

Full-Endoscopic Lumbar Discectomy vs Standard Discectomy: A Noninferiority Study on Clinically Relevant Changes

Joel Beck, Olof Westin, Mikael Klingenstierna and Adad Baranto

Int J Spine Surg published online 14 June 2023
<https://www.ijssurgery.com/content/early/2023/06/09/8458>

This information is current as of August 9, 2024.

Email Alerts Receive free email-alerts when new articles cite this article. Sign up at:
<http://ijssurgery.com/alerts>

Full-Endoscopic Lumbar Discectomy vs Standard Discectomy: A Noninferiority Study on Clinically Relevant Changes

JOEL BECK, MD, PhD¹; OLOF WESTIN, MD, PhD¹; MIKAEL KLINGENSTIERNA, MD¹; AND ADAD BARANTO, MD, PhD¹

¹Department of Orthopaedics, Institute of Clinical Sciences at Sahlgrenska Academy, University of Gothenburg and Sahlgrenska University Hospital, Gothenburg, Sweden

ABSTRACT

Background: Surgery for lumbar disc herniation (LDH) has had a remarkable technological development during the past 20 years. Microscopic discectomy has traditionally been the gold standard method to treat symptomatic LDH before the introduction of full-endoscopic lumbar discectomy (FELD). The FELD procedure allows unsurpassed magnification and visualization and is currently the most minimally invasive surgical technique. In this study, FELD was compared with standard surgery for LDH, with a focus on medically relevant changes in patient-reported outcome measures (PROMs).

Purpose: The purpose of this study was to investigate whether FELD is noninferior to other surgical methods for LDH surgery in the most common PROMs, including postoperative leg pain and disability, while still reaching the necessary thresholds for relevant clinical and medical improvements.

Methods: Patients undergoing a FELD procedure at the Sahlgrenska University Hospital, Gothenburg, Sweden, between 2013 to 2018 were included. A total of 80 (41 men and 39 women) patients were enrolled. The FELD patients were matched 1:5 to controls from the Swedish spine register (Swespine) who had a standard microscopic or mini-open discectomy surgery. PROMs, including the Oswestry Disability Index (ODI) and the Numerical Rating Scale (NRS), as well as the patient acceptable symptom states (PASS) and the minimal important change (MIC), were used to compare the efficacy of the 2 surgical approaches.

Results: The FELD group achieved medically relevant and significant improvements noninferior to standard surgery within the predefined thresholds of MIC and PASS. No differences could be found in disability measured by ODI FELD -28.4 (SD 19.2) vs standard surgery -28.7 (SD 18.9) or leg pain NRS_{Leg} FELD -4.35 (SD 2.93) vs standard surgery -4.99 (SD 3.12). All intragroup score changes were significant.

Conclusions: The FELD results are not inferior to standard surgery 1 year postoperatively after LDH surgery. There were no medically significant differences regarding MIC achieved or final PASS in any of the measured PROMs, including leg pain, back pain, or disability (ODI) between the surgical methods.

Clinical Relevance: The present study highlights that FELD is noninferior to standard surgery in clinically relevant PROMs.

Level of Evidence: 2.

Endoscopic Minimally Invasive Surgery

Keywords: Lumbar disc herniation, full-endoscopic lumbar discectomy, minimal invasive spine surgery, FELD, PROMs

INTRODUCTION

Historically, lumbar disc herniation (LDH) surgery was an extensive procedure with significant morbidity.¹ With the introduction of full-endoscopic lumbar discectomy (FELD), a truly minimally invasive surgical technique has been developed.^{2,3} Current research has yet to show that a FELD procedure has significant medical gains and advantages.⁴ However, if proven noninferior to other methods, one can hypothesize that the potential for minimal tissue damage and decreased surgical and hospital length of stay might motivate the initial investment in equipment and training.⁵

MATERIALS AND METHODS

The hypothesis of the study was that patient-reported outcome measures (PROMs) in a FELD cohort matched to LDH patients having standard surgery were noninferior in regard to minimal important change (MIC) and postoperative patient acceptable symptom state (PASS) for all measured PROMs.⁵⁻⁷

