US009037250B2

(12) **United States Patent**
Kaula et al.

(10) **Patent No.: US 9,037,250 B2**
(45) **Date of Patent: May 19, 2015**

(54) **SYSTEM AND METHODS FOR DETERMINING NERVE PROXIMITY, DIRECTION AND PATHOLOGY DURING SURGERY**

(71) Applicant: **NuVasive, Inc.**, San Diego, CA (US)

(72) Inventors: **Norbert Kaula**, Arvada, CO (US); **Jeffrey J. Blewett**, San Diego, CA (US); **James Gharib**, San Diego, CA (US); **Allen Farquhar**, Portland, OR (US)

(73) Assignee: **NuVasive, Inc.**, San Diego, CA (US)

(*) Notice: Subject to any disclaimer, the term of this patent is extended or adjusted under 35 U.S.C. 154(b) by 0 days.

(21) Appl. No.: **13/767,355**

(22) Filed: **Feb. 14, 2013**

(65) **Prior Publication Data**

US 2013/0165814 A1 Jun. 27, 2013

Related U.S. Application Data

(60) Continuation of application No. 13/465,666, filed on May 7, 2012, now Pat. No. 8,812,116, which is a continuation of application No. 13/292,065, filed on Nov. 8, 2011, now Pat. No. 8,634,904, which is a

(Continued)

(51) **Int. Cl.**

A61N 1/00	(2006.01)
A61M 29/00	(2006.01)
A61B 5/05	(2006.01)
A61B 5/04	(2006.01)
A61B 5/0488	(2006.01)
A61B 5/00	(2006.01)

(Continued)

(52) **U.S. Cl.**

CPC ***A61B 5/04001*** (2013.01); ***A61B 5/0488*** (2013.01); *A61B 5/1106* (2013.01); ***A61B 5/4893*** (2013.01); ***A61N 1/08*** (2013.01); *A61B 5/7217* (2013.01); *A61B 5/743* (2013.01)

(58) **Field of Classification Search**

CPC A61B 5/04001; A61B 5/0488; A61B 5/4893; A61B 1/08; A61B 5/1106; A61B 5/743; A61B 5/7217

USPC 607/48; 600/554, 202

See application file for complete search history.

(56) **References Cited**

U.S. PATENT DOCUMENTS

208,227 A 9/1878 Dorr
972,983 A 10/1910 Arthur

(Continued)

FOREIGN PATENT DOCUMENTS

DE 299 08 259 7/1999
DE 100 48 790 4/2002

(Continued)

OTHER PUBLICATIONS

Baulot et al., Adjuvant Anterior Spinal Fusion Via Thorascopy, *Lyon Chirurgical*, 1994, 90(5):347-351 including English Translation and Certificate of Translation.

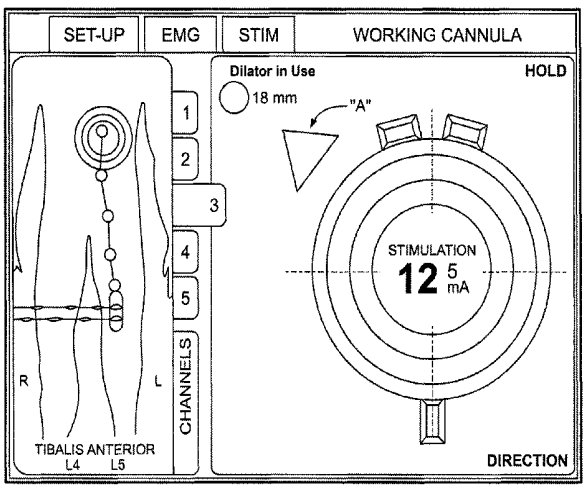
(Continued)

Primary Examiner — Catherine Voorhees
(74) *Attorney, Agent, or Firm* — Fish & Richardson P.C.

(57) **ABSTRACT**

The present invention involves systems and methods for determining nerve proximity, nerve direction, and pathology relative to a surgical instrument based on an identified relationship between neuromuscular responses and the stimulation signal that caused the neuromuscular responses.

13 Claims, 15 Drawing Sheets



Related U.S. Application Data

continuation of application No. 13/080,493, filed on Apr. 5, 2011, now Pat. No. 8,055,349, which is a division of application No. 12/711,937, filed on Feb. 24, 2010, now Pat. No. 7,920,922, which is a continuation of application No. 10/754,899, filed on Jan. 9, 2004, now Pat. No. 8,068,912, which is a continuation of application No. PCT/US02/22247, filed on Jul. 11, 2002.

(60) Provisional application No. 60/305,041, filed on Jul. 11, 2001.

(51) **Int. Cl.**

A61N 1/08	(2006.01)
A61B 5/11	(2006.01)

(56) **References Cited**

U.S. PATENT DOCUMENTS

1,003,232	A		10/1910	Cerbo
1,044,348	A		6/1912	Cerbo
1,328,624	A		1/1920	Graham
1,548,184	A		8/1925	Cameron
1,919,120	A		7/1933	O'Connor et al.
2,594,086	A		4/1952	Smith
2,704,064	A		6/1955	Fizzell et al.
2,736,002	A		2/1956	Oriel
2,808,826	A		10/1957	Reiner et al.
3,364,929	A		1/1968	Ide et al.
3,664,329	A		5/1972	Naylor
3,682,162	A		8/1972	Colyer
3,785,368	A		1/1974	McCarthy et al.
3,803,716	A		4/1974	Garnier
3,830,226	A		8/1974	Staub et al.
3,957,036	A		5/1976	Normann
D245,789	S		9/1977	Shea et al.
4,099,519	A		7/1978	Warren
4,164,214	A		8/1979	Stark et al.
4,207,897	A		6/1980	Lloyd et al.
4,224,949	A		9/1980	Scott et al.
4,226,228	A		10/1980	Shin et al.
4,226,288	A		10/1980	Collins, Jr.
4,235,242	A		11/1980	Howson et al.
4,285,347	A		8/1981	Hess
4,291,705	A		9/1981	Severinghaus et al.
4,449,532	A		5/1984	Storz
4,461,300	A		7/1984	Christensen
4,512,351	A		4/1985	Pohndorf
4,515,168	A		5/1985	Chester et al.
4,519,403	A		5/1985	Dickhudt
4,545,374	A		10/1985	Jacobson
4,552,127	A		11/1985	Schiff
4,561,445	A		12/1985	Berke et al.
4,562,832	A		1/1986	Wilder et al.
4,573,448	A		3/1986	Kambin
4,592,369	A		6/1986	Davis et al.
4,595,013	A		6/1986	Jones et al.
4,595,018	A		6/1986	Rantala
4,611,597	A		9/1986	Kraus
4,616,635	A		10/1986	Caspar et al.
4,616,660	A		10/1986	Johns
4,633,889	A		1/1987	Talalla
4,658,835	A		4/1987	Pohndorf
D295,445	S		4/1988	Freeman
4,744,371	A		5/1988	Harris
4,753,223	A		6/1988	Bremer
4,759,377	A		7/1988	Dykstra
4,784,150	A		11/1988	Voorhies et al.
4,807,642	A		2/1989	Brown
D300,561	S		4/1989	Asa et al.
4,862,891	A		9/1989	Smith
4,892,105	A		1/1990	Prass
4,913,134	A		4/1990	Luque
4,917,274	A		4/1990	Asa et al.
4,917,704	A		4/1990	Frey et al.
4,926,865	A		5/1990	Oman
4,950,257	A		8/1990	Hibbs et al.
4,962,766	A		10/1990	Herzon
4,964,411	A		10/1990	Johnson et al.
5,007,902	A		4/1991	Witt
5,015,247	A		5/1991	Michelson
5,045,054	A		9/1991	Hood et al.
5,052,373	A		10/1991	Michelson
5,058,602	A		10/1991	Brody
5,081,990	A		1/1992	Deletis
5,092,344	A		3/1992	Lee
5,125,406	A		6/1992	Goldstone et al.
5,127,403	A		7/1992	Brownlee
5,161,533	A		11/1992	Prass et al.
5,171,279	A		12/1992	Mathews
5,192,327	A		3/1993	Brantigan
5,195,541	A		3/1993	Obenchain
5,196,015	A		3/1993	Neubardt
5,215,100	A	*	6/1993	Spitz et al. 600/554
RE34,390	E		9/1993	Culver
D340,521	S		10/1993	Heinzelman et al.
5,255,691	A		10/1993	Otten
5,282,468	A		2/1994	Klepinski
5,284,153	A		2/1994	Raymond et al.
5,284,154	A	*	2/1994	Raymond et al. 600/554
5,295,994	A		3/1994	Bonutti
5,299,563	A		4/1994	Seton
5,312,417	A		5/1994	Wilk
5,313,956	A		5/1994	Knutsson et al.
5,313,962	A		5/1994	Obenchain
5,327,902	A		7/1994	Lemmen
5,331,975	A		7/1994	Bonutti
5,333,618	A		8/1994	Lekhtman et al.
5,342,384	A		8/1994	Sugarbaker
5,357,983	A		10/1994	Mathews
5,375,067	A		12/1994	Berchin
5,375,594	A		12/1994	Cueva
5,378,241	A		1/1995	Haindl
5,383,876	A		1/1995	Nardella
5,395,317	A		3/1995	Kambin
5,450,845	A		9/1995	Axelgaard
5,472,426	A		12/1995	Bonati et al.
5,474,057	A		12/1995	Makower et al.
5,474,558	A		12/1995	Neubardt
5,480,440	A		1/1996	Kambin
5,482,038	A		1/1996	Ruff
5,484,437	A		1/1996	Michelson
5,487,739	A		1/1996	Aebischer et al.
5,509,893	A		4/1996	Pracas
5,514,153	A		5/1996	Bonutti
5,540,235	A		7/1996	Wilson
5,549,656	A		8/1996	Reiss
5,560,372	A		10/1996	Cory
5,566,678	A		10/1996	Cadwell
5,569,248	A		10/1996	Matthews
5,569,290	A		10/1996	McAfee
5,571,149	A		11/1996	Liss et al.
5,579,781	A		12/1996	Cooke
5,593,429	A		1/1997	Ruff
5,599,279	A		2/1997	Slotman et al.
5,601,608	A		2/1997	Mouchawar
5,630,813	A		5/1997	Kieturakis
5,667,508	A		9/1997	Errico et al.
5,671,752	A		9/1997	Sinderby et al.
5,681,265	A		10/1997	Maeda et al.
5,688,223	A		11/1997	Rosendahl
5,707,359	A		1/1998	Bufalini
5,711,307	A		1/1998	Smits
5,728,046	A		3/1998	Mayer et al.
5,741,253	A		4/1998	Michelson
5,741,261	A		4/1998	Moskovitz et al.
5,759,159	A		6/1998	Masreliez
5,762,629	A		6/1998	Kambin
5,772,661	A		6/1998	Michelson
5,775,331	A		7/1998	Raymond et al.
5,776,144	A		7/1998	Leysieffer et al.
5,779,642	A		7/1998	Nightengale
5,785,658	A		7/1998	Benaron

(56) **References Cited**

U.S. PATENT DOCUMENTS

5,792,044 A 8/1998 Foley et al.
5,797,854 A 8/1998 Hedgecock
5,797,909 A 8/1998 Michelson
5,814,073 A 9/1998 Bonutti
5,817,071 A 10/1998 Dewindt et al.
5,830,151 A 11/1998 Hadzic et al.
5,851,191 A 12/1998 Gozani
5,853,373 A 12/1998 Griffith et al.
5,860,973 A 1/1999 Michelson
5,862,314 A 1/1999 Jeddeloh
5,872,314 A 2/1999 Clinton
5,885,210 A 3/1999 Cox
5,885,219 A 3/1999 Nightengale
5,888,196 A 3/1999 Bonutti
5,891,147 A 4/1999 Moskovitz et al.
5,902,231 A 5/1999 Foley et al.
5,928,139 A 7/1999 Koros et al.
5,928,158 A 7/1999 Aristides
5,931,777 A 8/1999 Sava
5,935,131 A 8/1999 Bonutti et al.
5,938,688 A 8/1999 Schiff
5,944,658 A 8/1999 Koros et al.
5,976,094 A 11/1999 Gozani et al.
5,976,146 A 11/1999 Ogawa et al.
6,004,262 A 12/1999 Putz et al.
6,004,312 A 12/1999 Finneran
6,007,487 A 12/1999 Foley et al.
6,010,520 A 1/2000 Pattison
6,011,985 A 1/2000 Athan et al.
6,024,696 A 2/2000 Hoftman et al.
6,024,697 A 2/2000 Pisarik
6,027,456 A 2/2000 Feler et al.
6,038,469 A 3/2000 Karlsson et al.
6,038,477 A 3/2000 Kayyali
6,050,992 A 4/2000 Nichols
6,074,343 A 6/2000 Nathanson et al.
6,080,105 A 6/2000 Spears
6,083,154 A 7/2000 Liu et al.
6,095,987 A 8/2000 Shmulewitz et al.
6,104,957 A 8/2000 Alo et al.
6,104,960 A 8/2000 Duysens et al.
6,119,068 A 9/2000 Kannonji
6,120,503 A 9/2000 Michelson
6,126,660 A 10/2000 Dietz
6,128,576 A 10/2000 Nishimoto
6,132,386 A 10/2000 Gozani et al.
6,132,387 A 10/2000 Gozani et al.
6,135,965 A 10/2000 Tumer et al.
6,139,493 A 10/2000 Koros et al.
6,139,545 A 10/2000 Utley
6,142,931 A 11/2000 Kaji
6,146,335 A 11/2000 Gozani
6,146,371 A 11/2000 Dewindt et al.
6,152,871 A 11/2000 Foley et al.
6,159,179 A 12/2000 Simonson
6,161,047 A 12/2000 King et al.
6,174,311 B1 1/2001 Branch et al.
6,181,961 B1 1/2001 Prass
6,196,969 B1 3/2001 Bester et al.
6,206,826 B1 3/2001 Mathews et al.
6,217,509 B1 4/2001 Foley et al.
6,217,527 B1 4/2001 Selmon et al.
6,221,049 B1 4/2001 Selmon et al.
6,224,549 B1 5/2001 Drongelen
6,231,546 B1 5/2001 Milo et al.
6,245,082 B1 6/2001 Gellman et al.
6,259,945 B1 7/2001 Epstein et al.
6,264,651 B1 7/2001 Underwood et al.
6,266,558 B1 7/2001 Gozani et al.
6,270,505 B1 8/2001 Yoshida et al.
6,273,905 B1 8/2001 Streeter
6,292,701 B1 9/2001 Prass et al.
6,306,100 B1 10/2001 Prass
6,308,712 B1 10/2001 Shaw
6,312,392 B1 11/2001 Herzon
6,325,764 B1 12/2001 Griffith et al.
6,334,068 B1 12/2001 Hacker
6,348,058 B1 2/2002 Melkent et al.
6,360,750 B1 3/2002 Gerber et al.
6,371,968 B1 4/2002 Kogasaka et al.
6,393,325 B1 5/2002 Mann et al.
6,395,007 B1 5/2002 Bhatnagar et al.
6,416,465 B2 7/2002 Brau
6,425,859 B1 7/2002 Foley et al.
6,425,887 B1 7/2002 McGuckin et al.
6,425,901 B1 7/2002 Zhu et al.
6,447,484 B1 9/2002 Briscoe et al.
6,450,952 B1 9/2002 Rioux et al.
6,451,015 B1 9/2002 Rittman, III et al.
6,466,817 B1 10/2002 Kaula et al.
6,468,205 B1 10/2002 Mollenauer et al.
6,468,207 B1 10/2002 Fowler, Jr.
6,494,882 B1 12/2002 LeBouitz et al.
6,500,116 B1 12/2002 Knapp
6,500,128 B2 12/2002 Marino
6,507,755 B1 1/2003 Turner et al.
6,514,217 B1 2/2003 Selmon et al.
6,520,907 B1 2/2003 Foley et al.
6,524,320 B2 2/2003 DiPoto
6,535,759 B1 3/2003 Epstein et al.
6,564,078 B1 5/2003 Marino et al.
6,579,244 B2 6/2003 Goodwin
6,582,441 B1 6/2003 He et al.
6,585,638 B1 7/2003 Yamamoto
6,599,294 B2 7/2003 Fuss et al.
6,618,626 B2 9/2003 West et al.
6,620,157 B1 9/2003 Dabney et al.
6,641,613 B2 11/2003 Sennett
6,645,194 B2 11/2003 Briscoe et al.
6,679,833 B2 1/2004 Smith et al.
6,719,692 B2 4/2004 Kleffner et al.
6,760,616 B2 7/2004 Hoey et al.
6,770,074 B2 8/2004 Michelson
6,796,985 B2 9/2004 Bolger et al.
6,810,281 B2 10/2004 Brock et al.
6,819,956 B2 11/2004 DiLorenzo
6,829,508 B2 12/2004 Schulman et al.
6,847,849 B2 1/2005 Mamo et al.
6,849,047 B2 2/2005 Goodwin
6,855,105 B2 2/2005 Jackson, III et al.
6,869,398 B2 3/2005 Obenchain
6,871,099 B1 3/2005 Whitehurst et al.
6,902,569 B2 6/2005 Parmer et al.
6,916,330 B2 7/2005 Simonson
6,926,728 B2 8/2005 Zucherman et al.
6,929,606 B2 8/2005 Ritland
6,945,933 B2 9/2005 Branch
6,951,538 B2 10/2005 Ritland
7,008,431 B2 3/2006 Simonsom
7,047,082 B1 5/2006 Schrom et al.
7,050,848 B2 5/2006 Hoey et al.
7,079,883 B2 7/2006 Marino et al.
7,089,059 B1 8/2006 Pless
7,177,677 B2 2/2007 Kaula et al.
7,198,598 B2 4/2007 Smith et al.
7,207,949 B2 4/2007 Miles et al.
7,226,451 B2 6/2007 Shluzas et al.
7,261,688 B2 8/2007 Smith et al.
7,276,055 B2 10/2007 Dewindt et al.
7,294,127 B2 11/2007 Leung et al.
7,310,546 B2 12/2007 Prass
7,311,719 B2 12/2007 Bonutti
7,470,236 B1 12/2008 Kelleher et al.
7,473,222 B2 1/2009 Dewey et al.
7,481,766 B2 1/2009 Lee et al.
7,522,953 B2 4/2009 Kaula et al.
7,556,601 B2 7/2009 Branch et al.
7,582,058 B1 9/2009 Miles et al.
7,643,884 B2 1/2010 Pond et al.
7,691,057 B2 4/2010 Miles et al.
7,693,562 B2 4/2010 Marino et al.
7,717,959 B2 5/2010 William et al.
7,819,801 B2 10/2010 Miles et al.
7,935,051 B2 5/2011 Miles et al.

