

Back to Life

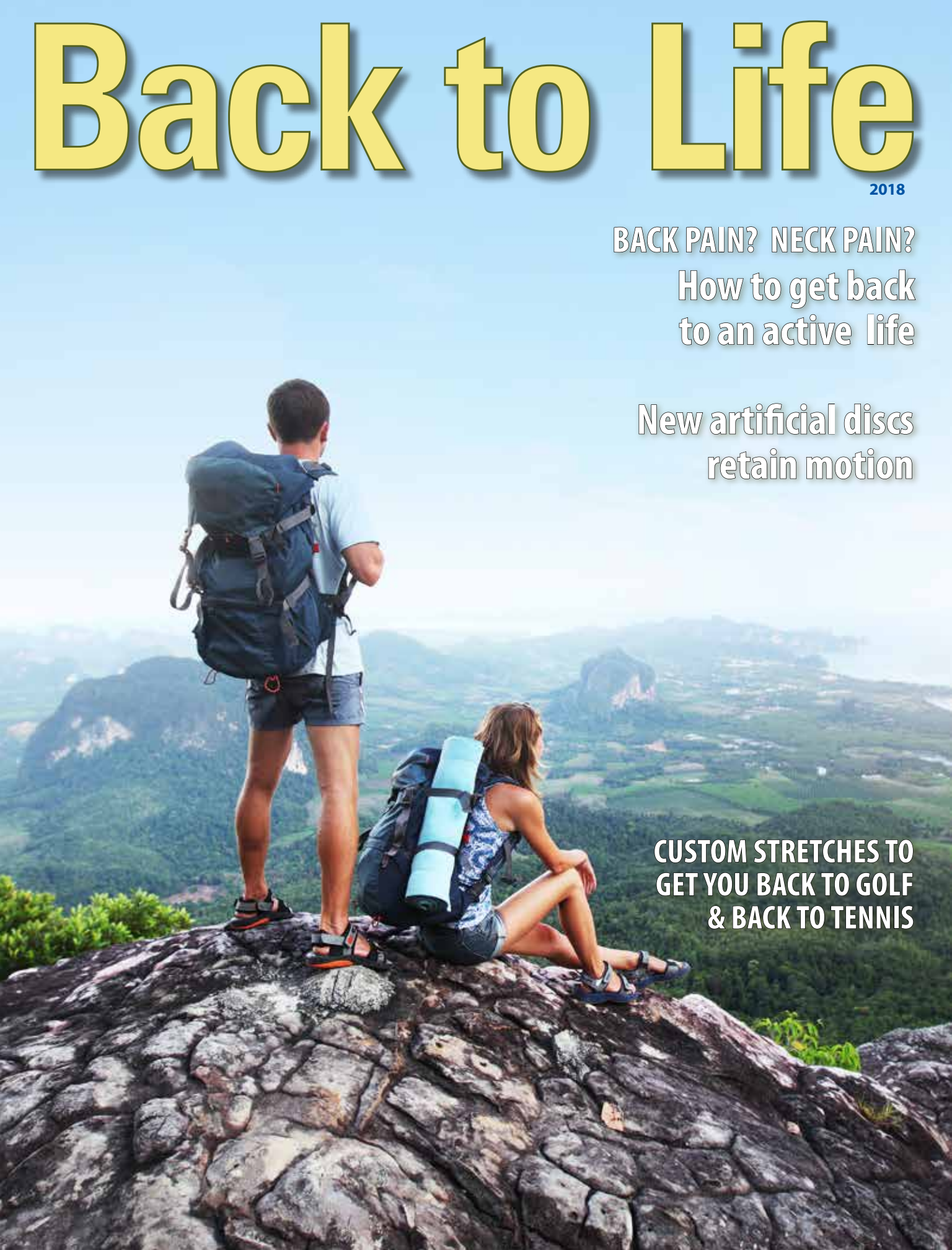
2018

BACK PAIN? NECK PAIN?

How to get back
to an active life

New artificial discs
retain motion

CUSTOM STRETCHES TO
GET YOU BACK TO GOLF
& BACK TO TENNIS





GET THE Rx FOR ROTATION IN RECREATION

Why is that all of the fun outdoor sports place extra strain on the back? The reality is that tennis and golf are perhaps the two most demanding “rotational” sports. Both sports require the core of the body to rotate, often in a bent over posture.

For someone recovering from a back strain, it can be a challenge to get back on the tennis court or golf course. “The key is stretching and making the back stronger, more flexible and resistant to a future strain,” says Dr. Adebukola Onibokun, MD, a spine neurosurgeon at San Jose Neurospine. “The reason you had a back pain attack in the first place may have been that your back was not flexible enough. To get back to some

your favorite recreational activities you’ll need to improve your back’s ability to handle rotation. Secondly, phase back into the sport. With golf, kick the ball out of deep rough. With tennis, start back with doubles rather than singles.”