Study Design

This study was conducted as a matched cohort study, comparing FELD patients operated at Sahlgrenska University Hospital, Gothenburg, Sweden between 2013 and 2018 with controls having standard LDH surgery (microscopic or mini-open procedure) from the Swespine register.⁸ A total of 92 FELD patients were initially enrolled, and 80 patients with complete 1-year postoperative follow-up were analyzed in the study. Patients were matched according to age ± 3 years, sex, preoperative leg pain duration, and lumbar level of disc herniation.

Patient-Reported Outcome Measures

The Oswestry Disability Index (ODI) was used to assess the disability.⁹ Leg and back pain were rated with the Numerical Rating Scale (NRS 0–10).

At 1-year follow-up, a qualitative single-item leg/back pain question-global assessment ($GA_{\text{Leg/Back}}$) was formulated as “How do you rate your leg/back pain today as compared with before you had your back surgery?” with a 6-level response option: 0—had no preoperative leg/back pain, 1—pain free, 2—much better, 3—somewhat better, 4—unchanged, 5—worse.¹⁰

Minimal Important Change and Patient Acceptable Symptom State

To study clinically important differences, use of the MIC score and PASS have been suggested. The PASS gives a threshold on what a mean tolerable baseline level is for a PROM score (“feeling good”), whereas the MIC value states the minimum change needed to be perceived as meaningful for the patient and still being able to be registered on the PROM scale (“feeling better”). Values used in this study are in-line with and derived from previously published articles and are presented in Table 1.^{11–19}

Table 1. MIC and PASS^a values used in the study.

Outcome Measure	MIC	PASS Level	Comment
Leg pain NRS (0–10)	3.5	2	NRS
Back pain NRS (0–10)	2.5	2	NRS
Oswestry Disability Index (0–100)	–20	22	Composite score

Abbreviations: MIC, minimal important change; NRS, numerical rating scale; PASS, patient acceptable symptom state.

^aPASS indicates the highest score on that scale that is acceptable to a generalized population.

Surgical Indication and Inclusion Criteria

The indication for a FELD discectomy was unsustainable leg pain for more than 6 weeks, with or without motor and sensory deficit, which failed to respond to conservative or physiotherapeutic treatment.²⁰ Exclusion criteria were cauda equina syndrome, previous spinal surgery, lumbar fracture, and incomplete preoperative data.

Surgical Techniques

Full-Endoscopic Lumbar Discectomy

The surgical FELD method has been described thoroughly in several original articles and was performed according to the description by Rutten et al.^{20–22}

Standard Procedures

The control group had a conventional lumbar discectomy, either by a microscopic or mini-open approach. These techniques can be considered comparable in all relevant long-term outcomes.^{6,23,24}

Statistical Analysis

The data from the FELD and control groups were compiled using SAS statistical software version 9.4 (SAS Institute Inc) for statistical analysis. Descriptive statistics for patient demographics and outcomes were reported as proportion and count for categorical variables. Continuous variables were reported as mean and SD and with median and the first and third quartiles. A post hoc power analysis for NRS_{Leg} was performed at 80% with an intergroup noninferiority difference of < 2 to verify a sufficient sample size. The Fisher exact test was used for dichotomous variables, the Mantel-Haenszel χ^2 test was used for ordered categorical variables, and the Pearson χ^2 test was used for nonordered categorical variables. The Wilcoxon test was used for paired data. McNemar test was used to compare paired samples for nominal and dichotomous variables. All significance tests were 2 sided and conducted at the 5% significance level. The multilevel GA_{Leg} and GA_{Back} were dichotomized to allow for a robust comparison between the groups.

RESULTS

A total of 80 FELD patients were eligible for the study. They were matched to 400 controls from the Swespine register, creating a 1:5 inclusion ratio. The baseline values for the groups are shown in Table 2. Mean preoperative leg pain intensity measured by

Table 2. Demographic parameters at baseline.

