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(54) **EXPANDABLE INTERVERTEBRAL IMPLANT FOR TREATMENT OF SCOLIOSIS**

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(58) **Field of Classification Search**

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See application file for complete search history.

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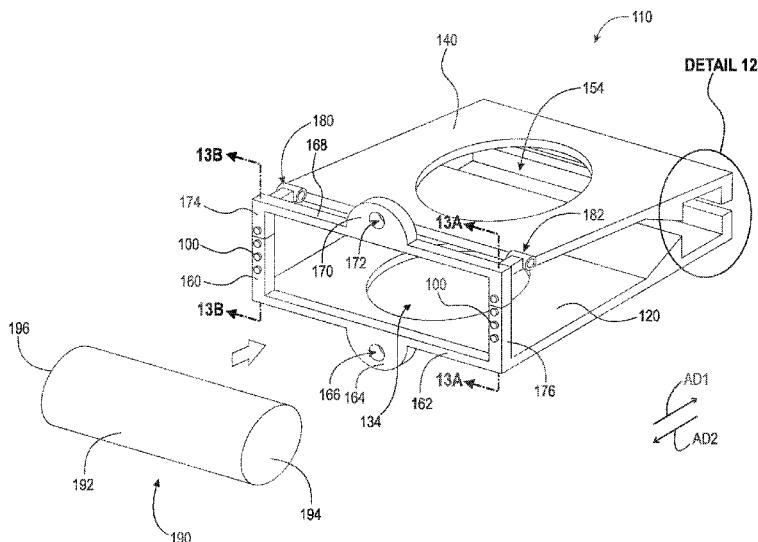
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(57) **ABSTRACT**

An expandable intervertebral implant, including a support component, an inferior component, including a first proximate end connected to the support component, a first distal end, a first top surface, and a first bottom surface, a superior component, including a second proximate end connected to the support component, a second distal end, a second top surface, and a second bottom surface, and a wedging component operatively arranged to be slid along the first top surface and the second bottom surface and expand the expandable intervertebral implant.

**15 Claims, 16 Drawing Sheets**



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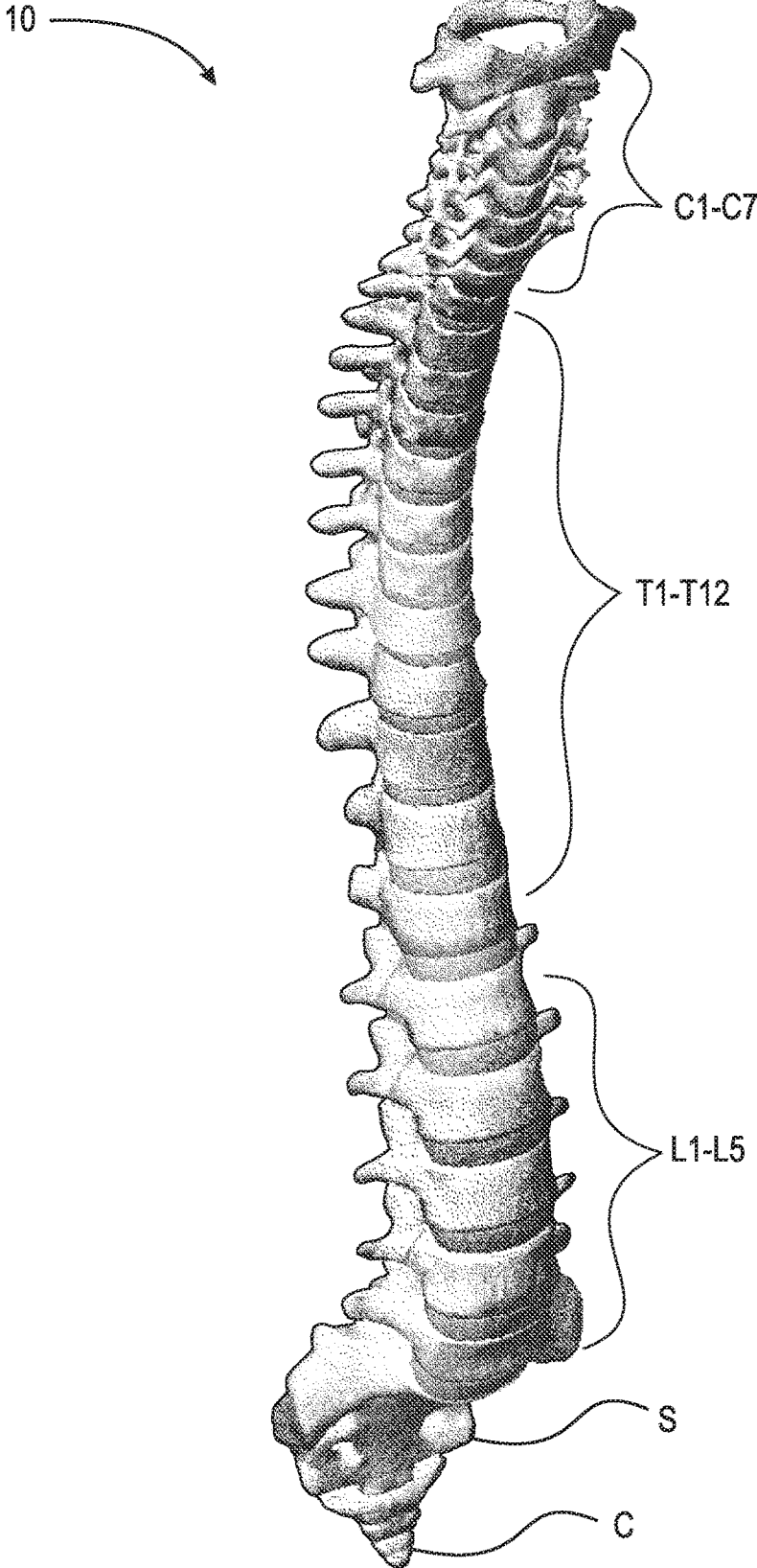


