

# Understanding Retroperitoneal Anatomy for Lateral Approach Spine Surgery

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## Abstract:

Lateral approach spine surgery provides effective interbody stabilization, and correction and indirect neural decompression with minimal-incision and less invasive surgery compared with conventional open anterior lumbar fusion. It may also avoid the trauma to paraspinal muscles or facet joints found with transforaminal lumbar interbody fusion and posterior lumbar interbody fusion. However, because lateral approach surgery is fundamentally retroperitoneal approach surgery, it carries potential risk to intra- and retroperitoneal structures, as seen in a conventional open anterior approach. There is an innovative lateral approach technique that reveals different anatomical views; however, it requires reconsideration of the traditional surgical anatomy in more detail than a traditional open anterior approach. The retroperitoneum is the compartmentalized space bounded anteriorly by the posterior parietal peritoneum and posteriorly by the transversalis fascia. The retroperitoneum is divided into three compartments by fascial planes: anterior and posterior pararenal spaces and the perirenal space. Lateral approach surgery requires mobilization of the peritoneum and its content and accurate exposure to the posterior pararenal space. The posterior pararenal space is confined anteriorly by the posterior renal fascia, anteromedially by the lateroconal fascia, and posteriorly by the transversalis fascia. The posterior renal fascia, the lateroconal fascia or the peritoneum should be detached from the transversalis fascia and the psoas fascia to allow exposure to the posterior pararenal space. The posterior pararenal space, however, does not allow a clear view and identification of these fasciae as this relationship is variable and the medial extent of the posterior pararenal space varies among patients. Correct anatomical recognition of the retroperitoneum is essential to success in lateral approach surgery. Spine surgeons must be aware that the retroperitoneal membrane and fascia is multilayered and more complex than is commonly understood. Preoperative abdominal images would facilitate more efficient surgical considerations of retroperitoneal membrane and fascia in lateral approach surgery.

## Keywords:

Lateral approach spinal surgery, Extreme lateral interbody fusion, Oblique lateral interbody fusion, Retroperitoneum, Renal fascia, Lateroconal fascia, Posterior pararenal space, Transversalis fascia

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Lumbar spinal fusion is a common surgical procedure for various spinal disorders<sup>1)</sup>. Surgical lumbar interbody fusion is an effective treatment option to stabilize the painful moving segment, and may provide indirect decompression of the neural elements, correct deformity, and restore lordosis<sup>2-5)</sup>. Many lumbar interbody fusion techniques have been developed and popularized, including anterior lumbar interbody fusion (ALIF), posterior lumbar interbody fusion (PLIF) and transforaminal lumbar interbody fusion (TLIF). Each of

these techniques has advantages and disadvantages<sup>6-11)</sup>.

An anterior approach to the lumbar spine was initially introduced to manage spondylolisthesis and Pott's disease in the 1930s<sup>12,13)</sup>. ALIF has become a common and widely accepted lumbar fusion technique over the last decade<sup>14-18)</sup>. Benefits of ALIF approach include access to the disc space, broad surface area for placement of a large structural graft, and the ability to take down the anterior longitudinal ligament, correct intervertebral height, and distract across the

disc space to create lordosis<sup>19,20</sup>. Posterior fixation, including transpedicular screw or translaminar screw supplemented ALIF, significantly improves segmental flexibility and fixation stiffness<sup>19,21-23</sup>. However, ALIF with posterior instrumented fusion requires two separate approaches (anterior/posterior), which prolongs operative time in a single day or necessitates staging of procedures<sup>24</sup>. In addition, ALIF has potential approach-related serious risks and complications, including vascular injury, ureteral damage, ileus, and retrograde ejaculation in males<sup>25-32</sup>. Anterior approaches may also involve unfamiliar anatomy for spine surgeons, potentially placing the patient at risk for approach-related complications; therefore, many spine surgeons prefer the assistance of an “access surgeon” to perform the exposure<sup>33</sup>.

PLIF has evolved since the initial description of the technique<sup>34</sup>, with the development of additional autologous and synthetic bone grafting options, more advanced methods of spinal segmental fusion techniques, innovative implants, and the pedicle screw fixation. PLIF is a traditional posterior lumbar approach that many spine surgeons are very familiar with and well-trained in performing. The posterior exposure provides excellent visualization of the nerve roots and allows for neural decompression while maintaining posterior support structures. Furthermore, PLIF also allows for a 360-degree fusion through a single approach<sup>2,3,8,10,11,35,36</sup>. Traditional open TLIF was first described in 1982<sup>37</sup>. The main concerns with the PLIF are the extent of neural retraction required, potential nerve root injury, dural tears, and epidural fibrosis. TLIF avoids these complications by providing direct, unilateral access to the intervertebral foraminal space, and reducing direct dissection and surgical trauma to spinal muscles and structural integrity<sup>20,38-42</sup>. Traditional open PLIF and TLIF have advanced to become mini-open or minimally invasive approaches<sup>43</sup>.

The posterior approach in PLIF and TLIF, however, is associated with potential risks and complications such as significant iatrogenic paraspinal muscle damage, inadvertent durotomy, and retraction injury of nerve roots causing fibrosis and chronic radiculopathy. It may also be relatively more difficult to correct coronal imbalance and restore lordosis with PLIF/TLIF than ALIF. Furthermore, endplate preparation may be difficult compared to anterior fusion approaches<sup>20,38,44-47</sup>.

More recently, the lateral trans-psoas approach, termed extreme, direct or lateral lumbar interbody fusion (XLIF<sup>®</sup>, Nuvasive; DLIF<sup>®</sup>, Medtronic; LLIF), has gained popularity. Initially developed in the late 1990s by Luiz Pimenta as a lateral endoscopic trans-psoas retroperitoneal approach<sup>48</sup>, it was first published in the literature in 2006 by Ozgur et al.<sup>49</sup>. Since then, LLIF has gained exponential acceptance as a minimally invasive option for thoracolumbar fusions. Compared with traditional open anterior access, LLIF allows a less invasive approach corridor and avoidance of great vessels<sup>48-50</sup>. Oblique lateral interbody fusion (OLIF, Medtronic<sup>®</sup>), another lateral approach surgery, was subsequently introduced as an alternative procedure to a lateral trans-

psoas approach. The OLIF procedure allows for psoas-preserving access via an anterior oblique retroperitoneal approach<sup>51</sup>.