Characteristic	FELD Group (n = 80)	Control Group (n = 400)	P Value	Difference Between Groups, Mean (95% CI)
Age, y, Mean (SD) (95% CI for mean)	n = 80 32.4 (10.4) (30.1; 34.7)	n = 400 33.2 (10.0) (32.2; 34.2)	0.53	-0.763 (-3.209; 1.682)
Sex, n (%)	n = 80	n = 400		
Men	41 (51.3%)	205 (51.3%)		0.0 (-12.7; 12.7)
Women	39 (48.8%)	195 (48.8%)	>0.99	0.0 (-12.7; 12.7)
Body mass index Mean (SD) (95% CI for mean)	n = 80 25.0 (4.0) (24.1; 25.9)	n = 400 25.3 (3.3) (25.0; 25.6)	0.46	-0.309 (-1.173; 0.504)
Smoker, n (%)	n = 69	n = 398		
No	59 (85.5%)	343 (86.2%)		-0.7 (-10.5; 9.1)
Yes	10 (14.5%)	55 (13.8%)	>0.99	0.7 (-9.1; 10.5)
Leg pain (NRS 0–10) Mean (SD) (95% CI for mean)	n = 56 7.34 (1.98) (6.81; 7.87)	n = 389 6.99 (2.18) (6.78; 7.21)	0.27	0.347 (-0.231; 0.936)
Back pain (NRS 0–10) Mean (SD) (95% CI for mean)	n = 56 5.11 (2.74) (4.37; 5.84)	n = 388 4.81 (2.83) (4.53; 5.09)	0.45	0.295 (-0.510; 1.080)
Duration of leg pain, n (%)	n = 80	n = 400		
<3 mo	6 (7.5%)	30 (7.5%)		
3–12 mo	49 (61.3%)	245 (61.3%)		
12–24 mo	13 (16.3%)	65 (16.3%)		
>24 mo	12 (15.0%)	60 (15.0%)	>0.99	
Oswestry Disability Index Mean (SD) (95% CI for mean)	n = 55 46.5 (18.5) (41.5; 51.5)	n = 392 46.5 (17.8) (44.7; 48.3)	0.97	-0.007 (-4.939; 4.958)
Lumbar disc herniation level, n (%)	n = 80	n = 400		
L4-L5	25 (31.3%)	153 (38.3%)		-7.0 (-19.0; 5.0)
L5-S1	55 (68.8%)	247 (61.8%)	0.29	7.0 (-5.0; 19.0)

Abbreviations: FELD, full-endoscopic lumbar discectomy; NRS, numerical rating scale.

NRS_{Leg} for the FELD group was 7.34 SD (1.98), and mean back pain (NRS_{Back}) was 5.11 (SD 2.74). The patients were, according to their mean ODI of 46.5 (SD 18.5), severely affected by their LDH, resulting in significant disability. There were no significant differences between the groups at inclusion.

At the 1-year follow-up, the FELD group rated their residual leg pain NRS_{Leg} 2.69 (SD 2.68), and their NRS leg pain change score (Δ NRS_{leg}) showed a -4.35 (SD 2.93) difference (baseline - 1 year follow-up) or a 60.2% (SD 36.7%) decrease in leg pain. A comparison with the control group revealed no differences in any of the recorded PROMs as illustrated in Table 3.

In analogy with the postoperative decrease in NRS_{Leg + Back} for the FELD group, the reported mean residual disability measured by the ODI 17.3 (SD 16.7) was below the PASS without any differences between the groups. Among the FELD patients, 58.2% reached PASS in NRS_{Leg} compared with open surgery (71.7%). The difference was not significant ($P = 0.055$). As illustrated in Table 4, by using the predefined PASS score for ODI set at 22, the FELD group attained a similar proportion of patients achieving PASS as the control group.

The MIC values are provided in Table 5. In NRS_{Leg}, 60.5% (FELD) and 73.6% (controls), respectively, attained the MIC or better. No significant differences between the groups were recorded for the NRS or ODI.

