

Dr. Michael Gleiber uses new minimally invasive surgery to get back patients on their feet within a day

BY MARY JANE FINE

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(<http://mpb.floridaweekly.com/node/41357>) BACK IN '64, DURING HIS AIR Force days, Airman 2nd class Charlie Brower sometimes worked on tanker planes, the aircraft used for in-flight refueling. Many's the time he clambered across the wings of those workhorse planes, lugging a hose filled with de-icing fluid. Which is what he was doing one frigid day when he slid off a wing – SMACK! – onto his butt.

“And ever since then,” he says, “I always had lower back pain.”

It hurt when he walked. It hurt when he lifted. But most vexing, it hurt when he climbed into, and especially out of, the old Piper Cub he's kept at North County Airport so he could soar into the lofty skies across and around South Florida “every chance I get,” he says. Meaning whenever pain didn't ground him.

The pain ceased on March 13. It was a Wednesday, he remembers with a smile and glance over at Michael Gleiber, the spinal surgeon who allowed him to straighten up and fly right.

(<http://mpb.floridaweekly.com/node/41358>) Since the surgery, Charlie Brower has been able to fly his Piper without pain. COURTESY PHOTO

The two men sit maybe six feet apart in Dr. Gleiber's Jupiter office on this recent Tuesday morning, in a small, square room.

Three-plus months have passed since the day that nurses at Palm Beach Gardens Medical Center wheeled Mr. Brower into surgery. The time was 7:20 a.m. Fifteen minutes later, Dr. Gleiber made a two-inch incision to begin the intricate surgery.

“And I was up, walking, at — what? — 11:30, without pain,” the former patient says. “I went flying the following Tuesday. My flying buddy took a video of me, and I said, “I know who I'm going to send that to!”

It celebrated the end of an old problem, thanks to a new solution.

Mr. Brower spent just a single night in the hospital, most of that pacing back and forth, back and forth, apologizing to the nurse who had to be in attendance, but eager to test his new free-from-pain body and prove it all real and lasting. If the nurses were, in Dr. Gleiber's words, “kind of shocked themselves” by Mr. Brower's immediate mobility, that was understandable, since many medical professionals are still unaware of the technological advances that allow it.

(<http://mpb.floridaweekly.com/node/41359>) Dr. Michael Gleiber, left, performed the minimally invasive spine surgery on Charlie Brower.

“After early morning surgery, a person can walk 5,000 feet by noon,” the doctor says, repeating instructions he would jot on a patient's medical chart. “At first, physical therapists would call me and ask if I'd made a mistake in the protocol.”

He had not. Minimally invasive spine surgery (known as MISS) uses advancements in technology to pinpoint a problem area — a herniated disc or, as in Mr. Brower's case, spinal stenosis — so that just a small incision is needed.

(<http://mpb.floridaweekly.com/node/41360>) This image is of a normal spine with no stenosis centrally or by where the nerves exit.

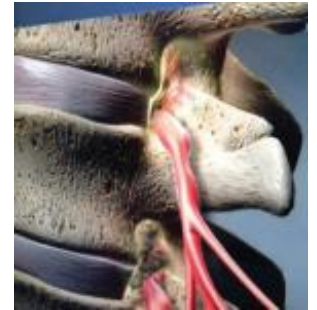
A nasty condition, spinal stenosis. But let the doctor demonstrate what it involves. Two strides and he's across the examining room, cradling a model of the lumbar region, the five spiny vertebrae that support the weight of the upper body. Stenosis is a narrowing of the



spinal canal, that encases and protects the spinal cord — here, this vertical hollow, where he’s poking his index finger, see? And, sometimes, over here, too, where it can narrow the foramina, the openings along either side of the vertebrae, through which nerves branch out from the spinal cord to the rest of the body. Charlie Brower suffered from both.

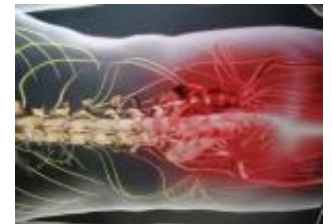
(<http://mpb.floridaweekly.com/node/41361>) Dr. Gleiber bends the model into arched-back posture, an arch that causes an “ouch” because it narrows the spinal canal, pinching the nerves. Then he bends the model forward, into a leaningover posture, to show how that opens the canal, providing a brief respite from pressure that can trigger paralysis, loss of motor control, pain extreme enough to make stars bloom before one’s eyes.

That bowed-forward position — “Shopping Cart Syndrome,” in pain-management lingo — often shows itself at the supermarket, the doctor says, where you’ll see people bent over, pushing a shopping cart, to relieve an aching back. Mr. Brower, a retired phone company cable-maintenance technician, used to be one of them.



