a removeable manual handle such as handles 310 and 316, discussed below in relation to the rotation and lateral retraction assemblies.

[0072] The central miter gear 292 may be enmeshed between two opposing vertical miter gears 298, each defining a center axis 300 that is perpendicular to and that intersects the center axis 294 of the central miter gear 292. Each of the vertical miter gears 298 may be affixed to a worm screw 302 that is, in turn, enmeshed with a corresponding worm wheel 304 affixed to a proximal end of the associated adjustable wing 252. To operate, the hex key/handle may be rotated within the hexagonal socket 296 to rotate the central miter gear 292, which, in turn rotates the vertical miter gears 298, the attached worms screws 302, and the corresponding worm wheels 304 affixed each adjustable wing 252 to move the wings 252 through 90 degrees in the direction of arrow C relative to the inner surface 235 of the blade 244, as shown in FIGS. 25-31.

[0073] Like the lower blade portion 248, the adjustable wings 252 may be single-use components that vary in length based upon an overall length of the blade 244 required to accommodate the patient's size and/or shape. Moreover, each of the adjustable wings 252 may form an active

monitoring tip **283** (FIG. **12**) on its outer surface similar to the active monitoring tips **222** and **256** of the dilator **202** and the blade **244**, respectively.

[0074] Returning to the method and in relation to FIGS. **15-19**, after the dual-blade assembly **230** is passed over the dilator **202** in a direction along the fibers of the psoas muscle **102** (FIG. **35A**, **512**), the dual-blade assembly **230** may be rotated approximately 45-50 degrees in the direction of arrow **A** about the K-wire **214**, from its initial insertion orientation **239** parallel to the fibers of the psoas muscle **102**, shown in FIGS. **15-17**, to a final rotated orientation **306** parallel to the disc space **110**, in which the blades **244** of the dual-blade assembly **230** are positioned transverse to the fibers of the psoas muscle **102** and begin to separate the fibers of the psoas muscle **102**, as shown in FIG. **18** (FIG. **35B**, **516**).

[0075] To rotate the dual-blade assembly **230** from the insertion orientation **239** to the rotated orientation **306** (FIG. **35B**, **516**), additional assemblies may be operably coupled with the dual-blade assembly **230**, as shown in FIGS. **15-19**. Initially, a lateral actuation gearbox **308** and an actuating handle **310** may be securely attached to a fixed reference point such as a surgical table **233** via a standard tooth jaw and universal joint mechanism (not shown) (FIG. **35B**, **518**), as shown in FIG. **15**. Then a rotation assembly **312** may be coupled between the blade assembly **230** and the lateral actuation gearbox **308** (FIG. **35B**, **520**).

[0076] In further detail and in one embodiment shown in FIGS. **17-19**, the rotation assembly **312** may include a rotation gearbox **314**, an actuating handle **316**, and a pair of connecting rods **318** coupled between the rotation gearbox **314** and the lateral actuation gearbox **308**, each having a first end **320** affixed to the a housing **324** of the rotational gearbox **314** and a second end **322** affixed to a housing **342** of the lateral actuation gearbox **308**. The first and second ends **320**, **322** of the connecting rods **318** may be affixed to the rotational gearbox housing **324** and the lateral actuation gearbox housing **342**, respectively, in any appropriate manner including, for example, via threaded fasteners.

[0077] FIG. **19** illustrates a perspective view of one embodiment of the rotation gearbox **314** and the connecting rods **318**, with the housing **324** of the rotation gearbox **314** in which the housing **324** is shown in wireframe to reveal the details of the gearbox **314**. In this embodiment, the rotation gearbox **314** may contain first, second, and third rotational gears **326**, **328**, **330**, respectively, that are rotationally mounted relative to one another within the housing **324**. The first rotational gear **326** may include a hexagonal or other appropriately configured socket **332** adapted to receive a distal end of the handle **316**, which, in this embodiment, may be configured as a hex key. The third rotational gear **330** may be affixed to an upper coupling device **334** having a top surface **336** adapted to attach to the third rotational gear **330** and a bottom surface **338** having two circular protrusions **340** extending therefrom. Each of the circular protrusions **340** may, when the rotation gearbox **314** is assembled to the blade assembly **230** as shown in FIGS. **17-18**, extend into the circular receivers **247** of the lower coupling device **242** of the blade assembly **230**, shown in FIG. **16** and detailed above in relation to FIGS. **9-10**.

