



a passion for innovation

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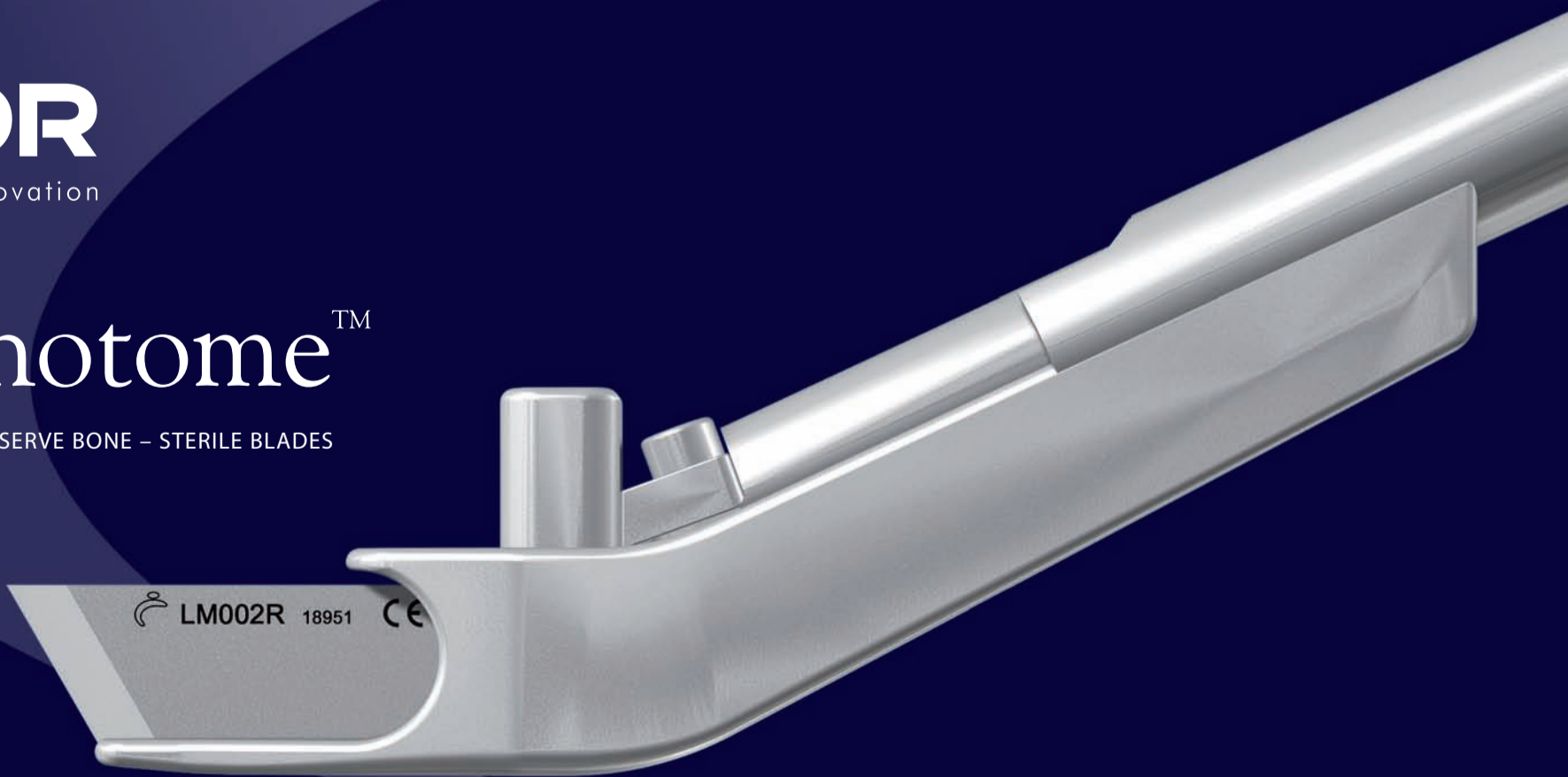
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# Laminotome™