Here are some rotational exercises to help get you back outside and into your favorite recreational activity.

“If surgery ultimately is necessary, get informed about the latest artificial discs that retain the rotary motion of the spine,” Dr. Onibokun adds.



DOUBLE KNEE TO FLOOR:
Start with your knees together pointed up. Next slowly let both knees fall to the left toward the floor. Hold for 5 seconds. Return to starting position and rotate to the right.



PIRIFORMIS STRETCH:
This is a great back stretch. With arms spread out against the floor, bring your right knee up and across your body toward the floor as shown. Hold for 5 seconds, return to start, and then move your left knee over to the right.



STANDING SIDE STRETCH:
With your hands above your head as shown, slowly lean to the right and hold for 5 seconds, then return to upright position. Repeat to the left side.



ADVANCED STRETCH:
On all fours on the floor, raise and outstretch your right arm while extending your left leg backward. Hold for 5 seconds. Return to start and reach out with the left arm, and extend the right leg backward.



ROTATION STRETCH:
Put a golf club or racquet behind your back as shown. Rotate your upper body to the right as far as you can go without discomfort. Then repeat with a rotation to the left. Give yourself several weeks to improve your flexibility.

PATIENT SUCCESS STORY: BACK TO GOLF AFTER YEARS OF BACK PAIN

William was an avid golfer, but suffered with back pain for many years. After multiple spinal injections failed to alleviate his pain symptoms, William was referred to Dr. Onibokun at San Jose Neurospine. Following minimally invasive spine surgery, William is back on the golf course and walking five miles a day. His full video story is online at SanJoseNeurospine.com.

THE ARTIFICIAL DISC: NEW HOPE FOR THOSE WITH HERNIATED DISCS

While most back or neck pain is caused by either a muscle or ligament strain, which never requires surgery, some people can herniate a disc which can require spine surgery to relieve the symptoms. In some cases, the presence of a herniated disc can imply that the patient is at risk of degenerative disc disease, meaning that they may experience herniations at other levels as well.

Consequently, those who have a herniated disc at one level in their low back or neck, can sometimes have additional herniated discs appear in the future. For these people, the newest FDA-approved artificial discs available in 2017 can be of great benefit.

The role of the healthy disc

A healthy disc acts like a shock absorber in between the bony vertebrae of the spine, enabling the spine to rotate. The disc itself resembles a jelly donut. If the disc is compressed or ruptures (from trauma or the stress of lifting something heavy) the jelly center, called the nucleus pulposus, can break through the wall of the disc.

This disc nucleus can then press on nearby spinal nerves causing radiating pain and numbness. Herniated discs in the low back typically cause radiating pain or numbness or weakness in a leg or foot. Herniated discs in the neck conversely cause radiating pain or numbness or weakness into an arm or hand.

While a person can use watchful waiting for three to six months for radiating pain into a leg or arm, that is not the case when the symptom is numbness or weakness in a leg or arm. This symptom is called “neurological deficit” and signals that the herniated

disc is pressing on a nerve root off the spinal cord.

Those with symptoms of numbness or weakness in a leg or arm need to be seen by a spine surgeon within 48 hours. Left untreated these symptoms can become permanent and lifelong. Another emergency symptom that appears less frequently is called cauda equina, where the person experiences loss of control of bowel or bladder because of a herniated disc in the low back.

With these symptoms, the nerve root can be permanently damaged by the pressure on the nerve root, much like a car parked in the driveway on a garden hose. Even if the car is moved, the hose may be permanently crimped.

Fixing a herniated disc

When a disc herniates, it’s important to understand that the surgeon cannot repair the disc wall. The surgeon instead removes the part of the disc that is pressing on a nearby nerve root. If the disc has been compressed, the surgeon

must restore the disc space between the vertebrae by inserting a spacer between the two vertebrae.

The spacer could be a piece of bone harvested from the patient’s own hip bone, or a sterilized piece of cadaver bone from a bone bank. The process of removing the damaged disc and inserting the bone spacer is called a spinal fusion.

Each year in the U.S., more than 200,000 spinal fusion surgeries are performed to relieve pain or numbness caused by damaged discs in the low back and neck.