Fig. 1

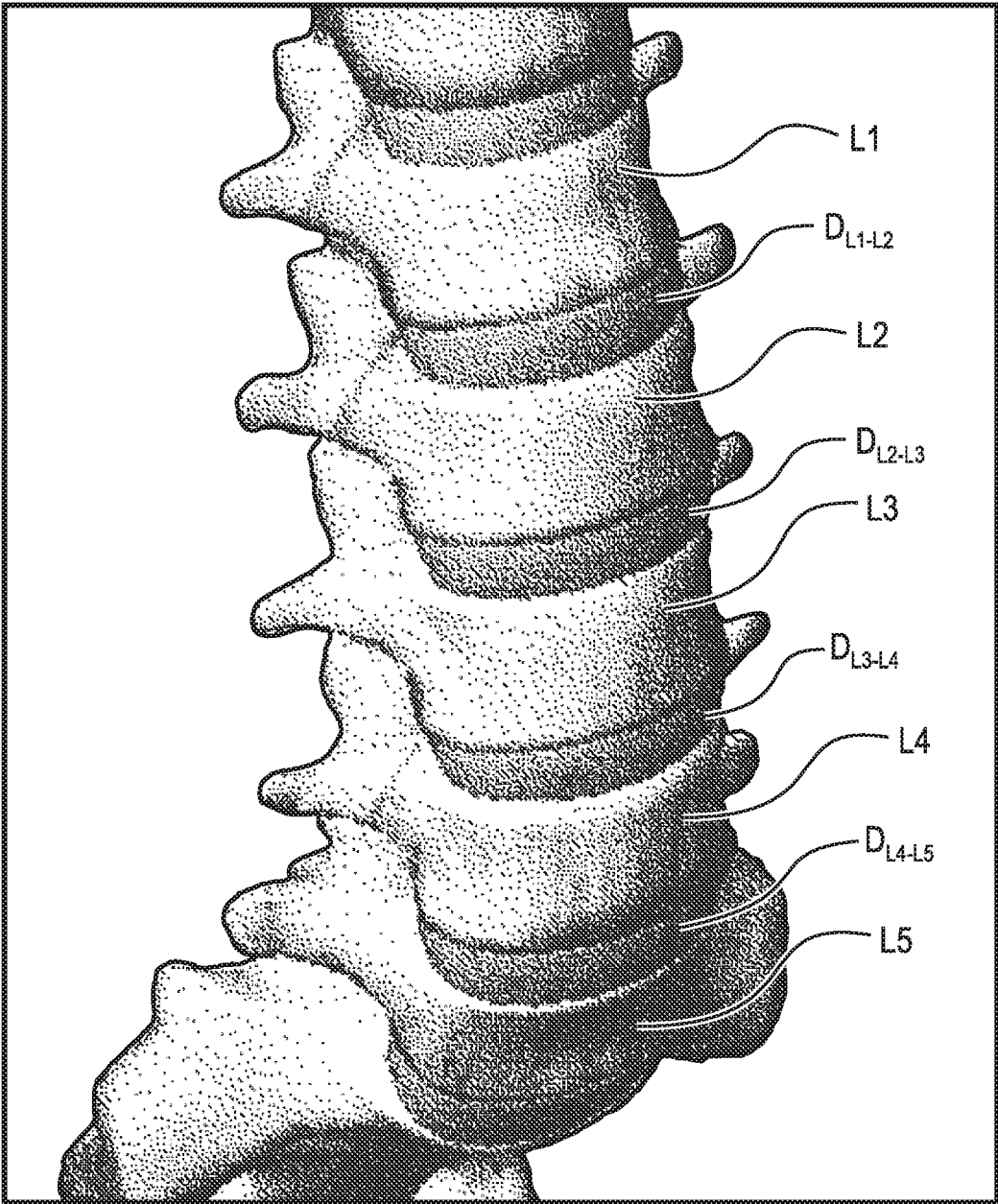


Fig. 2

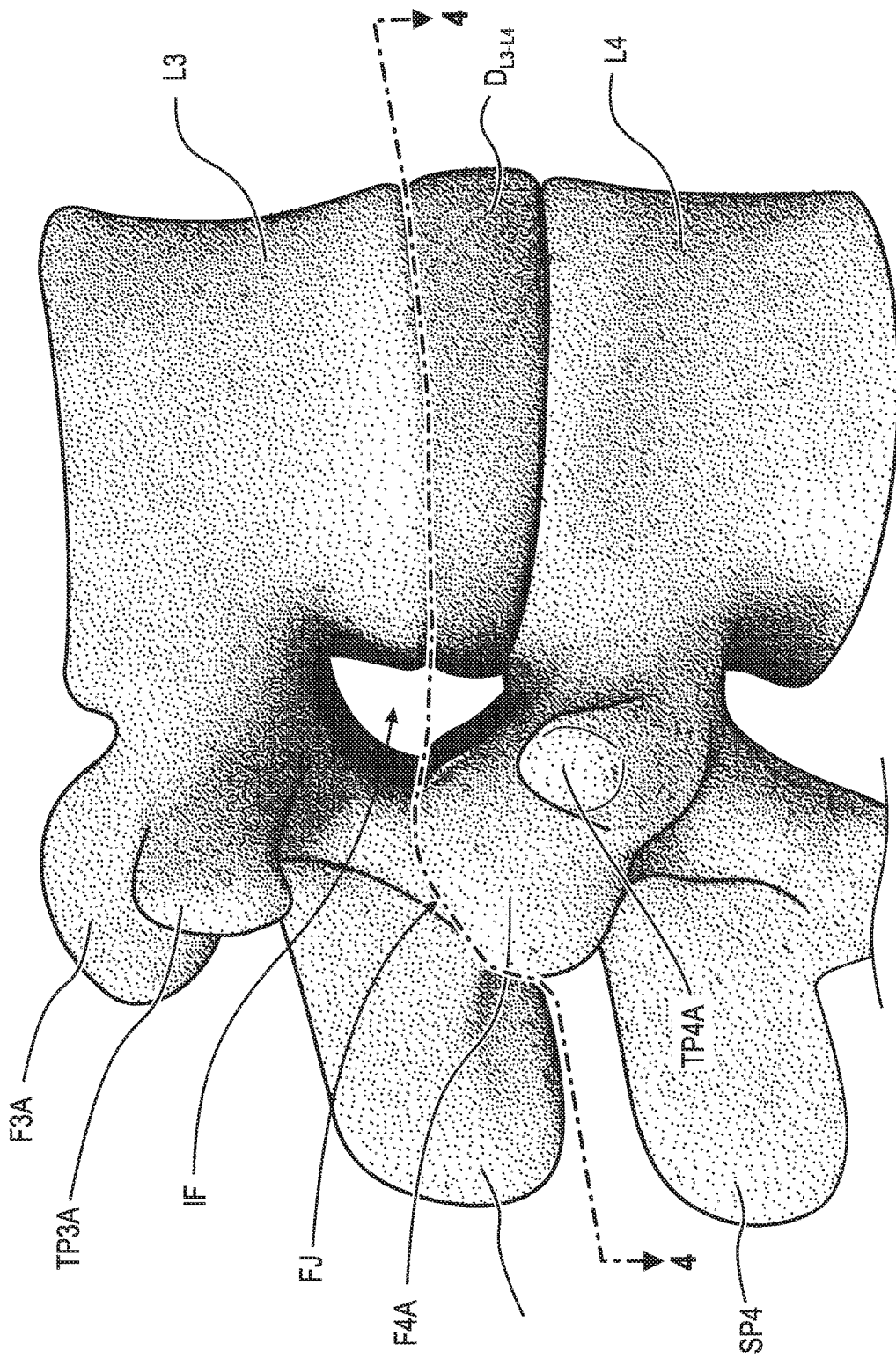


Fig. 3

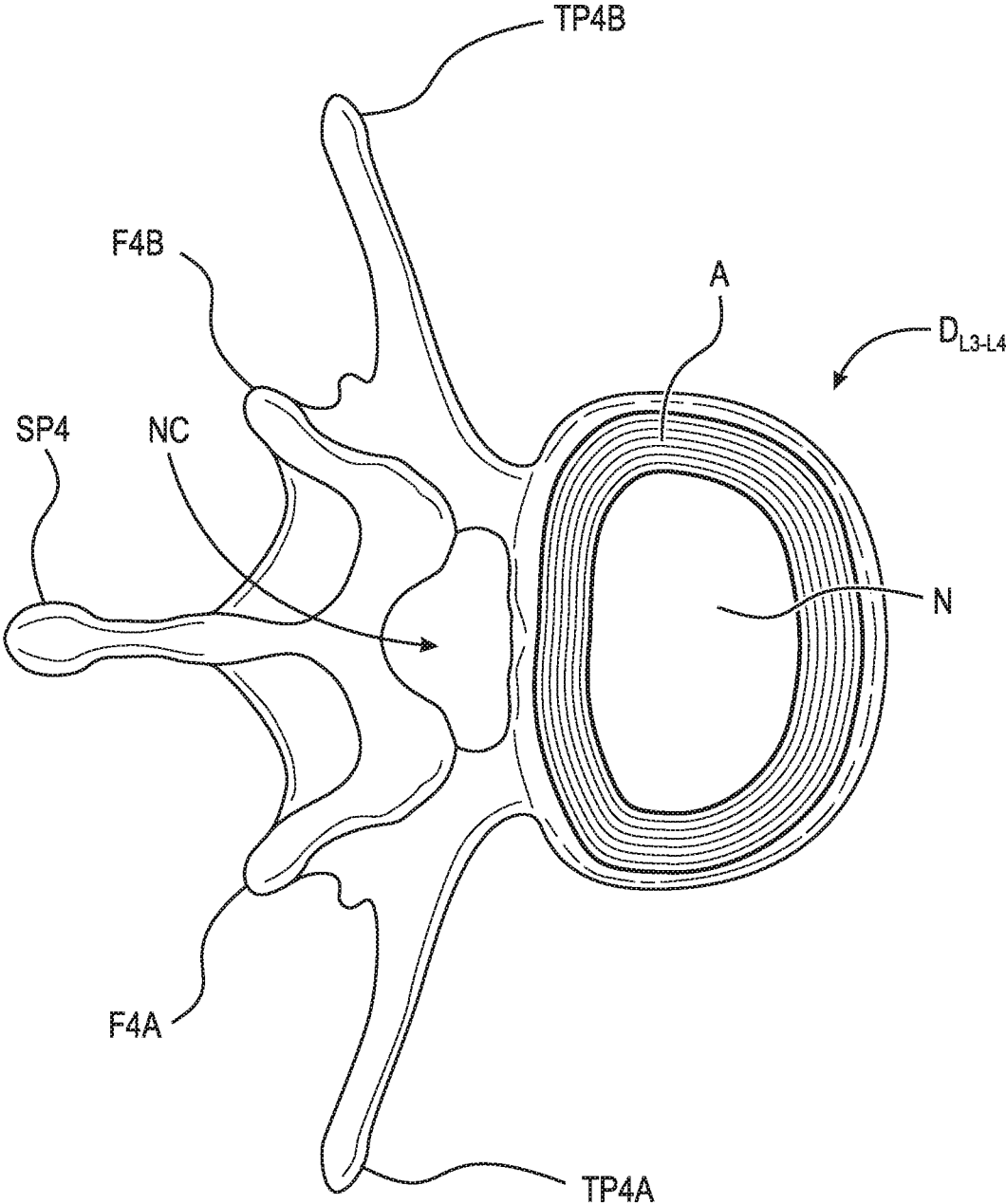