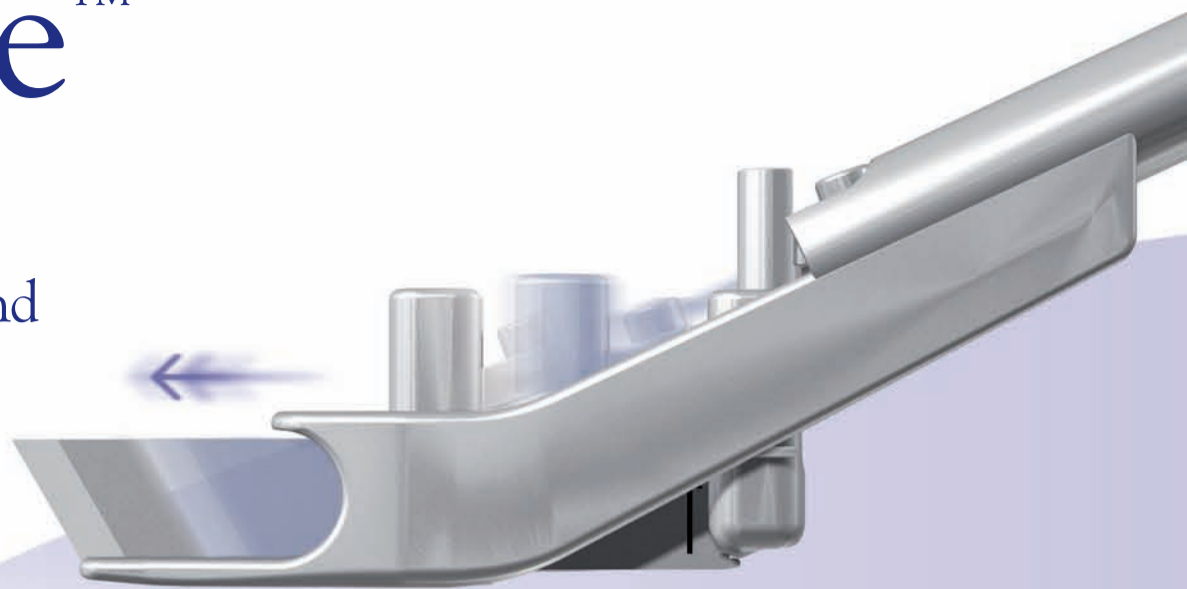
INCREASE SAFETY – PRESERVE BONE – STERILE BLADES



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# Laminotome™

The Laminotome offers a simpler and more effective surgical technique compared to the standard surgery for radicular decompression in narrow lumbar canal pathologies.