DISCUSSION

The main finding in the study is that FELD is non-inferior to standard surgery and showed medically relevant improvements in clinically used PROMs, within specified MIC and PASS values. No clinically relevant differences could be discerned regarding leg and back pain-specific outcomes, disability, or quality-of-life scores at 1-year follow-up.

Leg pain (sciatica) and its detrimental effect on quality of life is the most common complaint for LDH. In our study, the entire study population had severe pre-operative leg pain (NRS_{Leg} with a mean 7.04 [SD 2.15]) that responded positively to surgery. The FELD group achieved a high level of pain reduction measured in NRS_{Leg}, where 60.5% reached the MIC threshold and 58.2% reached PASS, which were comparable with that of standard surgery. The intergroup differences were not statistically significant, but a very slight benefit could be noted for the standard surgery group in postoperative residual leg pain, perhaps illustrating a potential benefit for the extensive decompressive approach of a standard procedure vs the ultraminimal invasive FELD in certain cases. This is in analogy with a previously published randomized controlled trial that also could not discern medically relevant differences between the surgical methods.^{25,26}

However, back pain can also be a significant factor in the symptomatology of LDH patients. Moreover,

Table 3. Postoperative patient-reported outcome measures for FELD and Swespine controls.

Patient-Reported Outcome Measure	FELD Group (n = 80)	Control Group (n = 400)	P Value	Difference Between Groups, Mean (95% CI)
NRS _{Leg} (1 y)	n = 67	n = 223		
Mean (SD) (range)	2.69 (2.68) (2.03; 3.34)	1.97 (2.49) (1.64; 2.30)	0.065	0.718 (-0.040; 1.429)
NRS _{Leg} decrease	n = 43	n = 219		
Mean (SD) (range)	-4.35 (2.93) (-5.25; -3.45)	-4.99 (3.12) (-5.40; -4.57)	0.24	0.637 (-0.421; 1.657)
NRS _{Leg} % change	n = 43	n = 219		
Mean (SD) (range)	-60.2 (36.7) (-71.4; -48.9)	-65.3 (65.0) (-73.9; -56.6)	0.57	5.13 (-18.07; 22.31)
NRS _{Back} (1 y)	n = 62	n = 224		
Mean (SD) (range)	2.56 (2.38) (1.96; 3.17)	2.34 (2.46) (2.02; 2.67)	0.54	0.221 (-0.444; 0.891)
NRS _{Back} decrease	n = 36	n = 200		
Mean (SD) (range)	-2.72 (2.59) (-3.60; -1.85)	-2.47 (3.05) (-2.89; -2.04)	0.66	-0.257 (-1.310; 0.848)
NRS _{Back} % change	n = 36	n = 200		
Mean (SD) (range)	-46.5 (47.8) (-62.7; -30.3)	-32.1 (108.1) (-47.1; -17.0)	0.47	-14.4 (-57.0; 14.6)
ODI (1 y)	n = 64	n = 225		
Mean (SD) (range)	17.3 (16.7) (13.2; 21.5)	15.6 (14.7) (13.7; 17.6)	0.46	1.67 (-2.79; 5.89)
1-y ODI decrease	n = 41	n = 223		
Mean (SD) (range)	-28.4 (19.2) (-34.5; -22.3)	-28.7 (18.9) (-31.2; -26.2)	0.92	0.336 (-5.833; 6.645)
ODI % change	n = 41	n = 223		
Mean (SD) (range)	-61.7 (38.6) (-73.9; -49.5)	-62.9 (35.1) (-67.6; -58.3)	0.84	1.22 (-11.43; 13.17)
EQ-VAS (1 y)	n = 64	n = 218		
Mean (SD) (range)	72.1 (19.1) (67.3; 76.8)	76.4 (16.9) (74.2; 78.7)	0.095	-4.35 (-9.14; 0.65)
EQ-VAS increase	n = 42	n = 208		
Mean (SD) (range)	28.1 (21.5) (21.4; 34.8)	27.1 (25.2) (23.6; 30.5)	0.80	1.03 (-6.71; 9.38)
EQ-VAS % change	n = 42	n = 205		
Mean (SD) (range)	98.3 (121.3) (60.5; 136.1)	98.6 (160.9) (76.4; 120.7)	0.96	-0.284 (-56.365; 43.688)
GA _{Leg}				
GA _{Leg} 1-2 ^a	42 (71.2%)	183 (81.3%)		-10.1 (-23.8; 3.6)
GA _{Leg} 3-5 ^b	17 (28.8%)	42 (18.7%)	0.13	10.1 (-3.6; 23.8)
GA _{Back}				
GA _{Back} 1-2 ^a	44 (80.0%)	154 (76.6%)		3.4 (-9.9; 16.6)
GA _{Back} 3-5 ^b	11 (20.0%)	47 (23.4%)	0.74	-3.4 (-16.6; 9.9)