While the intent of a spinal fusion is to relieve the symptoms of pain or numbness, the downside of spinal fusion surgery is that it causes two vertebrae to become locked in place. This in turn puts additional stress on discs above and below the affected area, which can lead to further disc herniation with the discs

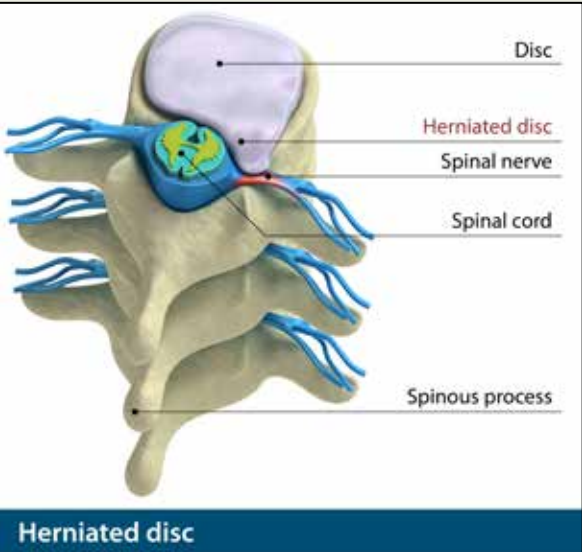


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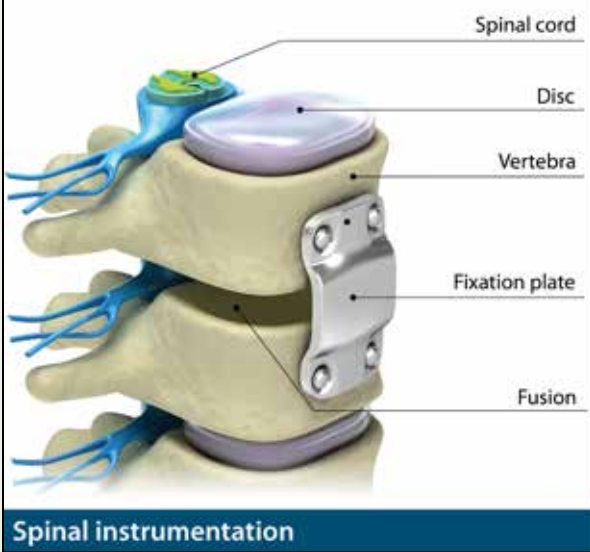
The benefit of an artificial disc is that it retains the natural rotation of the vertebrae in the neck, which would otherwise be locked together in a traditional spine fusion surgery. By preserving motion, this lessens the risk that other adjacent discs might herniate as well.

The problem with fusion & instrumentation

Surgery to relieve the symptoms of a herniated disc involves removing some or all of the damaged disc. But something has to be inserted between the two vertebrae in the place of the disc tissue that is removed. For the majority of patients a spinal fusion is the typical surgery. A piece of bone is inserted and often a fixation plate holds the fusion in position. However, this is less than ideal in that two vertebrae are then locked together, which can stress other discs above and below. The artificial disc, conversely, is designed to retain natural motion.



Herniated disc



Spinal instrumentation

above and below the damaged disc. This process is called “adjacent segment disease” and it’s one of the main issues that artificial discs were designed.

How an artificial disc works

An artificial disc replacement is intended to duplicate the rotation of a normal, healthy disc and retain motion in the spine, which lessens the risk of herniation at the other disc levels. Artificial discs have been used in Europe since 1987. Because of the FDA’s approval process, artificial disc use in the U.S. did not begin until 2004.

Future development of new artificial discs attempt to not only mimic and reproduce the function of the normal disc by providing rotational movement

but also up and down shock absorption. Other issues in artificial disc design try to take into account the possibility of revision and replacement surgery if an artificial disc wears out over 10 to 20 years.

Artificial discs for the low back

There is a big difference in the artificial discs used in the lumbar (low back) area, and the artificial discs used in the cervical (neck) area. Because of the weight of the body and the rotational stress that the trunk places on discs in the low back (lumbar) area, more stress is placed on artificial discs in the lumbar area than in the neck (cervical) area, which only supports the weight of the head.

A second issue relates to the ease of the artificial disc surgery and any

necessary revision surgery to replace a worn out artificial disc. Because the surgeon must access the front of the spine, an incision is made in the abdomen for lumbar discs. This can require navigating around internal organs to access the discs at the front of the spine in the low back.

Conversely, the surgeon can easily access the cervical discs through a small incision in the front of the neck.

Dr. Onibokun at San Jose Neurospine does not currently perform artificial disc surgery for the low back. Like many other spine surgeons, he believes the disc technology is still evolving and there is the issue of complex revision surgery for discs that wear out.

According to Dr. Onibokun not every patient is a candidate for an artificial disc, as the guidelines and indications are narrow. The spine surgeon evaluates each patient case, with selection criteria

relating to the disc level in the neck that needs replacement and the extent of the disc herniation.