(56) **References Cited**

U.S. PATENT DOCUMENTS

8,000,782	B2	8/2011	Gharib et al.
8,005,535	B2	8/2011	Gharib et al.
8,021,430	B2	9/2011	Michelson
8,055,349	B2	11/2011	Gharib et al.
8,133,173	B2	3/2012	Miles et al.
8,182,423	B2	5/2012	Miles et al.
8,192,356	B2	6/2012	Miles et al.
8,244,343	B2	8/2012	Gharib et al.
8,251,997	B2	8/2012	Michelson
8,303,458	B2	11/2012	Fukano et al.
8,343,046	B2	1/2013	Miles et al.
8,343,224	B2	1/2013	Lynn et al.
8,388,527	B2	3/2013	Miles
8,740,783	B2	6/2014	Gharib et al.
2001/0039949	A1	11/2001	Loubser
2001/0056280	A1	12/2001	Underwood et al.
2002/0007129	A1	1/2002	Marino
2002/0010392	A1	1/2002	Desai
2002/0072686	A1	6/2002	Hoey et al.
2002/0077632	A1	6/2002	Tsou
2002/0123744	A1	9/2002	Reynard
2002/0123780	A1	9/2002	Grill et al.
2002/0161415	A1	10/2002	Cohen et al.
2002/0193843	A1	12/2002	Hill et al.
2003/0032966	A1	2/2003	Foley et al.
2003/0070682	A1	4/2003	Wilson et al.
2003/0078618	A1	4/2003	Fey et al.
2003/0083688	A1	5/2003	Simonson
2003/0105503	A1	6/2003	Marino
2003/0139648	A1	7/2003	Foley et al.
2003/0149341	A1	8/2003	Clifton
2003/0225405	A1	12/2003	Weiner
2003/0229353	A1	12/2003	Cragg
2003/0236544	A1	12/2003	Lunsford et al.
2004/0181231	A1	9/2004	Emstad et al.
2004/0199084	A1	10/2004	Kelleher et al.
2004/0225228	A1	11/2004	Ferree
2005/0004593	A1	1/2005	Simonson
2005/0004623	A1	1/2005	Miles et al.
2005/0033380	A1	2/2005	Tanner et al.
2005/0075578	A1	4/2005	Gharib et al.
2005/0080320	A1	4/2005	Lee et al.
2005/0080418	A1	4/2005	Simonson et al.
2005/0119660	A1	6/2005	Burloin
2005/0149035	A1	7/2005	Pimenta et al.
2005/0182454	A1	8/2005	Gharib et al.
2005/0192575	A1	9/2005	Pacheco
2005/0256582	A1	11/2005	Ferree
2006/0025703	A1	2/2006	Miles et al.
2006/0052828	A1	3/2006	Kim et al.
2006/0069315	A1	3/2006	Miles et al.
2006/0224078	A1	10/2006	Hoey et al.
2007/0016097	A1	1/2007	Farquhar et al.
2007/0198062	A1	8/2007	Miles et al.
2007/0293782	A1	12/2007	Marino
2008/0015612	A1	1/2008	Urmey
2008/0039914	A1	2/2008	Cory et al.
2008/0058606	A1	3/2008	Miles et al.
2008/0058838	A1	3/2008	Steinberg
2008/0064976	A1	3/2008	Kelleher et al.
2008/0064977	A1	3/2008	Kelleher et al.
2008/0065144	A1	3/2008	Marino et al.
2008/0065178	A1	3/2008	Kelleher et al.
2008/0071191	A1	3/2008	Kelleher et al.
2008/0097164	A1	4/2008	Miles et al.
2008/0300465	A1	12/2008	Feigenwinter et al.
2009/0124860	A1	5/2009	Miles et al.
2009/0138050	A1	5/2009	Ferree
2009/0192403	A1	7/2009	Gharib et al.
2009/0204016	A1	8/2009	Gharib et al.
2010/0069783	A1	3/2010	Miles et al.
2010/0130827	A1	5/2010	Pimenta et al.
2010/0152603	A1	6/2010	Miles et al.
2010/0160738	A1	6/2010	Miles et al.
2010/0174146	A1	7/2010	Miles
2010/0174148	A1	7/2010	Miles et al.
2011/0313530	A1	12/2011	Gharib et al.
2012/0238822	A1	9/2012	Miles
2012/0238893	A1	9/2012	Farquhar et al.

FOREIGN PATENT DOCUMENTS

EP	0 334 116	9/1989
EP	0 567 424	10/1993
EP	0 759 307	2/1997
EP	0 972 538	1/2000
EP	1 002 500	5/2000
FR	2 795 624	1/2001
FR	2 796 846	2/2001
JP	793186	5/1990
JP	10-14928	3/1996
JP	11-076430	3/1999
JP	2001-170190	6/2001
KR	3019990007098	11/1999
WO	94/28824	12/1994
WO	97/00702	1/1997
WO	98/23324	6/1998
WO	99/52446	10/1999
WO	00/27291	5/2000
WO	00/38574	7/2000
WO	00/44288	8/2000
WO	00/62660	10/2000
WO	00/66217	11/2000
WO	00/67645	11/2000
WO	01/03604	1/2001
WO	01/08563	2/2001
WO	01/37728	5/2001
WO	01/60263	8/2001
WO	02/054960	7/2002
WO	02/058780	8/2002
WO	02/071953	9/2002
WO	02/087678	11/2002
WO	03/005887	1/2003
WO	03/026482	4/2003
WO	03/037170	5/2003
WO	2004/12809	2/2004
WO	2005/013805	2/2005
WO	2005/030318	4/2005
WO	2006/042241	4/2006
WO	2006/066217	6/2006

OTHER PUBLICATIONS

Anatomy of the Lumbar Spine in MED TM MicroEndoscopic Discectomy (1997 Ludann Grand Rapids MI), 14 pgs.

Dirksmeier et al., "Microendoscopic and Open Laminotomy and Discectomy in Lumbar Disc Disease" *Seminars in Spine Surgery*, 1999, 11(2): 138-146.

METRx Delivered Order Form, 1999, 13 pages.

Medtronic Sofamor Danek "METRx™ MicroDisectomy System," *Medtronic Sofamor Danek USA*, 2000, 21 pgs.

Medtronic Sofamor Danek "METRx System Surgical Technique," 2004, 22 pages.

"MetRx System MicroEndoscopic Discectomy: An Evolution in Minimally Invasive Spine Surgery," *Sofamor Danek*, 1999, 6 pages.

Smith and Foley "MetRx System MicroEndoscopic Discectomy: Surgical Technique" *Medtronic Sofamor Danek*, 2000, 24 pages.

"Sofamor Danek MED Microendoscopic Discectomy System Brochure" including Rapp "New endoscopic lumbar technique improves access preserves tissue" Reprinted with permission from: *Orthopedics Today*, 1998, 18(1): 2 pages.

Japanese Patent Office JP Patent Application No. 2006-528306 Office Action with English Translation, Jun. 10, 2009, 4 pages.

Plaintiffs' Preliminary Invalidity Contentions re US Patents 7207949; 7470236 and 7582058, Sep. 18, 2009, 19 pages.

Plaintiffs' Preliminary Invalidity Contentions-Appendices, Sep. 18, 2009, 191 pages.

Plaintiffs' Supplemental Preliminary Invalidity Contentions re US Patents 7207949, 7470236, and 7582058, Sep. 29, 2009, 21 pages.

Plaintiffs' Supplemental Preliminary Invalidity Contentions-Appendices, Sep. 29, 2009, 294 pages.

(56) **References Cited**

OTHER PUBLICATIONS

Axon 501(k) Notification: Epoch 2000 Neurological Workstation, Dec. 3, 1997, 464 pages.
Foley and Smith, "Microendoscopic Discectomy," *Techniques in Neurosurgery*, 1997, 3(4):301-307.
Medtronic Sofamor Danek "Union™ / Union-L™ Anterior & Lateral Impacted Fusion Devices: Clear choice of stabilization," *Medtronic Sofamor Danek*, 2000, 4 pages.
NuVasive Vector™ Cannulae, 2000, 1 page.
NuVasive Triad™ Tri-Columnar Spinal EndoArthrodesis™ via Minimally Invasive Guidance, 2000, 1 page.
NuVasive Triad™ Cortical Bone Allograft, 2000, 1 page.
NuVasive Vertebral Body Access System, 2000, 1 page.
Marina, "New Technology for Guided Navigation with Real Time Nerve Surveillance for Minimally Invasive Spine Discectomy & Arthrodesis," *Spineline*, 2000, p. 39.
NuVasive "INS-1 Screw Test," 2001, 10 pages.
NuVasive letter re 510k Neuro Vision JJB System, Oct. 16, 2001, 5 pages.
NuVasive letter re 510k Guided Arthroscopy System, Oct. 5, 1999, 6 pages.
NuVasive letter re 510k INS-1 Intraoperative Nerve Surveillance System, Nov. 13, 2000, 7 pages.
"NuVasiveTM Receives Clearance to Market Two Key Elem Minimally Invasive Spine Surgery System," Nov. 27, 2001, 20 pages.
Schick et al., "Microendoscopic lumbar discectomy versus open surgery: an intraoperative EMG study," *Eur Spine J*, 2002, 11: 20-26.
NuVasive letter re: 510(k) for Neurovision JJB System (Summary), Sep. 25, 2001, 28 pages.
NuVasive letter re: Special 510(k) Premarket Notification: Neurovision JJB System (Device Description), Jul. 3, 2003, 18 pages.
NuVasive letter re: Special 510(k) Premarket Notification: Neurovision JJB System (Device Description), Mar. 1, 2004, 16 pages.
NuVasive letter re: Special 510(k) Premarket Notification: Neurovision JJB System (Device Description), May 26, 2005, 17 pages.
NuVasive letter re: 510(k) Premarket Notification: Neurovision JJB System (Device Description), Jun. 24, 2005, 16 pages.
NuVasive letter re: Special 510(k) Premarket Notification: Neurovision JJB System (Device Description), Sep. 14, 2006, 17 pages.
NuVasive 510(k) Premarket Notification: Neurovision JJB System (Device Description), Aug. 20, 2007, 8 pages.
NuVasive letter re: 510(k) Premarket Notification: Guided Spinal Arthroscopy System (Device Description), Feb. 1, 1999, 40 pages.
NuVasive 510(k) Premarket Notification: Spinal System (Summary), Apr. 12, 2004, 10 pages.
NuVasive 510(k) Summary NIM Monitor, Sep. 4, 1998, 4 pages.
NuVasive correspondence re 510(k) Premarket Notification INS-1 Intraoperative Nerve Surveillance System: Section IV Device Description, pp. 12-51 (prior to Sep. 25, 2003).
Isley et al., "Recent Advances in Intraoperative Neuromonitoring of Spinal Cord Function: Pedicle Screw Stimulation Techniques," *American Journal of Electroneurodagnostic Technology*, Jun. 1997, 37(2): 93-126.
Mathews et al., "Laparoscopic Discectomy with Anterior Lumbar Interbody Fusion," *Spine*, 1995, 20(16): 1797-1802.
Rose et al., "Persistently Electrified Pedicle Stimulation Instruments in Spinal Instrumentation: Techniques and Protocol Development," *Spine*, 1997, 22(3): 334-343.
"Electromyography System," International Search report from International Application No. PCT/US00/32329, Apr. 27, 2001, 9 pages.
"Nerve Proximity and Status Detection System and Method," International Search Report from International Application No. PCT/US01/18606, Oct. 18, 2001, 6 pages.
"Relative Nerve Movement and Status Detection System and Method," International Search Report from International Application No. PCT/US01/18579, Jan. 15, 2002, 6 pages.
"System and Method for Determining Nerve Proximity Direction and Pathology During Surgery," International Search Report from International Application No. PCT/US02/22247, Mar. 27, 2003, 4 pages.
"System and Methods for Determining Nerve Direction to a Surgical Instrument," International Search Report from International Application No. PCT/US03/02056, Aug. 12, 2003, 5 pages.
"Systems and Methods for Performing Percutaneous Pedicle Integrity Assessments," International Search Report from International Application No. PCT/US02/35047, Aug. 11, 2003, 5 pages.
"Systems and Methods for Performing Surgery Procedures and Assessments," International Search Report from International Application No. PCT/US02/30617, Jun. 5, 2003, 4 pages.
Lenke et al., "Triggered Electromyographic Threshold for Accuracy of Pedicle Screw Placement," *Spine*, 1995, 20(4): 1585-1591.
"Brackmann II EMG System," *Medical Electronics*, 1999, 4 pages.
"Neurovision SE Nerve Locator/Monitor", RLN Systems Inc. Operators Manual, 1999, 22 pages.
"The Brackmann II EMG Monitoring System," Medical Electronics Co. Operator's Manual Version 1.1, 1995, 50 pages.
"The Nicolet Viking IV," Nicolet Biomedical Products, 1999, 6 pages.
Anderson et al., "Pedicle screws with high electrical resistance: a potential source of error with stimulus-evoked EMG," *Spine*, Department of Orthopaedic Surgery University of Virginia, Jul. 15, 2002, 27(14): 1577-1581.
Bose et al., "Neurophysiologic Monitoring of Spinal Nerve Root Function During Instrumented Posterior Lumber Spine Surgery," *Spine*, 2002, 27(13):1444-1450.
Calancie et al., "Stimulus-Evoked EMG Monitoring During Transpedicular Lumbosacral Spine Instrumentation" *Spine*, 1994, 19(24): 2780-2786.
Clements et al., "Evoked and Spontaneous Electromyography to Evaluate Lumbosacral Pedicle Screw Placement," *Spine*, 1996, 21(5): 600-604.
Danesh-Clough et al. ,"The Use of Evoked EMG in Detecting Misplaced Thoracolumbar Pedicle Screws," *Spine*, Orthopaedic Department Dunedin Hospital, Jun. 15, 2001, 26(12): 1313-1316.
Darden et al., "A Comparison of Impedance and Electromyogram Measurements in Detecting the Presence of Pedicle Wall Breakthrough," *Spine*, Charlotte Spine Center North Carolina, Jan. 15, 1998, 23(2): 256-262.
Ebraheim et al., "Anatomic Relations Between the Lumbar Pedicle and the Adjacent Neural Structures," *Spine*, Department of Orthopaedic Surgery Medical College of Ohio, Oct. 15, 1997, 22(20): 2338-2341.
Ford et al. "Electrical Characteristics of Peripheral Nerve Stimulators Implications for Nerve Localization," *Regional Anesthesia*, 1984, 9: 73-77.
Glassman et al., "A Prospective Analysis of Intraoperative Electromyographic Monitoring of Pedicle Screw Placement With Computed Tomographic Scan Confirmation," *Spine*, 1995, 20(12): 1375-1379.
Greenblatt et al., "Needle Nerve Stimulator-Locator: Nerve Blocks with a New Instrument for Locating Nerves," *Anesthesia& Analgesia*, 1962, 41(5): 599-602.
Haig, "Point of view," *Spine*, 2002, 27(24): 2819.
Haig et al., "The Relation Among Spinal Geometry on MRI, Paraspinal Electromyographic Abnormalities, and Age in Persons Referred for Electrodiagnostic Testing of Low Back Symptoms," *Spine*, Department of Physical Medicine and Rehabilitation University of Michigan, Sep. 1, 2002, 27(17): 1918-1925.
Holland et al., "Higher Electrical Stimulus Intensities are Required to Activate Chronically Compressed Nerve Roots: Implications for Intraoperative Electromyographic Pedicle Screw Testing," *Spine*, Department of Neurology, Johns Hopkins University School of Medicine, Jan. 15, 1998, 23(2): 224-227.
Holland, "Intraoperative Electromyography During Thoracolumbar Spinal Surgery," *Spine*, 1998, 23(17): 1915-1922.
Journee et al., "System for Intra-Operative Monitoring of the Cortical Integrity of the Pedicle During Pedicle Screw Placement in Low-Back Surgery: Design and Clinical Results," *Sensory and Neuromuscular Diagnostic Instrumentation and Data Analysis I, 18th Annual International Conference on Engineering in Medicine and Biology Society*, Amsterdam, 1996, pp. 144-145.

(56) **References Cited**

OTHER PUBLICATIONS

Maguire et al., "Evaluation of Intrapedicular Screw Position Using Intraoperative Evoked Electromyography," *Spine*, 1995, 20(9): 1068-1074.

Martin et al. "Initiation of Erection and Semen Release by Rectal Probe Electrostimulation (RPE)," *The Journal of Urology*, The Williams& Wilkins Co., 1983, 129: 637-642.

Minahan et al., "The Effect of Neuromuscular Blockade on Pedicle Screw Stimulation Thresholds" *Spine*, Department of Neurology, Johns Hopkins University School of Medicine, Oct. 1, 2000, 25(19): 2526-2530.

Pither et al., "The Use of Peripheral Nerve Stimulators for Regional Anesthesia: Review of Experimental Characteristics Technique and Clinical Applications," *Regional Anesthesia*, 1985, 10:49-58.

Raj et al., "Infraclavicular Brachial Plexus Block—A New Approach" *Anesthesia and Analgesia*, 1973, (52)6: 897-904.

Raj et al., "The Use of Peripheral Nerve Stimulators for Regional Anesthesia," *Clinical Issues in Regional Anesthesia*, 1985, 1(4):1-6.

Raj et al., "Use of the Nerve Stimulator for Peripheral Blocks," *Regional Anesthesia*, Apr.-Jun. 1980, pp. 14-21.

Raymond et al., "The Nerve Seeker: A System for Automated Nerve Localization," *Regional Anesthesia*, 1992, 17(3): 151-162.

Shafik, "Cavernous Nerve Simulation through an Extrapelvic Subpubic Approach: Role in Penile Erection," *Eur. Urol*, 1994, 26: 98-102.

Toleikis et al., "The Usefulness of Electrical Stimulation for Assessing Pedicle Screw Replacements," *Journal of Spinal Disorder*, 2000, 13(4): 283-289.

Medtronic Sofamor Danek "Union™ / Union-L™ Anterior & Lateral Impacted Fusion Devices: Surgical Technique" *Medtronic Sofamor Danek*, 2001, 20 pages.

Defendant's Disclosure of Asserted Claims and Preliminary Infringement Contentions Regarding USP 7207949; 7470236 and 7582058, Aug. 31, 2009, 21 pages.

Bergey et al., "Endoscopic Lateral Transpsoas Approach to the Lumbar Spine," *Spine*, 2004, 29(15): 1681-1688.

Dezawa et al., "Retroperitoneal Laparoscopic Lateral Approach to the Lumbar Spine: A New Approach, Technique, and Clinical Trial," *Journal of Spinal Disorders*, 2000, 13(2): 138-143.

Gardocki, "Tubular diskectomy minimizes collateral damage: A logical progression moves spine surgery forward," *AAOS Now*, 2009, 5 pages.

Hovorka et al., "Five years' experience of retroperitoneal lumbar and thoracolumbar surgery," *Eur Spine J.*, 2000, 9(1): S30-S34.

Kossman et al., "The use of a retractor system (SynFrame) for open, minimal invasive reconstruction of the anterior column of the thoracic and lumbar spine," *Eur Spine J.*, 2001, 10:396-402.

Mayer, "A New Microsurgical Technique for Minimally Invasive Anterior Lumbar Interbody Fusion," *Spine*, 1997, 22(6): 691-699.

Mayer, "The ALIF Concept," *Eur Spine J.*, 2000, 9(1): S35-S43.

Mayer and Wiechert, "Microsurgical Anterior Approaches to the Lumbar Spine for Interbody Fusion and Total Disc Replacement," *Neurosurgery*, 2002, 51(2): 159-165.

McAfee et al., "Minimally Invasive Anterior Retroperitoneal Approach to the Lumbar Spine: Emphasis on the Lateral BAK," *Spine*, 1998, 23(13): 1476-1484.

Rao, et al. "Dynamic retraction of the psoas muscle to expose the lumbar spine using the retroperitoneal approach," *J. Neurosurg Spine*, 2006, 5: 468-470.

Wolfla et al., "Retroperitoneal lateral lumbar interbody fusion with titanium threaded fusion cages," *J. Neurosurg* (*Spine 1*), 2002, 96: 50-55.

Moed et al., "Insertion of an iliosacral implant in an animal model," Journal of Bone and Joint Surgery, Nov. 1999, 81A(11): 1529-1537.

Larson, Sanford J. et al., "Surgery of the Lumbar Spine," 1999, pp. 305-319.

NIM-Response, so advanced . . . yet so simple, XoMed, Inc. 1999, 12 pages.

Moed et al., "Intraoperative monitoring with stimulus-evoked electromyography during placement of iliosacral screws," The Journal of Bone and Joint Surgery, Apr. 1998, 81A(4): 10 pages.