Fig. 4



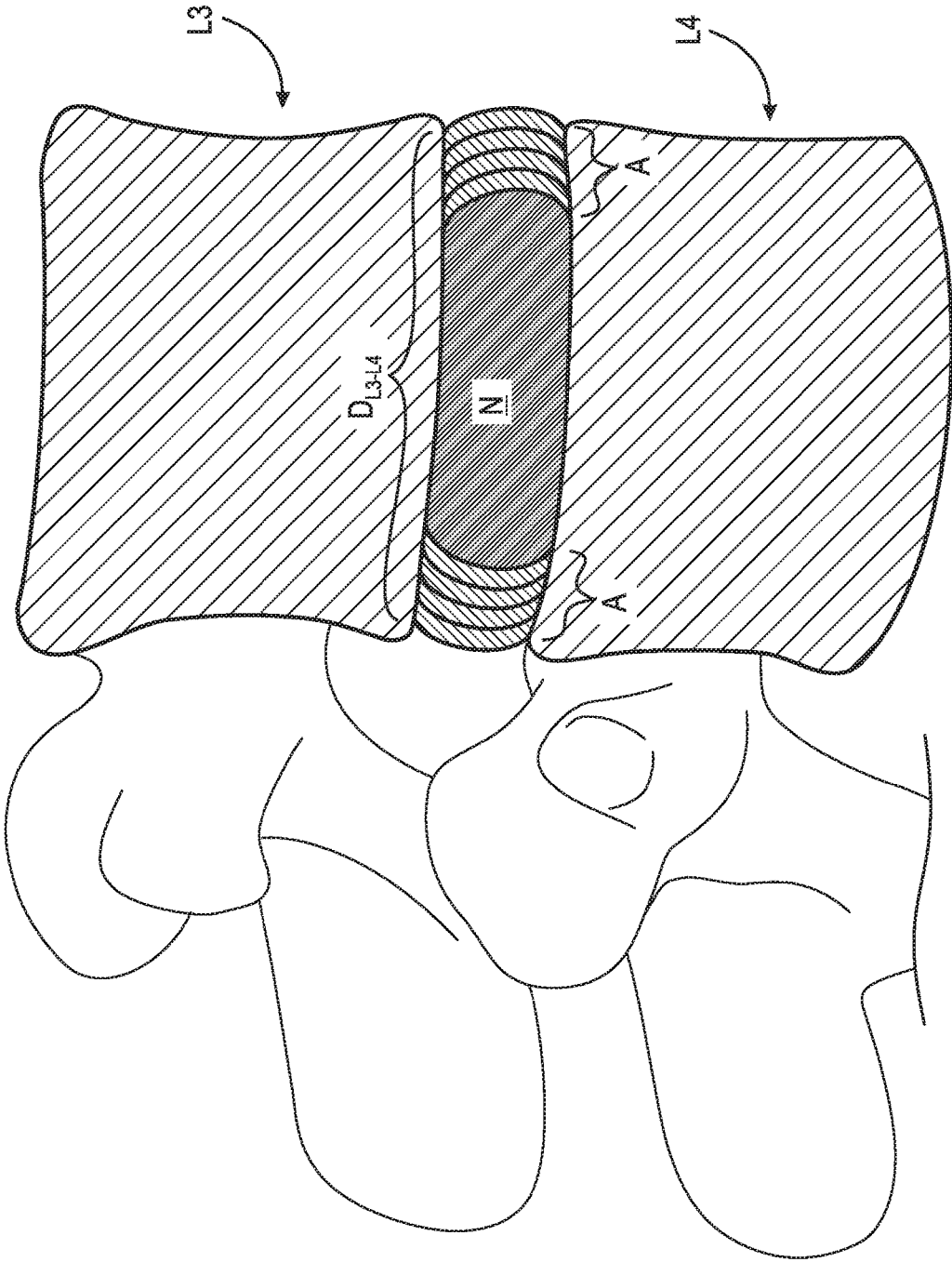
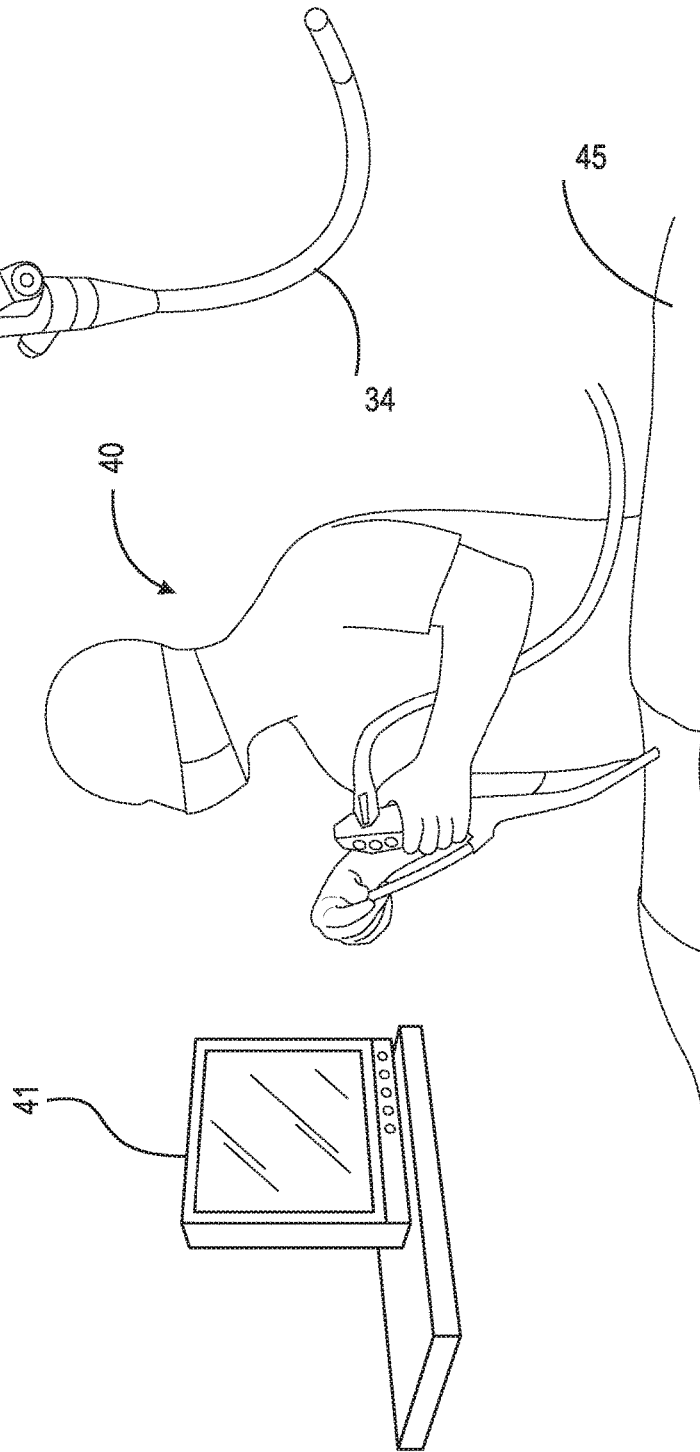
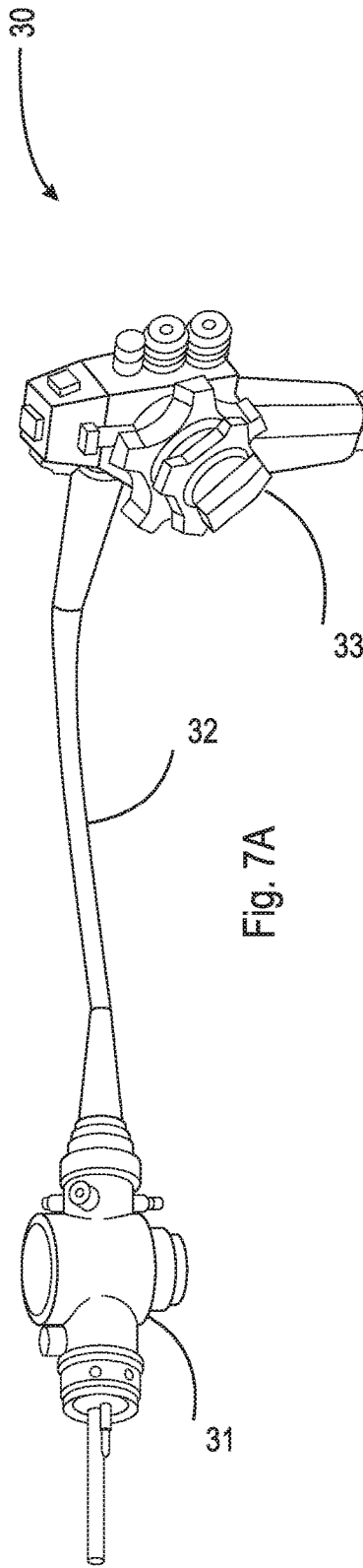