“When I took my mother to the store,” he says, “I was the one leaning on the cart. My mother is 91. It was getting hard to keep up with her, so I knew I had to do something.”

(<http://mpb.floridaweekly.com/node/41362>) LEFT: Pictorial of the pain from nerve impingement. ABOVE: Spinal stenosis where the nerves are coming out - foraminal stenosis. Essentially this picture shows what causes the buttock and leg pain commonly referred to as sciatica.



He knew it, but he’d gone years — hell, he’d gone decades — without knowledge leading to serious action. He’d tried wearing a girdle-like back support, which helped a little. He’d visited a chiropractor, which sometimes helped, sometimes hurt. He’d had a myelogram, a spinal-canal X-ray following the injection of dye. And he’d had CT scans, but submitting to back surgery had always seemed so radical, so last resort, so scary. Until the final-straw day, the day that propelled him past his reluctance to go under the knife. It happened in a flash: One minute, he’s in his garage, lifting a laundry basket off the washing machine; the next, he’s down on the floor. “It’s hard to describe,” he says. “I didn’t have any control.”

Dr. Gleiber nods. That sudden loss of strength in the legs is not uncommon. But spinal stenosis isn’t a “one-size-fits all” condition. For some, it causes a burning sensation in the buttocks that brings them to their knees, literally and figuratively; for others, it’s strictly pain.

In January, Charlie Brower’s pain got really bad, a 10 on the 1-to-10 scale, and he began a computer search for a surgeon, zeroing in on Dr. Gleiber, whose online patient reviews impressed him. An unsolicited second opinion came from an acquaintance who, he says, “saw me hobbling around the parking lot at Publix” and recommended his own surgeon: Dr. Gleiber. For the first time, Mr. Brower began to nurse the hope of being pain-free.

Traditional spine surgery requires a five- or six-inch incision, followed by the slicing-through or retraction — moving aside — of muscles surrounding the spine and the risk of damage to normal tissue. It can lead to hospital stays of five or more days and, according to the American Association of Neurological Surgeons (AANS), “prolonged pain and recovery periods, the need for postoperative narcotic use, significant operative blood loss and risk of tissue infection.”

Dr. Gleiber proposed an entirely different approach.

“What we did with Charlie is, first, we brought him in and listened to him, his clinical symptoms,” Dr. Gleiber says. “A diagnosis should never be made on the basis of an MRI or an X-ray alone. If an MRI showed stenosis but if the symptoms were manageable, we wouldn’t propose surgery.”

“There’s a major problem: Companies go out and give seminars across the country and market themselves. They’ll have stations where you can bring your MRI and doctors or nurses will tell you whether you’re a candidate for surgery. They’re taking advantage of patients in one of their most desperate times of need. What upsets me the most is the snake oil. You can never make a diagnosis for surgery just from an MRI. It’s a confirmatory tool.”

Charlie Brower’s MRI and X-rays confirmed a narrowing of the spinal canal at specific vertebrae: Lumbar 4, 5 and the

sacrum, the large triangular bone at the base of the spine, as well as arthritic build up in the channels through which nerves threaded. In lay terms, his back was a mess.

“I looked Charlie in the eye,” recalls Dr. Gleiber, “and I said, ‘This is curable, this is fixable.’”

“He actually said, ‘I can fix you.’” Mr. Brower amends. “I’m talking to him for a full hour or so.”

The surgery, called a laminectomy, utilized magnification to see inside the two-inch incision and precisely locate the lamina — the top portion of the vertebra — for removal, widening the spinal canal and creating more space for the spinal nerves. A foraminotomy removed arthritic debris from the foramina, those small pockets on either side of the vertebrae. For Mr. Brower’s operation, Dr. Gleiber wore surgical loupes, like minimicroscopes, over his eyes and a strong headlamp strapped to his forehead.

The first minimally invasive spine surgery was performed in the early 1980s, according to the American Association of Neurological Surgeons, “to treat disorders of the spine with less disruption to the muscles. This can result in quicker recovery, decrease operative blood loss, and speed patient return to normal function.” Significant advances in the field are far more recent – recent enough that they weren’t a focus when Dr. Gleiber was in training at Columbia University Medical Center. He knew about it, though, and moved to Louisville, Ky., to attend the prestigious Kenton D. Leatherman Spine Surgery Institute.

The AANS estimates that some 400,000 Americans, most of them 60 or older, may be suffering with lumbar spinal stenosis, and as many as 1.2 million with back and leg pain related to any type of spinal stenosis. †