Medtronic Xomed Surgical Products, Inc. "NIM-Response Nerve Integrity Monitor Intraoperative EMG Monitor User's Guide, Revision B," 2000.

"New data analyzer combines the functions of six instruments in one unit" News Release, Nov. 11, 1987, 3 pages.

"NuVasive's spine surgery system cleared in the US," Pharm & Medical Industry Week, Dec. 10, 2001, 1 page.

"Risk Capital Funds," *Innovation*, Mar. 6, 1990, 172: 3 pages.

Pimenta, "Initial Clinical Results of Direct Lateral, Minimally Invasive Access to the Lumbar Spine for Disc Nucleus Replacement Using a Novel Neurophysiological Monitoring System." *The 9th IMAST*, May 2002, 1 page.

Pimenta et al., "The Lateral Endoscopic Transpsoas Retroperitoneal Approach (Letra) for Implants in the Lumbar Spine," *World Spine II—Second Interdisciplinary Congress on Spine Care*, Aug. 2003, 2 pages.

Friedman, "Percutaneous discectomy: An alternative to chemonucleolysis," Neurosurgery, 1983, 13(5): 542-547.

Crock, H.V. MD., "Anterior Lumbar Interbody Fusion," Clinical Orthopaedics and Related Research, Number One Hundred Sixty Five, 1982, pp. 157-163, 13 pages.

Mayer and Brock, "Percutaneous endoscopic discectomy: surgical technique and preliminary results compared to microsurgical discectomy," *J. Neurosurg*, 1993, 78: 216-225.

Schaffer and Kambin, "Percutaneous Posterolateral Lumbar Discectomy and Decompression with a 6.9-Millimeter Cannula," *The Journal of Bone and Joint Surgery*, 1991, 73A(6): 822-831.

Request for Inter PartesReexamination in re U.S. Patent 7,905,840, dated Feb. 8, 2012, 204 pages.

Brau, "Chapter 22: Anterior Retroperitoneal Muscle-Sparing approach to L2-S1 of the Lumbar Spine," *Surgical Approaches to the Spine*. Robert G. Watkins, MD. (ed) 2003. pp. 165-181.

Kossmann et al., "Minimally Invasive Vertebral Replacement with Cages in Thoracic and Lumbar Spine," *European Journal of Trauma*, 2001, 27: 292-300.

Mayer H. M. (ed.) *Minimally Invasive Spine Surgery: A Surgical Manual*. 2000. 51 pages.

Pimenta et al., "Implante de protese de nucleo pulposo: analise inicial," *Journal Brasileiro de Neurocirurgia*, 2001, 12(2): 93-96.

Traynelis, "Spinal Arthroplasty," *Neurological Focus*, 2002, 13(2): 12 pages.

Zdeblick, Thomas A. (ed.). Anterior Approaches to the Spine. 1999. 43 pages.

Amended Complaint for *NuVasive, Inc.* v. *Globus Medical, Inc.*, Case No. 1:10-cv-0849 (D. Del., Oct. 5, 2010), 28 pages.

Request for Inter PartesReexamination in re U.S. Patent 7,819,801, dated Feb. 8, 2012, 89 pages.

Kossman et al., "The use of a retractor system (SynFrame) for open, minimal invasive reconstruction of the anterior column of the thoracic and lumbar spine," *Eur Spine J*, 2001, 10: 396-402.

de Peretti et al., "New possibilities in L2-L5 lumbar arthrodesis using a lateral retroperitoneal approach assisted by laparoscopy: preliminary results," *Eur Spine J*, 1996, 5: 210-216.

Litwin et al., "Hand-assisted laparoscopic surgery (HALS) with the handport system," *Annals of Surgery*, 2000, 231(5): 715-723.

Acland's Video Atlas of Human Anatomy, Section 3.1.7: Paravertebral Muscles. Available online: http://aclandanatomy.com/abstract/4010463. Accessed Jul. 11, 2012.

MedlinePlus, a Service of the U.S. National Library of Medicine and National Institutes of Health. Available online: http://www.nlm.nih.gov/medlineplus/. Accessed Jul. 11, 2012.

Baulot et al., Adjuvant Anterior Spinal Fusion Via Thoracoscopy, *Lyon Chirurgical*, 1994, 90(5):347-351 including English Translation and Certificate of Translation.

Leu et al., "Percutaneous Fusion of the Lumbar Spine," *Spine*, 1992, 6(3): 593-604.

Rosenthal et al., "Removal of a Protruded Thoracic Disc Using Microsurgical Endoscopy," *Spine*, 1994, 19(9): 1087-1091.

Counterclaim Defendants' Corrected Amended Invalidity Contentions re U.S. Patent Nos. 8,000,782; 8,005,535; 8,016,767;

(56) **References Cited**

OTHER PUBLICATIONS

8,192,356; 8,187,334; 8,361,156, D652,922; D666,294 re Case No. 3:12-cv-02738-CAB(MDD), dated Aug. 19, 2013, 30 pages.
Petition for Inter Partes Review IPR2014-00034, filed Oct. 8, 2013, 65 pages.
Petition for Inter Partes Review IPR2014-00035, filed Oct. 8, 2013, 65 pages.
Declaration of Lee Grant, from IPR2014-00034, Oct. 7, 2013, 36 pages.
Declaration of David Hacker from IPR2014-00034, Oct. 4, 2013, 64 pages.
NuVasive, Inc's Opening Claim Construction Brief Regarding U.S. Patent Nos. 8,000,782; 8,005,535; 8,016,767; 8,192,356; 8,187,334; 8,361,156; D652,922; and 5,676,146 C2, filed Sep. 3, 2013, in *Warsaw Orthopedic, Inc.* v. *NuVasive, Inc.*, No. 3:12-cv-02738-CAB-MDD (S.D. Cal.)., 34 pages.
Petition for Inter Partes Review IPR2014-00073, filed Oct. 18, 2013, 65 pages.
Petition for Inter Partes Review IPR2014-00074, filed Oct. 18, 2013, 65 pages.
Petition for Inter Partes Review IPR2014-00075, filed Oct. 21, 2013, 66 pages.
Petition for Inter Partes Review IPR2014-00076, filed Oct. 21, 2013, 65 pages.
Petition for Inter Partes Review IPR2014-00081, filed Oct. 22, 2013, 64 pages.
Petition for Inter Partes Review IPR2014-00087, filed Oct. 22, 2013, 64 pages.
Declaration of Lee Grant, from IPR2014-00073, Oct. 9, 2013, 36 pages.
Declaration of David Hacker, from IPR2014-00073, Oct. 10, 2013, 64 pages.
U.S. Appl. No. 60/392,214, filed Jun. 26, 2002, 97 pages.
Amendment in reply to Feb. 15, 2012 Office Action in U.S. Appl. No. 12/635,418, dated Mar. 16, 2012, 24 pages.
Decision on Appeal in Inter Partes Reexamination Control No. 95/001,247, dated Mar. 18, 2013, 49 pages.
Declaration of Lee Grant, from IPR2014-00074, Oct. 9, 2013, 36 pages.
Declaration of David Hacker, from IPR2014-00074, Oct. 10, 2013, 64 pages.
Declaration of David Hacker, from IPR2014-00075, Oct. 10, 2013, 64 pages.
Amendment in reply to Action of Feb. 7, 2011 and Notice of May 12, 2011, in U.S. Appl. No. 11/789,284, dated May 17, 2011, 16 pages.
Notice of Allowance in U.S. Appl. No. 11/789,284, dated Jul. 18, 2011, 8 pages.
Office action from U.S. Appl. No. 11/789,284, dated Feb. 7, 2011, 10 pages.
Merriam-Webster's Collegiate Dictionary, p. 65 (10th ed. 1998).
Declaration of Lee Grant, from IPR2014-00076, Oct. 9, 2013, 36 pages.
Moed et al., "Evaluation of Intraoperative Nerve-Monitoring During Insertion of an Iliosacral Implant in an Animal Model, *Journal of Bone and Joint Surgery*," 1999, 81-A(11): 9.
Declaration of Lee Grant, from IPR2014-0081, Oct. 9, 2013, 36 pages.
Declaration of David Hacker from IPR2014-00081, Oct. 10, 2013, 64 pages.
U.S. Appl. No. 60/325,424, filed Sep. 25, 2001, 346 pages.
Declaration of Lee Grant, from IPR2014-0087, Oct. 9, 2013, 36 pages.
Declaration of David Hacker from IPR2014-00087, Oct. 10, 2013, 64 pages.
Request for Inter Partes Reexamination in re: U.S. Patent 7,691,057, dated Feb. 8, 2012, 50 pages.
Declaration of Daniel Schwartz, Ph.D. from IPR2014-00034, Oct. 7, 2013, 1056 pages.
Declaration of Daniel Schwartz, Ph.D. from IPR2014-00035, Oct. 7, 2013, 661 pages.
510(K) No. K002677, approved by the FDA on Nov. 13, 2000, 634 pages.
510(K) No. K013215, approved by the FDA on Oct. 16, 2001, 376 pages.
Declaration of Robert G. Watkins, from IPR2014-00073, Oct. 18, 2013, 1101 pages.
Declaration of Daniel Schwartz, from IPR2014-00073, Oct. 12, 2013, 1226 pages.
Declaration of Robert G. Watkins, from IPR2014-00074, Oct. 18, 2013, 548 pages.
Declaration of Daniel Schwartz, from IPR2014-00074, Oct. 12, 2013, 565 pages.
Declaration of Robert G. Watkins, from IPR2014-00075, Oct. 18, 2013, 674 pages.
Declaration of Daniel Schwartz, from IPR2014-00075, Oct. 12, 2013, 1107 pages.
Declaration of Robert G. Watkins, from IPR2014-00076, Oct. 18, 2013, 543 pages.
Declaration of Daniel Schwartz, from IPR2014-00076, Oct. 12, 2013, 1247 pages.
Declaration of David Hacker, from IPR2014-00076, Oct. 10, 2013, 64 pages.
Declaration of Daniel Schwartz, from IPR2014-0081, Oct. 21, 2013, 585 pages.
Declaration of Daniel Schwartz from IPR2014-0087, Oct. 21, 2013, 585 pages.
Patent Owner NuVasive Inc's Preliminary Response from IPR2014-00034, dated Jan. 15, 2014, 66 pages.
Patent Trial and Appeal Board Decision from IPR 2014-00034, dated Apr. 8, 2014, 35 pages.
Patent Owner NuVasive Inc's Preliminary Response from IPR2014-00035, dated Jan. 15, 2014, 42 pages.
Patent Trial and Appeal Board Decision from IPR 2014-00035, dated Apr. 8, 2014, 12 pages.
Patent Owner NuVasive Inc's Preliminary Response from IPR2014-00073, dated Jan. 31, 2014, 46 pages.
Patent Trial and Appeal Board Decision from IPR 2014-00073, dated Apr. 8, 2014, 34 pages.
Patent Owner NuVasive Inc's Preliminary Response from IPR2014-00074, dated Jan. 31, 2014, 68 pages.
Patent Trial and Appeal Board Decision from IPR 2014-00074, dated Apr. 8, 2014, 28 pages.
Patent Owner NuVasive Inc's Preliminary Response from IPR2014-00075, dated Jan. 31, 2014, 54 pages.
Patent Trial and Appeal Board Decision from IPR 2014-00075, dated Apr. 8, 2014, 23 pages.
Patent Owner NuVasive Inc's Preliminary Response from IPR2014-00076, dated Jan. 31, 2014, 58 pages.
Patent Trial and Appeal Board Decision from IPR 2014-00076, dated Apr. 8, 2014, 11 pages.
Patent Owner NuVasive Inc's Preliminary Response from IPR2014-00081, dated Jan. 31, 2014, 47 pages.
Patent Trial and Appeal Board Decision from IPR 2014-00081, dated Apr. 8, 2014, 31 pages.
Patent Owner NuVasive Inc's Preliminary Response from IPR2014-00087, dated Jan. 31, 2014, 51 pages.
Patent Trial and Appeal Board Decision from IPR 2014-00087, dated Apr. 8, 2014, 31 pages.
Final Written Decision from IPR 2014-00034, dated Apr. 3, 2015, 48 pages.
Final Written Decision from IPR 2014-00073, dated Apr. 3, 2015, 36 pages.
Final Written Decision from IPR 2014-00074, dated Apr. 3, 2015, 31 pages.
Final Written Decision from IPR 2014-00075, dated Apr. 3, 2015, 39 pages.
Final Written Decision from IPR 2014-00081, dated Apr. 3, 2015, 44 pages.
Final Written Decision from IPR 2014-00087, dated Apr. 3, 2015, 36 pages.

* cited by examiner

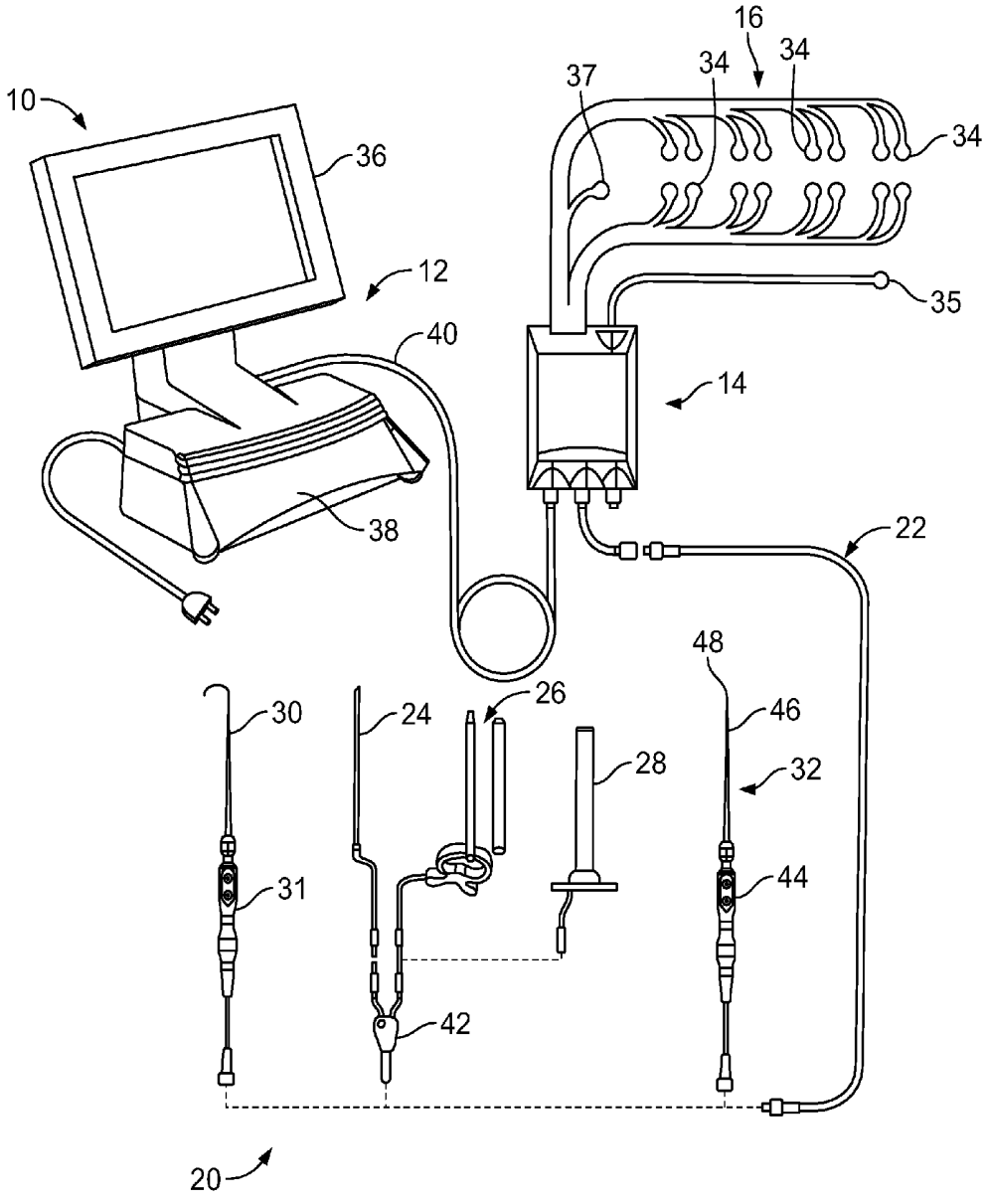


FIG. 1

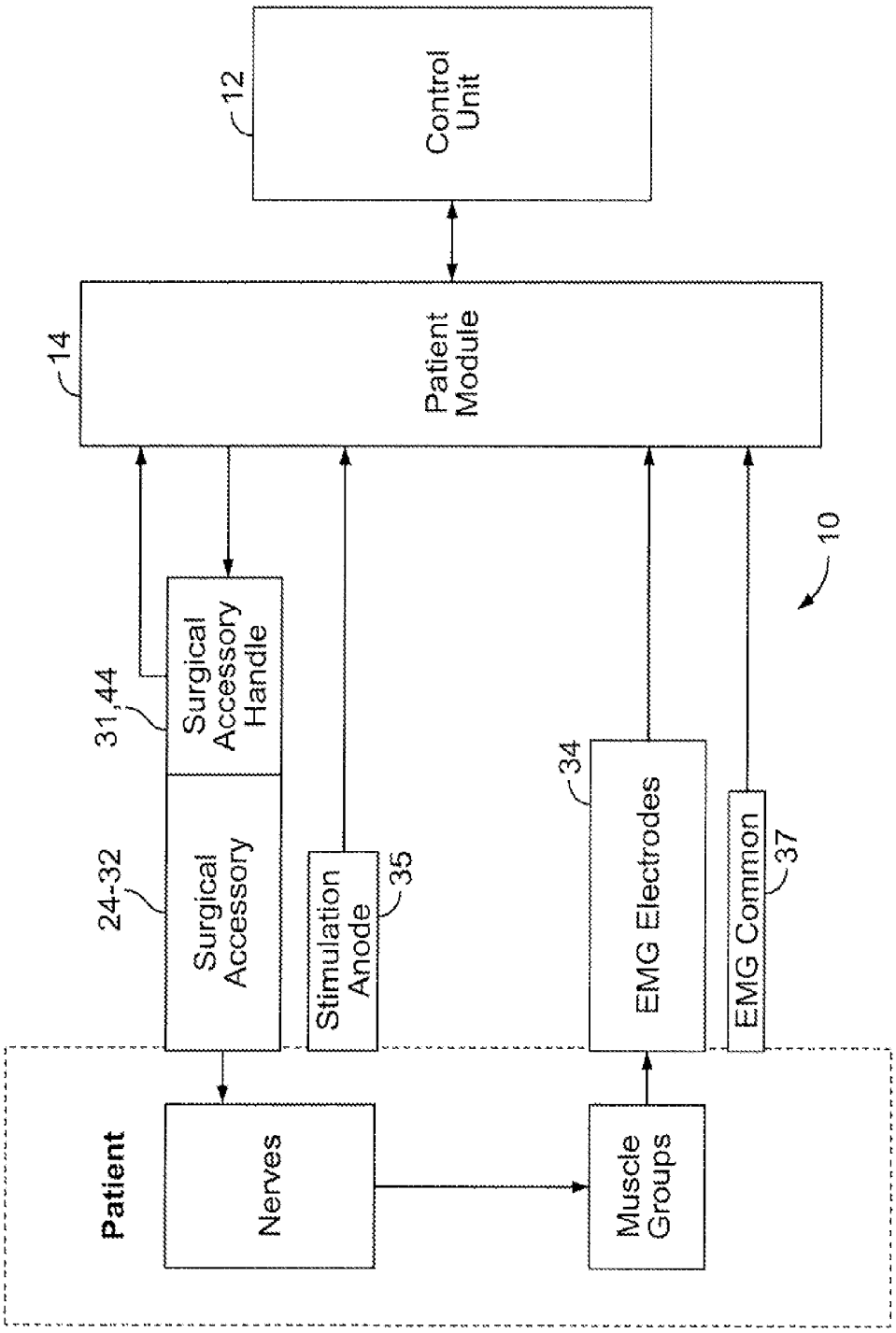

12
Control Unit
14
Patient Module
10
31,44
Surgical Accessory Handle
24-32
Surgical Accessory
Stimulation Anode
35
34
EMG Electrodes
EMG Common
37
Patient
Nerves
Muscle Groups