Artificial disc surgery in the neck

There are a variety of FDA-approved artificial discs available for the neck. The Mobi-C disc is the first disc approved by the US Food and Drug Administration (FDA) for use at two levels in the neck. This can be of great benefit to those people with degenerative discs at more than one level in the neck and would otherwise need a fusion at the other level which in turn would restrict rotation.

The lifespan of an artificial disc

As with knee or hip joint replacement, surgeons try to postpone the implantation of an artificial joint until it is absolutely necessary so that you do not outlive your artificial joint, which may last from 15 to 20 years.

But unlike knee and hip replacement patients, who are typically in their 50s or 60s when arthritis can become common, many spine patients can benefit from artificial disc technology at a much younger age — in their 20s or 30s.

As with any artificial joint replacement, the earlier an artificial joint is implanted, the greater likelihood that it will need to be revised in the future because of normal wear and tear.

Secondly, not all disc herniations are suitable to be replaced by an artificial disc. As part of the medical exam and qualification process, Dr. Onibokun reviews the patient’s medical history, MRI films that show the location of the herniation, the extent of the herniation and the patient’s symptoms.

Spine surgery is evolving and holds great promise with innovation. It is important to remember that artificial disc technology is still evolving with new

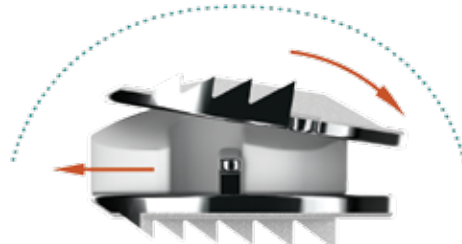
implants continually in development. Your spine surgeon is the best resource to discuss if it is appropriate for you, and what model of artificial disc is best suited for your case.

To see if you are a candidate for artificial disc replacement, or for a second opinion on spine surgery, call San Jose Neurospine at 408-377-3331 for a physician evaluation.

The person with a herniated disc in their neck needs to locate a spine surgeon who is trained and proficient in artificial disc technology. The Mobi-C artificial disc was the first disc to be approved by the FDA for two levels in the neck.



Mobi-C images © LDR Spine • All rights reserved



The Mobi-C artificial disc is designed to replicate the natural motion of the vertebrae in the neck. During surgery, the trained spine surgeon installs the disc through the front of the neck.



OPERATING THROUGH INSTRUMENTS THE WIDTH OF A BALLPOINT PEN

Spine surgery has evolved greatly over the last 10 years. The most advanced spine centers now embrace new minimally invasive technology — along with the time involved in training and the expense of the necessary instrumentation — as crucial to the spine surgery patient.

“Operating through a 1-inch incision can mean covering the area with a medium size Band-aid and enabling the patient to be home later that evening,” explains Dr. Adebukola Onibokun, a spine neurosurgeon at San Jose Neurospine.

With that said, there are some surgeons who are more comfortable doing traditional back and neck surgery through 3-inch long incisions because of the time involved to be trained in minimally invasive spine surgery.

The hospital stay is longer; there is the potential need for donated blood with the inherent risks of that; and a longer time in recovery along with more discomfort from the larger incision.

Consequently, a patient needs to be well informed about the options available to them and to select a surgeon who is able to use the new instrumentation involved with minimally invasive spine surgery. A



While it involves extensive training for a spine surgeon to become proficient in minimally invasive surgery, the main beneficiary is the patient, says Dr. Adebukola Onibokun, spine neurosurgeon at San Jose Neurospine.

patient should ask if a minimally invasive approach will be used, the length of the incision involved, and the length of time in recovery after surgery.

Compared to a 3-inch incision in traditional spine surgery, a surgeon performing minimally invasive spine surgery can access the spine through a small hole the size of a nickel to allow special tubular retractors and instrumentation to be inserted.

At the end of the instrument is a camera with a video feed to a TV screen, enabling the surgeon to view and enlarge the surgical area through the scope.

A minimally invasive tubular retractor (MITR) is used to gain access to the spinal column. The device goes through a small keyhole in the muscles of the back, reducing damage and disruption to the spine.

The portals are left in during the entire surgery to allow specially designed surgical tools to move freely into the patient’s spinal column. Consequently, there is far less disruption to the soft tissue in the back.

When the portal is removed at the end of the surgery, the surrounding soft tissues slowly fall back into their normal place and a small amount of stitches are needed to close the area.

The area can often be covered with a large Band-aid. By contrast, traditional open back surgery pulls the muscles away from the spine which disrupts the tissue causing more discomfort after surgery.

“While it takes a commitment from the spine surgeon to learn how to perform minimally invasive surgery there biggest

benefactor is the patient,” explains Dr. Onibokun. “No one wants to spend several days in the hospital if they could be home faster and back on the golf course quicker and with less pain.”