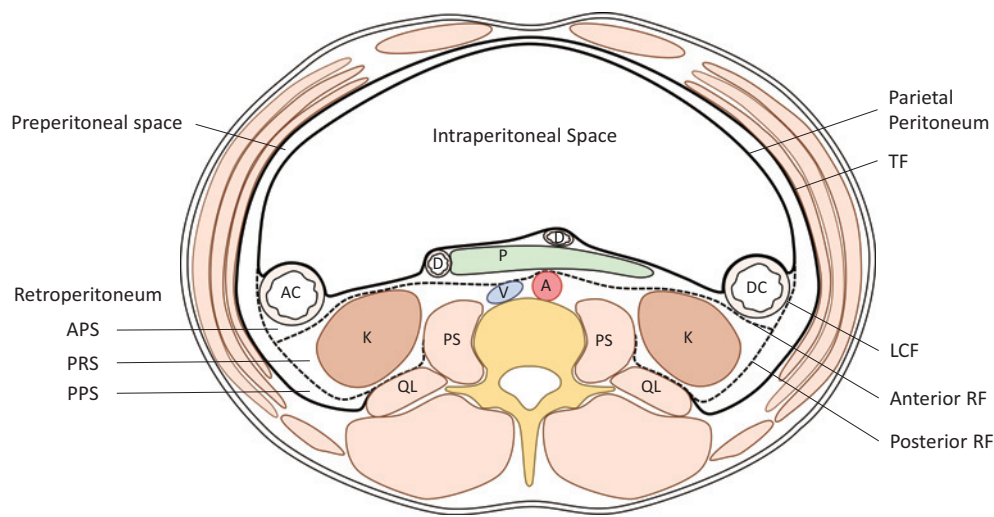
These lateral procedures have advantages over the minimally invasive technique, including direct visualization with novel special instruments and light equipment, excellent disc space preparation, and the ability to place larger interbody cages; therefore, resisting subsidence and creating a biomechanically superior environment for bone healing. LLIF also allows disc height and alignment restoration, and decompression of the nerve roots by powerful indirect decompression through the ligamentotaxis created with intact anterior and posterior longitudinal ligament, as these ligaments have a key role in spinal alignment and stabilization<sup>49,52-54</sup>. Furthermore, the LLIF approach, including lateral release and ligamentotaxis by disc height restoration, is an excellent option for sagittal and coronal deformity correction, especially in lumbar degenerative scoliosis with laterolisthesis<sup>55-57</sup>. Numerous lateral procedures have been performed worldwide, and variations and technical refinements have been proposed. The procedure has also been extended to a wider range of indications, now including primary and revision surgery for degenerative problems, adult deformity, trauma, and thoracic disc herniation<sup>52,58-67</sup>.

The most recent advance in lateral approach surgery has received attention for its application to other spinal problems that were not indicated for original LLIF procedures. A lateral approach corpectomy and vertebral reconstruction with a vertebral cage comprising rectangular footplates (X-Core2<sup>®</sup>, Nuvasive), which may provide better subsidence resistance, is an effective alternative to conventional approaches for the treatment of trauma and tumor<sup>68-71</sup>. Another advanced lateral approach technique is anterior column realignment (ACR<sup>®</sup>, Nuvasive), which provides a solution for sagittal imbalance. ACR involves a deliberate release of the anterior longitudinal ligament (ALL) and placement of hyperlordotic interbody cages at either 20 or 30 degrees of lordosis, which are then fixed to the vertebral body with one or two screws. ACR results in greater segmental correction than achieved with LLIF alone, successfully restores lumbar lordosis in patients with adult spinal deformity with sagittal imbalance<sup>72-76</sup>.

However, potential LLIF-related risks include injury to the psoas muscle and the lumbar plexus, and to the nerves that lie within it<sup>77-80</sup>. Therefore, the procedure requires the use of real-time electromyographic (EMG) monitoring<sup>81</sup>. Fundamentally, lateral approach surgery including LLIF, lateral corpectomy, and ACR is retroperitoneal approach surgery. An anterior retroperitoneal approach uses the latent space between the back and psoas muscles and the peritoneal content. As this approach has the potential risk for intraperitoneal or retroperitoneal structures (including viscera and vessels), surgical exposure requires extensive mobilization of the great vessels and the peritoneal content. Traditional ALIF method using a wide-open anterior approach, have largely been abandoned because of significant compli-

**Table 1.** The Extrapерitoneal Spaces.

	Portion of the abdominal wall	Area
Retroperitoneal space =Retroperitoneum	Posteriorly Laterally	Between the parietal peritoneum of the posterior abdominal wall and transversalis fascia
Preperitoneal space (Properitoneal space)	Anteriorly	Between the parietal peritoneum of the anterior abdominal wall and the transversalis fascia.
Subperitoneal pelvic space	Caudally	Under the peritoneum



**Figure 1.** Extrapерitoneal space and organs.  
TF=transversalis fascia; RF=renal fascia; LCF=lateroconal fascia; PS=psoas muscle; QL=quadratus lumborum muscle; P=pancreas; K=kidney; AC=ascending colon; DC=descending colon; D=duodenum; A=aorta; V=vena cava.

cation rates and the high incidence of pain and abdominal wall herniation after surgery. A lateral approach with specialized instruments should be developed as a less invasive alternative to conventional open ALIF to avoid such complaints. However, one of present author’s major concerns is the limited visualization of the retroperitoneal space and minimized working space. Limited visualization does not warn the surgeon of the presence of viscera and vessels, even at close quarters. Minimized working space makes it more difficult to control vascular or visceral injury if it occurs. Many studies have described complications of lateral approach surgery concerning vascular or visceral injury<sup>73,76,82-86)</sup>, with some complications being catastrophic<sup>87-89)</sup>. As the lateral approach requires mobilization of the peritoneum for exposure to the retroperitoneal space and subsequent lateral access, misunderstanding about the peritoneum and inadequate exposure to the retroperitoneal space increases the risk of injury to the peritoneum and its content. To avoid or manage such complications, surgeons should be aware of potential complications associated with the anterior approach and recognize the importance of a comprehensive understanding of the anatomy of the retroperitoneal space and its content. This article reviews the clinically relevant anatomy of the abdominal retroperitoneal spaces (the retroperitoneum) to facilitate the safe and reliable exposure to the