Fig. 6





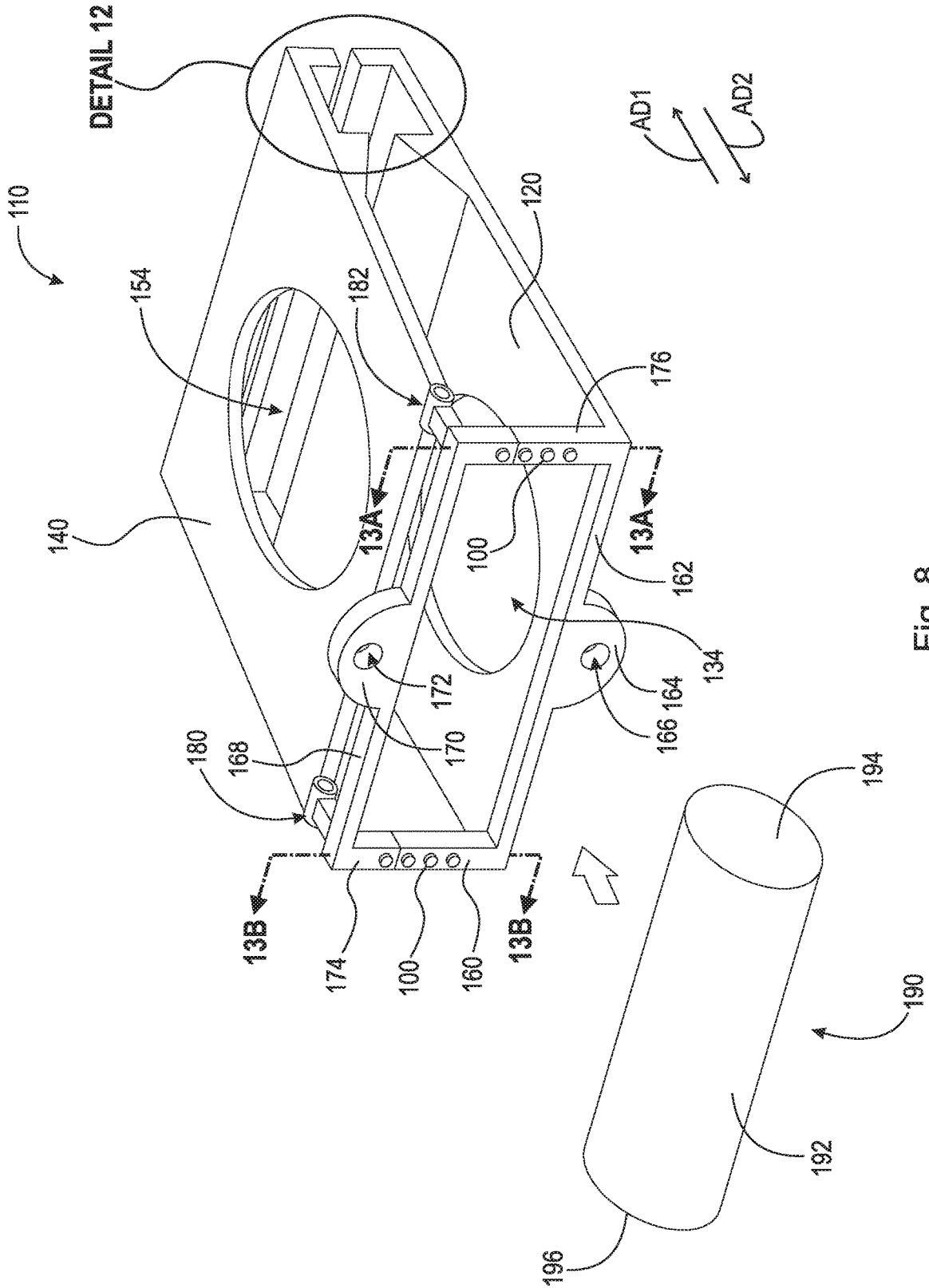


Fig. 8

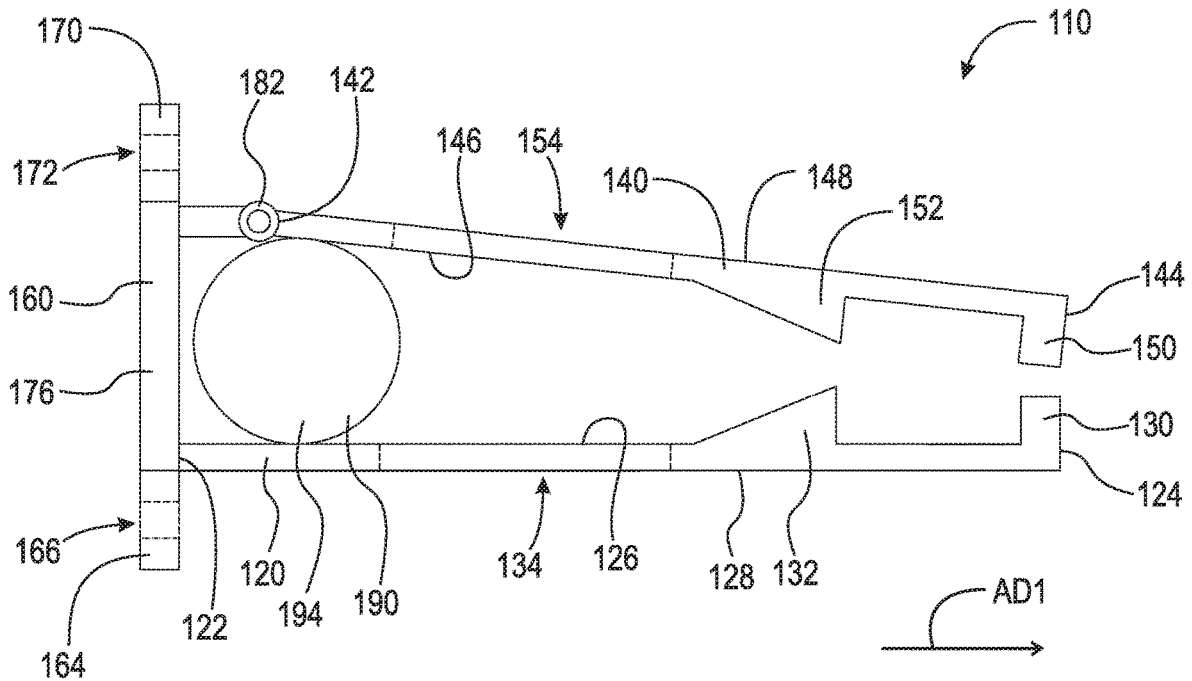


Fig. 9A

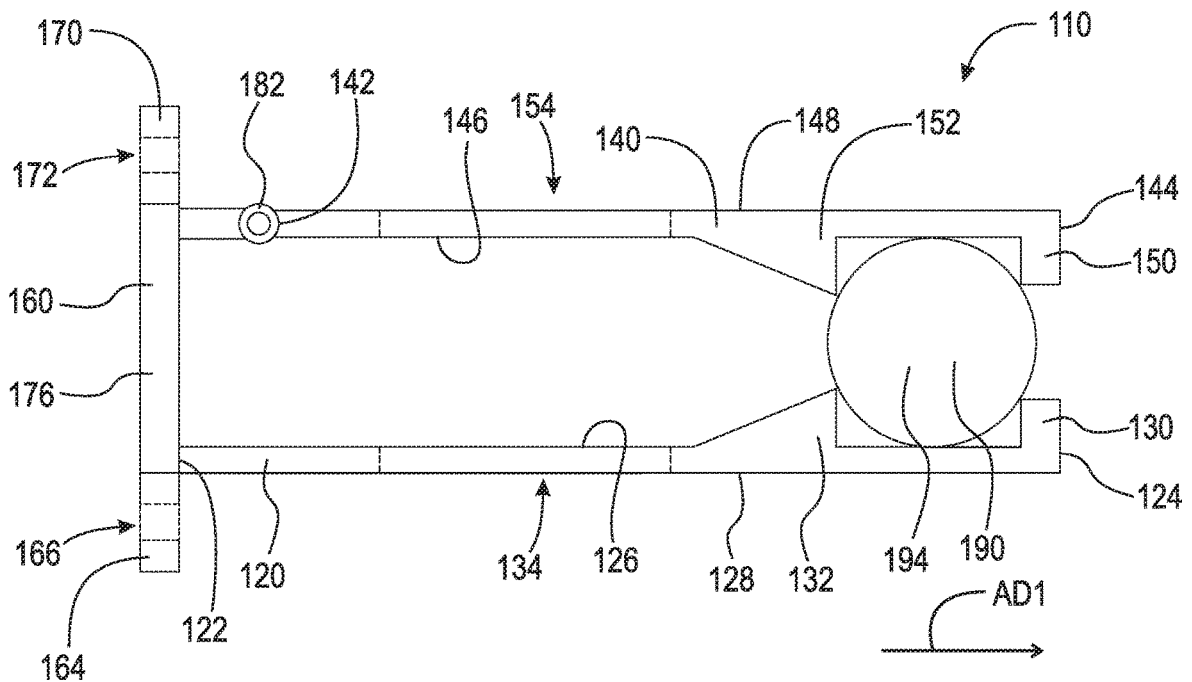


Fig. 9B

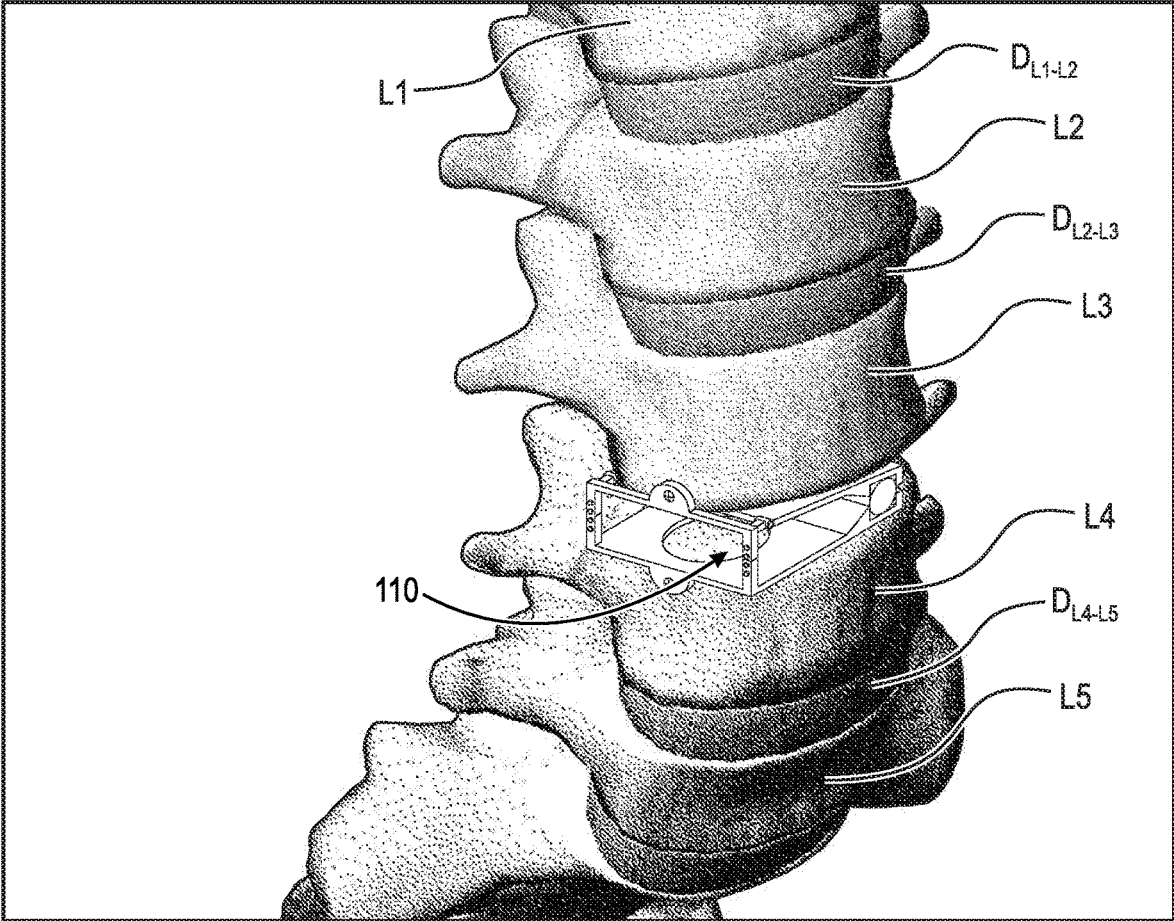


Fig. 10

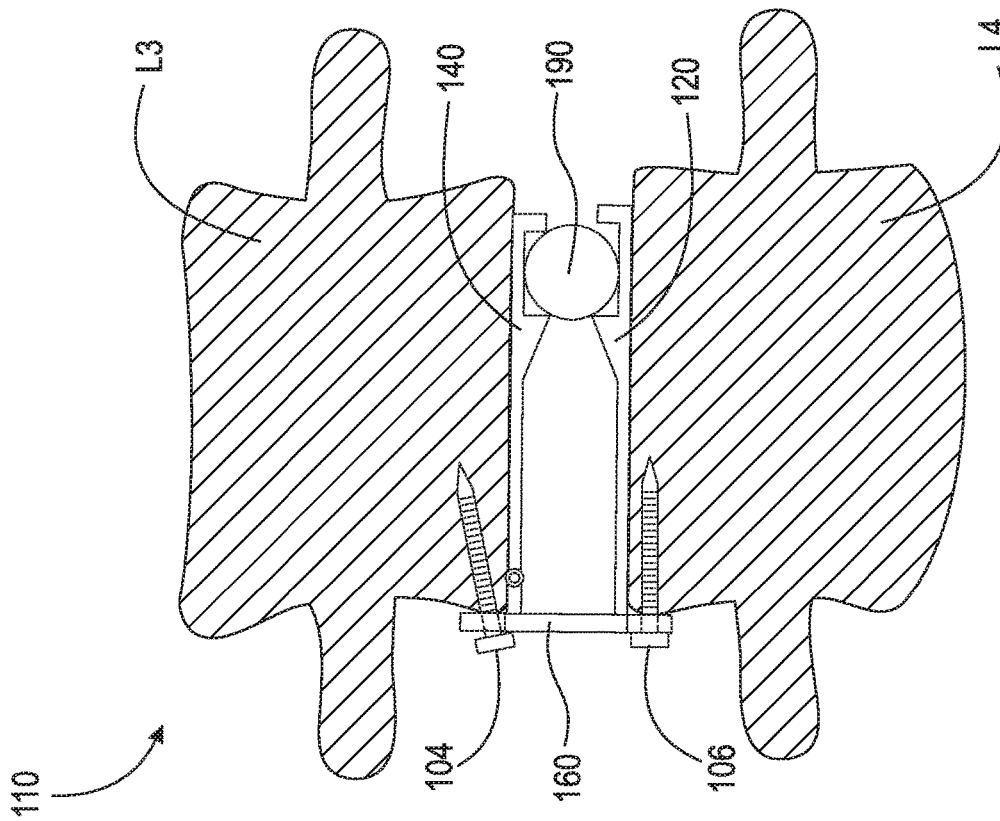