HOW IT WORKS

In traditional spine surgery, the surgeon makes a three inch incision to access the herniated disc, which can disrupt ligaments and tendons making recovery longer and more painful.

By contrast, a surgeon who is proficient in Minimally Invasive Surgery uses special tools called tubular retractors. A small half-inch incision is made and the tubular retractor is inserted through the skin and soft tissues to access the spinal column. The surgeon accesses the spine using instruments that fit through the center of the tube. Some surgeries require more than one retractor. The surgeon also uses fluoroscopy to display real-time x-ray images of the patient’s spine on a screen throughout the surgery.

HOW YOU BENEFIT

Benefits of minimally invasive spine surgery include:

- Smaller incision
- Smaller scar
- Home the same day
- Less damage to tissues
- Less pain after surgery
- Less blood loss
- Less pain in recovery
- Faster return to activity
- Less risk of complications from a larger incision and longer hospital stay



Instead of a large 3 inch incision, the trained spine surgeon operates through a half-inch incision with the aid of a narrow tubular retractor.

The surgeon visualizes the disc area through a microscope and a camera projects the disc area onto a large video display in the operating room, show above.

Minimally invasive spine surgery requires extensive training, which older surgeons may be reluctant to do, since they are more comfortable working through larger incisions over their career.

However, minimally invasive spine surgery holds significant benefits for the patient with less pain, less blood loss and a faster recovery. Many patients can go home the same day, instead of several days in the hospital.

MINIMALLY INVASIVE SURGERIES PERFORMED BY SAN JOSE NEUROSPINE

If nonsurgical treatment options fail to relieve symptoms, San Jose Neurospine emphasizes minimally invasive spine surgery that reduces the length of the incision, lessens disruption to muscles and tendons, allows a shorter time in the hospital (patients often go home the same day) and a faster and less painful recovery. While many surgeons may claim to use “minimally invasive techniques” in an effort to attract patients, sometimes the patient may end up with a traditional, open spine surgery. Dr. Onibokun is proficient in the following minimally invasive spine surgery techniques:

MIS Lumbar Microdiscectomy / Laminectomy

A minimally invasive lumbar discectomy is when a herniated disc is removed in the lower back that pinches a nerve that may cause severe leg pain, numbness, or weakness. This procedure is done by making a small 1-inch incision over the herniated disc and inserting a tubular retractor. Then the surgeon removes a small amount of the lamina bone that allows the surgeon to view the spinal nerve and disc. Once the surgeon can view the spinal nerve and disc, the surgeon will retract the nerve, remove the damaged disc, and replace it with bone graft material.

MIS Posterior Cervical Discectomy

A minimally invasive posterior cervical discectomy is when a herniated disc is removed in the back of the neck that pinches a nerve that may cause severe leg pain, numbness, or weakness. This

procedure is done by making a small 1-inch incision over the herniated disc and inserting a tubular retractor. Then the surgeon removes a small amount of the lamina bone that allows the surgeon to view the spinal nerve and disc. Once the surgeon can view the spinal nerve and disc, the surgeon will retract the nerve, remove the damaged disc, and replace it with bone graft material.

MIS Lumbar Fusion

A minimally invasive lumbar fusion can be performed the same way as traditional open lumbar fusion, either from the back, through the abdomen, or from the side.

Lateral interbody fusion (LIF)

A lateral interbody fusion, often used to treat spondylolysis, degenerative disc disease and herniated discs, is performed by removing a disc and

replacing it with a spacer that will fuse with the surrounding vertebra. The procedure is completed on the side of the body in order to reduce the effect on the nerves and muscle of the back.

Posteriorcervicalmicroforaminotomy (PCMF)

A PCMF is performed to help relieve pressure and discomfort in the spine by making a small incision in the back of the neck and removing excess scar tissue and bone graft material.

Anterior cervical discectomy

An anterior cervical discectomy is used to reduce pressure or discomfort in the neck by removing a herniated disc through a small incision in the front of the neck. The space is then filled with bone graft material and plates or screws may be used to increase stability.



Using new endoscopes with video cameras in the tip, a trained spine surgeon can perform spine surgery through tiny incisions that reduce blood loss, lessen time in the hospital and provide for a shorter and less painful recovery.

HOW DOES LASER SPINE SURGERY WORK?

Laser surgery involves the use of a precisely focused beam of light as a cutting tool. LASER stands for “Light Amplification by Stimulated Emission of Radiation.”

In industry, a powerful laser beam can actually cut through heavy metal.

In the medical field, lasers can similarly be used as a cutting tool with the heat and cauterizing characteristics playing a role with such things as laser hair removal.