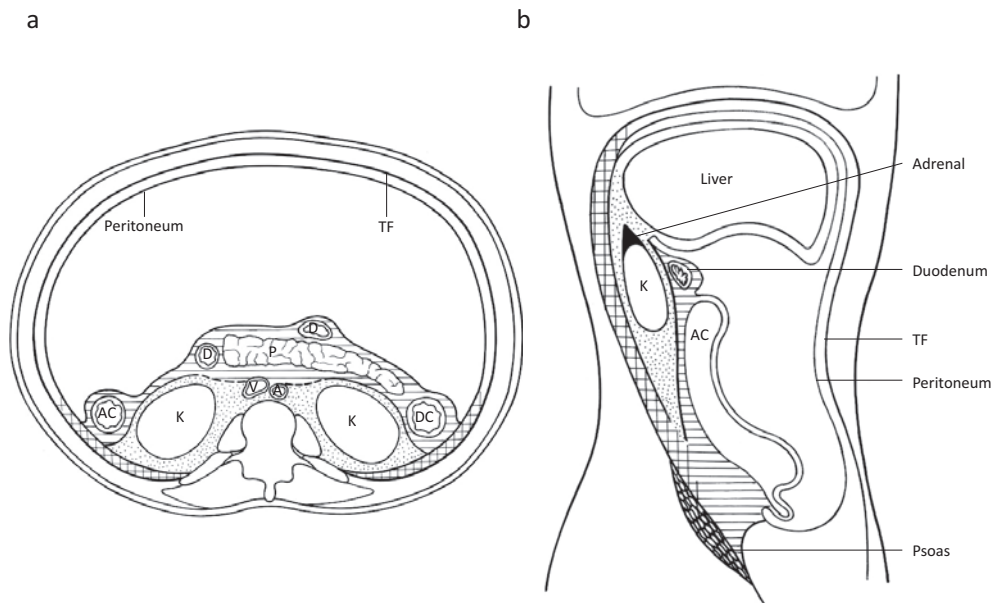
retroperitoneal space for lateral approach surgery.

**Extrapерitoneal space**

The extraperitoneal space is the space between the parietal peritoneum and the investing fascia of the muscles. It circumferentially surrounds the abdominal cavity; posteriorly and laterally (retroperitoneal space), anteriorly (preperitoneal space), and caudally (subperitoneal pelvic space) (Table 1) (Fig. 1). In the posterior abdominal wall, the extraperitoneal space is called the retroperitoneum, which is confined to the posterior and lateral portion of the abdominal and pelvic wall. The investing fascia of the diaphragm, quadratus lumborum muscle, and the transversus muscle (with or without psoas muscle) is called transversalis fascia (TF). The extraperitoneal space in the anterior abdominal wall is called the preperitoneal space. In the pelvis, the extraperitoneal space is called the subperitoneal pelvic space<sup>90)</sup>.

**The retroperitoneum**

The retroperitoneum is the compartmentalized space bounded anteriorly by the posterior parietal peritoneum and posteriorly by the TF. It extends from the diaphragm superiorly to the pelvic brim inferiorly.



**Figure 2.** The three extraperitoneal compartments.  
Striped areas=anterior pararenal space; stippled areas=perirenal space; cross-hatched areas=posterior pararenal space; TF=transversalis fascia; P=pancreas; K=kidney; AC=ascending colon; DC=descending colon; D=duodenum; A=aorta; V=vena cava.  
Meyers MA, Charnsangavej C, Oliphant M. Meyers’ dynamic radiology of the abdomen: normal and pathologic anatomy. New York: Springer; 2011. xviii, 419 p. p 116; with permission.

**Table 2.** Three Compartments of Retroperitoneum.

		Boundary	Organs
Anterior pararenal space	APS	Anterior: Posterior parietal peritoneum Posterior: Anterior renal fascia Lateral: Lateroconal fascia	Ascending/descending colon Duodenal loop Pancreas
Perirenal space	PRS	Anterior: Anterior renal fascia (Gerota fascia) Posterior: Posterior renal fascia (Zuckermandl fascia)	Kidney Renal vessel Adrenal glands Renal pelvis Proximal ureter
Posterior pararenal space	PPS	Anterior: Posterior renal fascia Anteromedial: Lateroconal fascia Posterior: Transversalis fascia Medial: Psoas fascia Superior: Subdiaphragmatic layer Inferior: Open to the pelvis	Fat tissue

**Three compartments anatomy of the retroperitoneum**

The retroperitoneum is divided by fascial planes into precisely three individual compartments: the anterior and posterior pararenal spaces and the perirenal space<sup>91-96)</sup> (Fig. 2) (Table 2).

**Anterior pararenal space (APS)**

The APS is confined anteriorly by the posterior parietal peritoneum, and posteriorly the anterior renal fascia (RF). Significantly, it is confined laterally by the lateroconal fascia (LCF). It contains the ascending and descending colon, the duodenal loop, and the pancreas. Ventrally, the APS is anatomically continuous with the roots of the small bowel mes-

entery and transverse mesocolon<sup>97,98)</sup>.

**Perirenal space (PRS)**

The PRS has the shape of an inverted cone extending from the diaphragmatic fascia to the iliac fossa. It is confined by the anterior RF (Gerota fascia<sup>99)</sup>) and posterior RF (Zuckermandl fascia<sup>100)</sup>). The PRS contains the kidneys, renal vessels, adrenal glands, renal pelvis, proximal ureters, and its investing fat (perirenal fat).

There is some controversy regarding the medial and inferior extents of the PRS. Historically, it was assumed that the PRS generally had no continuity across the midline<sup>92,96)</sup>. Medially, the posterior fascial layer fuses with the psoas or quadratus lumborum fascia<sup>101)</sup>, and the anterior RF blends



**Table 3.** Retroperitoneal Fasciae (Abbreviations Used in This Article).

RF	Renal fascia (anterior, posterior)
LCF	Lateroconal fascia
TF	Transversalis fascia
FF	Fusion fascia
TLF	Thoracolumbar fascia

into the dense mass of connective tissue surrounding the great vessels at the root of the mesentery and behind the pancreas and duodenum<sup>102</sup>. However, in vivo cases and cadaveric injection studies suggest there may be some communication across the midline below the level of the renal hilum<sup>103,104</sup>. In addition, there is controversy regarding the patency and caudal extent of the PRS. Previously, it was suggested that the PRS is closed inferiorly by the fusion of RF. However, in vivo cases and cadaveric injection studies demonstrated that the cone-like shape of PRS is open at its inferior extent in the extraperitoneal pelvis<sup>103,105</sup> (Fig. 2b).