Abbreviations: FELD, full-endoscopic lumbar discectomy; GA, global assessment; NRS, Numerical Rating Scale; ODI, Oswestry Disability Index.

GA was measured using a 5-level Likert-scale patient recall question.

^aGA values 1-2 = pain free and much better.

^bGA values 3-5 = better, somewhat better, and worse.

residual back pain is known to be a major patient complaint following LDH surgery.²⁷ Perceived increased back pain after spinal procedures is such an established concept that it has become an entity of its own, with thousands of people suffering from *failed back surgery syndrome* or, more recently and perhaps more adequately named, *chronic pain after spinal surgery*.²⁸ A method to decrease the amount of tissue trauma in LDH

surgery could potentially offer huge advantages for patients and doctors alike.

Regarding disability, both the FELD and control group had more than 63% of patients reaching MIC in ODI, whereas only 24.9% did not attain the PASS limit. Both groups had similar changes in ODI, and FELD was noninferior in ODI.

Table 4. Attained PASS scores for the groups.

PASS Scores	Total (N = 480)	FELD Group (n = 80)	Control Group (n = 400)	P Value	Difference Between Groups, Mean (95% CI)
NRS _{Leg} ≤2, n (%)					
No	91 (31.4%)	28 (41.8%)	63 (28.3%)		13.5 (-0.6; 27.7)
Yes	199 (68.6%)	39 (58.2%)	160 (71.7%)	0.055	-13.5 (-27.7; 0.6)
Missing	190	13	177		
NRS _{Back} ≤2, n (%)					
No	112 (39.2%)	28 (45.2%)	84 (37.5%)		7.7 (-7.3; 22.6)
Yes	174 (60.8%)	34 (54.8%)	140 (62.5%)	0.34	-7.7 (-22.6; 7.3)
Missing	194	18	176		
Oswestry Disability Index ≤22, n (%)					
No	72 (24.9%)	18 (28.1%)	54 (24.0%)		4.1 (-9.2; 17.5)
Yes	217 (75.1%)	46 (71.9%)	171 (76.0%)	0.60	-4.1 (-17.5; 9.2)
Missing	191	16	175		

Abbreviations: FELD, full-endoscopic lumbar discectomy; NRS, Numerical Rating Scale; PASS, patient acceptable symptom state.

Table 5. MIC values for the different surgical groups.

MIC	FELD Group (n = 80)	Control Group (n = 400)	P Value	Difference Between Groups, Mean (95% CI)
NRS _{Leg} change ≥ 3.5 , n (%)				
No	17 (39.5%)	58 (26.4%)	0.12	13.2 (-3.9; 30.3)
Yes	26 (60.5%)	162 (73.6%)		
Missing	37	180		
NRS _{Back} change ≥ 2.5 , n (%)				
No	23 (59.0%)	125 (56.8%)	0.94	2.2 (-16.1; 20.4)
Yes	16 (41.0%)	95 (43.2%)		
Missing	41	180		
Oswestry Disability Index change ≤ 20 , n (%)				
No	26 (63.4%)	148 (66.4%)	0.84	-3.0 (-20.4; 14.5)
Yes	15 (36.6%)	75 (33.6%)		
Missing	39	177		

Abbreviations: FELD, full endoscopic lumbar discectomy; MIC, minimal important change; NRS, Numerical Rating Scale.