In spine surgery the laser is sometimes used for removing tumors from the spinal cord, removing soft tissue around a nerve and shrinking disc material around a nerve. In the laser assisted microdiscectomy procedure, diseased or damaged discs are trimmed with the use of the laser.



In industry, the power of a laser is used to cut through heavy sheet metal.

“It is important to understand that the laser is not suitable for all spinal surgical procedures,” explains Dr. Onibokun.

He cites current research and position papers from spine societies that haven’t yet documented a patient benefit from the use of a laser in surgery.

According to a position paper authored by the North American Spine Society (NASS), the largest society of U.S. spine surgeons: “There are no high quality studies to support a recommendation for cervical or lumbar laser spine surgery. Though less blood loss was noted with the laser surgery, this was not associated with improved outcomes. To summarize, three systematic reviews found no clear evidence to benefit lumbar laser spine

surgery. Three case-control studies were found, the Tassi (2006) study, the Lee et al. (1996) study, and the Knight et al. study (2001), which used historical controls.”

Similarly the Cochrane Review, an authoritative source of medical research, concluded: “Laser Spine Surgery in the cervical or lumbar spine is not indicated at this time. Due to lack of high quality clinical trials concerning laser spine surgery with the cervical or lumbar spine, it cannot be endorsed as an adjunct to open, minimally invasive, or percutaneous surgical techniques.”

As one of the leaders in the development of minimally invasive spine surgery techniques, Dr. Onibokun is an advocate of new technology in the field of spine and performs most of his surgery through tiny incisions with the use of tubular retractors and advanced camera systems.

“Part of the issue that many spine surgeons consider, is that while a laser is perceived to be an advanced technology by the lay consumer, the laser itself does not provide the same 3 dimensional control as a cutting device in that it’s more difficult to control the depth of the incision with a laser beam. And when you are operating around the spinal cord, those concerns are significant. So in a sense, the vast majority of spine surgeons believe there is more marketing aspect to lasers right now than real patient benefit.”

The true advance in spinal surgery is minimally invasive spine surgery, according to Dr. Onibokun. “While surgeons might say they are doing minimally invasive spine surgery because they try to make a small 2-inch open incision, in truth there are relatively few centers that are doing spine surgery through tubular retractors and 1-inch long incisions,” Dr. Onibokun adds.

“To be proficient in minimally invasive surgery requires a very high level of training and experience. There is a big difference between operating through a 1/2-inch incision and operating through a 3-inch open incision. With the 1/2-inch incision you are visualizing the disc area through tubular retractors and seeing the surgical area on a video monitor. The safe execution of these procedures requires an immense level of hand eye coordination and microsurgical skill. One has to perform these procedures on a regular basis in order to achieve world-class proficiency.”

At San Jose Neurospine, Dr. Onibokun has performed over 2,000 successful minimally invasive spine surgery procedures. The spine center works closely with pain management specialists, physical medicine specialists and therapists in the region to emphasize non-surgical treatment options in advance of spine surgery.

SAN JOSE NEUROSPINE TREATMENT PHILOSOPHY

- We understand the negative impact chronic neck or lower back pain can have on quality of life.
- We are fully aware that these conditions cause a significant amount of suffering for our patients. We also understand the significant fear and anxiety most patients have about the prospects of having to undergo spinal surgery.
- We do NOT believe in conventional open spinal surgery techniques because they are too invasive and the recovery is too long and painful.
- We are STRONG believers in MIS Surgery Techniques and we possess world class expertise in this field.
- We believe that the results with MIS surgery are far superior to those with open spine surgery with less blood loss and quicker recovery.
- We believe the overwhelming majority of spinal conditions could be treated effectively through tiny incisions using endoscopic techniques.
- We believe in muscle and soft tissue sparing surgery techniques.
- We believe that patients recover much faster when MIS surgery techniques are employed as opposed to open surgical techniques.
- We believe in consistently maintaining an obsession with achieving the very best patient outcomes and our safety record is second to none nationwide.
- We believe in preserving spinal motion whenever possible through artificial disc technology.
- Our core purpose is to return our patients back to life and activity utilizing highly sophisticated and advanced minimally invasive surgical techniques. The surgery is only the means to the end.



UNDERSTANDING YOUR BACK OR NECK SYMPTOMS: WHEN YOU CAN USE WATCHFUL WAITING & WHEN YOU CANNOT

NOTE: A person may use “watchful waiting” for a few days for symptoms of muscle strain or even radiating pain into an arm or leg.
 + However, ANY WEAKNESS OR NUMBNESS in an arm or leg, or loss of control of bowel or bladder, are emergency symptoms. You need to see a spine specialist promptly (as noted below) to prevent the symptoms from becoming permanent.