Fig. 11B

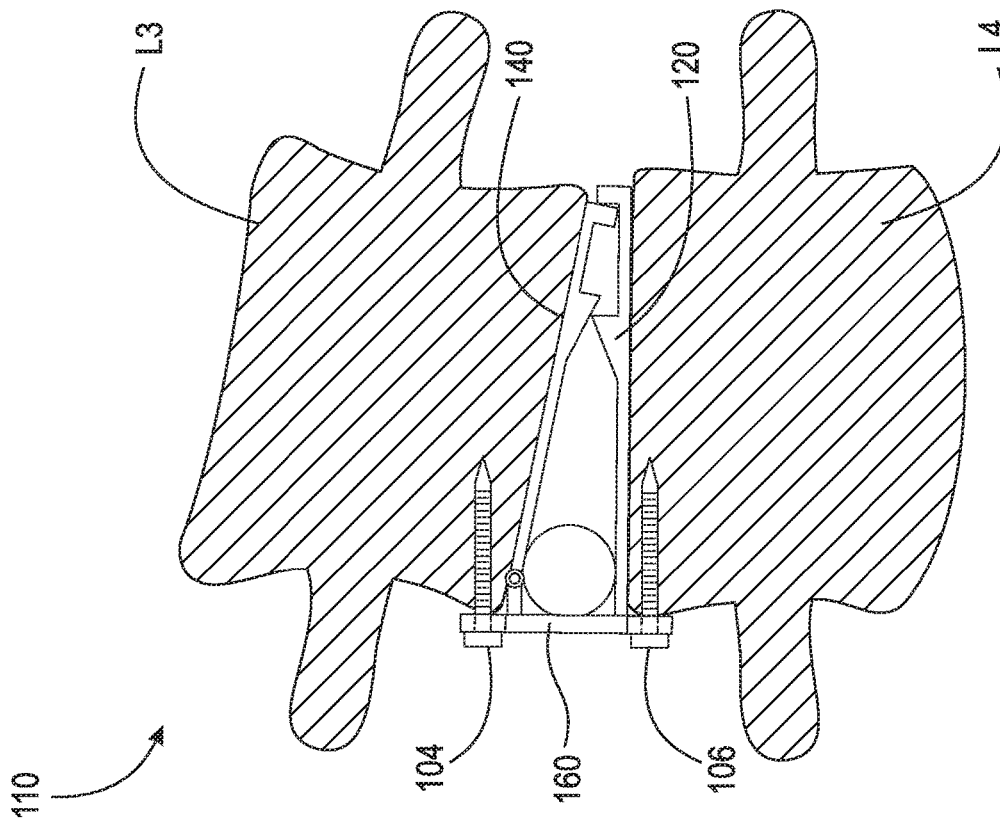


Fig. 11A

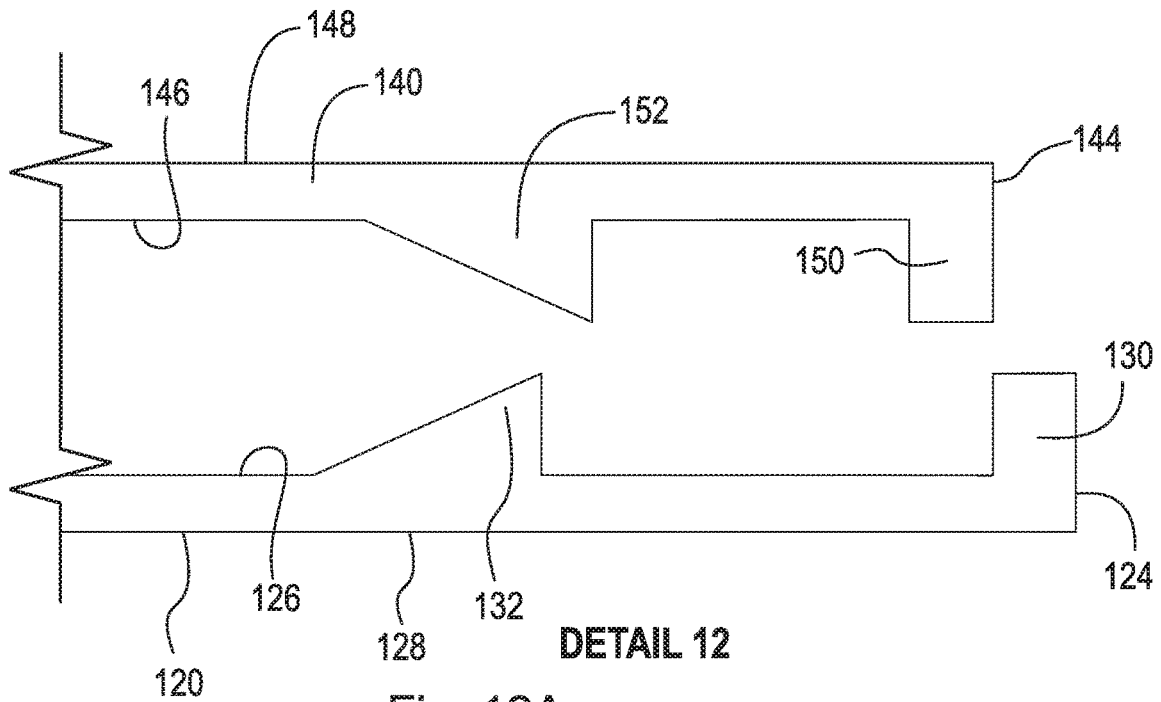


Fig. 12A

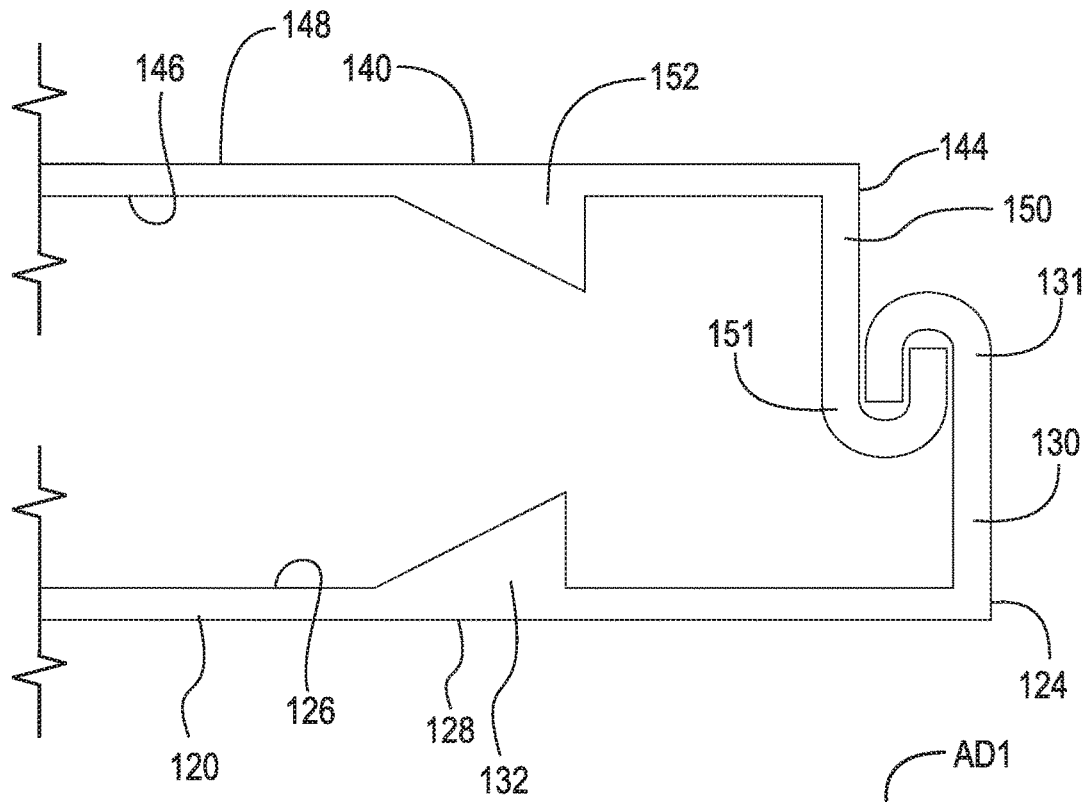
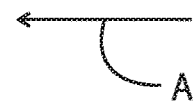
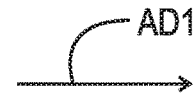