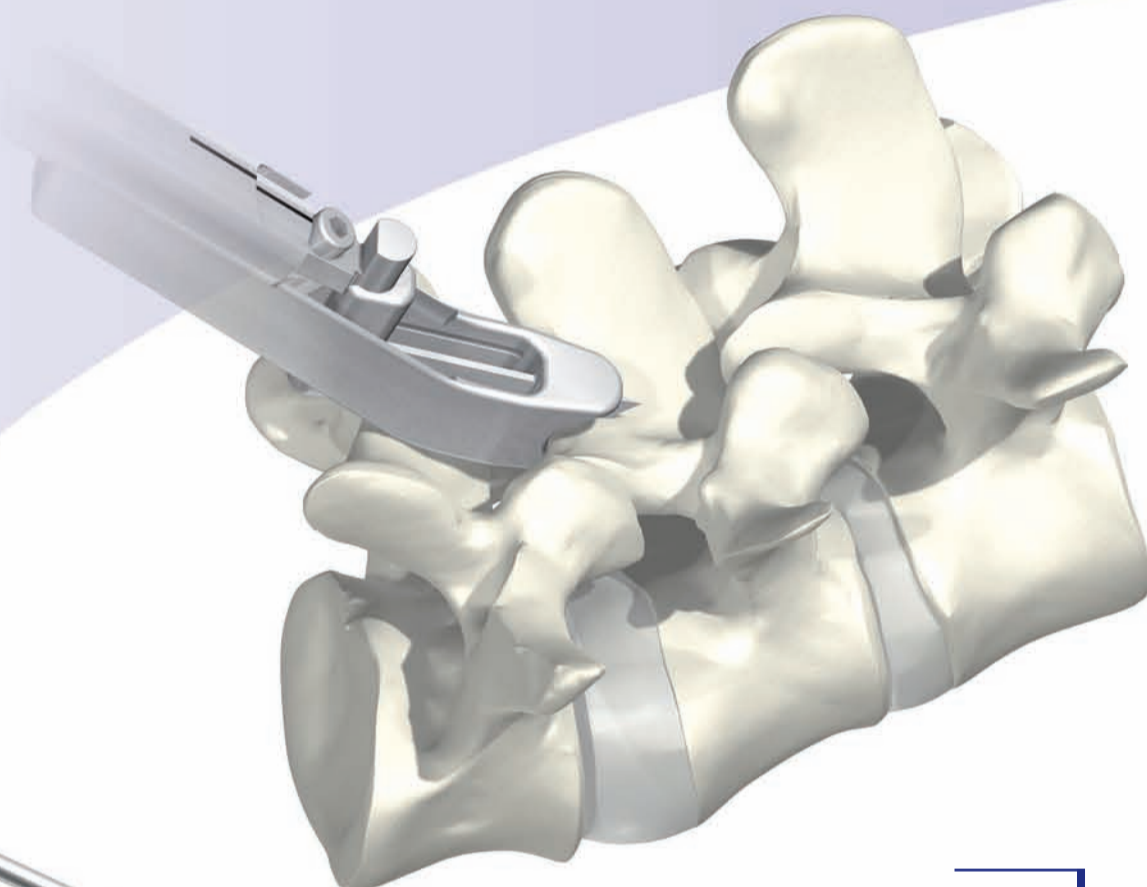


The Laminotome does not require any power tools and provides safeguards making it more reliable than traditional methods. In addition, the technique does not sacrifice any autologous bone graft as compared to high speed burr techniques.

The Laminotome incorporates a guiding spatula under the cutter which elevates the tip when cutting. This reduces the risk of pushing the instrument too far into the canal.

The blade comes sterile packaged for one time use, assuring the quality, sterility and blade sharpness.

The Laminotome can be used in most cases, except for patients with extremely narrow canals where limited space makes introduction of the guiding spatula unfeasible.



## Surgical technique

Developed in conjunction with P. Mangione, M.D.

### Partial bilateral arthrectomy

After exposing the lamina, the inferior articular apophysis is resected with a Kerrison Rongeur in an upward and diverging motion. This allows good visualization of the cancellous bone of the inferior part of the lamina and of the ligamentum flavum, which runs the length of the spine on the anterior aspect of the lamina.

### Detachment of the ligamentum flavum

The ligamentum flavum is detached from the lamina using a Cobb Elevator. Carefully hold the Cobb Elevator with both hands to control its movement. Apply leverage to press the Cobb Elevator onto the anterior surface of the lamina thereby releasing the ligamentum flavum from the anterior aspect of the lamina. The canal, between the ligamentum flavum and anterior aspect of the lamina, having been enlarged by the insertion of the instrument now allows the surgeon to slightly rotate the elevator from left to right in

order to progressively detach the ligament, while avoiding sudden movement into the canal.

### Protection of dura mater

The dura mater can be protected by two small patties, which should be pushed upwards between the lamina and the dura mater.

### Insertion of Laminotome spatula

Insert the spatula of the Laminotome as laterally as possible and under the lamina, maintaining contact with the anterior surface of the lamina, until the stop of the Laminotome engages the lamina.

### Laminectomy

Antero-posterior leverage (anterior pressure on the distal part of the handle) may help to correctly maintain bone contact with the Laminotome and anterior aspect of the

lamina. Care should be used to maintain this leverage effect while using the mallet to push the blade of the Laminotome through the lamina. After the two laminotomies have been completed, the lamina can be removed with forceps. If the lamina is very large, there may be an apical fragment remaining. This can be easily resected with a Kerrison Rongeur or bone-cutting forceps.

### Lateral decompression

After the laminectomy, which decompresses the central part of the canal, it is necessary to complete decompression laterally, using typical decompression techniques.

These steps comprise a recommended technique and should be adapted to suit the surgeon's usual technique and practices. For the Laminotome to be used appropriately, it is advisable to go through every step in the surgical technique as described above.