The GA_{Leg} and GA_{Back} have been suggested to be used as surrogate variables for assessing surgical outcomes, and, in analogy with the other measured PROMs in this study, no intergroup differences were found.

The standard LDH surgery still offers excellent efficacy and value, and FELD should be considered an alternative surgical approach but perhaps still in search of its true signature indication where superiority can be proven. Decreasing the amount of tissue trauma and postoperative back pain is a tantalizing prospect for physicians and patients alike. The increasing prevalence of obesity poses a particular risk for operative and postoperative management and complications, and this might be the perfect indication for FELD, especially for lateral or foraminal disc herniations.

During the past 15 years, FELD has evolved to become a viable alternative to other visualized operative techniques for discectomy.^{24,29–31} Theoretically, there are several advantages with the method that would facilitate a safer and less invasive surgery with potential for enhanced recovery and superior results. Modern endoscopes offer an incomparable overview, illumination, and visualization of the operative field when compared with either microscopic enhancement or simple loupes, and the decreased amount of intraoperative trauma has the potential to reduce the risk of postoperative persistent back pain.

Limitations

This study comprised a consecutive cohort from a single center. The study cohorts were matched on gender, age, preoperative pain duration, and level of disc herniation only. While all of these parameters are relevant and important in a preoperative selection process, none of them are very strong predictors for currently used PROMs. A more extensive matching procedure

might eliminate some of the inherent bias in this study design.

CONCLUSION

The FELD results are not inferior to standard surgery 1 year postoperatively for LDH. There were no significant differences regarding MIC achieved or final PASS in any of the measured PROMs, including leg pain, back pain, or disability (ODI) between the surgical methods. FELD is an alternative to standard surgery for LDHs.

REFERENCES

- Mixter WJ, Ayer JB, Barr JS. The Intervertebral disk. *BMJ*. 1940;1(4141):829–830. doi:10.1136/bmj.1.4141.829-c
- Ruetten S, Komp M, Godolias G. A new full-endoscopic technique for the Interlaminar operation of lumbar disc herniations using 6-mm Endoscopes: prospective 2-year results of 331 patients. *Minim Invasive Neurosurg*. 2006;49(2):80–87. doi:10.1055/s-2006-932172
- Caspar W, Campbell B, Barbier DD, Kretschmmer R, Gotfried Y. The Caspar microsurgical discectomy and comparison with a conventional standard lumbar disc procedure. *Neurosurgery*. 1991;28(1):78–86. doi:10.1097/00006123-199101000-00013
- Ruetten S, Komp M, Merk H, Godolias G. Full-endoscopic interlaminar and transforaminal lumbar discectomy versus conventional microsurgical technique: a prospective, randomized, controlled study. *Spine*. 2008;33(9):931–939. doi:10.1097/BRS.0b013e31816c8af7
- Bai X, Lian Y, Wang J, et al. Percutaneous endoscopic lumbar discectomy compared with other surgeries for lumbar disc herniation: a meta-analysis. *Medicine (Baltimore)*. 2021;100(9):e24747. doi:10.1097/MD.00000000000024747
- Feng F, Xu Q, Yan F, et al. Comparison of 7 surgical interventions for lumbar disc herniation: a network meta-analysis. *Pain Physician*. 2017;20(6):E863–E871.
- Kim J-S MD, PhD. Percutaneous endoscopic lumbar discectomy as an alternative to open lumbar microdiscectomy for large lumbar disc herniation. *Pain Phys*. 2016;19(2;2):E291–E300. <https://painphysicianjournal.com/current/past?journal=94>. doi:10.36076/ppj/2016.19.E291