At the level of the iliac crest, below the cone of RF, the anterior and posterior pararenal spaces are in potential communication. At this same level, the LCF disappears as a distinct boundary, and the APS communicates laterally with the preperitoneal fat of the flank stripe. Superiorly, posterior pararenal fat continues as a thin subdiaphragmatic layer of extraperitoneal fat<sup>91,92,96</sup>.

**Posterior pararenal space (PPS)**

The PPS is confined anteriorly by the posterior RF, posteriorly by the TF, and medially by the psoas muscle. It continues laterally external to the LCF as the preperitoneal fat of the abdominal wall. Inferiorly, the PPS is open to the pelvis<sup>106</sup>. As opposed to the other two extraperitoneal spaces, the PPS contains no organs, and almost always only contains fat. Furthermore, its most notable feature is that it continues uninterrupted external to the LCF as preperitoneal fat on the abdominal wall. It is important to recognize that it is posterior pararenal fat, as it courses laterally external to the LCF and deep to the TF<sup>105</sup>. The space is open laterally toward the flank and inferiorly toward the pelvis. Bilaterally, they are potentially in communication only via the preperitoneal fat of the anterior abdominal wall deep to the TF.

**Interfascial planes**

This traditional three-compartmental anatomy does not provide a complete explanation for the spread of fluid collections or tumors in the retroperitoneum. It is now believed that the retroperitoneal fasciae are multilaminated structures with potentially expandable interfascial planes<sup>107</sup>. These planes are represented by the retromesenteric, retrorenal, lateroconal, and combined interfascial planes. Knowledge of the anatomy and interconnections of these interfascial planes can facilitate understanding of the extent and pathways of spread of retroperitoneal disease<sup>108</sup>.

**Membrane and fasciae**

Fascia is fundamental to understanding retroperitoneal anatomy, but is often misunderstood in surgical practice. Definitions of fascia vary between texts and between countries<sup>109</sup>. The retroperitoneal fascial planes are multilaminated rather than composed of single membranes. The fasciae are lamina of connective tissue approximately 2 mm thick that form the partitions between retroperitoneum compartments<sup>110</sup>. A clear concept and definition of fascia is important when approaching the retroperitoneum (Table 3).

**Peritoneum**

The peritoneum is a thin, translucent, serous membrane. The peritoneum that lines the abdominal wall is called the parietal peritoneum, whereas the peritoneum that covers a viscus or an organ is visceral peritoneum. Both types of peritoneum consist of a single layer of simple low-cuboidal epithelium called a mesothelium. The peritoneal cavity is the potential space between the parietal peritoneum, which lines the abdominal wall, and the visceral peritoneum, which envelops the abdominal organs<sup>111</sup>.

**Retroperitoneal fascial development**

Derived from the mesoderm, the primitive mesenchyme differentiates to form subcutaneous, body, and retroperitoneal layers. The retroperitoneal layer forms three strata in late fetal development: the outer, intermediate, and inner strata<sup>112</sup>.

Some orthopedic surgeons interpret the term fascia to always mean the membrane capsuling the myotome. However, this is not true. The retroperitoneal fasciae are not related to the fasciae of the dorsal myotomes. The abdominopelvic fasciae evolve from a continuous layer of retroperitoneal connective tissue. The outer stratum covers the epimysium of the abdominal wall muscles, forms the abdominal and pelvic fascia, and becomes the TF. The intermediate stratum forms the fascia that encloses the urinary tract, and the inner stratum is the connective tissue associated with the coelomic epithelium (peritoneum) itself. This becomes the fascia involved with the intestinal tract<sup>113</sup>. These embryologic strata categorize the retroperitoneal fasciae, which compartmentalize the spaces within the retroperitoneum<sup>114</sup>.

**Renal fascia (RF)**

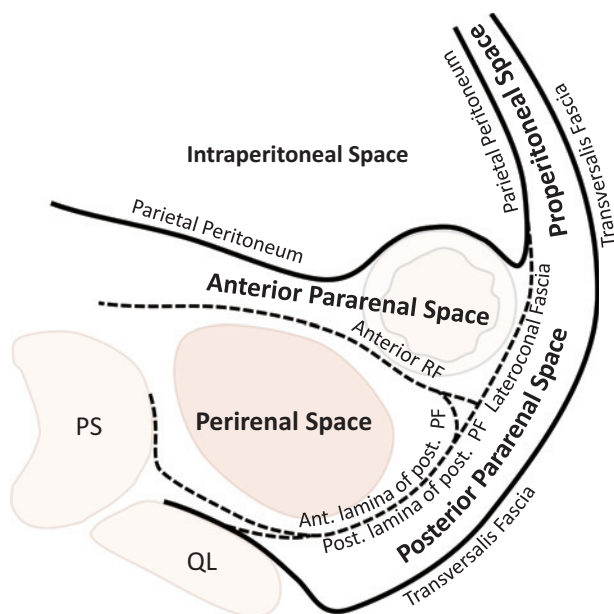
The RF is a dense, collagenous, elastic connective tissue sheath that envelops the kidney and perirenal fat. The posterior RF was first described by Zuckerkandl<sup>100</sup> and the anterior RF by Gerota<sup>99</sup>, but both fasciae have since been named Gerota’s fascia<sup>115</sup>. Its two layers fuse behind the ascending or descending colon to form the LCF, which continues around the flank to blend with the peritoneal reflection to form the paracolic gutter. The posterior RF fuses with the psoas or quadratus lumborum fascia at the level of the renal hilum. Further down, it withdraws toward the quadratus lumborum muscle, and fuses with the posterolateral margin

of the psoas muscle at the level of the inferior apex of the cone<sup>105,116,117</sup>.