[0078] Once the rotation assembly **312** is coupled between the blade assembly **230** and the lateral actuation gearbox **308** (FIG. **35B**, **520**), as shown in FIG. **17**, the handle may be manually actuated (FIG. **35B**, **522**) to turn the first rotational

gear **326**, which, in turn, rotates the enmeshed second rotational gear **328** and then the enmeshed third rotational gear **330**. Because the lateral actuation gearbox **308**, the connecting rods **318**, and the rotation gearbox **314** are fixed relative to the operating table (not shown), rotation of the third rotational gear **330** causes the upper coupling device **334** to turn the attached lower coupling device **242** about the K-wire **214**, which causes the two attached blade subassemblies **240** to rotate in the direction of arrow **A** (FIGS. **15-16**) from the initial insertion orientation **239** of FIG. **17** to the final rotated orientation **306** of FIG. **18**.

[0079] After the dual-blade assembly **230** has been rotated into the final rotated orientation **306** (FIG. **35B**, **516**), the system may be reconfigured for separation, or lateral retraction, of the two opposing blade subassemblies **240** via the steps illustrated in FIGS. **20-25** (FIG. **35B**, **524**). First, and as shown in FIG. **20**, a pair of opposing passive lateral arms **344** may be attached between the lateral actuation gearbox **308** and the battery housings **270** of the blade subassemblies **240** (FIG. **35B**, **526**). Each of the passive lateral arms **344** may have a first end **346** that is rotationally coupled with one of the battery housings **270** and a second end **348** that is rotationally coupled with the housing **342** of the lateral actuation gearbox **308**, such that the passive lateral arms **344** may provide stabilization to the blade assembly **230** as the rotation gearbox **314** is removed, as shown in FIG. **21**, as well as passively accommodate the lateral separation of the blade subassemblies **240**, as discussed further below in relation to FIGS. **26-31**. The rotational couplings between the passive lateral arms **344**, the battery housings **270**, and the lateral actuation gearbox **308** may take any appropriate shape, configuration, or type. In this embodiment, the first and the second ends **346**, **348** of each of the passive lateral arms **344** may form a receiver **350** configured to receive a corresponding protrusion **352** extending from the battery housing **270** and from the lateral actuation gearbox **308** via a friction fit.

[0080] Once the passive lateral arms **344** are attached (FIG. **35B**, **526**), the rotation assembly **312**, including the rotation gearbox **314**, the manual handle **316**, and the connecting rods **318**, may be removed as shown in FIGS. **20-21** by disengaging the upper and the lower coupling devices **334** and **242**, all the while relying on the passive lateral arms **344** for stabilization of the blade assembly **230** during removal (FIG. **35B**, **528**). Then a pair of opposing lateral drive arms **354** may be coupled between the lateral actuation gearbox **308** and the battery housings **270** of the blade subassemblies **240** (FIG. **35B**, **530**), as shown in FIG. **22**. Each of the lateral drive arms **354** may have a first end **356** that is rotationally coupled to one of the battery housings **270** of the blade subassemblies **240** and a second end **358** that is rotationally coupled to the housing **342** of the lateral actuation gearbox **308**. These rotational couplings may take any appropriate form, though in one embodiment, they may mimic the structure of the rotational couplings of the passive lateral arms **344** in that each of the first and the second ends **356**, **358** may form a receiver **360** configured to receive a corresponding protrusion **362** extending from the battery housing **270** and from the lateral actuation gearbox housing **342**, respectively, via a friction fit.

[0081] After the lateral drive arms **354** are attached, the K-wire **214** and the lower coupling device **242** may be removed, as shown in FIG. **23** (FIG. **35B**, **532**), followed by the dilator **202**, as shown in FIG. **24** (FIG. **35B**, **534**).

[0082] After removal of the K-wire 214, the lower coupling device 242, and the dilator 202, a lateral retraction assembly 370, which, in this embodiment, may include the handle 310, the lateral actuation gearbox 308, the opposing passive lateral arms 344, and the opposing lateral drive arms 354, may be employed to separate or laterally retract the blade subassemblies 240 from a closed position 390, shown in FIGS. 25-27, to a retracted position 392, shown in FIGS. 28-31 (FIG. 35B, 524, 536).