Fig. 12B



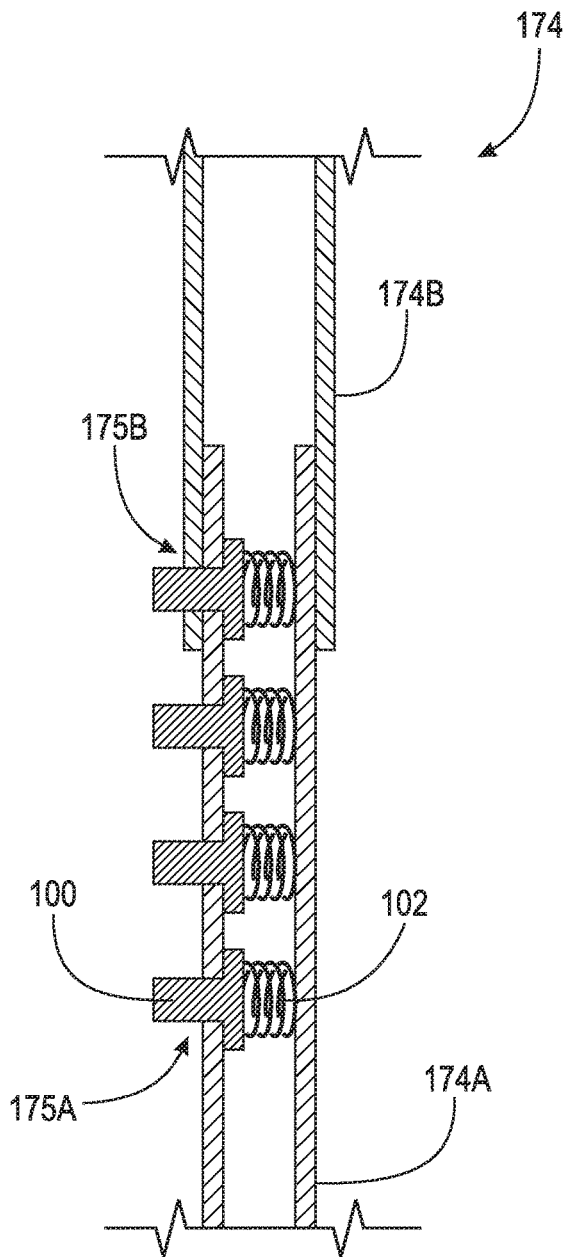


Fig. 13A

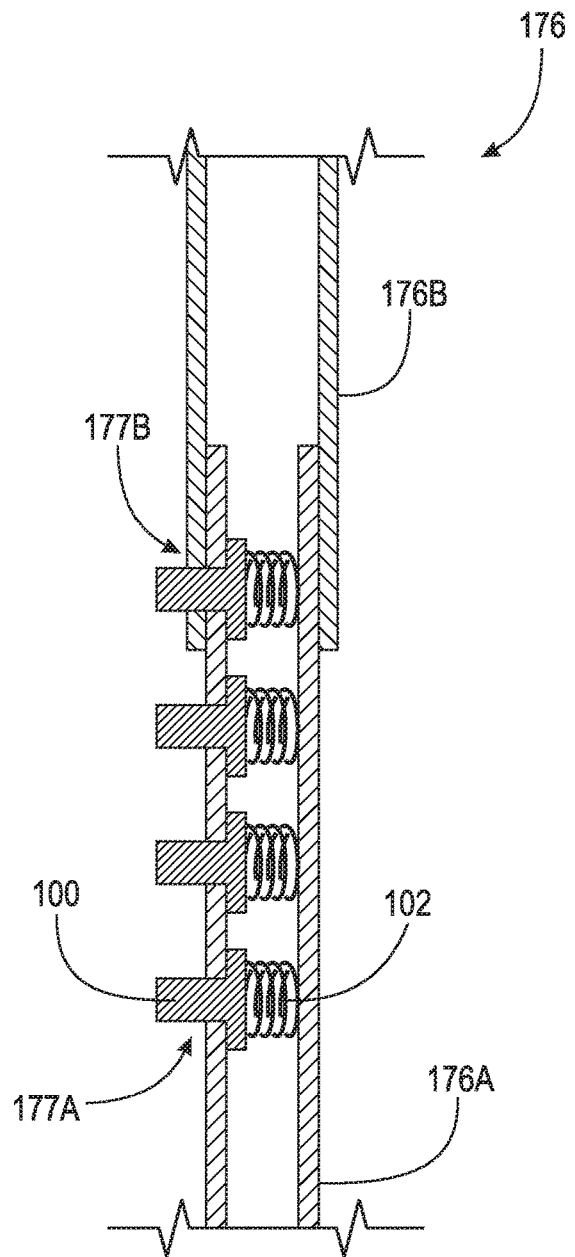


Fig. 13B

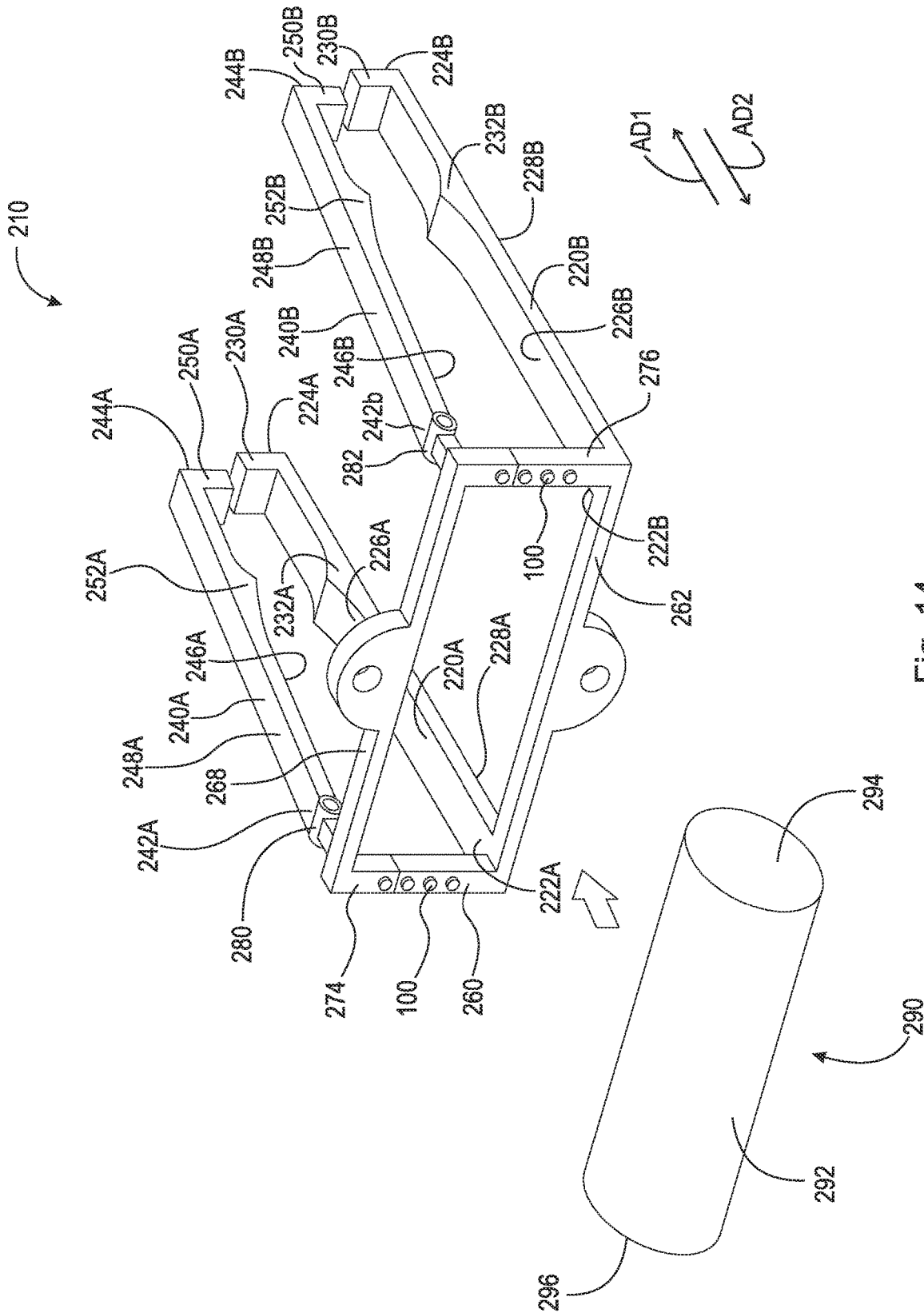


Fig. 14



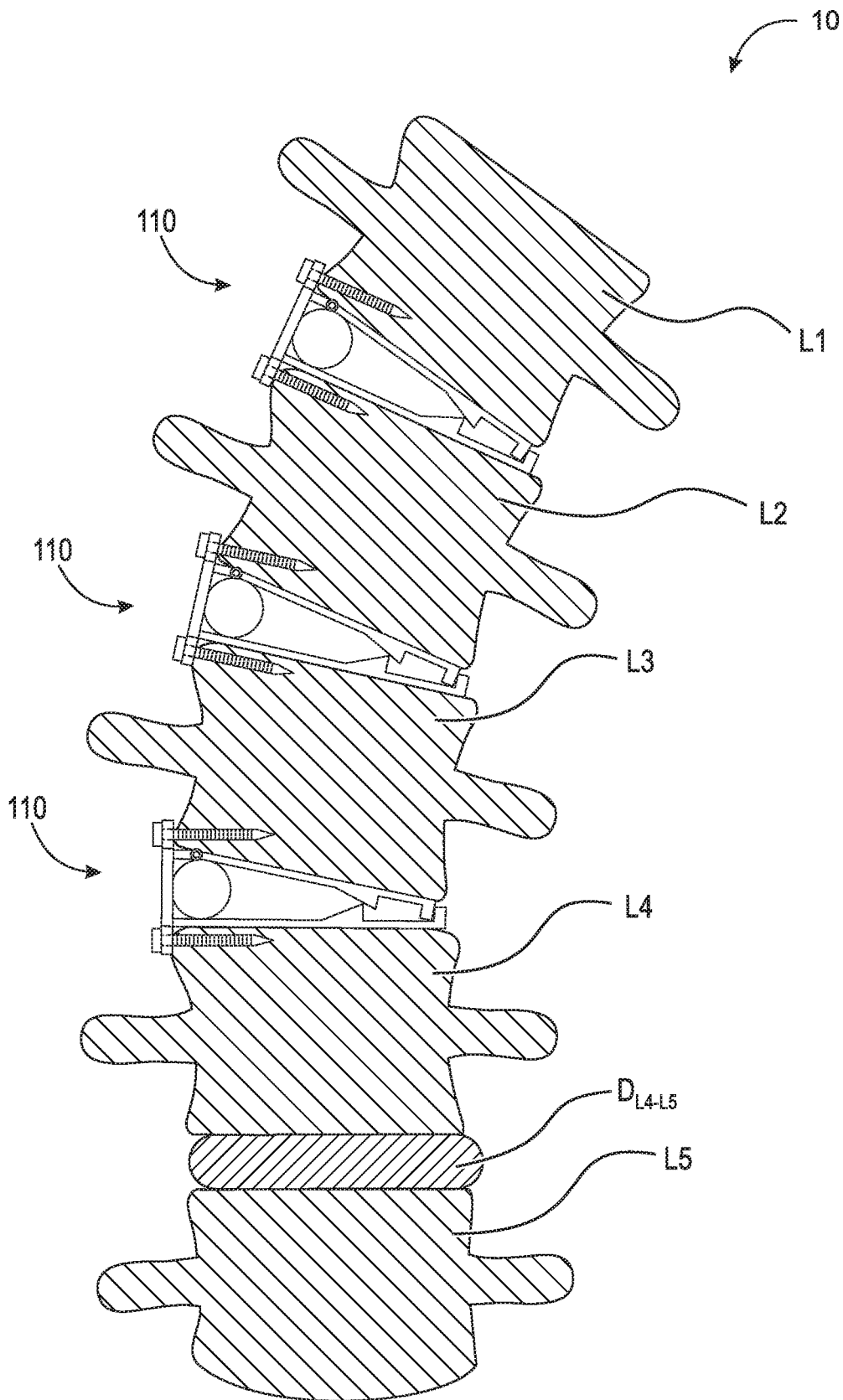


Fig. 15A

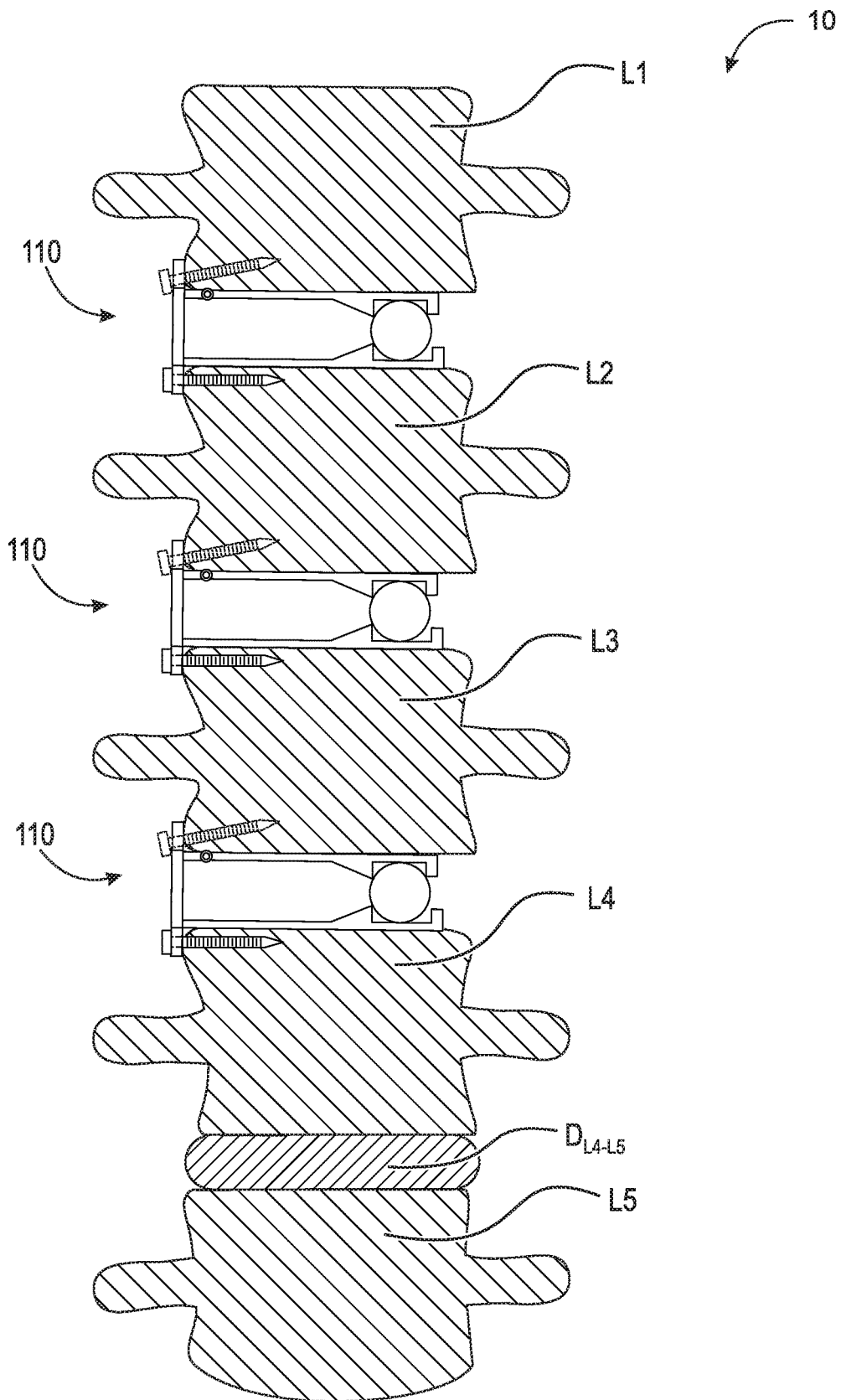


Fig. 15B

## EXPANDABLE INTERVERTEBRAL IMPLANT FOR TREATMENT OF SCOLIOSIS

### FIELD

The present disclosure relates to orthopedic surgery, and more particularly to an expandable intervertebral implant serving to improve alignment between vertebral elements of the spine affected by an abnormal curvature due to disc degeneration or scoliosis.

### BACKGROUND

The spinal column, or backbone, is one of the most important parts of the body. It provides the main support, allowing us to stand upright, bend, and twist. As shown in FIG. 1, thirty three (33) individual bones interlock with each other to form the spinal column. The vertebrae are numbered and divided into regions. The cervical vertebrae C1-C7 form the neck, support the head and neck, and allow nodding and shaking of the head. The thoracic vertebrae T1-T12 join with the ribs to form the rib cage. The five lumbar vertebrae L1-L5 carry most of the weight of the upper body and provide a stable center of gravity when a person moves. Five vertebrae of the sacrum S and four of the coccyx C are fused. This comprises the back wall of the pelvis. Intervertebral discs are located between each of the mobile vertebra. Intervertebral discs comprise a thick outer layer with a crisscrossing fibrous structure annulus A that surrounds a soft gel-like center, the nucleus N. Discs function like shock-absorbing springs. The annulus pulls the vertebral bodies together against the elastic resistance of the gel-filled nucleus. When we bend, the nucleus acts like a ball bearing, allowing the vertebral bodies to roll over the incompressible gel. Each disc works in concert with two facet joints, forming a spinal motion segment. The biomechanical function of each pair of facet joints is to guide and limit the movement of the spinal motion segment. The surfaces of the joint are coated with cartilage that helps each joint move smoothly. Directly behind the discs, the ring-like vertebral bodies create a vertical tunnel called the spinal canal or neuro canal. The spinal cord and spinal nerves pass through the spinal canal, which protects them from injury. The spinal cord is the major column of nerve tissue that is connected to the brain and serves as an information super-highway between the brain and the body. The nerves in the spinal cord branch off to form pairs of nerve roots that travel through the small openings between the vertebrae and the intervertebral foramina.

Various medical conditions require a surgeon to repair, remove and/or replace the aforementioned discs. For example, in one surgical procedure, known as a discectomy (or diskectomy) with interbody fusion, the surgeon removes the nucleus of the disc and replaces it with an implant. As shown in FIG. 2, it may be necessary, for example, for the surgeon to remove the nucleus of the disc between the L3 and L4 vertebrae. Disc  $D_{L3-L4}$  is shown in an enlarged view in FIG. 3. This figure also shows various anatomical structures of the spine, including facets F3A and F4A, facet joint FJ, spinous processes SP3 (not shown) and SP4, transverse processes TP3A and TP4A, and intervertebral foramen IF. FIG. 4 is a top view of the section of the spinal column shown in FIG. 3, with the L3 vertebra removed to expose annulus A and nucleus N of disc  $D_{L3-L4}$ . Neural canal NC is also shown. FIG. 5 is an anterior perspective view of the section of the spinal column shown in FIG. 4. FIG. 6 is a partial cross-sectional view of the section of the spinal

column shown in FIG. 5, taken generally along line 6-6, but with vertebra L3 in place atop disc  $D_{L3-L4}$ .

One common tool used in these spinal surgical procedures is an endoscope. A representative endoscope 30 is shown in FIG. 7A. Endoscopes are complex biomedical devices. The complexity results from the need for fiberoptic bundles and multiple long narrow channels to be contained within a tubular structure that is constrained by the limited dimensions of the body cavity opening. As shown in FIG. 7A, endoscope 30 broadly comprises light guide connector 31, light guide tube 32, control body 33, and insertion tube 34. As will be described infra, the inflatable abrading device of the embodiment is introduced into the disc space via insertion tube 34. As shown in FIG. 7B, surgeon 40 uses the endoscope both to observe and guide the procedure via monitor 41, and to introduce and manipulate surgical instruments and tools during surgery on patient 45.