FIG. 2

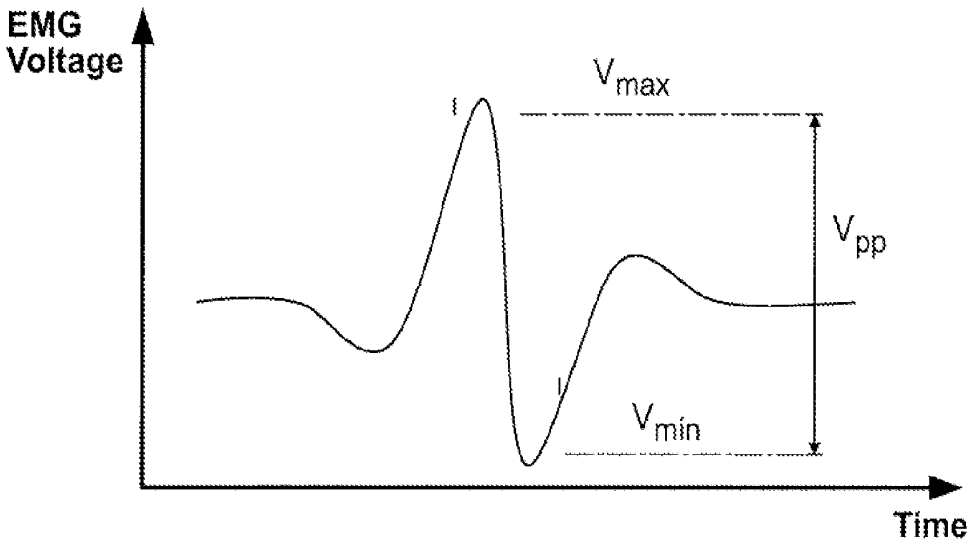


FIG. 3

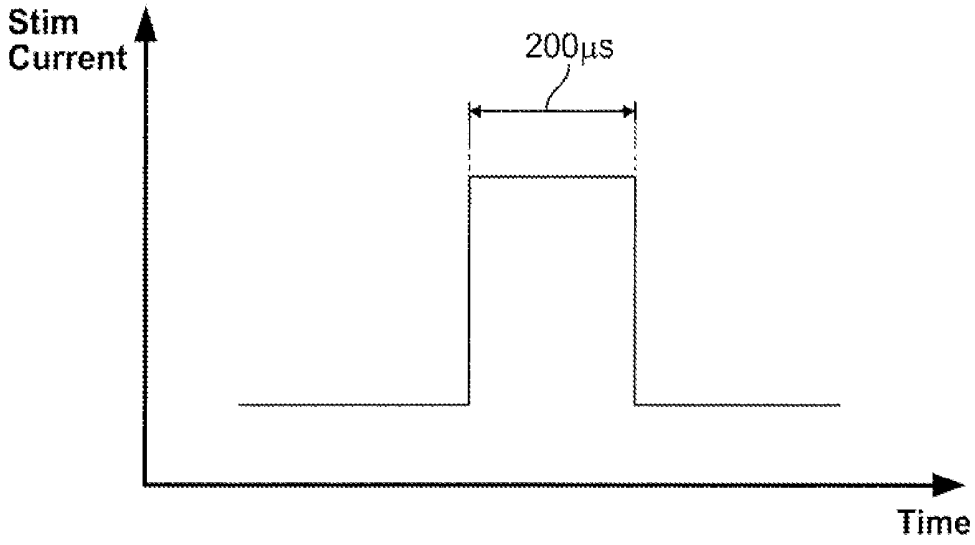


FIG. 4

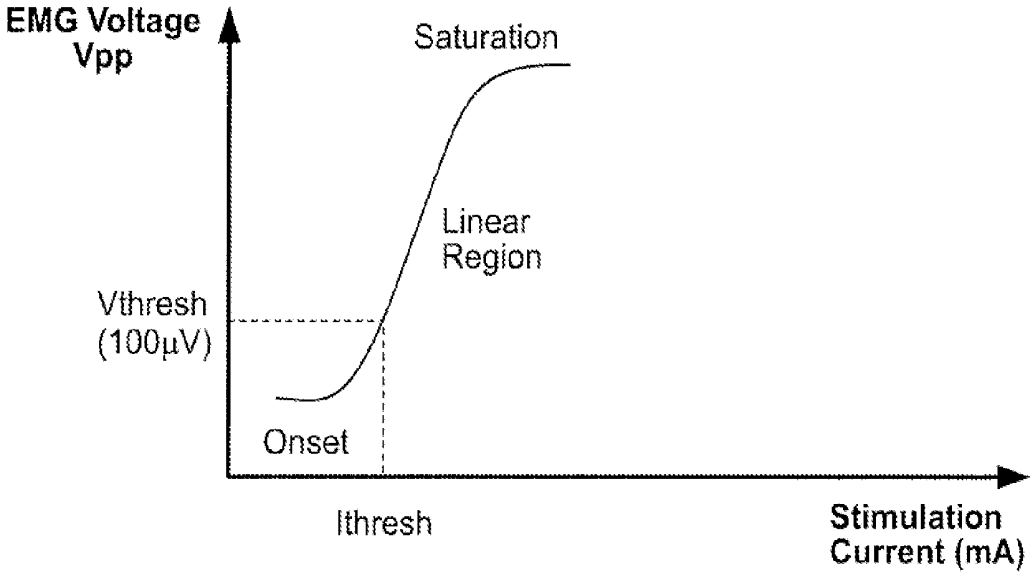

EMG Voltage
Vpp
Saturation
Linear
Region
Vthresh
(100μV)
Onset
Ithresh
Stimulation
Current (mA)

FIG. 5

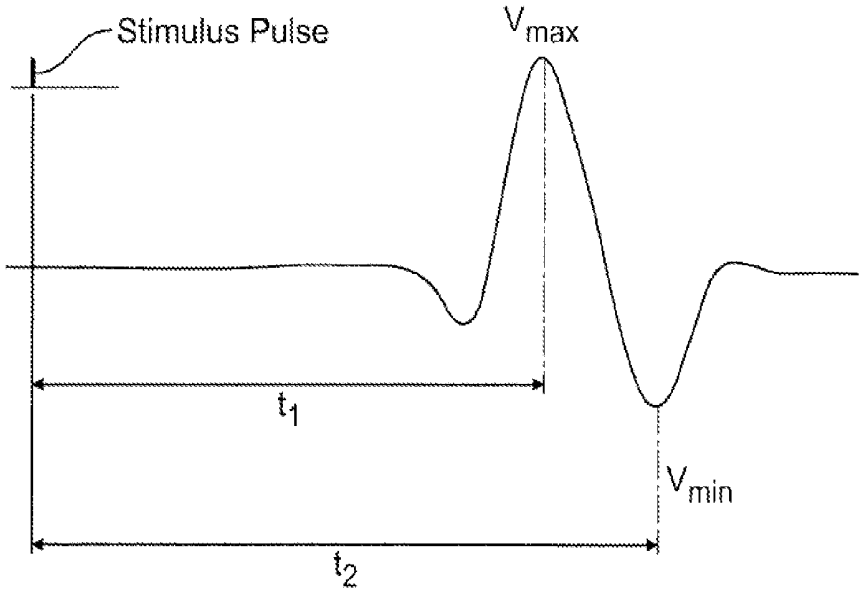

Stimulus Pulse
V_{max}
t_1
V_{min}
t_2

FIG. 6

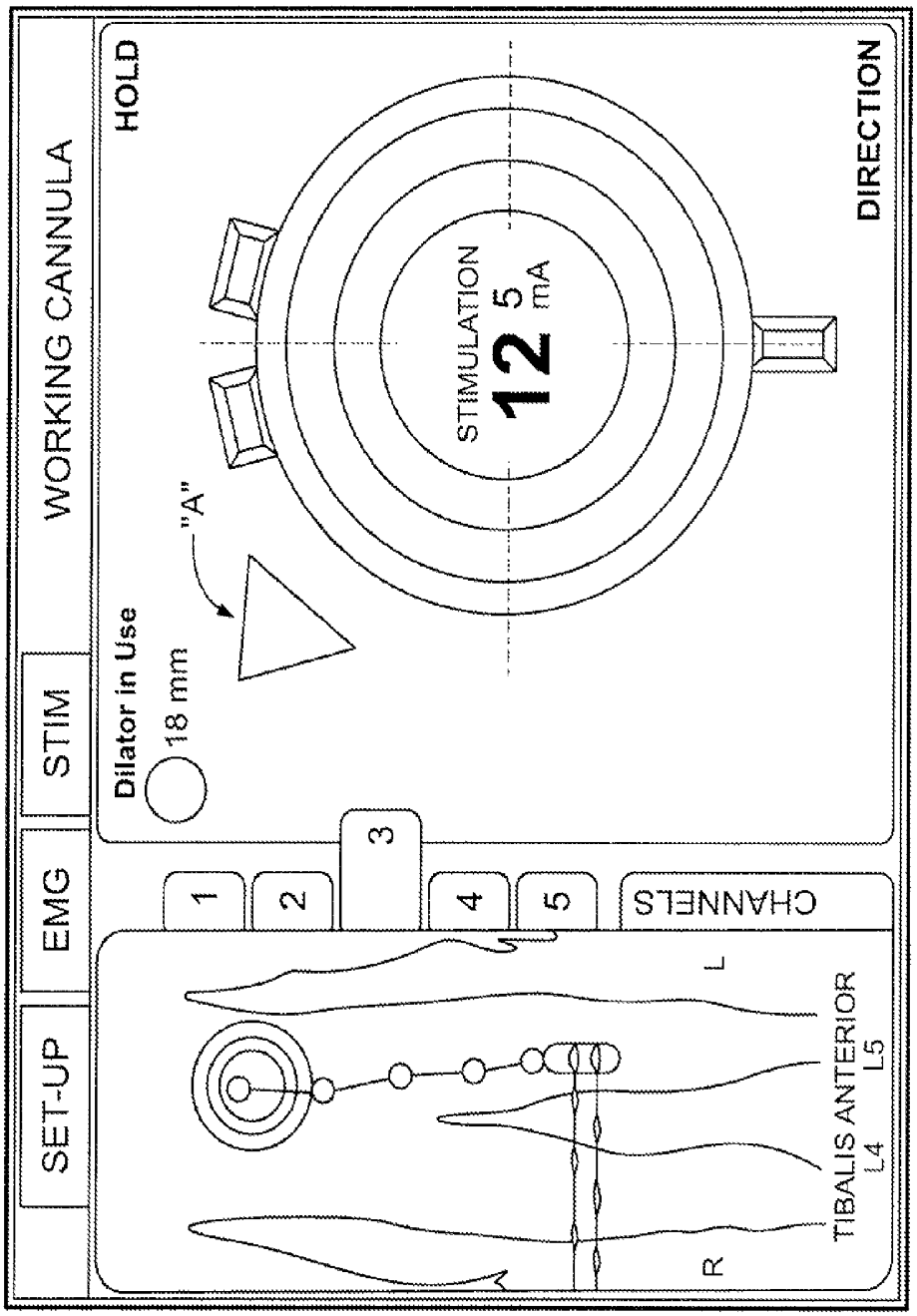

SET-UP
EMG
STIM
WORKING CANNULA
HOLD
DIRECTION
Dilator in Use
18 mm
"A"
STIMULATION
12 5 mA
1
2
3
4
5
CHANNELS
L
R
TIBALIS ANTERIOR
L4 L5