[0083] In further detail, FIG. 25 illustrates a perspective view of the lateral retraction assembly 370 having an open housing 342 of the lateral actuation gearbox 308 to detail one embodiment of the mechanics of the gearbox 308. In this embodiment, the handle 310 may incorporate a worm gear 372 at its distal end. The worm gear 372 may be positioned between and enmeshed with two opposing lateral gears 374, one bordering either side of the worm gear 372. Each of the lateral gears 374 may include a pivot point 375 about which the remaining components of the gear 374 rotate, a teeth portion 376 that engages with the worm gear 374, and a drive portion 378 containing a protrusion 362 configured to frictionally fit within the receiver 360 of the second end 358 of one of the lateral drive arms 354.

[0084] The teeth portion 376 of each of the lateral gears 374 may have a variable radius that extends between the pivot point 375 and the teeth portion 376. The variable radius may increase from a first radius, r_1 , located at a first end 380 of the teeth portion 376 to a larger second radius, r_2 , located at a second end 382 of the teeth portion 376.

[0085] In actuating the lateral retraction assembly 370 (FIG. 35B, 536), rotation of the worm gear 372 via the handle 342 causes the enmeshed teeth portions 376 of the opposing lateral gears 374 to travel from the first ends 380 engaged with the worm gear 372 at the smaller radius, r_1 , to the second ends 382 engaged with the worm gear 372 at the larger radius, r_2 . This travel causes the lateral gears 374 to pivot about the pivot points 375, such that the drive portions 378 of the gears swing outward in the direction of arrow B as the radius of each lateral gear 374 increases from r_1 to r_2 . This outward trajectory, in turn, drives the lateral drive arms 354, and thus the connected blade subassemblies 240, in the outward direction of arrow B, from the closed position 390 of FIGS. 25-27 to the retracted position 392 of FIGS. 28-31.

[0086] Before, after, or at increments during the process of actuating the lateral retraction assembly 270 (FIG. 35B, 536), and as discussed above in relation to FIGS. 11-13, the wing actuation assembly 290 of each blade subassembly 240 may be employed to adjust the adjustable wings 252 from the open position 280 parallel with the blades 244, shown in FIGS. 25-27, the closed position 282 perpendicular to the blades 244, shown in FIG. 30, and any position therebetween, such as the angled position (e.g., 27 degrees relative to the blade 244), shown in FIGS. 28-29 and 31 (FIG. 35B, 538). In this regard, the two opposing blades 244 are sufficient for lateral retraction, without the need for additional blades as required by existing retractor systems, as the adjustable wings 252 prevent creep of the muscle between the blades 244 and into the surgical pathway 114 during retraction. Throughout the steps of rotating the dual-blade assembly 230 from the insertion orientation 239 to the rotated orientation 306 (FIG. 35B, 516), laterally retracting the blade subassemblies 240 from the closed position 390 to the retracted position 392 (FIG. 35B, 524), and adjusting the adjustable wings 252 between the open position 280 and the

closed position 282 (FIG. 35B, 538), the active monitoring tips 256 and 283 of the blades 244 and the wings 252, respectively, may be used to provide real-time neuromonitoring to prevent impingement and/or encroachment upon adjacent nerve structures (FIG. 35B, 542).

[0087] FIG. 32 illustrates a perspective view of a fully assembled lateral retractor system 200, including all of the components, assemblies, and subassemblies discussed above. In addition and in this embodiment, the housing 342 of the lateral actuation gearbox 308 may incorporate a level 384 to assist in positioning components of the system 200 when carrying out the disclosed method 500 of creating a surgical pathway 114 using embodiments the lateral retractor system 200, as provided in FIG. 35. The level 384 may be calibrated to level the system with respect to the floor, the surgical table 233, or any appropriate reference plane. Relying on the level 384 for partial positioning reduces the amount of real-time x-ray technology (e.g., fluoroscopy) required to locate the system 200 during operation, resulting in less radiation exposure to the patient, the surgeon, and everyone else in the operating theater. In one embodiment, the level 384 may be a bubble or spirit level, or the level may be a gyroscope.