The endoscope is only one element of the system. Other required elements are a light source, video processor, monitor and water bottle. For the purpose of describing an endoscope in this disclosure, we refer to videoscopes, which represent a newer technology in endoscope development as compared to fiberoptic endoscopes. In videoscopes, the "viewing" fibre bundle is replaced by a miniature charged coupled device (CCD) video camera chip that transmits signals via wires.

Videoscopes include three major sections: connector 31 (sometimes referred to as the "umbilical" section), control body 33 and insertion tube 34. Endoscopes require a watertight internal compartment integrated through all components for electrical wiring and controls, which protects them from exposure to patient secretions during use and facilitates the endoscope being submerged for cleaning and subsequent disinfection. Example embodiments are not intended to be limited to any particular type of endoscope.

Control body 33 provides connections for four systems: the electrical system, the light system, the air and water system, and the suction system. A cable with video signal, light control, and remote switching from the video processor is connected in the electrical system. A watertight cap is required for leak testing and reprocessing. The electrical connector is the only opening to the internal components. The connector is inserted into the light source and directs light via the fiberoptic bundle in the light guide to the distal end of the insertion tube. Air pressure is provided from a pump to the air pipe, and the water bottle is also connected here (there is no water channel or water connection for bronchoscopes). In some endoscope models, the separate air and water channels merge just prior to the distal end where they exit through a single channel. In other models, the air and water channels are totally separate and do not merge. The air and water channels are usually of one millimeter internal diameter, which is too small for brushing. A portable or wall suction system is connected to the suction port. The Universal cord encases the electrical wiring and air, water and suction channels from the connector to the control section. Teflon® (PTFE) tubing is commonly used for channels, and advances in technology have led to more pliable and smooth materials for instrument channels with better anti-adhesion properties. The suction channel size can vary from two to four millimeters internal diameter depending on scope make and model. There is a biopsy port on the side of the insertion tube that allows instruments to be passed down the insertion tube to the distal end (referred to as the instrument channel or biopsy/suction channel).

Control body 33 has moveable knobs that allow the physician to control all scope functions. The angulation

control knobs drive the angulation wires and control the bending section at the distal end of the insertion tube, thereby providing two-dimensional angulation. Locking mechanisms are provided to hold the bending section in a specific position. The suction cylinder and valve connects the suction channel to the instrument channel in the insertion tube. By pressing the valve button, suction can be provided to the instrument channel. The air/water cylinder and valve are similar to the suction cylinder/valve except that a two-way button valve is used in a dual channel cylinder thereby providing air or water to the lens at the distal end to wash and insufflate for better vision. Both valves are removable for cleaning. The air and water channels also require a cleaning adapter valve that is to be used at the end of each procedure. Insertion of the cleaning adapter initiates air flow through both air and water channels, and once activated, water is pumped through both channels. The instrument channel port (often referred to as the "biopsy port") is located on the lower part of the control section. It enters the instrument channel at a Y-piece union with the suction channel. A valve is required to close the port so that suctioning may be facilitated. Remote switches present on the top of the control section are usually programmable, allowing control of the video processor (i.e., contrast, iris and image capture functions).

Of all animals possessing a backbone, human beings are the only creatures who remain upright for significant periods of time. From an evolutionary standpoint, this erect posture has conferred a number of strategic benefits, not the least of which is freeing the upper limbs for purposes other than locomotion. From an anthropologic standpoint, it is also evident that this unique evolutionary adaptation is a relatively recent change, and as such has not benefitted from natural selection as much as have backbones held in a horizontal attitude. As a result, the stresses acting upon the human backbone (or "vertebral column"), are unique in many senses, and result in a variety of problems or disease states that are peculiar to the human species.