FIG. 7

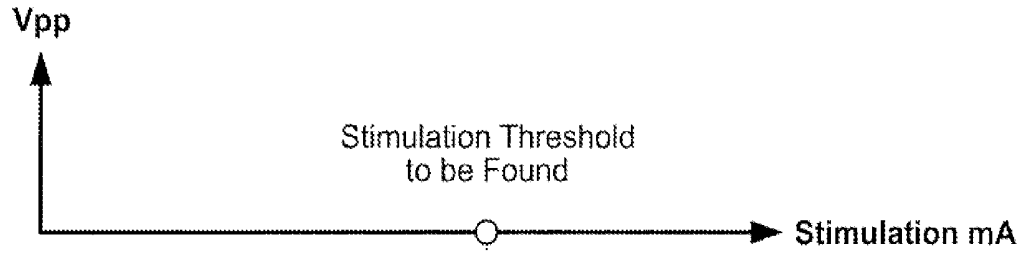


FIG. 8A

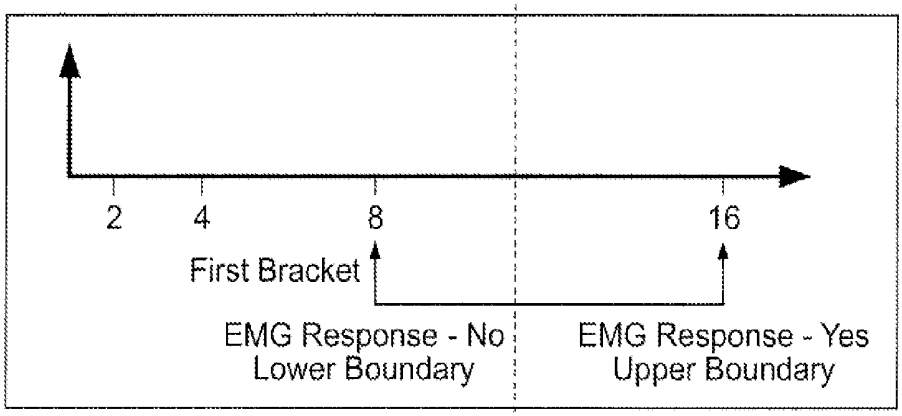


FIG. 8B

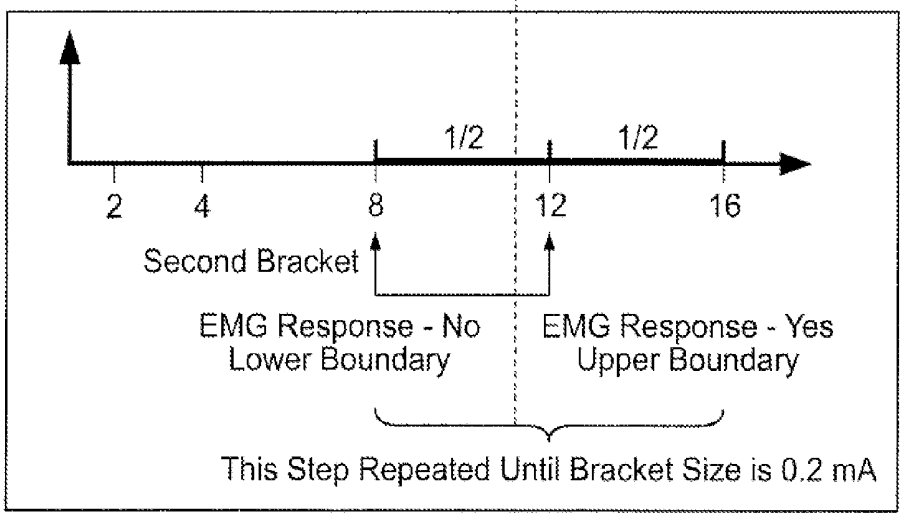


FIG. 8C

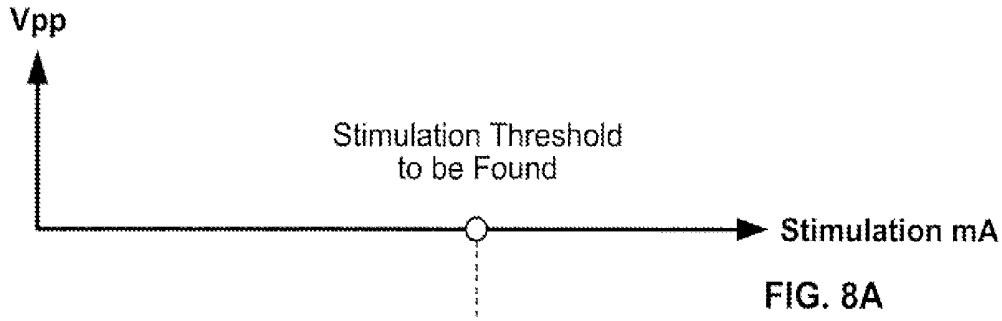


FIG. 8A

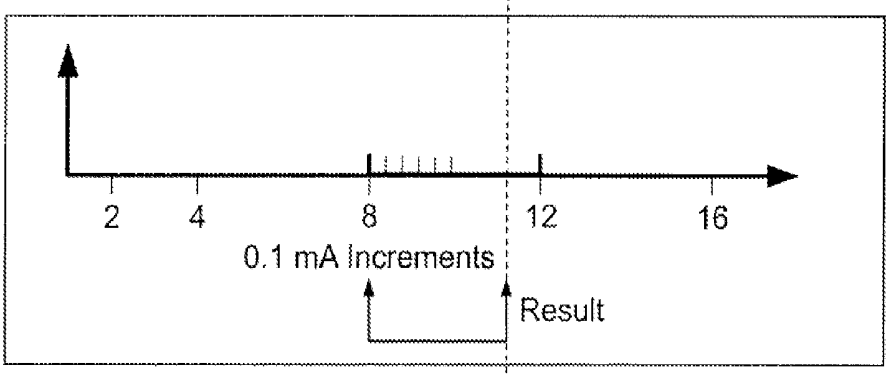


FIG. 8D

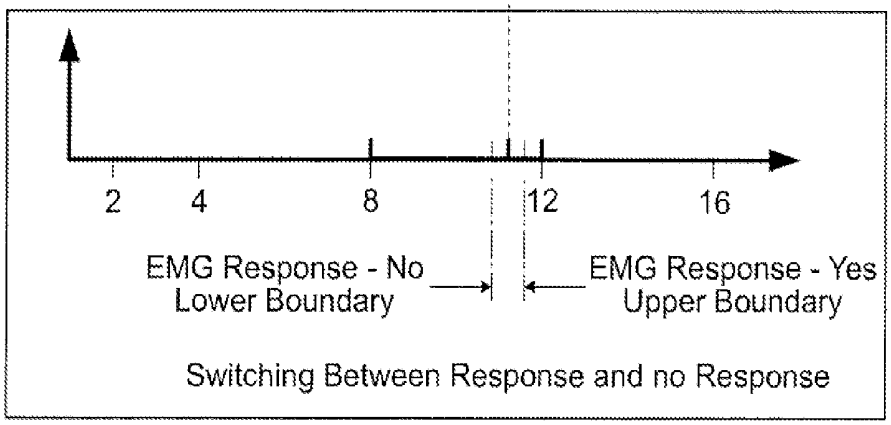


FIG. 8E

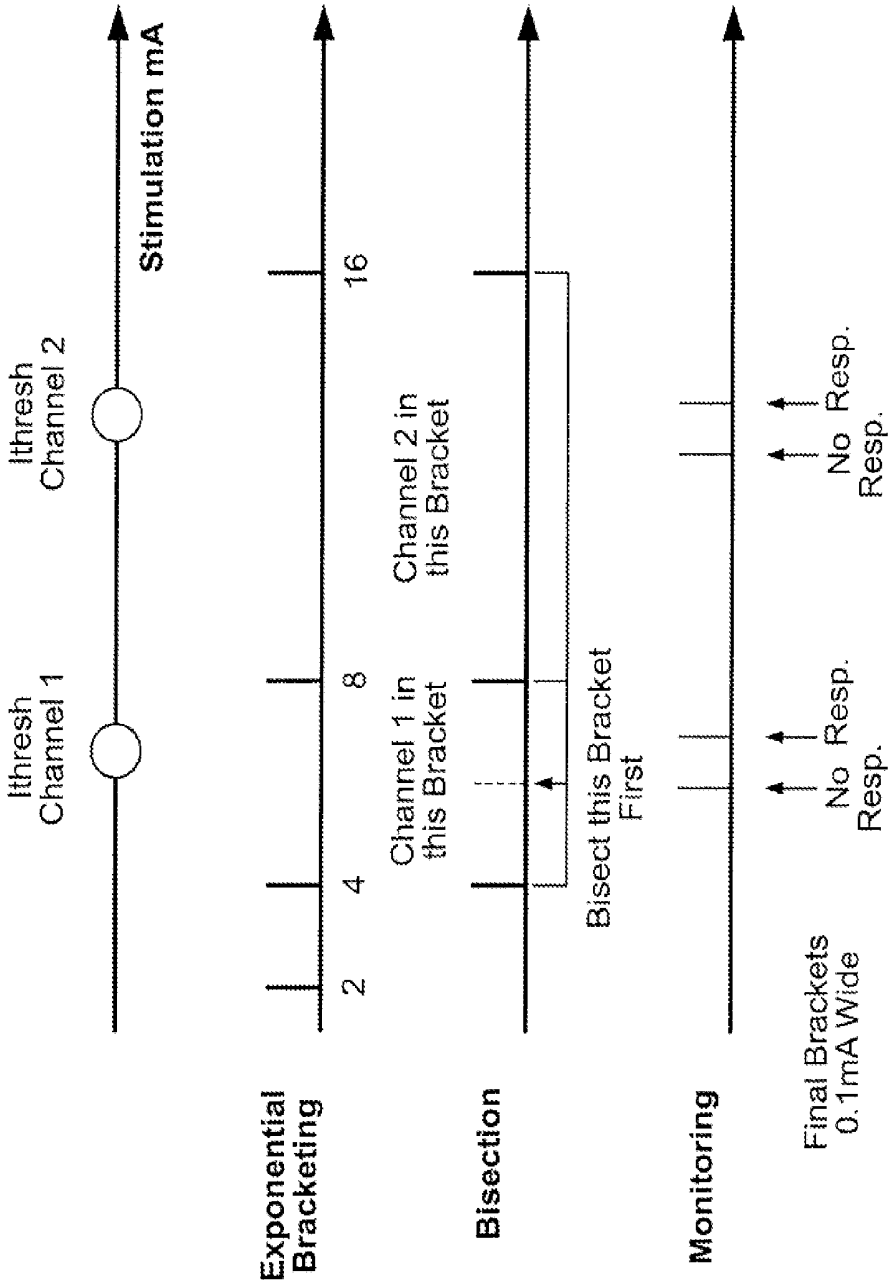

Stimulation mA
Ithresh Channel 2
Ithresh Channel 1
Exponential Bracketing
2
4
8
16
Channel 1 in this Bracket
Channel 2 in this Bracket
Bisection
Bisect this Bracket First
Monitoring
Final Brackets 0.1mA Wide
No Resp.
Resp.
No Resp.
Resp.
Note: not to scale

FIG. 9

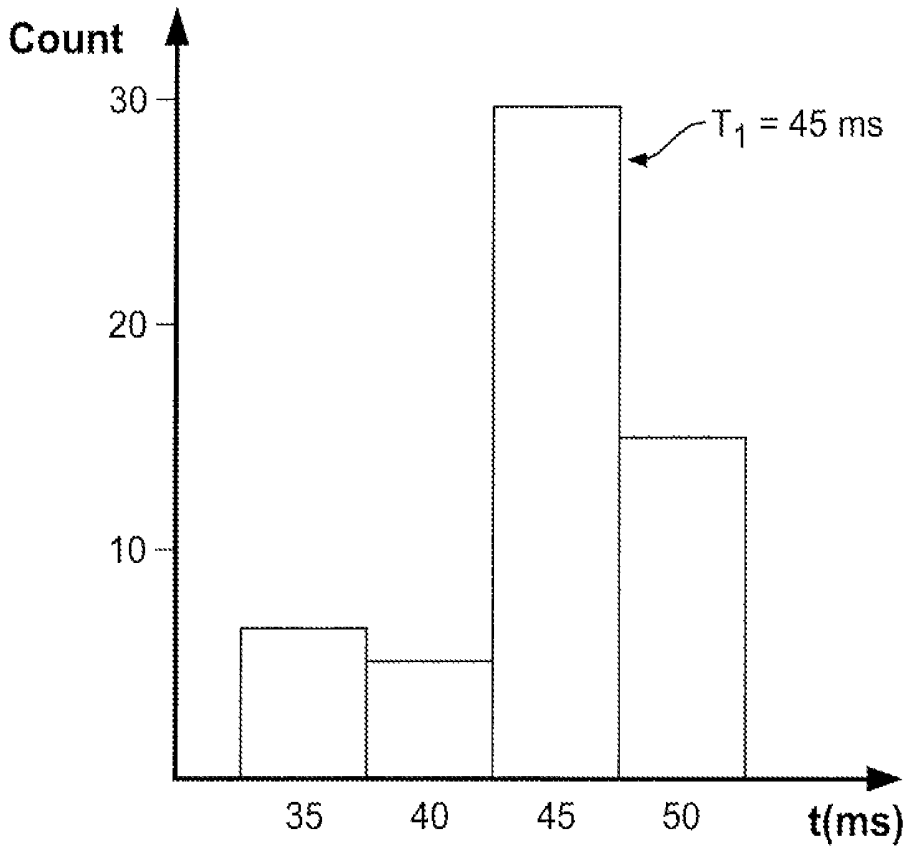


FIG. 10

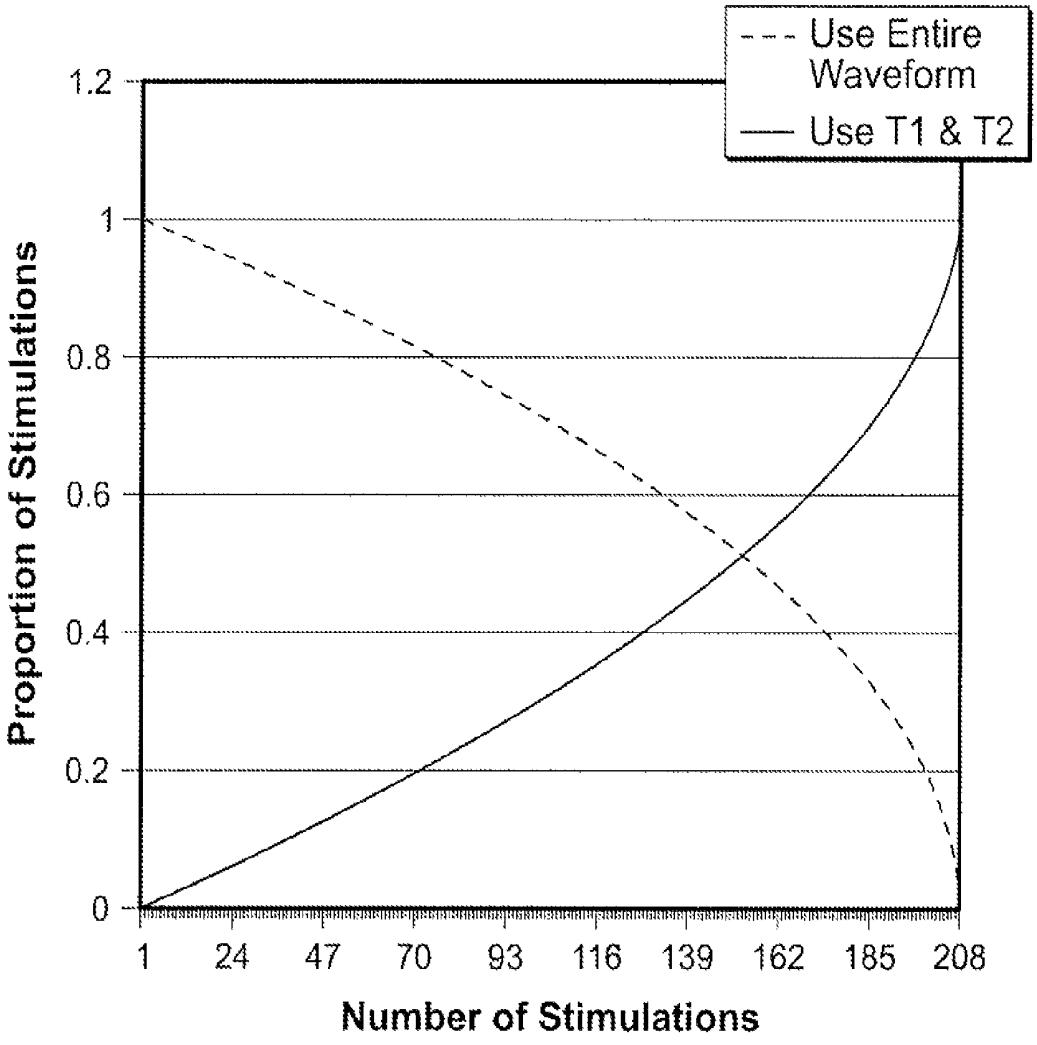

Use Entire Waveform
Use T1 & T2
1.2
1
0.8
0.6
0.4
0.2
0
Proportion of Stimulations
1
24
47
70
93
116
139
162
185
208
Number of Stimulations

FIG. 11

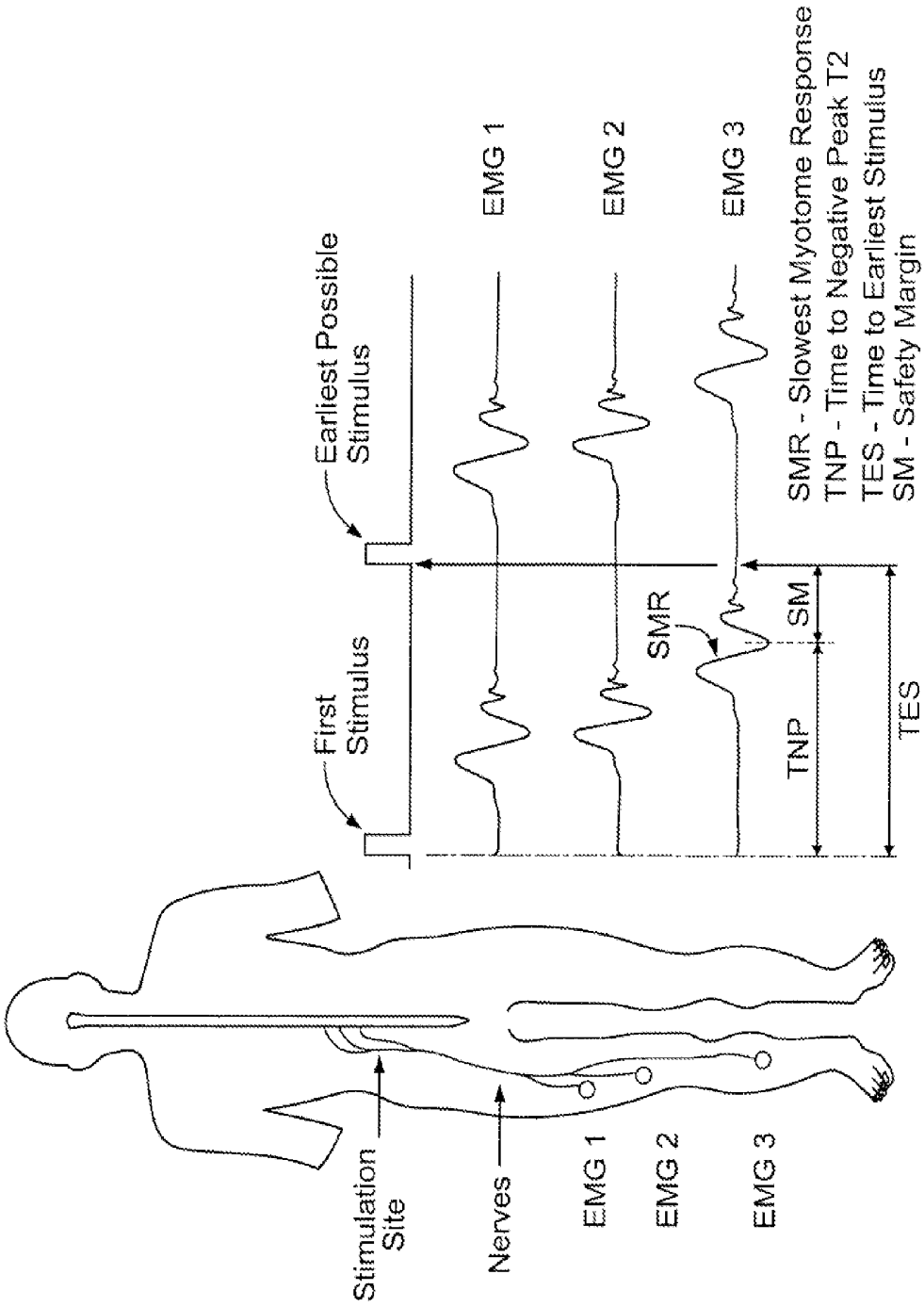

Earliest Possible Stimulus
First Stimulus
EMG 1
EMG 2
EMG 3
SMR
SM
TNP
TES
SMR - Slowest Myotome Response
TNP - Time to Negative Peak T2
TES - Time to Earliest Stimulus
SM - Safety Margin
Stimulation Site
Nerves
EMG 1
EMG 2
EMG 3

FIG. 12

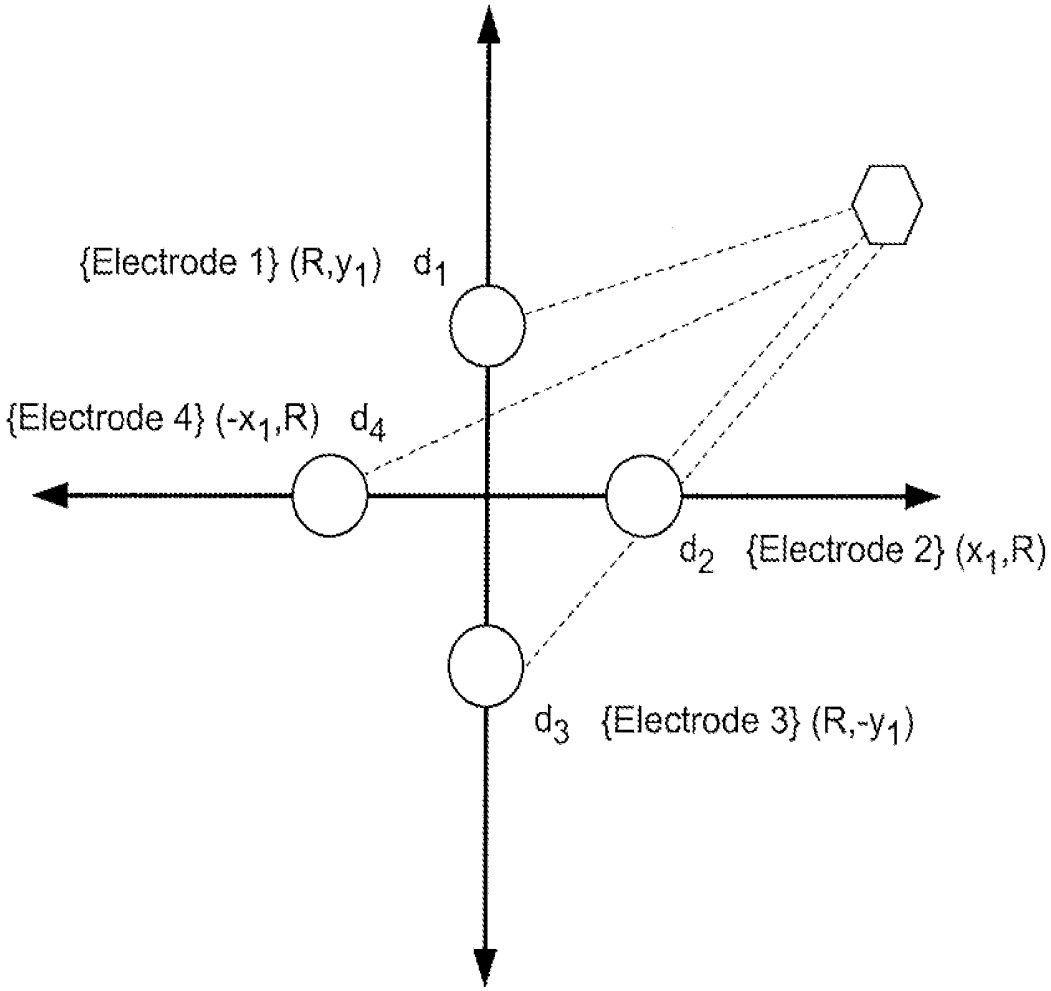

{Electrode 1} (R,y_1) d_1
{Electrode 4} (-x_1,R) d_4
d_2 {Electrode 2} (x_1,R)
d_3 {Electrode 3} (R,-y_1)

FIG. 13

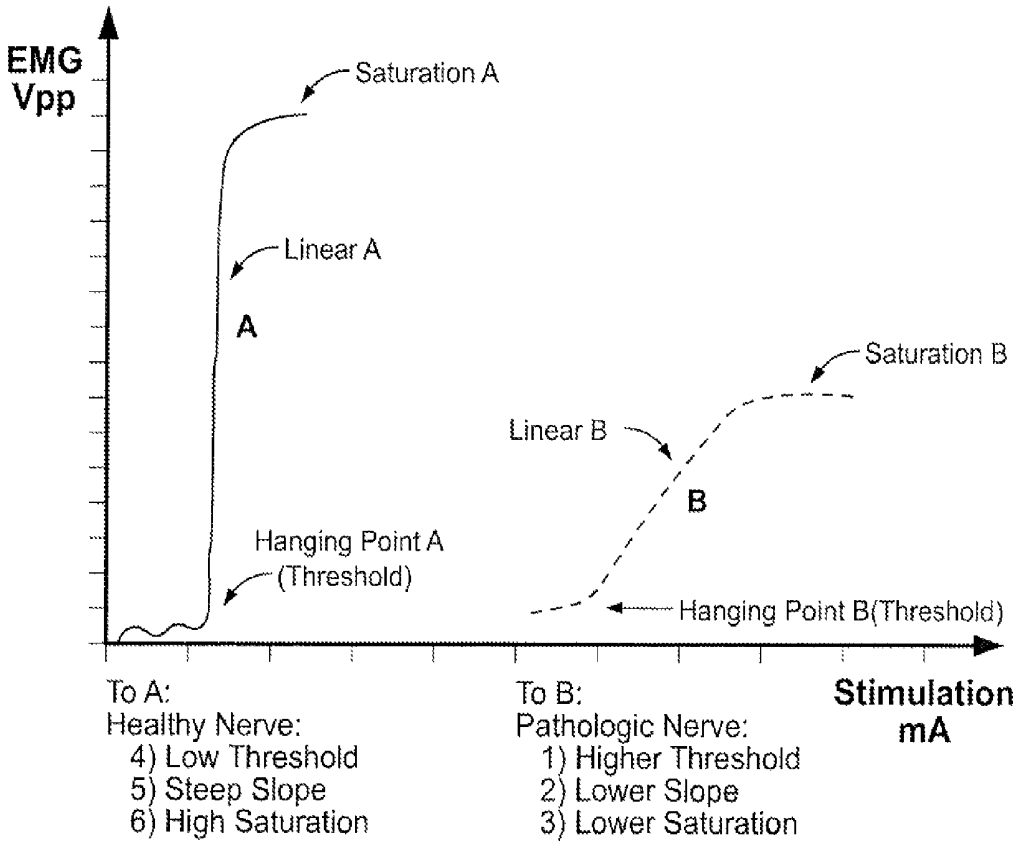

EMG
Vpp
Saturation A
Linear A
A
Saturation B
Linear B
B
Hanging Point A
(Threshold)
Hanging Point B(Threshold)
To A:
Healthy Nerve:
4) Low Threshold
5) Steep Slope
6) High Saturation
To B:
Pathologic Nerve:
1) Higher Threshold
2) Lower Slope
3) Lower Saturation
Stimulation
mA