[0088] Once the lateral retraction assembly 270 has been employed to retract the blade subassemblies 240 to form the surgical pathway 114, the surgeon may access the spine 100 (FIG. 35B, 540) via the resulting surgical pathway 114, leveraging the LED lights 254 illuminating the surgical area 266 as desired, as shown in FIG. 33, and observing the images transmitted from the surgical area 266 via the video output 278 from the video cameras 276, as shown in FIG. 34.

[0089] Each of the components that form embodiments of lateral retractor system 200 discussed above may be formed of any appropriate conductive or nonconductive, autoclavable or otherwise sterilizable metal or plastic using any appropriate manufacturing method. As discussed, some components may be disposable to improve efficiency and customizability and reduce the possibility of disease transmission, while others may be reusable and sterilizable.

[0090] Embodiments of the lateral retractor system 200 provide three separate kinds of movement—rotation of the single-component dilator 202 and the dual-blade assembly 230 from the insertion orientation 239 to the final rotated orientation 306, rotation of the adjustable wings 252 from the open position 280 to the closed position 282, and retraction of the blade subassemblies 240 from the closed position 390 to the retracted position 392—that allow for a more sophisticated initial placement of the single-component dilator 202 and the dual-blade assembly 230 in a manner parallel to the psoas muscle 102 and, therefore, less damaging to the muscle and nerve structures adjacent to the patient's spine. Rather than crushing or trapping sensitive body tissues beneath the dilator and/or the blade assembly, the disclosed lateral retractor system enables embodiments of the dilator 102 and the dual-blade assembly 230 to bypass those tissues and instead “separate” them to create the surgical pathway 114, as desired, with the use of an elegant design that features only two blades. In addition, rotation of the flat, narrow dilator 202 allows the dilator 202 to separate the psoas muscle tissues without the need for a more complicated series of progressively larger circular dilators, as required in the prior art.

[0091] Further, built-in lighting and video capabilities provide the surgeon with streamlined and flexible lighting of

the surgical area and the ability to view his or her actions without hunching over the patient and/or the surgical apparatus. Detachable and disposable distal blade portions and adjustable wings allow the system to accommodate any patient physiology and can be selected in the operating theater as deemed necessary by the surgeon. In sum, the unique lateral retractor system allows for a lateral approach to the spine to be made in a more safe and efficient manner for the patient and for the surgeon.

[0092] In addition, continuous, real-time neuromonitoring via the active neuromonitoring tips 222, 256, and 283 located at the distal ends of the dilator 102, the blades 244, and the adjustable wings 252, respectively, further assists in reducing damage to the patient's nerves and plexus in that the system may continuously monitor, and avoid, impingement or encroachment upon nerve structures within a 360-degree monitoring range about the circumference of the system 200. This continuous neuromonitoring occurs throughout the process of forming the surgical pathway 114 and any subsequent surgical procedure.

[0093] In one embodiment shown in FIGS. 36A-36B, a dilator 202a may be substituted for the dilator 202, discussed above, to provide neuromonitoring capabilities free of internal wires. In this embodiment, the dilator 202a may be formed of a conductive material such as, for example, aluminum and may leverage the internal conductivity of the dilator's rectangular body 204a to form a conductive electrical pathway 205 between one or more conductive input surfaces 207 formed at a proximal end 206a of the rectangular body 204a and a conductive active monitoring tip 222a disposed at a distal end 208a of the rectangular body 204a.

[0094] In this embodiment, the electrical pathway 205 may be configured via selective shielding applied to portions of the dilator 202a. For instance, dilator surfaces intended to be nonconductive, insulated surfaces may be coated with an insulative or nonconductive layer. In one embodiment, a portion of an outer surface 211 of the aluminum body 204a may be coated with an anodized layer 213, which may be nonconductive and also provide a hardened surface that resists scratching and other damage to the dilator 202a. In one embodiment, a non-stick material such as Teflon may be added to the anodization to render the anodized layer 213 "slippery" such that the dilator 202a more easily glides relative to other system components and/or bodily tissues during the insertion and removal processes.