Dissection studies have shown the posterior RF is divided into two laminae at a variable point from the kidney<sup>117</sup>. The thinner anterior leaf extends anteriorly, continuous with the anterior RF. The thicker posterior lamina continues the LCF. The potential space between the two laminae is anatomically continuous with the anterior pararenal space<sup>117</sup> (Fig. 3).

### *Lateroconal fascia (LCF)*

Although spine surgeons may not be familiar with this



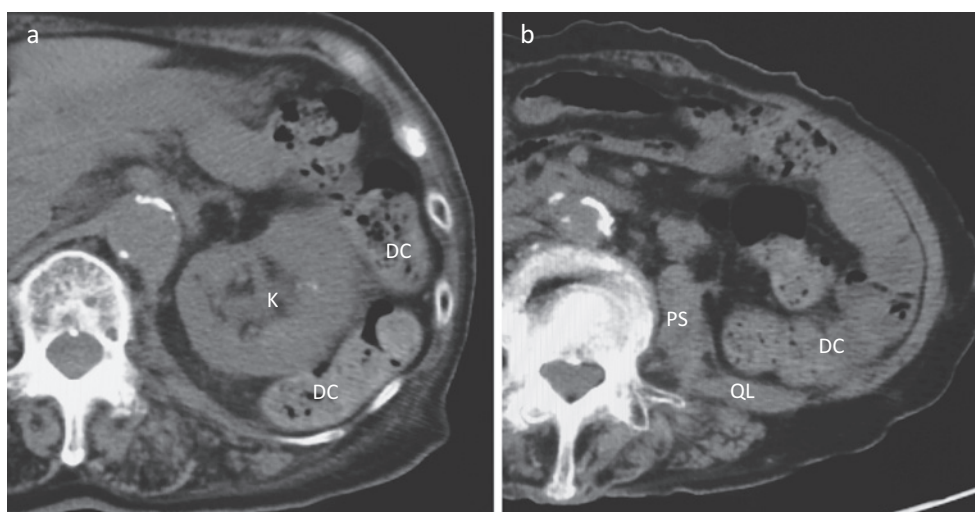
**Figure 3.** Schema of the retroperitoneal fasciae and spaces. RF=renal fascia; PS=psoas muscle; QL=quadratus lumborum muscle

fascia, the LCF was first described in early the 1900s<sup>101,118,119</sup>. The anterior and posterior RF merge laterally on each side behind the ascending and descending colon to form the LCF, separating the APS and PPS and continuing antero-laterally deep to the TF<sup>102,120,121</sup>. This space is occupied by a flat, capsule-like body of fat, similar to the renal adipose capsule in the perirenal space. The term “flank pad” is used for the flat fatty mass between the LCF and TF<sup>120</sup>. However, variations in this fascia in adult specimens have been investigated. The site of blending of the LCF with the RF varies between patients, as well as from side-to-side and from cephalad to caudad, and ranges from a location anterior to one posterior to the kidney<sup>121</sup>. LCF variations may explain the uncommon occurrence of the retrorenal colon<sup>122-124</sup> (Fig. 4). Abundant perirenal or pararenal fat is much more common in men than in women, and a lack of this adipose tissue may contribute to the colon lying lateral to, or even behind, the kidney<sup>122</sup>. Caution about retrorenal colon may have practical applications when an invasive retroperitoneal procedure is planned<sup>125</sup>.

Furthermore, the origin of the LCF remains unknown. A recent study of human fetuses at two different developmental stages reported that the LCF did not appear to be a primary structure such as the RF, but a result of secondary mechanical stress due to fatty tissue developing earlier along the TF than in the perirenal space<sup>125</sup>.

### *Fusional fasciae (FF)*

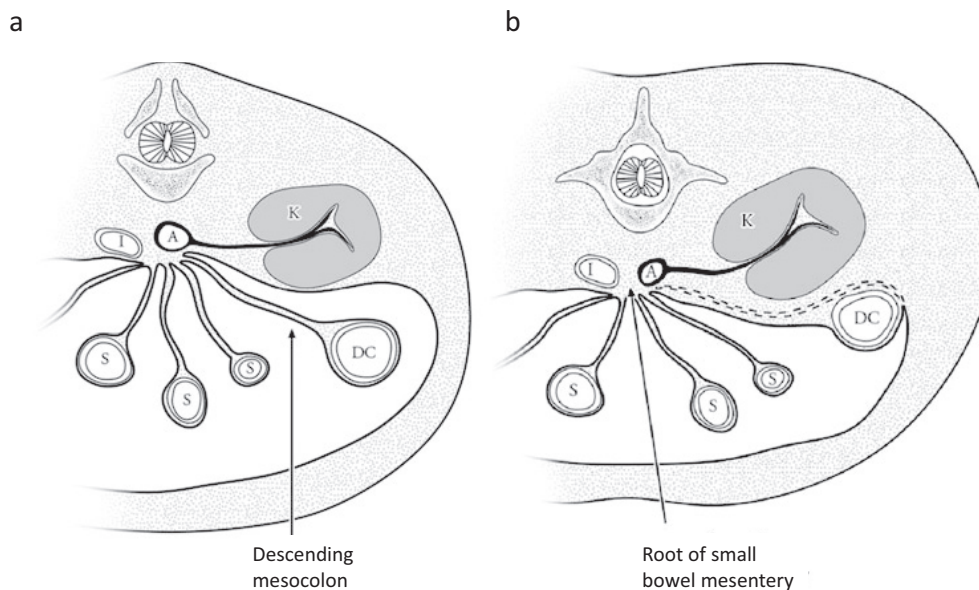
The FF behind the right and left retroperitonealized mesocolon are called the right and left retrocolic fasciae of Toldt<sup>101,126</sup>. This construct describes a retroperitoneal fascia formed by the fusion of an embryonic mesentery with embryonic retro-peritoneum (Fig. 5). The FF is created during embryogenesis when the inner stratum forms a multilayer



**Figure 4.** An 82-year-old woman with retrorenal colon.

Axial computed tomography images show the descending colon wrapping around the left kidney (a), and extending posteriorly to the quadratus lumborum muscle and medially to the psoas muscles at L3/4 level (b).

