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Citation

Authors' conclusions
Lumbar disc herniation (LDH) occurs when a tear in the outer fibrous ring of an intervertebral disc allows prolapse of the softer central nucleus pulposus portion. Disc herniation may also occur when the outer fibrous ring is intact but bulges under pressure. Surgical intervention for LDH is indicated when severe lower back pain, leg pain, or both are refractory to conservative treatment for > 6 weeks; when neurological deficits develop; or if the patient is intolerant of conservative measures. Description of Technology: Percutaneous discectomy is defined as a discectomy procedure that does not require open dissection of the thoracolumbar fascia. In percutaneous endoscopic discectomy, access to the herniated disc is made under fluoroscopic guidance with a portal through which an endoscope and specialized surgical instruments are inserted. Removal of disc material is performed with a laser or mechanically. This is an indirect visualization technique using both an endoscope and fluoroscopy. Patient Population: Percutaneous endoscopic lumbar discectomy (PELD) is indicated in patients with LDH with a positive straight leg-raising test with persistent, symptomatic low back pain with or without radiculopathy. Refractory pain despite conservative management for >= 6 weeks is recommended prior to determining eligibility for PELD. LDH is confirmed on diagnostic imaging with magnetic resonance imaging or computed tomography. Clinical Alternatives: Surgical alternatives to PELD for the treatment of LDH include, but are not limited to, traditional open lumbar discectomy, open lumbar microdiscectomy, full or fully endoscopic lumbar disc surgery, microdiscectomy, microendoscopic discectomy, automated percutaneous lumbar discectomy, transforaminal endoscopic surgical system, selective endoscopic discectomy, chymopapain chemonucleolysis, and nucleoplasty.

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