FIG. 14

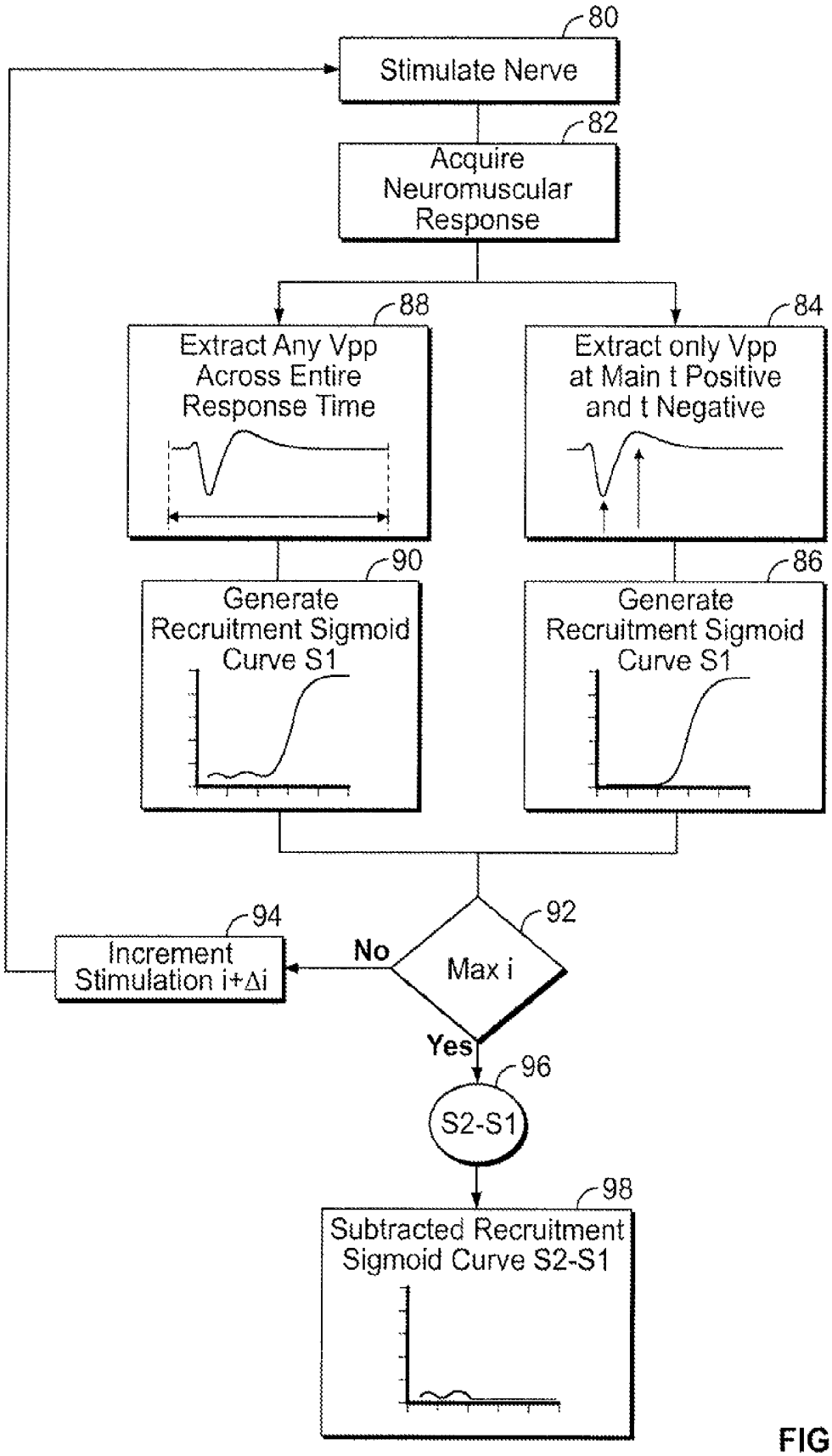

80
Stimulate Nerve
82
Acquire Neuromuscular Response
88
Extract Any Vpp Across Entire Response Time
84
Extract only Vpp at Main t Positive and t Negative
90
Generate Recruitment Sigmoid Curve S1
86
Generate Recruitment Sigmoid Curve S1
92
Max i
No
94
Increment Stimulation i+Δi
Yes
96
S2-S1
98
Subtracted Recruitment Sigmoid Curve S2-S1

FIG. 15

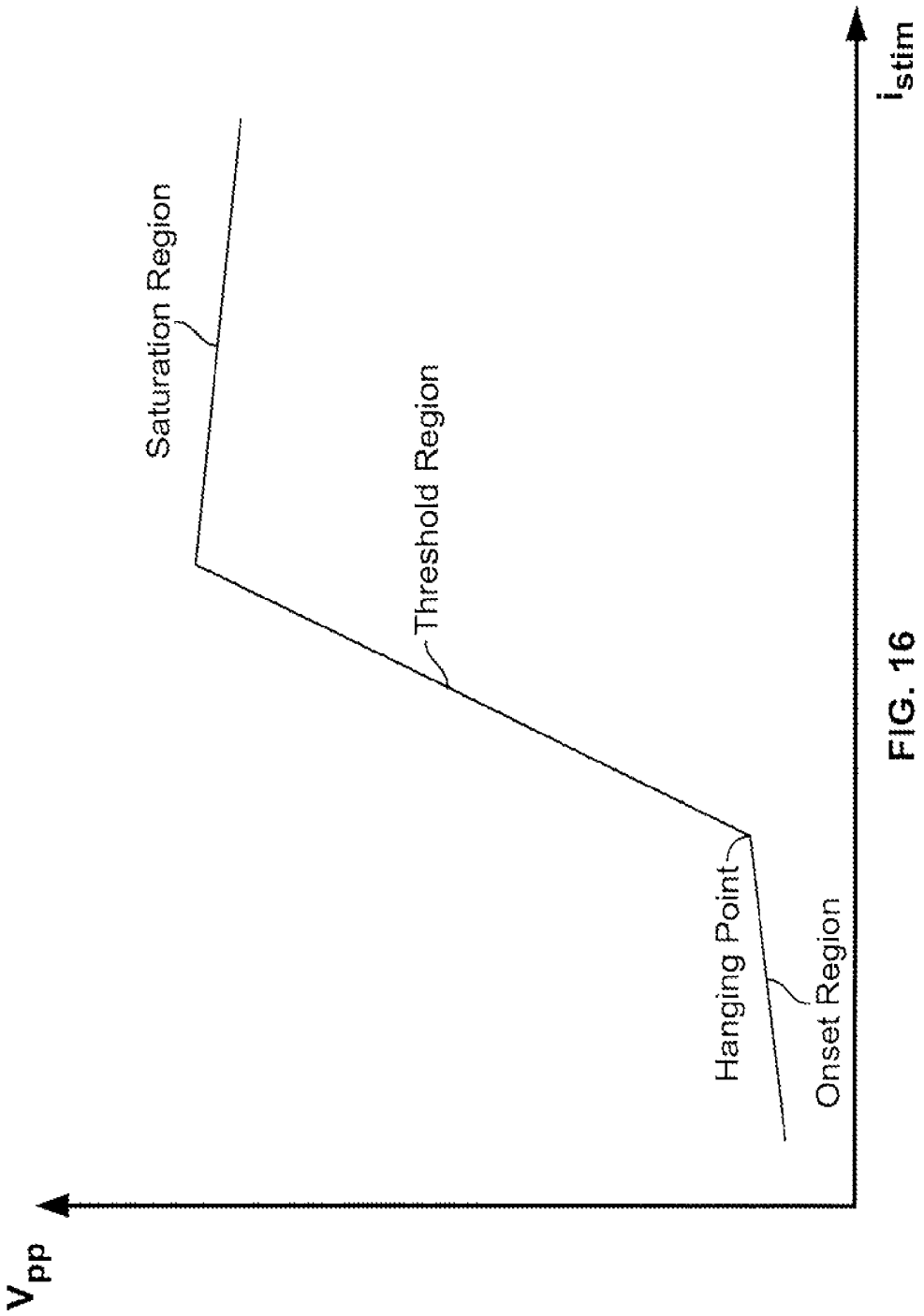

Saturation Region
Threshold Region
Hanging Point
Onset Region
V_{pp}
i_{stim}

FIG. 16

SYSTEM AND METHODS FOR DETERMINING NERVE PROXIMITY, DIRECTION AND PATHOLOGY DURING SURGERY

CROSS-REFERENCES TO RELATED APPLICATIONS

This application is a continuation of U.S. patent application Ser. No. 13/465,666 filed by Gharib et al. on May 7, 2012 (the contents being incorporated herein by reference), which is a continuation of U.S. patent application Ser. No. 13/292,065 filed by Gharib et al. on Nov. 8, 2011 (the contents being incorporated herein by reference), which is a continuation of U.S. patent application Ser. No. 13/080,493 (now U.S. Pat. No. 8,055,349) filed by Gharib et al. on Apr. 5, 2011 (the contents being incorporated herein by reference), which is a division of U.S. patent application Ser. No. 12/711,937 (now U.S. Pat. No. 7,920,922) filed by Gharib et al. on Feb. 24, 2010 (the contents being incorporated herein by reference), which is a continuation of U.S. patent application Ser. No. 10/754,899 (now U.S. Pat. No. 8,068,912) filed by Gharib et al. on Jan. 9, 2004 (the contents being incorporated herein by reference), which is a continuation of PCT Patent Application Ser. No. PCT/US02/22247 filed on Jul. 11, 2002 and published as W003/005887 (the contents being incorporated herein by reference), which claims priority to U.S. Provisional Patent Application Ser. No. 60/305,041 filed Jul. 11, 2001 (the contents being incorporated herein by reference).

BACKGROUND OF THE INVENTION

I. Field of the Invention

This invention relates to nerve monitoring systems and to nerve muscle monitoring systems, and more particularly to systems and methods for determining nerve proximity, nerve direction, and pathology during surgery.

II. Description of Related Art

Systems and methods exist for monitoring nerves and nerve muscles. One such system determines when a needle is approaching a nerve. The system applies a current to the needle to evoke a muscular response. The muscular response is visually monitored, typically as a shake or "twitch." When such a muscular response is observed by the user, the needle is considered to be near the nerve coupled to the responsive muscle. These systems require the user to observe the muscular response (to determine that the needle has approached the nerve). This may be difficult depending on the competing tasks of the user. In addition, when general anesthesia is used during a procedure, muscular response may be suppressed, limiting the ability of a user to detect the response.

While generally effective (although crude) in determining nerve proximity, such existing systems are incapable of determining the direction of the nerve to the needle or instrument passing through tissue or passing by the nerves. This can be disadvantageous in that, while the surgeon may appreciate that a nerve is in the general proximity of the instrument, the inability to determine the direction of the nerve relative to the instrument can lead to guess work by the surgeon in advancing the instrument and thereby raise the specter of inadvertent contact with, and possible damage to, the nerve.

Another nerve-related issue in existing surgical applications involves the use of nerve retractors. A typical nerve retractor serves to pull or otherwise maintain the nerve outside the area of surgery, thereby protecting the nerve from inadvertent damage or contact by the "active" instrumentation used to perform the actual surgery. While generally advantageous in protecting the nerve, it has been observed that such retraction can cause nerve function to become impaired or otherwise pathologic over time due to the retraction. In certain surgical applications, such as spinal surgery, it is not possible to determine if such retraction is hurting or damaging the retracted nerve until after the surgery (generally referred to as a change in "nerve health" or "nerve status"). There are also no known techniques or systems for assessing whether a given procedure is having a beneficial effect on a nerve or nerve root known to be pathologic (that is, impaired or otherwise unhealthy).

Based on the foregoing, a need exists for a better system and method that can determine the proximity of a surgical instrument (including but not limited to a needle, catheter, cannula, probe, or any other device capable of traversing through tissue or passing near nerves or nerve structures) to a nerve or group of nerves during surgery. A need also exists for a system and method for determining the direction of the nerve relative to the surgical instrument. A still further need exists for a manner of monitoring nerve health or status during surgical procedures.

The present invention is directed at eliminating, or at least reducing the effects of, the above-described problems with the prior art, as well as addressing the above-identified needs.

SUMMARY OF THE INVENTION

The present invention includes a system and related methods for determining nerve proximity and nerve direction to surgical instruments employed in accessing a surgical target site, as well as monitoring the status or health (pathology) of a nerve or nerve root during surgical procedures.

According to a broad aspect, the present invention includes a surgical system, comprising a control unit and a surgical instrument. The control unit has at least one of computer programming software, firmware and hardware capable of delivering a stimulation signal, receiving and processing neuromuscular responses due to the stimulation signal, and identifying a relationship between the neuromuscular response and the stimulation signal. The surgical instrument has at least one stimulation electrode electrically coupled to said control unit for transmitting the stimulation signal, wherein said control unit is capable of determining at least one of nerve proximity, nerve direction, and nerve pathology relative to the surgical instrument based on the identified relationship between the neuromuscular response and the stimulation signal.

In a further embodiment of the surgical system of the present invention, the control unit is further equipped to communicate at least one of alpha-numeric and graphical information to a user regarding at least one of nerve proximity, nerve direction, and nerve pathology.

In a further embodiment of the surgical system of the present invention, the surgical instrument may comprise at least one of a device for maintaining contact with a nerve during surgery, a device for accessing a surgical target site, and a device for testing screw placement integrity.

In a further embodiment of the surgical system of the present invention, the surgical instrument comprises a nerve root retractor and wherein the control unit determines nerve pathology based on the identified relationship between the neuromuscular response and the stimulation signal.

In a further embodiment of the surgical system of the present invention, the surgical instrument comprises a dilating instrument and wherein the control unit determines at least one of proximity and direction between a nerve and the

instrument based on the identified relationship between the neuromuscular response and the stimulation signal.

In a further embodiment of the surgical system of the present invention, the dilating instrument comprises at least one of a K-wire, an obturator, a dilating cannula, and a working cannula.

In a further embodiment of the surgical system of the present invention, the surgical instrument comprises a screw test probe and wherein the control unit determines the proximity between the screw test probe and an exiting spinal nerve root to assess whether a medial wall of a pedicle has been breached by at least one of hole formation and screw placement.

BRIEF DESCRIPTION OF THE DRAWINGS

FIG. **1** is a perspective view of a surgical system **10** capable of determining, among other things, nerve proximity, direction, and pathology according to one aspect of the present invention;

FIG. **2** is a block diagram of the surgical system **10** shown in FIG. **1**;

FIG. **3** is a graph illustrating a plot of the neuromuscular response (EMG) of a given myotome over time based on a current stimulation pulse (similar to that shown in FIG. **4**) applied to a nerve bundle coupled to the given myotome;

FIG. **4** is a graph illustrating a plot of a stimulation current pulse capable of producing a neuromuscular response (EMG) of the type shown in FIG. **3**;

FIG. **5** is a graph illustrating a plot of peak-to-peak voltage (Vpp) for each given stimulation current level (I_{Stim}) forming a stimulation current pulse train according to the present invention (otherwise known as a "recruitment curve");

FIG. **6** is a graph illustrating a plot of a neuromuscular response (EMG) over time (in response to a stimulus current pulse) showing the manner in which maximum voltage (V_{Max}) and minimum voltage (V_{Min}) occur at times T**1** and T**2**, respectively;

FIG. **7** is an exemplary touch-screen display according to the present invention, capable of communicating a host of alpha-numeric and/or graphical information to a user and receiving information and/or instructions from the user during the operation of the surgical system **10** of FIG. **1**;

FIGS. **8**A-**8**E are graphs illustrating a rapid current threshold-hunting algorithm according to one embodiment of the present invention;

FIG. **9** is a series of graphs illustrating a multi-channel rapid current threshold-hunting algorithm according to one embodiment of the present invention;

FIG. **10** is a graph illustrating a T**1**, T**2** artifact rejection technique according to one embodiment of the present invention via the use of histograms;

FIG. **11** is a graph illustrating the proportion of stimulations versus the number of stimulations employed in the T**1**, T**2** artifact rejection technique according to the present invention;

FIG. **12** is an illustrating (graphical and schematic) of a method of automatically determining the maximum frequency (F_{Max}) of the stimulation current pulses according to one embodiment of the present invention;

FIG. **13** is a graph illustrating a method of determining the direction of a nerve (denoted as an "octagon") relative to an instrument having four (4) orthogonally disposed stimulation electrodes (denoted by the "circles") according to one embodiment of the present invention;

FIG. **14** is a graph illustrating recruitment curves for a generally healthy nerve (denoted "A") and a generally unhealthy nerve (denoted "B") according to the nerve pathology determination method of the present invention;

FIG. **15** is flow chart illustrating an alternate method of determining the hanging point of a recruitment curve according to an embodiment of the present invention; and

FIG. **16** is a graph illustrating a simulated recruitment curve generated by a "virtual patient" device and method according to the present invention.

DESCRIPTION OF THE SPECIFIC EMBODIMENTS

Illustrative embodiments of the invention are described below. In the interest of clarity, not all features of an actual implementation are described in this specification. It will of course be appreciated that in the development of any such actual embodiment, numerous implementation-specific decisions must be made to achieve the developers' specific goals, such as compliance with system-related and business-related constraints, which will vary from one implementation to another. Moreover, it will be appreciated that such a development effort might be complex and time-consuming, but would nevertheless be a routine undertaking for those of ordinary skill in the art having the benefit of this disclosure. The systems disclosed herein boast a variety of inventive features and components that warrant patent protection, both individually and in combination.

FIG. **1** illustrates, by way of example only, a surgical system **10** capable of employing the nerve proximity, nerve direction, and nerve pathology assessments according to the present invention. As will be explained in greater detail below, the surgical system **10** is capable of providing safe and reproducible access to any number of surgical target sites, and well as monitoring changes in nerve pathology (health or status) during surgical procedures. It is expressly noted that, although described herein largely in terms of use in spinal surgery, the surgical system **10** and related methods of the present invention are suitable for use in any number of additional surgical procedures wherein tissue having significant neural structures must be passed through (or near) in order to establish an operative corridor, or where neural structures are retracted.

The surgical system **10** includes a control unit **12**, a patient module **14**, an EMG harness **16** and return electrode **35** coupled to the patient module **14**, and a host of surgical accessories **20** capable of being coupled to the patient module **14** via one or more accessory cables **22**. The surgical accessories **20** may include, but are not necessarily limited to, surgical access components (such as a K-wire **24**, one or more dilating cannula **26**, and a working cannula **28**), neural pathology monitoring devices (such as nerve root retractor 30), and devices for performing pedicle screw test (such as screw test probe **32**). A block diagram of the surgical system **10** is shown in FIG. **2**, the operation of which is readily apparent in view of the following description.

The control unit **12** includes a touch screen display **36** and a base **38**. The touch screen display **36** is preferably equipped with a graphical user interface (GUI) capable of communicating information to the user and receiving instructions from the user. The base **38** contains computer hardware and software that commands the stimulation sources, receives digitized signals and other information from the patient module **14**, and processes the EMG responses to extract characteristic information for each muscle group, and displays the processed data to the operator via the display **36**. The primary functions of the software within the control unit **12** include receiving user commands via the touch screen display **36**,

activating stimulation in the requested mode (nerve proximity, nerve detection, nerve pathology, screw test), processing signal data according to defined algorithms (described below), displaying received parameters and processed data, and monitoring system status and report fault conditions.