[0095] In applying the anodized layer 213, portions of the outer surface 211 that are desired to be free of anodization, and thus conductive, may be masked during the anodizing process. In this embodiment, the conductive input surfaces 207 and the active monitoring tip 222a may be masked such that those surfaces remain conductive in their entireties. Thus, when an electrical signal is applied, through the monitoring cable 224 (FIG. 8) or otherwise, to the dilator 202a at the conductive input surfaces 207 at the proximal end 206a of the dilator 202a, the signal travels via the conductive electrical pathway(s) 205 to the active monitoring tip 222a, which spans 360 degrees of the distal end 208a of the dilator 222a.

[0096] Impingement or encroachment of the active monitoring tip 222a upon one or more nerve structures causes the nerve structures to fire and generate a responsive signal, which is conducted back through the electrical pathway(s) 205 to the monitoring cable(s) 224 in communication with

the electrical pathway(s) 205 at the conductive input surfaces 207, thereby translating the neurosensing stimulation of the active monitoring tip 222a to external monitoring equipment (not shown) via the monitoring cable 224 and determining, in real time, with 360 degrees of monitoring range, and with an internal-wire-free mechanism that is more simply and cost-effectively manufactured, a possibility of nerve or plexus injury as the dilator 202a is inserted (FIG. 35A, 508).

[0097] In a manner similar to the dilator, the blades and the adjustable wings may also be configured for continuous, real-time, 360-degree neuromonitoring that does not require a wired electrical pathway within their components. FIGS. 37A-37F illustrate front, rear, and numerous partial views of an exemplary embodiment of a blade 244a, hingedly bordered by two opposing adjustable wings 252a. In operation and in one embodiment, the blade 244a and the wings 252a may be electively substituted for the blade 244 and the wings 252 described above. In this embodiment, the blade 244a and the wings 252a are similar to the blade 244 and the wings 252, discussed above, in both structure and function, and additionally feature no-wire neuromonitoring capabilities similar to the dilator 202a, discussed above in relation to FIGS. 36A-36B.

[0098] In further detail and as shown in FIGS. 37A-37B, the blade 244a may have a proximal blade portion 246a, a detachable, disposable distal blade portion 248a, and opposing longitudinal edges 250a that extend between a proximal end 260a of the proximal blade portion 246a and a distal end 255a of the distal blade portion 248a. The opposing adjustable wings 252a may be hingedly coupled with each of the opposing longitudinal edges 250a via a plurality of hinge pins 249, as shown in FIGS. 37A-37B.

[0099] In this embodiment, all components forming the blade 244a and the adjustable wings 252a, including the proximal blade portion 246a, the removeable and disposable distal blade portion 248a, the wings 252a, and the hinge pins 249, may be formed of a conductive material such as, for example, aluminum and may be strategically coated with a nonconductive, insulated layer such as an anodized layer 271 so as to form an internal conductive electrical pathway 253 through the multiple components. In this regard, the proximal portion 246a of the blade 244a may include at least one conductive electrical connection point, conductive input surface, or "jack" 251, shown in FIGS. 37C-37D, and the distal portion 248a of the blade 244a and the opposing adjustable wings 252a may each terminate distally in respective active monitoring tips 256a, 283a similar to the active monitoring tip 222a of the dilator 202a. As shown in FIGS. 37E-37F, select surfaces of the proximal blade portion 246a and the distal blade portion 248a may be masked so as to form adjacent and contacting electrically conductive surfaces 257, 259 when the proximal and distal blade portions 246a, 246b are assembled together.

[0100] In operation, the electrical connection point 251 may act as an input point where electrical conduction initiates, via the monitoring cable 224 or another appropriate source, such that an applied electrical signal conducts from the electrical connection point 251, through the proximal blade portion 246a, to and through the wings 252a via the pins 249, to and through the distal blade portion 248a via the conductive surfaces 257, 259, and through the active monitoring tips 256a, 283a along the conductive electrical pathway 253 shown in FIG. 37B. This stimulus of the active