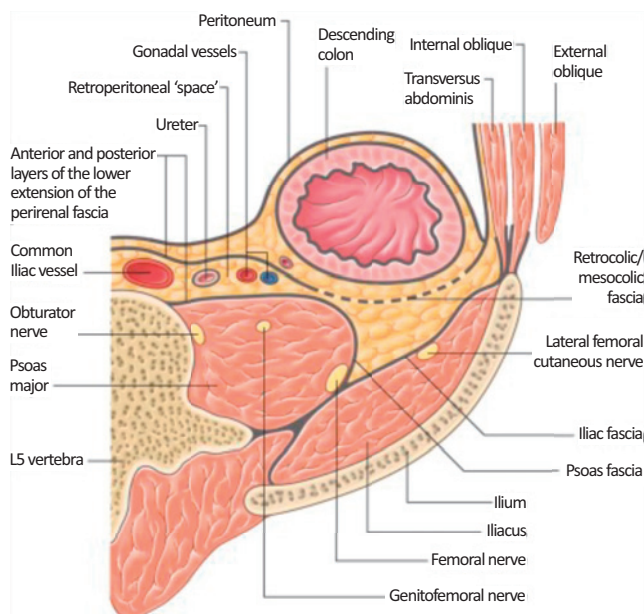
K=kidney; DC=descending colon; PS=psoas muscle; QL=quadratus lumborum muscle.



**Figure 5.** Origin of fusion fascia.

(a) Diagrammatic drawing of transverse section of a 12-week embryo. The colon has returned to the abdomen and is suspended by the dorsal mesentery. DC=descending colon; S=small bowel; A=aorta; I=inferior vena cava; K=kidney. (b) Fusion of the descending mesocolon with posterior parietal peritoneum (dashed lines). Note the subperitoneal region of the mesentery is preserved after fusion allowing continuity of the subperitoneal space.

Meyers MA, Charnsangavej C, Oliphant M. Meyers' dynamic radiology of the abdomen: normal and pathologic anatomy. New York: Springer; 2011. xviii, 419 p. 17; with permission.



**Figure 6.** Compartments and fasciae of the lower retroperitoneum.

A transverse section at approximately the L5 vertebral level, showing the location and relationship of the pericolic space. Standring S. Posterior abdominal wall and retroperitoneum. Forty-first edition. New York: Elsevier Limited; 2016. Gray's anatomy: the anatomical basis of clinical practice; Chapter 62, p. 1083-1097.e2; with permission.

FF with the primary dorsal peritoneum during the rotation and posterior attachment of the gastrointestinal viscera<sup>113</sup>. FF consists of thin (0.1-0.6 mm) connective tissue layers, sometimes bilaminar with a separate looser stratum<sup>105</sup>.

Clinically, the white line of Toldt is a significant landmark for digestive surgery because it can be developed to mobilize the colon after incising along the line of Toldt. It is an avascular layer that allows a dissection plane to be developed, and limits the spread of disease. The FF is also clinically significant for spine surgeons because it immobilizes the ascending or descending colon to the lateral or posterior aspect of the abdominal cavity, which lies anterior to the anterior RF or LCF (Fig. 6)<sup>127</sup>. Therefore, recognition of the ascending or descending colon position should always be considered in strategic retroperitoneal procedures.

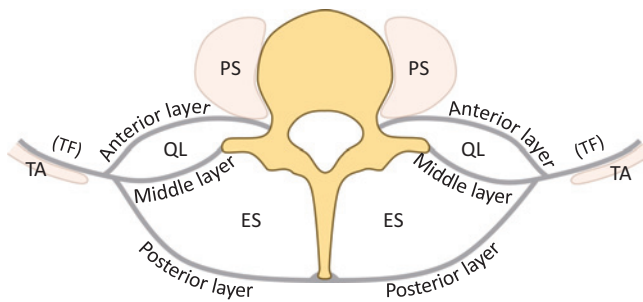
#### **Transversalis fascia (TF)**

The outer stratum forms the TF, which lies deep to the transversus abdominis muscle and superficial to the preperitoneal fat and peritoneum. The TF is posterior to the kidney, and anterior to the fascia surrounding the quadratus lumborum. Some texts include the fascia of the psoas muscle with the TF<sup>128</sup>. The TF may fuse medially with the posterior lamina of the posterior RF. This fusion creates the medial boundary of the posterior pararenal space<sup>112,114</sup>.

#### **Thoracolumbar fascia (TLF)**

The TLF is a girdling structure comprising a complex arrangement of several aponeurotic and multiple fascial layers





**Figure 7.** Laminae of the thoracolumbar fascia in the lumbar region.

The thoracolumbar fascia is composed of three distinct layers: posterior, middle, and anterior layers. Two compartments are delineated: the osteofibrous compartment for the erector spinae muscle, and the fascial compartment for the quadratus lumborum muscle.

PS=psoas muscle; QL=quadratus lumborum muscle; ES=erector spinae muscle; TA=transversus abdominis muscle; TF=transversalis fascia.

that separate the paraspinal muscles from the muscles of the posterior abdominal wall. In the lumbar region, the TLF is composed of three distinct layers: posterior, middle and anterior layers (Fig. 7). The posterior layer originates medially from the tip of the spinous processes of the lumbar vertebrae and the supraspinous ligament; a superficial lamina is the aponeurosis of the latissimus dorsi, and a deep lamina covers the posterior surface of the paraspinal muscles. The middle layer is attached to the tips of the transverse processes of the lumbar vertebrae and extends laterally behind the quadratus lumborum. The anterior layer covers the anterior surface of the quadratus lumborum and is attached medially to the transverse processes of the lumbar vertebrae behind psoas major. Superiorly, it is attached to the inferior border of the twelfth rib and extends to the transverse process of the first lumbar vertebra, forming the lateral arcuate ligament of the diaphragm<sup>109</sup>. These three layers merge into one as they travel laterally. A common access point for the retroperitoneum is near the tip of the 12th rib, where layers merge. This single TLF layer anterolaterally merges with the aponeurosis of the transversus abdominis muscle<sup>114</sup>. The retroperitoneum can be entered from this point without incising muscle, which is an entry point for the conventional open anterior approach.