The patient module **14** is connected via a serial cable **40** to the control unit **12**, and contains the electrical connections to all electrodes, signal conditioning circuitry, stimulator drive and steering circuitry, and a digital communications interface to the control unit **12**. In use, the control unit **12** is situated outside but close to the surgical field (such as on a cart adjacent the operating table) such that the display **36** is directed towards the surgeon for easy visualization. The patient module **14** should be located between the patient's legs, or may be affixed to the end of the operating table at mid-leg level using a bedrail clamp. The position selected should be such that the EMG leads can reach their farthest desired location without tension during the surgical procedure.

In a significant aspect of the present invention, the information displayed to the user on display **36** may include, but is not necessarily limited to, alpha-numeric and/or graphical information regarding nerve proximity, nerve direction, nerve pathology, stimulation level, myotome/EMG levels, screw testing, advance or hold instructions, and the instrument in use. In one embodiment (set forth by way of example only) the display includes the following components as set forth in Table 1:

TABLE 1

Screen Component	Description
Menu/ Status Bar	The mode label may include the surgical accessory attached, such as the surgical access components (K-Wire, Dilating Cannula, Working Cannula), nerve pathology monitoring device (Nerve Root Retractor), and/or screw test device (Screw Test Probe) depending on which is attached.
Spine Image	An image of a human body/skeleton showing the electrode placement on the body, with labeled channel number tabs on each side (1-4 on left and right). Left and Right labels will show the patient orientation. The Channel number tabs may be highlighted or colored depending on the specific function being performed.
Display Area	Shows procedure-specific information.
Myotome & Level Names	A label to indicate the Myotome name and corresponding Spinal Level(s) associated with the channel of interest.
Advance/ Hold	When in the Detection mode, an indication of "Advance" will show when it is safe to move the cannula forward (such as when the minimum stimulation current threshold I_{Thresh} (described below) is greater than a predetermined value, indicating a safe distance to the nerve) and "Hold" will show when it is unsafe to advance the cannula (such as when the minimum stimulation current threshold I_{Thresh} (described below) is less than a predetermined value, indicating that the nerve is relatively close to the cannula) and during proximity calculations.
Function	Indicates which function is currently active (Direction, Detection, Pathology Monitoring, Screw Test).
Dilator In Use	A colored circle to indicate the inner diameter of the cannula, with the numeric size. If cannula is detached, no indicator is displayed.

The surgical system **10** accomplishes safe and reproducible access to a surgical target site by detecting the existence of (and optionally the distance and/or direction to) neural structures before, during, and after the establishment of an operative corridor through (or near) any of a variety of tissues having such neural structures which, if contacted or impinged, may otherwise result in neural impairment for the patient. The surgical system **10** does so by electrically stimulating nerves via one or more stimulation electrodes at the distal end of the surgical access components **24-28** while monitoring the EMG responses of the muscle groups innervated by the nerves. In a preferred embodiment, this is accomplished via 8 pairs of EMG electrodes **34** placed on the skin over the major muscle groups on the legs (four per side), an anode electrode **35** providing a return path for the stimulation current, and a common electrode **37** providing a ground reference to pre-amplifiers in the patient module **14**. By way of example, the placement of EMG electrodes **34** may be undertaken according to the manner shown in Table 2 below for spinal surgery:

TABLE 2

Color	Channel ID	Myotome	Nerve	Spinal Level
Red	Right 1	Right Vastus Medialis	Femoral	L2, L3, L4
Orange	Right 2	Right TibialisAnterior	Peroneal	L4, L5
Yellow	Right 3	Right Biceps Femoris	Sciatic	L5, S1, S2
Green	Right 4	Right Gastroc. Medial	Post Tibialis	S1, S2
Blue	Left 1	Left Vastus Medialis	Femoral	L2, L3, L4
Violet	Left 2	Left Tibialis Anterior	Peroneal	L4, L5
Gray	Left 3	Left Biceps Femoris	Sciatic	L5, S1, S2
White	Left 4	Left Gastroc. Medial	Post Tibialis	S1, S2

Although not shown, it will be appreciated that any of a variety of electrodes can be employed, including but not limited to needle electrodes. The EMG responses provide a quantitative measure of the nerve depolarization caused by the electrical stimulus. Analysis of the EMG responses is then used to determine the proximity and direction of the nerve to the stimulation electrode, as will be described with particularity below.

The surgical access components **24-28** are designed to bluntly dissect the tissue between the patient's skin and the surgical target site. An initial dilating cannula **26** is advanced towards the target site, preferably after having been aligned using any number of commercially available surgical guide frames. An obturator (not shown) may be included inside the initial dilator **26** and may similarly be equipped with one or more stimulating electrodes. Once the proper location is achieved, the obturator (not shown) may be removed and the K-wire **24** inserted down the center of the initial dilating cannula **26** and docked to the given surgical target site, such as the annulus of an intervertebral disc. Cannulae of increasing diameter are then guided over the previously installed cannula **26** until the desired lumen is installed. By way of example only, the dilating cannulae **26** may range in diameter from 6 mm to 30 mm. In one embodiment, each cannula **26** has four orthogonal stimulating electrodes at the tip to allow detection and direction evaluation, as will be described below. The working cannula **28** is installed over the last dilating cannula **26** and then all the dilating cannulae **26** are removed from inside the inner lumen of the working cannula **28** to establish the operative corridor therethrough. A stimulator driver **42** is provided to electrically couple the particular surgical access component **24-28** to the patient module **14** (via accessory cable **22**). In a preferred embodiment, the stimulator driver **42** includes one or more buttons for selectively activating the stimulation current and/or directing it to a particular surgical access component.

The surgical system **10** accomplishes neural pathology monitoring by electrically stimulating a retracted nerve root

via one or more stimulation electrodes at the distal end of the nerve root retractor **30** while monitoring the EMG responses of the muscle group innervated by the particular nerve. The EMG responses provide a quantitative measure of the nerve depolarization caused by the electrical stimulus. Analysis of the EMG responses may then be used to assess the degree to which retraction of a nerve or neural structure affects the nerve function over time, as will be described with greater particularity below. One advantage of such monitoring, by way of example only, is that the conduction of the nerve may be monitored during the procedure to determine whether the neurophysiology and/or function of the nerve changes (for the better or worse) as the result of the particular surgical procedure. For example, it may be observed that the nerve conduction increases as the result of the operation, indicating that the previously inhibited nerve has been positively affected by the operation. The nerve root retractor **30** may comprise any number of suitable devices capable of maintaining contact with a nerve or nerve root. The nerve root retractor **30** may be dimensioned in any number of different fashions, including having a generally curved distal region (shown as a side view in FIG. **1** to illustrate the concave region where the nerve will be positioned while retracted), and of sufficient dimension (width and/or length) and rigidity to maintain the retracted nerve in a desired position during surgery. The nerve root retractor **30** may also be equipped with a handle **31** having one or more buttons for selectively applying the electrical stimulation to the stimulation electrode(s) at the end of the nerve root retractor **30**. In one embodiment, the nerve root retractor **30** is disposable and the handle **31** is reusable and autoclavable.

The surgical system **10** can also be employed to perform screw test assessments via the use of screw test probe **32**. The screw test probe **32** is used to test the integrity of pedicle holes (after formation) and/or screws (after introduction). The screw test probe **32** includes a handle **44** and a probe member **46** having a generally ball-tipped end **48**. The handle **44** may be equipped with one or more buttons for selectively applying the electrical stimulation to the ball-tipped end **48** at the end of the probe member **46**. The ball tip **48** of the screw test probe **32** is placed in the screw hole prior to screw insertion or placed on the installed screw head. If the pedicle wall has been breached by the screw or tap, the stimulation current will pass through to the adjacent nerve roots and they will depolarize at a lower stimulation current.

Upon pressing the button on the screw test handle **44**, the software will execute an algorithm that results in all channel tabs being color-coded to indicate the detection status of the corresponding nerve. The channel with the "worst" (lowest) level will be highlighted (enlarged) and that myotome name will be displayed, as well as graphically depicted on the spine diagram. A vertical bar chart will also be shown, to depict the stimulation current required for nerve depolarization in mA for the selected channel. The screw test algorithm preferably determines the depolarization (threshold) current for all 8 EMG channels. The surgeon may also set a baseline threshold current by stimulating a nerve root directly with the screw test probe **32**. The surgeon may choose to display the screw test threshold current relative to this baseline. The handle **44** may be equipped with a mechanism (via hardware and/or software) to identify itself to the system when it is attached. In one embodiment, the probe member **46** is disposable and the handle **44** is reusable and autoclavable.

An audio pick-up (not shown) may also be provided as an optional feature according to the present invention. In some cases, when a nerve is stretched or compressed, it will emit a burst or train of spontaneous nerve activity. The audio pick-up is capable of transmitting sounds representative of such activity such that the surgeon can monitor this response on audio to help him determine if there has been stress to the nerve.

Analysis of the EMG responses according to the present invention will now be described. The nerve proximity, nerve direction, and nerve pathology features of the present invention are based on assessing the evoked response of the various muscle myotomes monitored by the surgical system **10**. This is best shown in FIGS. **3-4**, wherein

FIG. **3** illustrates the evoked response (EMG) of a monitored myotome to the stimulation current pulse shown in FIG. **4**. The EMG response can be characterized by a peak to peak voltage of $V_{pp}=V_{max}-V_{min}$. The stimulation current is preferably DC coupled and comprised of monophasic pulses of 200 microsecond duration with frequency and amplitude that is adjusted by the software. For each nerve and myotome there is a characteristic delay from the stimulation current pulse to the EMG response.

As shown in FIG. **5**, there is a threshold stimulation current required to depolarize the main nerve trunk. Below this threshold, current stimulation does not evoke a significant V_{pp} response. Once the stimulation threshold is reached, the evoked response is reproducible and increases with increasing stimulation, as shown in FIG. **5**. This is known as a "recruitment curve." In one embodiment, a significant Vpp is defined to be a minimum of 100 uV. The lowest stimulation current that evoked this threshold voltage is called I_{thresh}. I_{thresh} decreases as the stimulation electrode approaches the nerve. This value is useful to surgeons because it provides a relative indication of distance (proximity) from the electrode to the nerve.

As shown in FIG. **6**, for each nerve/myotome combination there is a characteristic delay from the stimulation current pulse to the EMG response. For each stimulation current pulse, the time from the current pulse to the first max/min is T_1 and to the second max/min is T_2. The first phase of the pulse may be positive or negative. As will be described below, the values of T_1,T_2 are each compiled into a histogram with bins as wide as the sampling rate. New values of T_1, T_2 are acquired with each stimulation and the histograms are continuously updated. The value of T_1 and T_2 used is the center value of the largest bin in the histogram. The values of T_1, T_2 are continuously updated as the histograms change. Initially Vpp is acquired using a window that contains the entire EMG response. After 20 samples, the use of T_1, T_2 windows is phased in over a period of 200 samples. Vmax and Vmin are then acquired only during windows centered around T_1, T_2 with widths of, by way of example only, 5 msec. This method of acquiring V_{pp} is advantageous in that it automatically performs artifact rejection (as will be described in greater detail below).

As will be explained in greater detail below, the use of the "recruitment curve" according to the present invention is advantageous in that it provides a great amount of useful data from which to make various assessments (including, but not limited to, nerve detection, nerve direction, and nerve pathology monitoring). Moreover, it provides the ability to present simplified yet meaningful data to the user, as opposed to the actual EMG waveforms that are displayed to the users in traditional EMG systems. Due to the complexity in interpreting EMG waveforms, such prior art systems typically require an additional person specifically trained in such matters. This, in turn, can be disadvantageous in that it translates into extra expense (having yet another highly trained person in attendance) and oftentimes presents scheduling challenges because most hospitals do not retain such personnel. To account for the possibility that certain individuals will want to

see the actual EMG waveforms, the surgical system **10** includes an Evoked Potentials display that shows the voltage waveform for all 8 EMG channels in real time. It shows the response of each monitored myotome to a current stimulation pulse. The display is updated each time there is a stimulation pulse. The Evoked Potentials display may be accessed during Detection, Direction, or Nerve Pathology Monitoring.

Nerve Detection (Proximity)

The Nerve Detection function of the present invention is used to detect a nerve with a stimulation electrode (i.e. those found on the surgical access components **24-28**) and to give the user a relative indication of the proximity of the nerve to the electrode are advanced toward the surgical target site. A method of nerve proximity detection according one embodiment of the present invention is summarized as follows: (1) stimulation current pulses are emitted from the electrode with a fixed pulse width of 200 μs and a variable amplitude; (2) the EMG response of the associated muscle group is measured; (3) the Vpp of the EMG response is determined using T**1**, T**2**, and Fmax (NB: before T**2** is determined, a constant Fsafe is used for Fmax); (4) a rapid hunting detection algorithm is used to determine I_{Thresh} for a known Vthresh minimum; (5) the value of I_t is displayed to the user as a relative indication of the proximity of the nerve, wherein the I_{Thresh} is expected to decrease as the probe gets closer to the nerve. A detailed description of the algorithms associated with the foregoing steps will follow after a general description of the manner in which this proximity information is communicated to the user.

The Detection Function displays the value of I_{thresh} to the surgeon along with a color code so that the surgeon may use this to avoid contact with neural information tissues. This is shown generally in FIG. **7**, which illustrates an exemplary screen display according to the present invention. Detection display is based on the amplitude of the current (I_{thresh}) required to evoke an EMG Vpp response greater than V_{thresh} (nominally 100 uV). According to one embodiment, if I_{thresh} is <=4 mA red is displayed, the absolute value of I_{thresh} displayed. If 4 mA<I_{thresh}<10 mA yellow is displayed. If I_{thresh}>=10 mA green is displayed. Normally, I_{thresh} is only displayed when it is in the red range. However, the surgeon has the option of displaying I_{thresh} for all three ranges (red, yellow, green). The maximum stimulation current is preferably set by the user and is preferably within the range of between 0-100 mA. Detection is performed on all 4 channels of the selected side. EMG channels on the opposite side are not used. The first dilator **26** may use an obturator having an electrode for stimulation. In one embodiment, all subsequent dilators **26** and the working cannula **28** use four electrodes for stimulation. The lowest value of I_{thresh} from the 4 electrodes is used for display. There is an "Advance/Hold" display that tells the surgeon when the calculations are finished and he may continue to advance the instrument.

The threshold-hunting algorithm employs a series of monopolar stimulations to determine the stimulation current threshold for each EMG channel that is in scope. The nerve is stimulated using current pulses with amplitude of Istim. The muscle groups respond with an evoked potential that has a peak to peak voltage of Vpp. The object of this algorithm is to quickly find I_{Thresh}. This is the minimum Istim that results in a Vpp that is greater than a known threshold voltage Vthresh. The value of Istim is adjusted by a bracketing method as follows. The first bracket is 0.2 mA and 0.3 mA. If the Vpp corresponding to both of these stimulation currents is lower than Vthresh, then the bracket size is doubled to 0.2 mA and 0.4 mA. This exponential doubling of the bracket size continues until the upper end of the bracket results in a Vpp that is above Vthresh. The size of the brackets is then reduced by a bisection method. A current stimulation value at the midpoint of the bracket is used and if this results in a Vpp that is above Vthresh, then the lower half becomes the new bracket. Likewise, if the midpoint Vpp is below Vthresh then the upper half becomes the new bracket. This bisection method is used until the bracket size has been reduced to Ires mA. I_{Thresh} is the value of Istim that is the higher end of the bracket.

More specifically, with reference to FIGS. **8**A-**8**E, the threshold hunting will support three states: bracketing, bisection, and monitoring. A stimulation current bracket is a range of stimulation currents that bracket the stimulation current threshold I_{Thresh}. The upper and/or lower boundaries of a bracket may be indeterminate. The width of a bracket is the upper boundary value minus the lower boundary value. If the stimulation current threshold I_{Thresh} of a channel exceeds the maximum stimulation current, that threshold is considered out-of-range. During the bracketing state, threshold hunting will employ the method below to select stimulation currents and identify stimulation current brackets for each EMG channel in scope.

The method for finding the minimum stimulation current uses the methods of bracketing and bisection. The "root" is identified for a function that has the value −1 for stimulation currents that do not evoke adequate response; the function has the value +1 for stimulation currents that evoke a response. The root occurs when the function jumps from −1 to +1 as stimulation current is increased: the function never has the value of precisely zero. The root will not be known precisely, but only with some level of accuracy. The root is found by identifying a range that must contain the root. The upper bound of this range is the lowest stimulation current I_{Thresh} where the function returns the value +1, i.e. the minimum stimulation current that evokes response.

The proximity function begins by adjusting the stimulation current until the root is bracketed (FIG. **8**B). The initial bracketing range may be provided in any number of suitable ranges. In one embodiment, the initial bracketing range is 0.2 to 0.3 mA. If the upper stimulation current does not evoke a response, the upper end of the range should be increased. The range scale factor is 2. The stimulation current should never be increased by more than 10 mA in one iteration. The stimulation current should never exceed the programmed maximum stimulation current. For each stimulation, the algorithm will examine the response of each active channel to determine whether it falls within that bracket. Once the stimulation current threshold of each channel has been bracketed, the algorithm transitions to the bisection state.

During the bisection state (FIGS. **8**C and **8**D), threshold hunting will employ the method described below to select stimulation currents and narrow the bracket to a width of 0.1 mA for each EMG channel with an in-range threshold. After the minimum stimulation current has been bracketed (FIG. **8**B), the range containing the root is refined until the root is known with a specified accuracy. The bisection method is used to refine the range containing the root. In one embodiment, the root should be found to a precision of 0.1 mA. During the bisection method, the stimulation current at the midpoint of the bracket is used. If the stimulation evokes a response, the bracket shrinks to the lower half of the previous range. If the stimulation fails to evoke a response, the bracket shrinks to the upper half of the previous range. The proximity algorithm is locked on the electrode position when the response threshold is bracketed by stimulation currents separated by 0.1 mA. The process is repeated for each of the active channels until all thresholds are precisely known. At that time, the algorithm enters the monitoring state.

During the monitoring state (FIG. **8**E), threshold hunting will employ the method described below to select stimulation currents and identify whether stimulation current thresholds are changing. In the monitoring state, the stimulation current level is decremented or incremented by 0.1 mA, depending on the response of a specific channel. If the threshold has not changed then the lower end of the bracket should not evoke a response, while the upper end of the bracket should. If either of these conditions fail, the bracket is adjusted accordingly. The process is repeated for each of the active channels to continue to assure that each threshold is bracketed. If stimulations fail to evoke the expected response three times in a row, then the algorithm transitions back to the bracketing state in order to reestablish the bracket.

When it is necessary to determine the stimulation current thresholds (I_t) for more than one channel, they will be obtained by time-multiplexing the threshold-hunting algorithm as shown in FIG. **9**. During the bracketing state, the algorithm will start with a stimulation current bracket of 0.2 mA and increase the size of the bracket exponentially. With each bracket, the algorithm will measure the Vpp of all channels to determine which bracket they fall into. After this first pass, the algorithm will know which exponential bracket contains the I_t for each channel. Next, during the bisection state, the algorithm will start with the lowest exponential bracket that contains an I_t and bisect it until I_t is found within 0.1 mA. If there are more than one I_t within an exponential bracket, they will be separated out during the bisection process, and the one with the lowest value will be found first. During the monitoring state, the algorithm will monitor the upper and lower boundries of the brackets for each I_t, starting with the lowest. If the I_t for one or more channels is not found in it's bracket, then the algorithm goes back to the bracketing state to re-establish the bracket for those channels.