monitoring tips **256a**, **283a** causes nearby nerve structures to fire and generate a responsive electrical signal, which may in turn be conducted back from the active monitoring tips **256a**, **283a** to the electrical connection point **251** and to the monitoring cable **224** in electronic communication with external monitoring equipment, thereby sensing the stimulation of the active monitoring tips **256a**, **283a** caused by proximity to nearby nerve structure(s) in real time and with 360 degrees of monitoring range or field of view about an entirety of the distal ends of the blade **244a** and the wings **252a**. Thus, via the active monitoring tips **256a**, **283a** of each of the distal blade portions **248a** of the blades **244a**, continuous real-time neuromonitoring may be performed to prevent nerve or plexus injury when the blade assembly **230** is inserted over the dilator **202a** (FIG. **35A**, **512**, **514**), as well as when the blade assembly **230** is rotated (FIG. **35A**, **516**) and/or laterally separated or retracted (FIG. **35A**, **524**), as discussed above. Unlike existing systems, neuromonitoring over a full 360-degree monitoring range may continue throughout the procedure.

[0101] Due to the multi-component nature of the wings as assembled to the blade, the internal conductive electrical pathway **253** avoids the complexity of a design which routes a wired pathway to the active monitoring tips **256a**, **283a**, allowing for a more streamlined instrument with fewer components that is more efficient and less expensive to manufacture.

[0102] Although the above embodiments have been described in language that is specific to certain structures, elements, compositions, and methodological steps, it is to be understood that the technology defined in the appended claims is not necessarily limited to the specific structures, elements, compositions and/or steps described. Rather, the specific aspects and steps are described as forms of implementing the claimed technology. Since many embodiments of the technology can be practiced without departing from the spirit and scope of the invention, the invention resides in the claims hereinafter appended.

What is claimed is:

1-60. (canceled)

61. A method of forming a surgical pathway through a side of a patient's body and through a psoas muscle to an intervertebral disc space, comprising:

providing a dilator having a narrow body defined by opposing flat surfaces;

positioning the dilator at an insertion orientation in which the opposing flat surfaces of the dilator are disposed parallel to the psoas muscle;

traversing a plurality of fibers of the psoas muscle until the dilator spans the intervertebral disc space at the insertion orientation in which the opposing flat surfaces of the dilator are disposed parallel to the plurality of the fibers of the psoas muscle and at an angle of approximately 45 degrees to the intervertebral disc space.

62. The method of claim **61**, further comprising:

via a k-wire extending longitudinally through a center of the dilator, securing the dilator within the intervertebral disc space at the insertion orientation.

63. The method of claim **61**, further comprising:

providing a dual-blade assembly consisting of a pair of opposing blades, each having a planar inner surface and an opposing outer surface that extend from a proximal end to a distal end along two longitudinal sides; and

passing the dual-blade assembly proximally-to-distally over the dilator at the insertion orientation such that the planar inner surface of each of the opposing blades contacts one of the opposing flat surfaces of the dilator.

64. The method of claim **63**, further comprising:

rotating, via a rotation assembly operably coupled to the dual-blade assembly, the dilator and the dual-blade assembly about the k-wire from the insertion orientation to a rotated orientation in which the opposing flat surfaces of the dilator and the planar inner surfaces of the opposing blades are disposed parallel to the intervertebral disc space.

65. The method of claim **64**, further comprising:

retracting, via a lateral retraction assembly operably coupled to the dual-blade assembly, the pair of the opposing blades apart from one another to form the surgical pathway.

66. The method of claim **65**, wherein a wing is hinged coupled with each of the longitudinal sides of each of the opposing blades, the method further comprising:

rotating the wing from an open position parallel to the planar inner surface of the blade to which the wing is coupled to a closed position perpendicular to the planar inner surface of the blade to which the wing is coupled.

67. The method of claim **65**, further comprising:

during the step of traversing the plurality of the fibers of the psoas muscle, using a first active monitoring tip formed adjacent to the distal edge of the dilator to continuously and simultaneously detect an impingement of the dilator upon one or more nerve structures located adjacent to any portion in 360 degrees of a circumference of the distal end of the dilator.

68. The method of claim **65**, further comprising:

during the steps of passing the dual-blade assembly proximally-to-distally over the dilator, rotating the dilator and the dual-blade assembly about the k-wire from the insertion orientation to the rotated orientation, and retracting the pair of the opposing blades apart from one another, using a second active monitoring tip formed adjacent to the outer surface of the distal end of each of the pair of the opposing blades to simultaneously and continuously sense an impingement of the dual-blade assembly upon one or more nerve structures located adjacent to 360 degrees of the outer surfaces of the blades.