### **Psoas fascia**

A relatively dense fascia layer covers the anterior surface of psoas major and psoas minor. The psoas fascia merges above with the medial arcuate ligament of the diaphragm and laterally with the TF<sup>113</sup>. Some texts include the psoas fascia with the TF<sup>128</sup>. For spine surgeons, when mobilizing the abdominal, anterior pararenal, and perirenal cavities to exposure the PPS, it is significant that the psoas fascia and the anterior layer of the TF fuses with the posterior RF.

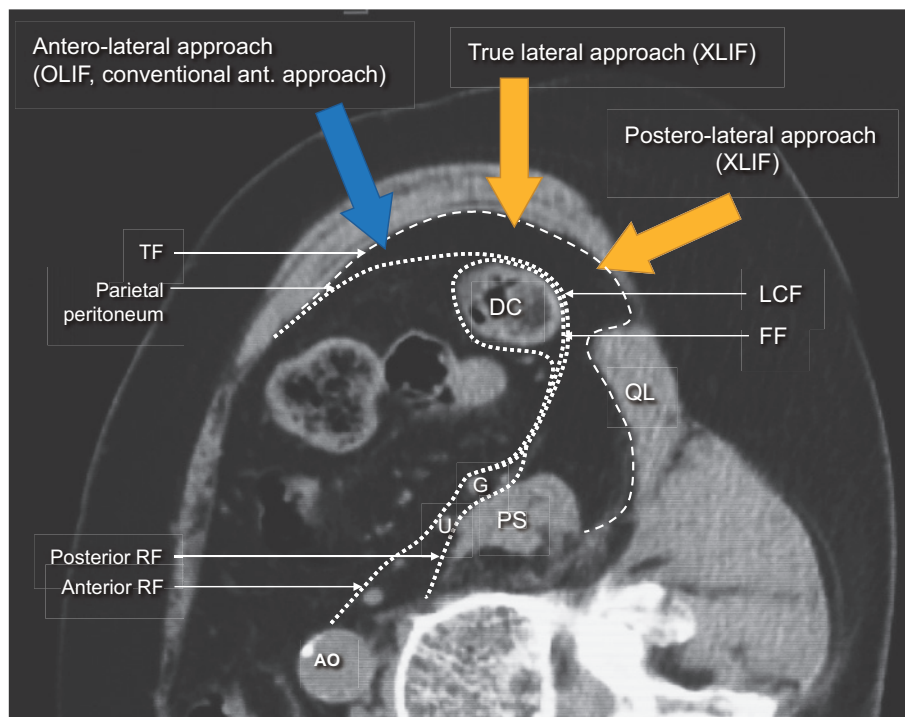
### **Safe and reliable exposure to retroperitoneal space for lateral surgery**

In contrast to the descriptions of the RF published by Gerota and Zuckerkandl over 100 years ago and that of the LCF published in 1920s, some of the surgical anatomy around the retroperitoneum remains controversial. The surgical interpretation of the retroperitoneum including the RF and LCF has changed over the years. Some of these changes can be observed in textbooks and manuscripts. This suggests that difficulty in discrimination result in misinterpretation of the laminar configurations during surgery. Laparoscopic urologic surgeons have emphasized a correct understanding of the LCF in the lateral aspect of the kidney<sup>129,130</sup>. However, the LCF remains unknown to many surgeons, especially spine surgeons, unfamiliar with older orthopedic or spinal surgery textbooks. As a result, most spine surgeons have a misunderstanding that the retroperitoneum is the compartmentalized space bounded anteriorly by only one membrane (namely the peritoneum) in any anterior aspect. Knowledge of the complex anatomy of the entities lying between the posterior abdominal wall and peritoneum, and recognition of common variations and their potential implications are crucial for successful surgery using a retroperitoneal approach.

Because lateral approach surgery is fundamentally retroperitoneal approach surgery, XLIF (DLIF) and OLIF can be considered as closely resembling the technique. However, there is a substantial difference between the two techniques regarding the first process of exposing the retroperitoneal space. The original OLIF technique use an antero-lateral approach similar to the conventional open anterior approach, in which the first process in exposing the retroperitoneal space to the preperitoneal space is confined between the parietal peritoneum of the anterior abdominal wall and the TF, including preperitoneal fat. Conversely, XLIF technique is true lateral or postero-lateral approach, in which the first process of exposing the retroperitoneal space to the PPS is confined between the posterior RF anteriorly and the TF posteriorly (Fig. 8). However, the anterior aspect of PPS is complex and diverse, including the posterior RF, the LCF, and the peritoneum. Furthermore, it is clinically significant for spine surgeons that the FF fuse the ascending or descending colon to the lateral or posterior aspect of the abdominal cavity, which lies closely anterior to the anterior RF or the LCF. This suggests that injury of the peritoneum or the fasciae in the first process of the exposure to the retroperitoneal space has a higher possibility of being injury to the ascending or descending colon in a true lateral approach than in an antero-lateral or conventional open anterior approach.

In the second LLIF process, mobilization of the peritoneum and its content or retroperitoneal content anteriorly is required to expose the PPS and allow subsequent lateral access. To provide this mobilization, the posterior RF and the LCF or the peritoneum should be detached from the TF and the psoas fascia, and extended into the immediate anterior side of the psoas. Understanding of the anatomical structures





**Figure 8.** Lateral lumbar interbody fusion approaches.

A substantial difference exists between these two techniques (OLIF and XLIF) in terms of the first process of exposing the retroperitoneal space.

DC=descending colon; PS=psoas muscle; QL=quadratus lumborum muscle; AO=aorta; G=gonadal vessels; U=Ureter; RF=renal fascia; LCF=lateroconal fascia; TF=transversalis fascia; FF=fusion fascia.

in the retroperitoneum, especially retroperitoneal fasciae, has recently advanced with the development of image diagnosis and innovative surgical techniques. The posterior RF fuses with the psoas fascia and the TF, and the thicker posterior lamina of the RF becomes the LCF laterally (Fig. 3). However, such a clear view and identification of the membrane and fasciae cannot be observed in the PPS during actual surgery (Fig. 9). This suggests that correct anatomical recognition of the posterior RF and the LCF during operation is sometimes difficult. In addition, the pararenal space contains connective tissue fibers similar to the perirenal space<sup>129</sup>. Therefore, clear anatomic assessment and identification of the pathway for exposure to the PPS in preoperative images is beneficial, and gentle and meticulous surgical detachment of the posterior RF, LCF, or the peritoneum from the TF and the psoas fascia is essential for safe and reliable lateral approach surgery. An alternative technique when there is no clear identification of the peritoneum and fasciae during surgery is the detachment of the psoas fascia and the fascia of the quadratus lumborum muscle from its own myotome, and mobilization of the peritoneum, the posterior RF, LCF, the psoas and quadratus lumborum fascia as one membrane.