The method of performing automatic artifact rejection according to the present invention will now be described. As noted above, acquiring V_{pp} according to the present invention (based on T**1**, T**2** shown in FIG. **6**) is advantageous in that, among other reasons, it automatically performs artifact rejection. The nerve is stimulated using a series of current pulses above the stimulation threshold. The muscle groups respond with an evoked potential that has a peak to peak voltage of Vpp. For each EMG response pulse, T**1** is the time is measured from the stimulus pulse to the first extremum (Vmax or Vmin) T**2** is the time measured from the current pulse to the second extremum (Vmax or Vmin) The values of T**1** and T**2** are each compiled into a histogram with Tbin msec bin widths. The value of T**1** and T**2** used for artifact rejection is the center value of the largest bin in the histogram. To reject artifacts when acquiring the EMG response, Vmax and Vmin are acquired only during windows that are T**1**±Twin and T**2**±Twin. Again, with reference to FIG. **6**, Vpp is Vmax-Vmin.

The method of automatic artifact rejection is further explained with reference to FIG. **10**. While the threshold hunting algorithm is active, after each stimulation, the following steps are undertaken for each EMG sensor channel that is in scope: (1) the time sample values for the waveform maximum and minimum (after stimulus artifact rejection) will be placed into a histogram; (2) the histogram bin size will be the same granularity as the sampling period; (3) the histogram will be emptied each time the threshold hunting algorithm is activated; (4) the histogram will provide two peaks, or modes, defined as the two bins with the largest counts; (5) the first mode is defined as T**1**; the second mode is defined as T**2**; (6) a (possibly discontinuous) range of waveform samples will be identified; (7) for the first stimulation after the threshold hunting algorithm is activated, the range of samples will be the entire waveform; (8) after a specified number of stimulations, the range of samples will be limited to T**1**±0.5 ms and T**2**±0.5 ms; and (9) before the specified number of stimulations, either range may be used, subject to this restriction: the proportion of stimulations using the entire waveform will decrease from 100% to 0% (a sample of the curve governing this proportion is shown in FIG. **11**). Peak-to-peak voltage (Vpp) will be measured either over the identified range of waveform samples. The specified number of stimulations will preferably be between **220** and **240**.

According to another aspect of the present invention, the maximum frequency of the stimulation pulses is automatically obtained with reference to FIG. **12**. After each stimulation, Fmax will be computed as: Fmax=1/(T**2**+Safety Margin) for the largest value of T**2** from each of the active EMG channels. In one embodiment, the Safety Margin is 5 ms, although it is contemplated that this could be varied according to any number of suitable durations. Before the specified number of stimulations, the stimulations will be performed at intervals of 100-120 ms during the bracketing state, intervals of 200-240 ms during the bisection state, and intervals of 400-480 ms during the monitoring state. After the specified number of stimulations, the stimulations will be performed at the fastest interval practical (but no faster than Fmax) during the bracketing state, the fastest interval practical (but no faster than Fmax/2) during the bisection state, and the fastest interval practical (but no faster than Fmax/4) during the monitoring state. The maximum frequency used until F_{max} is calculated is preferably 10 Hz, although slower stimulation frequencies may be used during some acquisition algorithms. The value of F_{max} used is periodically updated to ensure that it is still appropriate. This feature is represented graphically, by way of example only, in FIG. **12**. For physiological reasons, the maximum frequency for stimulation will be set on a per-patient basis. Readings will be taken from all myotomes and the one with the slowest frequency (highest T**2**) will be recorded.

Nerve Direction

Once a nerve is detected using the working cannula **28** or dilating cannulae **26**, the surgeon may use the Direction Function to determine the angular direction to the nerve relative to a reference mark on the access components **24**-**28**. This is also shown in FIG. **7** as the arrow A pointing to the direction of the nerve. This information helps the surgeon avoid the nerve as he or she advances the cannula. The direction from the cannula to a selected nerve is estimated using the 4 orthogonal electrodes on the tip of the dilating cannula **26** and working cannulae **28**. These electrodes are preferably scanned in a monopolar configuration (that is, using each of the 4 electrodes as the stimulation source). The nerve's threshold current (I_{thresh}) is found for each of the electrodes by measuring the muscle evoked potential response Vpp and comparing it to a known threshold Vthresh. This algorithm is used to determine the direction from a stimulation electrode to a nerve.

As shown in FIG. **13**, the four (4) electrodes are placed on the x and y axes of a two dimensional coordinate system at radius R from the origin. A vector is drawn from the origin along the axis corresponding to each electrode that has a length equal to I_{Thresh} for that electrode. The vector from the origin to a direction pointing toward the nerve is then computed. This algorithm employs the T**1**/T**2** algorithm discussed above with reference to FIG. **6**. Using the geometry shown in FIG. **10**, the (x,y) coordinates of the nerve, taken as a single point, can be determined as a function of the distance from the nerve to each of four electrodes. This can be expressly mathematically as follows:

Where the "circles" denote the position of the electrode respective to the origin or center of the cannula and the "octagon" denotes the position of a nerve, and d_1, d_2, d_3, and d_4 denote the distance between the nerve and electrodes **1-4** respectively, it can be shown that:

$$x = \frac{d_1^2 - d_3^2}{-4R} \text{ and } y = \frac{d_2^2 - d_4^2}{-4R}$$

Where R is the cannula radius, standardized to 1, since angles and not absolute values are measured.

After conversion from (x,y) to polar coordinates (r,θ), then θ is the angular direction to the nerve. This angular direction is then displayed to the user as shown in FIG. **7**, by way of example only, as arrow A pointing towards the nerve. In this fashion, the surgeon can actively avoid the nerve, thereby increasing patient safety while accessing the surgical target site. The surgeon may select any one of the 4 channels available to perform the Direction Function. The surgeon should preferably not move or rotate the instrument while using the Direction Function, but rather should return to the Detection Function to continue advancing the instrument.

Insertion and advancement of the access instruments **24-28** should be performed at a rate sufficiently slow to allow the surgical system **10** to provide real-time indication of the presence of nerves that may lie in the path of the tip. To facilitate this, the threshold current I_{Thresh} may be displayed such that it will indicate when the computation is finished and the data is accurate. For example, when the detection information is up to date and the instrument such that it is now ready to be advanced by the surgeon, it is contemplated to have the color display show up as saturated to communicate this fact to the surgeon. During advancement of the instrument, if a channel's color range changes from green to yellow, advancement should proceed more slowly, with careful observation of the detection level. If the channel color stays yellow or turns green after further advancement, it is a possible indication that the instrument tip has passed, and is moving farther away from the nerve. If after further advancement, however, the channel color turns red, then it is a possible indication that the instrument tip has moved closer to a nerve. At this point the display will show the value of the stimulation current threshold in mA. Further advancement should be attempted only with extreme caution, while observing the threshold values, and only if the clinician deems it safe. If the clinician decides to advance the instrument tip further, an increase in threshold value (e.g. from 3 mA to 4 mA) may indicate the Instrument tip has safely passed the nerve. It may also be an indication that the instrument tip has encountered and is compressing the nerve. The latter may be detected by listening for sporadic outbursts, or "pops", of nerve activity on the free running EMG audio output (as mentioned above). If, upon further advancement of the instrument, the alarm level decreases (e.g., from 4 mA to 3 mA), then it is very likely that the instrument tip is extremely close to the spinal nerve, and to avoid neural damage, extreme caution should be exercised during further manipulation of the Instrument. Under such circumstances, the decision to withdraw, reposition, or otherwise maneuver the instrument is at the sole discretion of the clinician based upon available information and experience. Further radiographic imaging may be deemed appropriate to establish the best course of action.

Nerve Pathology

As noted above, the surgical system **10** accomplishes neural pathology monitoring by electrically stimulating a retracted nerve root via one or more stimulation electrodes at the distal end of the nerve root retractor **30** while monitoring the EMG responses of the muscle group innervated by the particular nerve. FIG. **14** shows the differences between a healthy nerve (A) and a pathologic or unhealthy nerve (B). The inventors have found through experimentation that information regarding nerve pathology (or "health" of "status") can be extracted from the recruitment curves generated according to the present invention (see, e.g., discussion accompanying FIGS. **3-5**). In particular, it has been found that a health nerve or nerve bundle will produce a recruitment curve having a generally low threshold or "hanging point" (in terms of both the y-axis or Vpp value and the x-axis or I_{Stim} value), a linear region having a relatively steep slope, and a relatively high saturation region (similar to those shown on recruitment curve "A" in FIG. **14**). On the contrary, a nerve or nerve bundle that is unhealthy or whose function is otherwise compromised or impaired (such as being impinged by spinal structures or by prolonged retraction) will produce recruitment curve having a generally higher threshold (again, in terms of both the y-axis or Vpp value and the x-axis or I_{stim} value), a linear region of reduced slope, and a relatively low saturation region (similar to those shown on recruitment curve "B" in FIG. **14**). By recognizing these characteristics, one can monitor nerve root being retracted during a procedure to determine if its pathology or health is affected (i.e. negatively) by such retraction. Moreover, one can monitor a nerve root that has already been deemed pathologic or unhealthy before the procedure (such as may be caused by being impinged by bony structures or a bulging annulus) to determine if its pathology or health is affected (i.e. positively) by the procedure.

The surgical system **10** and related methods have been described above according to one embodiment of the present invention. It will be readily appreciated that various modifications may be undertaken, or certain steps or algorithms omitted or substituted, without departing from the scope of the present invention. By way of example only, certain of these alternate embodiments or methods will be described below.

a. Hanging Point Detection Via Linear Regression

As opposed to identifying the stimulation current threshold (I_{Thresh}) based on a predetermined V_{Thresh} (such as described above and shown in FIG. **5**), it is also within the scope of the present invention to determine I_{Thresh} via linear regression. This may be accomplished via, by way of example only, the linear regression technique disclosed in commonly owned U.S. patent application Ser. No. 09/877,713 (now U.S. Pat. No. 6,500,128), filed Jun, 8, 2001 and entitled "Relative Nerve Movement and Status Detection System and Methods," the entire contents of which is hereby expressly incorporated by reference as if set forth in this disclosure in its entirety.

b. Hanging Point Detection Via Dynamic Sweep Subtraction

With reference to FIG. **15**, the hanging point or threshold may also be determined by the following dynamic sweep subtraction method. The nerve is stimulated in step **80** using current pulses that increase from I_{Min} to I_{Max} (as described above). The resulting the neuromuscular response (evoked EMG) for the associated muscles group is acquired in step **82**. The peak-to-peak voltage (Vpp) is then extracted in step **84** for each current pulse according to the T**1**, T**2** algorithm described above with reference to FIGS. **3-6**. A first recruit-

ment curve (S1) is then generated by plotting Vpp vs. I_{Stim} in step **86**. The same nerve is then stimulated such that, in step **88**, the peak-to-peak voltage (Vpp) may be extracted by subtracting the V_{Max} from V_{Min} of each EMG response without the T1, T2 filters employed in step **84**. A second recruitment curve (S2) is then generated in step **90** by plotting Vpp vs. I_{Stim}. The generation of both recruitment curves S1, S2 continues until the maximum stimulation current (I_{max}) is reached (per the decision step **92**). If I_{max} is not reached, the stimulation current I_{Stim} is incremented in step **94**. If I_{max} is reached, then the first recruitment curve S1 is subtracted from the second recruitment curve S2 in step **96** to produce the curve "C" shown in step **98**. By subtracting S1 from S2, the resulting curve "C" is actually the onset portion of the recruitment curve (that is, the portion before the threshold is reached) for that particular nerve. In this fashion, the last point in the curve "C" is the point with the greatest value of I_{Stim} and hence the hanging point.

c. Peripheral Nerve Pathology Monitoring

Similar to the nerve pathology monitoring scheme described above, the present invention also contemplates the use of one or more electrodes disposed along a portion or portions of an instrument (including, but not limited to, the access components **24-28** described above) for the purpose of monitoring the change, if any, in peripheral nerves during the course of the procedure. In particular, this may be accomplished by disposing one or more stimulation electrodes a certain distance from the distal end of the instrument such that, in use, they will likely come in contact with a peripheral nerve. For example, a mid-shaft stimulation electrode could be used to stimulate a peripheral nerve during the procedure. In any such configuration, a recruitment curve may be generated for the given peripheral nerve such that it can be assessed in the same fashion as described above with regard to the nerve root retractor, providing the same benefits of being able to tell if the contact between the instrument and the nerve is causing pathology degradation or if the procedure itself is helping to restore or improve the health or status of the peripheral nerve.

d. Virtual Patient for Evoked Potential Simulation

With reference to FIG. **16**, the present invention also contemplates the use of a "virtual patient" device for simulating a naturally occurring recruitment curve. This is advantageous in that it provides the ability to test the various systems disclosed herein, which one would not be able to test without an animal and/or human subject. Based on the typically high costs of obtaining laboratory and/or surgical time (both in terms of human capital and overhead), eliminating the requirement of performing actual testing to obtain recruitment curves is a significant offering. According to the present invention, this can be accomplished by providing a device (not shown) having suitable software and/or hardware capable of producing the signal shown in FIG. **16**. The device will preferably accept a sweeping current signal according to the present invention (that is, 200 microseconds width pulses sweeping in amplitude from 0-100 mA) and produce a voltage pulse having a peak-to-peak voltage (Vpp) that varies with the amplitude of the current input pulse. The relationship of the output Vpp and the input stimulation current will produce a recruitment curve similar to that shown. In one embodiment, the device includes various adjustments such that the features of the recruitment curve may be selectively modified. For example, the features capable of being modified may include, but are not necessarily limited to, Vpp at onset, maximum stimulation current of onselt (hanging point), the slope of the linear region and/or the Vpp of the saturation region.

While this invention has been described in terms of a best mode for achieving this invention's objectives, it will be appreciated by those skilled in the art that variations may be accomplished in view of these teachings without deviating from the spirit or scope of the present invention. For example, the present invention may be implemented using any combination of computer programming software, firmware or hardware. As a preparatory step to practicing the invention or constructing an apparatus according to the invention, the computer programming code (whether software or firmware) according to the invention will typically be stored in one or more machine readable storage mediums such as fixed (hard) drives, diskettes, optical disks, magnetic tape, semiconductor memories such as ROMs, PROMs, etc., thereby making an article of manufacture in accordance with the invention. The article of manufacture containing the computer programming code is used by either executing the code directly from the storage device, by copying the code from the storage device into another storage device such as a hard disk, RAM, etc. or by transmitting the code on a network for remote execution. As can be envisioned by one of skill in the art, many different combinations of the above may be used and accordingly the present invention is not limited by the scope of the appended claims.

What is claimed is:

1. A system for establishing an operative corridor for spinal surgery, comprising:

a plurality of sequential dilator cannulas deliverable through bodily tissue having neural structures in a selected path toward a targeted intervertebral disc of a spine, the plurality of sequential dilator cannulas including at least an inner dilator cannula and an outer dilator cannula configured to be guided over the previously delivered inner dilator cannula, at least the inner dilator cannula of the plurality of sequential dilator cannulas having a stimulation electrode positioned along a distal tip region to deliver a stimulation signal to the bodily tissue when the inner dilator cannula is positioned in the selected path toward the targeted intervertebral disc of the spine;

a nerve monitoring system comprising a control unit and a plurality of leg muscle sensor electrodes, the nerve monitoring system being configured to deliver an electrical stimulation signal to the stimulation electrode when said inner dilator cannula is positioned along the selected path toward the targeted intervertebral disc of the spine, the nerve monitoring system being configured to monitor electrical activity detected by the plurality of leg muscle sensor electrodes in response to the electrical stimulation signal output from the stimulation electrode of said inner dilator cannula, and the control unit of the nerve monitoring system comprising a display device that simultaneously displays both: a numeric stimulation current threshold in units of milliAmps that changes in response to the detected electrical activity at one or more of said leg muscle sensor electrodes, and a graphic representation of human legs showing locations of leg muscle myotomes monitored by said leg muscle sensor electrodes; and

a working corridor instrument deliverable over the outer dilator cannula of the plurality of sequential dilator cannulas toward the targeted intervertebral disc of the spine, wherein the working corridor instrument is configured to establish an operative corridor to the targeted intervertebral disc of the spine.

2. The system of claim **1**, wherein the inner dilator cannula is an initial cannula, the initial cannula being part of an initial

dilating assembly configured to advance through the bodily tissue along the selected path toward the targeted intervertebral, the initial dilating assembly comprising the initial cannula and a removable inner element slidably disposed therein when the initial dilating assembly is positioned in the selected path toward the targeted intervertebral disc.

3. The system of claim **2**, wherein the control unit of the nerve monitoring system is configured to output said stimulation signal to the stimulation electrode of the removable inner element and, in response to receiving sensor signals from the leg muscle sensor electrodes, display neuromuscular response information which is indicative of nerve proximity.

4. The system of claim **3**, further comprising a guide wire insertable through a lumen of the initial cannula after the initial cannula is advanced through the bodily tissue, the guide wire being different from the removable inner element and having a tapered tip configured to penetrate an annulus of the targeted intervertebral disc of the spine.

5. The system of claim **4**, wherein the removable inner element of the initial dilating assembly comprises an obturator arranged inside the initial cannula and the at least one stimulation electrode.

6. The system of claim **4**, wherein the removable inner element is removable from the initial cannula prior to insertion of the guide wire through the initial cannula.

7. The system of claim **1**, wherein the plurality of sequential dilators cannulas are removable from the working corridor instrument to establish the operative corridor to the targeted intervertebral disc of the spine.

8. The system of claim **1**, wherein the working corridor instrument comprises a cannula.

9. The system of claim **1**, wherein the nerve monitoring system is configured to determine the numeric stimulation current threshold by automatically adjusting an intensity of the stimulation signal in response to signals from the leg muscle sensor electrodes.

10. The system of claim **1**, wherein the control unit of the nerve monitoring system is configured to display a color code corresponding to the numeric stimulation current threshold.

11. The system of claim **10**, wherein the color associated with the stimulation current threshold is one from the group of green, yellow, and red.

12. The system of claim **1**, wherein the control unit of the nerve monitoring system is configured to display neuromuscular response information indicative of nerve direction.

13. The system of claim **1**, wherein each of the plurality of sequential dilator cannulas has an outer diameter in a range of 6 mm to 30 mm.

* * * * *

专利名称(译)	用于确定手术期间神经接近，方向和病理的系统和方法		
公开(公告)号	US9037250	公开(公告)日	2015-05-19
申请号	US13/767355	申请日	2013-02-14
[标]申请(专利权)人(译)	NUVASIVE		
申请(专利权)人(译)	NuVasive公司，		
当前申请(专利权)人(译)	NUVASIVE INC.		
[标]发明人	KAULA NORBERT BLEWETT JEFFREY J GHARIB JAMES FARQUHAR ALLEN		
发明人	KAULA, NORBERT BLEWETT, JEFFREY J. GHARIB, JAMES FARQUHAR, ALLEN		
IPC分类号	A61N1/00 A61B5/05 A61M29/00 A61B5/00 A61B5/04 A61B5/0488 A61B5/11 A61B19/00 A61N1/08 A61N1/10 A61N1/18		
CPC分类号	A61B5/04001 A61B5/0488 A61B5/4893 A61N1/08 A61B5/1106 A61B5/7217 A61B5/743 A61B17/02 A61N1/36017 A61B17/00 A61B2017/00039		
代理机构(译)	FISH & RICHARDSON P.C.		
优先权	13/080493 2011-11-08 US 12/711937 2011-04-05 US 10/754899 2011-11-29 US 60/305041 2001-07-11 US		
其他公开文献	US20130165814A1		
外部链接	Espacenet USPTO		

摘要(译)

本发明涉及用于基于神经肌肉反应和引起神经肌肉反应的刺激信号之间的已识别关系来确定相对于手术器械的神经接近度，神经方向和病理的系统和方法。