69. The method of claim **65**, further comprising:

activating one or more light emitting diodes (LEDs) built into each of the opposing blades to illuminate the surgical pathway.

70. The method of claim **65**, further comprising:

activating a video camera built into one or both of the opposing blades to capture one or more video streams from within the surgical pathway.

71. A method of creating a surgical pathway to a patient's spine using a lateral retractor system including a single planar dilator having a flat cross-section, a retractable blade assembly including two opposing blades that each taper to a distal edge, a rotation assembly operably coupled with the retractable blade assembly, and a retraction assembly operably coupled with the retractable blade assembly, the method comprising:

inserting the single planar dilator through a psoas muscle of the patient such that the single planar dilator spans an

intervertebral disc space at an insertion orientation that is parallel to a plurality of fibers of the psoas muscle; using a k-wire extending longitudinally through a center of the single planar dilator, anchoring the single planar dilator at the intervertebral disc space; and rotating the single planar dilator about the k-wire from the insertion orientation that is parallel to the psoas muscle to a rotated orientation that is parallel to the intervertebral disc space.

72. The method of claim **71**, further comprising: during the steps of inserting, anchoring, and rotating the single planar dilator, and using a first active neuromonitoring tip positioned adjacent to the distal edge of the single planar dilator, monitoring continuously and simultaneously for an encroachment upon one or more nerve structures of the patient located adjacent to any portion in 360 degrees of a circumference of the first active neuromonitoring tip.

73. The method of claim **71**, wherein the inserting the single planar dilator comprises using the distal edge of the single planar dilator to traverse the one or more of the fibers of the psoas muscle without cutting or compressing the one or more of the fibers of the psoas muscle.

74. The method of claim **71**, wherein the first active monitoring tip comprises:

a series of horizontal sensing wires embedded within the single planar dilator adjacent to the distal edge of the single planar dilator; and

at least one conducting wire extending longitudinally through the single planar dilator, the at least one conducting wire electrically coupled with the series of the horizontal sensing wires.

75. The method of claim **71**, further comprising:

prior to the step of rotating the single planar dilator about the k-wire, passing the retractable blade assembly proximally-to-distally over the single planar dilator at the insertion orientation such that a planar inner surface of each of the two opposing blades contacts the single planar dilator; and

coupling the rotation assembly to the retractable blade assembly such that the step of rotating the single planar dilator about the k-wire comprises:

using the rotation assembly, rotating the single planar dilator and the retractable blade assembly about the k-wire from the insertion orientation to the rotated orientation.

76. The method of claim **74**, further comprising:

coupling the retraction assembly to the retractable blade assembly; and

using the retraction assembly, separating the two opposing blades of the retractable blade assembly apart from one another.

77. The method of claim **75**, further comprising:

during the steps of passing the retractable blade assembly proximally-to-distally over the single planar dilator, rotating the single planar dilator and the retractable blade assembly about the k-wire from the insertion orientation to the rotated orientation, and separating the two opposing blades of the retractable blade assembly apart from one another, using a second active neuromonitoring tip positioned adjacent the distal edge of each of the two opposing blades to monitor for an encroachment upon one or more nerve structures of the patient located adjacent to an outer circumference of a distal end of the retractable blade assembly.

78. The method of claim **76**, wherein the retractable blade assembly further comprises an adjustable wing hingedly coupled with each of two longitudinal sides along each of the two opposing blades, the method further comprising:

rotating the adjustable wing between an open position in which the adjustable wing extends parallel to an attached one of the two opposing blades and a closed position in which the adjustable wing extends perpendicular to the attached one of the two opposing blades.

79. The method of claim **77**, wherein:

during the steps of passing the retractable blade assembly proximally-to-distally over the single planar dilator, rotating the single planar dilator and the retractable blade assembly about the k-wire from the insertion orientation to the rotated orientation, separating the two opposing blades of the retractable blade assembly apart from one another, and rotating the adjustable wing between the open position and the closed position, using a third active neuromonitoring tip positioned adjacent to a distal edge of each of the adjustable wings to monitor for an encroachment upon one or more nerve structures of the patient located adjacent to an outer circumference of a distal end of the retractable blade assembly.

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