PAIN LIMITED TO THE NECK:
 Neck pain can be caused by traumatic injury, like whiplash from a car accident, or muscle or ligament strain. See our Home Remedies section on our Internet site. If pain persists beyond a week, you should see a spine specialist to determine the underlying cause.

+ **LOSS OF BOWEL OR BLADDER CONTROL:** This is a SERIOUS emergency symptom (cauda equina) that needs to be treated immediately by a spine surgeon within 24 hours. If you experience these symptoms at night or on the weekend, go to the emergency room. If not treated quickly, the person may lose control over their bowel and bladder permanently.

RADIATING PAIN INTO THE LEG: Pain that radiates into a leg below the knee can imply a herniated disc in the low back. But many times radiating pain can be treated non-surgically. Radiating pain should be seen by a spine specialist within 2 weeks.

+ **NUMBNESS OR WEAKNESS IN LEG OR FOOT:** Numbness or weakness in the leg or foot is a SERIOUS disc-related symptom that is NOT appropriate for watchful waiting. Left untreated, the symptom can become permanent. You should see a spine specialist within 3 days.

+ **TRAUMA / FALL/ACCIDENT:**
 Any time you fall, are in a car accident, or could have fractured a bone in your back, you should see a spine specialist immediately!

+ **FOOT DROP / WEAKNESS IN FOOT:**
 If pain, weakness or numbness extends into the foot so that you are unable to lift your toe as you walk, that is called Foot Drop, which is an emergency disc-related symptom. You need a spine specialist within 48 hours. If not treated promptly, it could lead to permanent weakness in the foot.

+ **FEVER, DROWSINESS, SEVERE HEADACHE, NAUSEA, VOMITING, UNUSUAL SENSITIVITY TO LIGHT?**
 Other symptoms may be unrelated to a back or neck problem, like cervical meningitis. This can be serious. You should consult a physician immediately for any of the above symptoms.

RADIATING PAIN IN THE ARM: Pain that radiates into an arm below the elbow can imply a herniated disc in the neck. Many times, radiating pain can be treated non-surgically. Radiating pain should be seen by a spine specialist within 2 weeks.

+ **NUMBNESS OR WEAKNESS IN ARM OR HAND:** Numbness or weakness in the arm or hand is a more serious disc-related symptom that is NOT appropriate for watchful waiting. Left untreated, the symptom can become permanent. You should see a spine specialist within 3 days.

PAIN LIMITED TO THE LOW BACK: Pain that is limited to the low back may be the result of muscle strain. Although pain spasms can be excruciating, muscle strain problems do not require surgery. (See our Home Remedies section on our Internet site for special stretches that can relieve pain and the proper use of anti-inflammatories.) Though it is less common, a kidney stone or infection also may cause low back pain symptoms. You should consult a spine specialist for symptoms that persist beyond five days to determine the cause and the best treatment options, including a customized home exercise program that will make your back stronger, more flexible and resistant to future strain.

PATIENT SUCCESS STORIES



COLLEEN'S STORY ABOUT MINIMALLY INVASIVE SPINE SURGERY

“THE PAIN started with my right thigh and I had difficulty walking. Then there was tingling, numbness. It started when we were on vacation in Vancouver, Canada... I had to keep sitting down. Over the following months It steadily got worse until I had a breakdown at a grocery store. I ended up sitting on the floor in line. My doctor suggested that I see Dr. Onibokun. He is very confident man, and I was very emotional. He had a silent, strong confidence that I had hope.

“The procedure that I had was minimally invasive so it was just two incisions about an inch in length for each. Soon after surgery, I was walking up and down the hospital corridor without pain. I was going up these little stairs and going back down. I got this huge smile on my face. And the nurses were like, “Are you okay?” I said, ‘look at me!’

“It was a miracle, and my life was changed. It’s been seven months... now I can play with my grand kids... go to the park. My husband I can walk to downtown, we can go anywhere we want. I danced last month at my daughter’s wedding... it was just amazing!

“I can’t say enough about Dr. Onibokun or San Jose Neurospine. It changed my life.”



MATTHEW'S STORY ABOUT MINIMALLY INVASIVE SPINAL STENOSIS SURGERY

I’M A VERY ACTIVE person. I fly airplanes, enjoy climbing and walking. About 25 years ago I started developing a low back problem. I tried a lot of physical therapy, but it never provided any lasting relief.

“Several docs said I had spinal stenosis. But I was reluctant to have surgery. I asked Dr. Onibokun how he would be different from the other doctors I’ve seen. He pointed out that the other doctors were all very good. But that he was younger and had more current training and experience with minimally invasive surgery.