8. Fritzell P, Swespine Årsrapport 2019 uppföljning av ryggkirurgi utförd i Sverige år 2018. 2019.
9. Fairbank JC, Pynsent PB. The Oswestry disability index. *Spine (Phila PA 1976)*. 2000;25(22):2940–2952. doi:10.1097/00007632-200011150-00017
10. Parai C, Hägg O, Lind B, Brisby H. The value of patient global assessment in lumbar spine surgery: an evaluation based on more than 90,000 patients. *Eur Spine J*. 2018;27(3):554–563. doi:10.1007/s00586-017-5331-0
11. Lewandrowski K-U, De Carvalho PST, De Carvalho P JR, Yeung A. Minimal clinically important difference in patient-reported outcome measures with the transforaminal endoscopic decompression for lateral recess and foraminal stenosis. *Int J Spine Surg*. 2020;14(2):254–266. doi:10.14444/7034
12. Lauridsen HH, Hartvigsen J, Manniche C, Korsholm L, Grunnet-Nilsson N. Responsiveness and minimal clinically important difference for pain and disability instruments in low back pain patients. *BMC Musculoskelet Disord*. 2006;7:82. doi:10.1186/1471-2474-7-82
13. Kovacs FM, Abaira V, Royuela A, et al. Minimal clinically important change for pain intensity and disability in patients with nonspecific low back pain. *Spine*. 2007;32(25):2915–2920. doi:10.1097/BRS.0b013e31815b75ae
14. Copay AG, Glassman SD, Subach BR, Berven S, Schuler TC, Carreon LY. Minimum clinically important difference in lumbar spine surgery patients: a choice of methods using the Oswestry disability index, medical outcomes study questionnaire short form 36, and pain scales. *Spine J*. 2008;8(6):968–974. doi:10.1016/j.spinee.2007.11.006
15. van Hooff ML, Mannion AF, Staub LP, Ostelo R, Fairbank JCT. Determination of the Oswestry disability index score equivalent to a "satisfactory symptom state" in patients undergoing surgery for degenerative disorders of the lumbar spine—a spine tango registry-based study. *Spine J*. 2016;16(10):1221–1230. doi:10.1016/j.spinee.2016.06.010
16. Fekete TF, Haschtmann D, Kleinstück FS, Porchet F, Jeszenszky D, Mannion AF. What level of pain are patients happy to live with after surgery for lumbar degenerative disorders? *Spine J*. 2016;16(4 Suppl):S12–8. doi:10.1016/j.spinee.2016.01.180
17. Solberg T, Johnsen LG, Nygaard ØP, Grotle M. Can we define success criteria for lumbar disc surgery?: Estimates for a substantial amount of improvement in core outcome measures. *Acta Orthop*. 2013;84(2):196–201. doi:10.3109/17453674.2013.786634
18. Werner DAT, Grotle M, Gulati S, et al. Can a successful outcome after surgery for lumbar disc herniation be defined by the Oswestry disability index raw score? *Global Spine J*. 2020;10(1):47–54. doi:10.1177/2192568219851480
19. Parai C, Hägg O, Lind B, Brisby H. ISSLS prize in clinical science 2020: the reliability and interpretability of score change in lumbar spine research. *Eur Spine J*. 2020;29(4):663–669. doi:10.1007/s00586-019-06222-8
20. Beck J, Westin O, Klingenstierna M, Baranto A. Successful introduction of full-endoscopic lumbar Interlaminar discectomy in Sweden. *Int J Spine Surg*. 2020;14(4):563–570. doi:10.14444/7075
21. Ruetten S, Meyer O, Godolias G. Endoscopic surgery of the lumbar epidural space (epiduroscopy): results of therapeutic intervention in 93 patients. *Minim Invasive Neurosurg*. 2003;46(1):1–4. doi:10.1055/s-2003-37962
22. Ruetten S, Komp M, Merk H, Godolias G. Use of newly developed instruments and endoscopes: full-endoscopic resection of lumbar disc herniations via the interlaminar and lateral transforaminal approach. *J Neurosurg Spine*. 2007;6(6):521–530. doi:10.3171/spi.2007.6.6.2