The FF, resulting from adherence of the peritoneum of the colonic mesentery with the primary posterior peritoneum, consists of thin (0.1-0.6 mm) connective tissue layers<sup>105</sup>. They lie anterior to the anterior RF or LCF, which are also thin layers. The normal thickness of these fascial planes is

1-2 mm<sup>105</sup>. This means the distance between the posterior or lateral aspect of the ascending or descending colon and the anterior wall of the PPS (including the peritoneum, posterior RF and LCF) is less than 2 mm. Although the thickness of this fascia plane varies because of containing connective tissue fibers and fat tissue, this fascia plane is less thin than commonly identified by many spinal surgeons during surgery. We evaluated intraoperative 3D-images immediately after LLIF, and found that 30% of patients showed a dangerously thin margin (less than 1 mm) between the posterior surface of the colon and the exposed PPS<sup>131</sup> (Fig. 10). These patients have a high possibility of colonic perforation during exposure to the PPS and the entire LLIF procedure after the setting of the retractor. To avoid colonic perforation during LLIF, anatomic assessment of the descending and ascending colon using preoperative abdominal computed tomography scans (e.g., the distance between the descending or ascending colon and the anterior margin of the quadratus lumborum muscle or amount of fat tissue in the PPS) is essential. Although special instruments and light equipment used in recent novel LLIF surgery are used for minimal-incision surgery as a less invasive alternative to conventional open ALIF, the most important factor is the safe and reliable creation of a spacious cavity in the retroperitoneum by entry along the correct planes.

## In conclusion

Lateral approach spine surgery can provide effective interbody stabilization and correction, and indirect neural decompression with minimal-incision and less invasive surgery compared with conventional open ALIF. It may also avert the trauma to paraspinal muscles or facet joints found in TLIF and PLIF. However, because lateral approach surgery is fundamentally retroperitoneal approach surgery, there is potential risk to intra- and retroperitoneal structures (including viscera and vessels) as seen with a conventional open anterior approach. Minimal-incision and less invasive lateral surgery may be a trade-off with the limited visualization of the retroperitoneal space and minimized working space. An innovative lateral approach technique has demonstrated different anatomical views, but requires reconsideration of the traditional surgical anatomy in more detail than a traditional open anterior approach. Correct anatomical recognition for the retroperitoneum is essential to success in lateral approach surgery. It must be clear to the spine surgeon that the retroperitoneal membrane and fascia are more multilayered and complex than commonly understood. Therefore, preoperative abdominal images will support more efficient surgical consideration about the retroperitoneal membrane and fascia in lateral approach surgery. Such anatomical knowledge is also useful in a conventional open approach.

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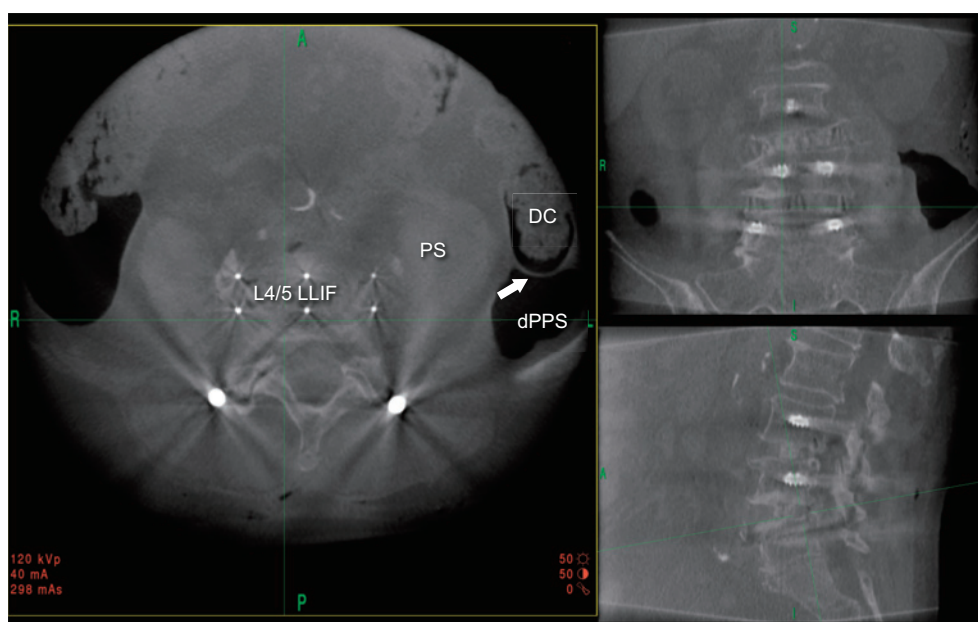


**Figure 9.** An anatomic cross-section below midlevel of the left kidney.

The anatomic cross-section shows the termination of the posterior renal fascia in relationship to the fascia of the quadratus lumborum muscle (arrow). A clear view and identification of these fasciae could not be observed at the posterior pararenal space because this relationship is variable and the medial extent of the posterior pararenal space varies from patient to patient.

K=kidney; PM=psoas muscle; C=descending colon; ARF=anterior renal fascia; LCF=lateroconal fascia; PRF=posterior renal fascia; 1=anterior pararenal space; 2=perirenal space; 3=posterior pararenal space.

Meyers MA, Charnsangavej C, Oliphant M. Meyers' dynamic radiology of the abdomen: normal and pathologic anatomy. New York: Springer; 2011. xviii, 419 p. 124; with permission.



**Figure 10.** Intraoperative three-dimensional (3D) images immediately after lateral lumbar interbody fusion (LLIF).

The intraoperative 3D-images in a prone position immediately after LLIF (L4/5) showed a dangerously thin margin (less than 1 mm, white arrow) between the posterior or lateral surface of the colon and the developed posterior pararenal space.

DC=descending colon; dPPS=developed posterior pararenal space by LLIF procedure; PS=psoas muscle.

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