“So I had the surgery, and the next morning in the hospital they wanted me to get up and walk. So I walked up and down the corridors. I was ecstatic to how I was able to do this right after surgery.

“I asked Dr. Onibokun how long before I could drive again, and he said immediately. But he did want me to wait a month before flying.

“Slowly, steadily, the pain started to disappear completely until I had no pain at all.

“I have never in my life seen any doctor who was so patient, so concerned about his patient, and responsive. After the surgery, when I was home if I had a question, he would either answer then, or call me back personally within a matter of hours, and always the same day. I’m extremely pleased with what has happened.”



NANCY'S STORY ABOUT MINIMALLY INVASIVE POSTERIOR SPINAL FUSION

“FOR YEARS I had symptoms of tingling numbness. It got to the point where I was afraid when I put my foot down that I wouldn’t be able to feel the ground underneath me.

“As time went on, besides numbness, I also had a lot of pain. I could hardly stand up long enough to chop carrots for a salad. Even making dinner was getting difficult, much less going out and doing things. I couldn’t walk. I used to love to walk 3 to 4 miles a day.

“I was referred to Dr. Onibokun. The very first time I met him, I just felt so confident in him. He just is so calm and secure. I asked him how many surgeries like this had he done. He said probably about 2,000 and I was like ‘Oh you’re hired!’

“I had a Minimally Invasive Posterior Lumbar Fusion. The very next day they had me walking in the hall. Now I can shop, stand and do grocery shopping and not come home exhausted. It just changed my whole life. I can stand and talk to people that without looking around for a chair to sit down on. And I feel like I have new life. I’m so happy I made this decision.”



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SAN MATEO: 101 S. San Mateo Drive, Suite 301, San Mateo, CA 94401

APPOINTMENTS & REFERRALS: 408-377-3331

San Jose Neurospine specializes in the treatment of back and neck pain and other spine problems. Through its three offices in the Silicon Valley and South San Francisco region, the spine center works closely with pain management specialists, physiatrists, and spine therapists in the medical community to exhaust non-surgical treatment options before surgery. When spine surgery is necessary, San Jose Neurospine provides the most advanced minimally invasive spine surgery options and artificial disc replacement.



See our videos at:
SanJoseNeurospine.com/videos



SANJOSENEUROSPINE.COM

Second opinion & MRI review

Through a second opinion you may learn that there is a non-surgical treatment option, or a minimally invasive procedure, that can have you home the same day for a quick recovery. Call: 408-377-3331 or submit our second opinion form at SanJoseNeurospine.com.



Home Remedy Book

San Jose Neurospine believes the best healthcare quality comes from a well-informed health care consumer. As a community service, the spine center produces this educational Back to Life Journal, a free 36-page Home Remedy Book for those in the San Jose region and an online spine encyclopedia at SanJoseNeurospine.com. Patients can request the Home Remedy Book online at SanJoseNeurospine.com. The Internet site has symptom charts, home remedies for back problems, medical illustrations and video animations on spine conditions and surgeries.



Physician Profile

ADEBOKOLA ONIBOKUN, MD

*Board-certified Neurological Surgeon
 Specializing in minimally invasive spine surgery*

San Jose Neurospine includes the expertise of Adebokola Onibokun, MD, a board-certified neurological surgeon who specializes in minimally invasive spine surgery.

Dr. Onibokun (pronounced "Oh-knee-bow-kun") is Board Certified by the American Board of Neurological Surgery and is a fellow of the American Association of Neurological Surgeons. Before medical school, he was a Magna Cum Laude graduate of Iowa State University. He received his medical degree from the prestigious Northwestern University Medical School, graduating with honors. He then completed seven years of Neurosurgery Residency training at UCLA Medical Center, a program that consistently ranks as one of the top five neurosurgery programs in the country.

During his training at UCLA, Dr. Onibokun worked with the world's leading visionaries in the field of minimally invasive spinal surgery. As a direct result of this work, Dr. Onibokun co-authored one of the sentinel articles on the technique of minimally invasive pedicle screw fixation.

Dr. Onibokun has previously served as Chief of Neurosurgery at Elmhurst Memorial Hospital in the Chicago area, where he established their Minimally Invasive Spine Surgery program. Prior to relocating to California, he was a Health System Clinician at the Northwestern Medicine Regional practice. Over the course of his career he has performed more than 2,000 successful operations.

Dr. Onibokun specializes in minimally invasive surgical techniques, motion preserving spinal technologies (artificial disc replacement), endoscopic spinal fusion techniques, robotic computer assisted image guided surgery, complex spinal reconstruction, chiari decompression, transphenoidal surgery and microvascular decompression surgery.