23. Tullberg T, Isacson J, Weidenhielm L. Does microscopic removal of lumbar disc herniation lead to better results than the standard procedure? Results of a one-year randomized study *Spine*. 1993;18(1):24–27. doi:10.1097/00007632-199301000-00005
24. Rasouli MR, Rahimi-Movaghar V, Shokraneh F, Moradi-Lakeh M, Chou R. Minimally invasive dscectomy versus microdiscectomy/open discectomy for symptomatic lumbar disc herniation. *Cochrane Database Syst Rev*. 2014;2014(9):CD010328. doi:10.1002/14651858.CD010328.pub2
25. Gadjradj PS, Rubinstein SM, Peul WC, et al. Full endoscopic versus open discectomy for sciatica: randomised controlled non-inferiority trial. *BMJ*. 2022;376:e065846. doi:10.1136/bmj-2021-065846
26. Seiger A, Gadjradj PS, Harhangi BS, et al. PTED study: design of a non-inferiority, randomised controlled trial to compare the effectiveness and cost-effectiveness of percutaneous transforaminal endoscopic discectomy (PTED) versus open microdiscectomy for patients with a symptomatic lumbar disc herniation. *BMJ Open*. 2017;7(12):e018230. doi:10.1136/bmjopen-2017-018230
27. Parker SL, Mendenhall SK, Godil SS, et al. Incidence of low back pain after lumbar discectomy for herniated disc and its effect on patient-reported outcomes. *Clin Orthop Relat Res*. 2015;473(6):1988–1999. doi:10.1007/s11999-015-4193-1
28. Christelis N, Simpson B, Russo M, et al. Persistent spinal pain syndrome: a proposal for failed back surgery syndrome and ICD-11. *Pain Med*. 2021;22(4):807–818. doi:10.1093/pm/pnab015
29. Phan K, Xu J, Schultz K, et al. Full-endoscopic versus microendoscopic and open discectomy: a systematic review and meta-analysis of outcomes and complications. *Clinical Neurology and Neurosurgery*. 2017;154:1–12. doi:10.1016/j.clineuro.2017.01.003
30. Ruan W, Feng F, Liu Z, Xie J, Cai L, Ping A. Comparison of percutaneous endoscopic lumbar discectomy versus open lumbar microdiscectomy for lumbar disc herniation: a meta-analysis. *International Journal of Surgery*. 2016;31:86–92. doi:10.1016/j.ijso.2016.05.061
31. Li X-C, Zhong C-F, Deng G-B, Liang R-W, Huang C-M. Full-endoscopic procedures versus traditional discectomy surgery for discectomy: a systematic review and meta-analysis of current global clinical trials. *Pain Physician*. 2016;19(3):103–118.

Funding: The authors acknowledge the financial support of The Medical Society of Gothenburg, Sweden and grants from the Swedish state under the agreement between the Swedish government and the county councils, the ALF agreement (Adad Baranto, ID number 238801).

Declaration of Conflicting Interests: Adad Baranto is a clinical lecturer for Riwospine, GMBH, and receives reimbursement for teaching positions. All other authors report no conflicts of interest in this work.

Ethics Statement: The present study was approved by the Regional Ethical Review Board in Gothenburg at The Sahlgrenska Academy, Gothenburg University, Gothenburg, Sweden (ID number: 753-17).

Corresponding Author: Joel Beck, Department of Orthopaedics, Institute of Clinical Sciences at Sahlgrenska Academy, University of Gothenburg and Sahlgrenska University Hospital, Bruna Stråket 11b, vån 4, 413 45 Gothenburg, Sweden; joel.beck@vgregion.se

This manuscript is generously published free of charge by ISASS, the International Society for the Advancement of Spine Surgery. Copyright © 2023 ISASS. To see more or order reprints or permissions, see <http://ijssurgery.com>.