The human vertebral column is essentially a tower of bones held upright by fibrous bands called ligaments and contractile elements called muscles. There are seven bones in the neck or cervical region, twelve in the chest or thoracic region, five in the lower back or lumbar region, and five in the pelvic or sacral region, which are normally fused together to form the back part of the pelvis. This column of bones is critical for providing structural support for the entire body.

Between the vertebral bones exist soft tissue structures, i.e., discs, composed of fibrous tissue and cartilage that are compressible and act as shock absorbers for sudden downward forces on the upright column. The discs allow the bones to move independently of each other, as well. The repetitive forces which act on these intervertebral discs during repetitive activities of bending, lifting, and twisting cause them to break down or degenerate over time.

Presumably, because of humans' upright posture their intervertebral discs have a high propensity to degenerate. Overt trauma or covert trauma, occurring in the course of repetitive activities, disproportionately affects the more highly mobile areas of the spine. Disruption of a disc's internal architecture leads to bulging, herniation, or protrusion of pieces of the disc and eventual disc space collapse. Resulting mechanical and even chemical irritation of surrounding neural elements (spinal cord and nerves) cause pain, attended by varying degrees of disability. In addition, loss of disc space height relaxes tension on the longitudinal spinal ligaments, thereby contributing to varying degrees of

spinal instability such as spinal curvature. Asymmetric loss of disc space height with degeneration causes adult degenerative scoliosis.

The time-honored method of addressing the issues of neural irritation and instability resulting from severe disc damage has largely focused on removal of the damaged disc and fusing the adjacent vertebral elements together. Removal of the disc relieves the mechanical and chemical irritation of neural elements, while osseous union (i.e., bone knitting) solves the problem of instability.

While cancellous bone appears ideal to provide the biologic components necessary for osseous union to occur, it does not initially have the strength to resist the tremendous forces that may occur in the intervertebral disc space, nor does it have the capacity to adequately stabilize the spine until long term bony union occurs. For these reasons, many spinal surgeons have found that interbody fusion using bone alone has an unacceptably high rate of bone graft migration or even expulsion or nonunion due to structural failure of the bone or residual degrees of motion that retard or prohibit bony union. Intervertebral prosthesis in various forms has therefore been used to provide immediate stability and to protect and preserve an environment that fosters growth of the grafted bone such that a structurally significant bony fusion can occur.

U.S. Pat. No. 6,159,244 (Suddaby) exhibits an expandable cage capable of nonparallel expansion but require a complex mechanism of ratcheting pillars. The implant disclosed in U.S. Pat. No. 5,483,463 (Qin et al.) is hollow and tubular, with communicating windows in the top and bottom surfaces, which would permit fusion but the design does little to correct scoliosis.

Many interbody devices in present day use, whether expandable or not, are used largely to facilitate interbody fusion in cases of degenerative disc disease and are not specifically designed to correct scoliosis, which is a pathologic curvature of the spine in the coronal or lateral plane that can be of degenerative, congenital, or idiopathic causes.

#### SUMMARY

According to aspects illustrated herein, there is provided an expandable intervertebral implant, comprising a support component, an inferior component, including a first proximate end connected to the support component, a first distal end, a first top surface, and a first bottom surface, a superior component, including a second proximate end connected to the support component, a second distal end, a second top surface, and a second bottom surface, and a wedging component operatively arranged to be slid along the first top surface and the second bottom surface and expand the expandable intervertebral implant.

According to aspects illustrated herein, there is provided an expandable intervertebral implant, comprising a support component, at least one inferior component, including a first proximate end connected to the support component, a first distal end, a first top surface, and a first bottom surface, at least one superior component, including, a second proximate end connected to the support component, a second distal end, a second top surface; and a second bottom surface, and a wedging component operatively arranged to be slid along the first top surface and the second bottom surface and expand the expandable intervertebral implant.

It is the object of this disclosure to provide for an expandable intervertebral implant having two vertebral end-plate contact surfaces connected in a pivotal fashion which

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can be separated from each other when a third component is wedged between them along their longitudinal axis.

This disclosure relates to an expandable intervertebral fusion implant serving to improve alignment between vertebral elements of the spine affected by an abnormal curvature due to disc degeneration or scoliosis, thereby facilitating the development of a bony union between them and thus fostering proper spinal alignment and thus long term spinal stability.

It is an object of this disclosure to provide for an expandable intervertebral fusion implant that is both simple to manufacture and simple to use in daily clinical surgical practice.

It is also an object of this disclosure that this device serve specifically to correct local spinal alignment issues between adjacent vertebral endplates such that scoliosis or abnormal curvature of the spine can be addressed through a minimally invasive approach.

According to aspects illustrated herein, there is provided a pair of endplate support elements, which are generally rectangular, joined together pivotally at one end. The pivotal end of the implant has vertical separation struts that are of variable length with interspace roughly representing the height of the normal disc space at the level to be addressed.

The distal or non-pivotal end of the implant has two rectangular elements juxtaposed in close proximity, i.e., not separated by a vertical member or strut, such that they form a wedge shape akin to that of a dull knife blade or an adze.

The implant further comprises a third element in the form of a wedging member. The wedging member is inserted into the pivotal end of the implant, which can be advanced along the axis of the longitudinal axis of the rectangular members, once they are positioned across a disc space that has undergone discectomy.

The wedging member is preferably substantially cylindrical in shape, with a diameter that approximates the vertical struts at the pivotal end. The cylindrical wedge component is placed between the rectangular elements at the pivotal end once the construct has been placed across a disc space and then is impelled toward the non-pivotal end, such that said distal elements are separated from each other as the wedging element is advanced.

When the wedging cylinder has reached the distal or non-pivotal end of the implant, the rectangular elements become more or less parallel to each other by virtue of the diameter of the cylinder approximating the height of the pivotal end.

Each rectangular element will harbor apertures or perforation such that bony or biologic materials placed within the implant, once expanded by the cylinder, will have close apposition to adjacent vertebral endplates and hence can foster interbody fusion.

Once the wedging cylinder has reached the distal end of the implant, it will be locked into position by a stop which prevents it from simply rolling back to its start point. By securing the wedging cylinder in such a fashion, implant stability is preserved.

It should be noted that, in an example embodiment, the pivotal end of the implant will be anchored to the vertebrae with one or more bone screws to prevent expulsion of the implant as the wedge cylinder is advanced and as the implant changes from a triangular or trapezoidal shape to a more rectangular configuration.

The present disclosure provides not only for an expandable interbody fusion implant, but also for an implant that can be placed via a lateral minimally invasive approach, from the easier access or convex side of a scoliotic spine,

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and restore the normal parallel attitude of adjacent endplates prior to insertion of final biologic fusion products.

Additionally, because the initial configuration of the implant is wedge shaped, it can be used to breach and release the contralateral annulus and associated ligamentous structures, should this be desired.

By using the implant at each spinal segment containing non-parallel adjacent endplates, spinal alignment can be restored through a minimally invasive or lateral lumbar interbody fusion (XLIF) surgical approach.

These and other objects, features, and advantages of the present disclosure will become readily apparent upon a review of the following detailed description of the disclosure, in view of the drawings and appended claims.

#### BRIEF DESCRIPTION OF THE DRAWINGS

Various embodiments are disclosed, by way of example only, with reference to the accompanying schematic drawings in which corresponding reference symbols indicate corresponding parts, in which:

FIG. 1 is an anterior perspective view of a spinal column;

FIG. 2 is an anterior perspective view of the lumbar section of the spinal column shown in FIG. 1;

FIG. 3 is a lateral perspective view of two vertebrae, a disc, and related spinal anatomy;

FIG. 4 is a top view of a section of the spinal column, taken generally along line 4-4 in FIG. 3;

FIG. 5 is an enlarged anterior perspective view of the spinal column shown in FIG. 2, except with the top vertebra and all other structure above the top vertebra removed;

FIG. 6 is a partial cross-sectional view of the top and bottom vertebrae and disc, taken generally along line 6-6 in FIG. 5;

FIG. 7A is a view of a typical endoscope;

FIG. 7B illustrates use of the endoscope shown in FIG. 7A by a surgeon performing a discectomy (discectomy);

FIG. 8 is a top perspective view of an expandable intervertebral implant, in a collapsed state;

FIG. 9A is a side elevational view of the expandable intervertebral implant shown in FIG. 8;

FIG. 9B is a side elevational view of the expandable intervertebral implant shown in FIG. 8 in an expanded state;

FIG. 10 is an anterior perspective view of a spinal column including the expandable intervertebral implant shown in FIG. 8;

FIG. 11A is a side elevational view of the expandable intervertebral implant shown in FIG. 10 in a collapsed state;

FIG. 11B is a side elevational view of the expandable intervertebral implant shown in FIG. 10 in an expanded state;

FIG. 12A is a side elevational view of the expandable intervertebral implant taken generally of detail 12 in FIG. 8;

FIG. 12B is a side elevational view of an expandable intervertebral implant;

FIG. 13A is a cross-sectional view of a vertical member taken generally along line 13A-13A in FIG. 8;

FIG. 13B is a cross-sectional view of a vertical member taken generally along line 13B-13B in FIG. 8;

FIG. 14 is a top perspective view of an expandable intervertebral implant in a collapsed state;

FIG. 15A is a side elevational view of a plurality of expandable intervertebral implants secured in a spinal column in a collapsed state; and,

FIG. 15B is a side elevational view of the plurality of expandable intervertebral implants secured in a spinal column, as shown in FIG. 15A, in an expanded state.

#### DETAILED DESCRIPTION

At the outset, it should be appreciated that like drawing numbers on different drawing views identify identical, or functionally similar, structural elements. It is to be understood that the claims are not limited to the disclosed aspects.

Furthermore, it is understood that this disclosure is not limited to the particular methodology, materials and modifications described and as such may, of course, vary. It is also understood that the terminology used herein is for the purpose of describing particular aspects only, and is not intended to limit the scope of the claims.

Unless defined otherwise, all technical and scientific terms used herein have the same meaning as commonly understood to one of ordinary skill in the art to which this disclosure pertains. It should be understood that any methods, devices or materials similar or equivalent to those described herein can be used in the practice or testing of the example embodiments.

It should be appreciated that the term “substantially” is synonymous with terms such as “nearly,” “very nearly,” “about,” “approximately,” “around,” “bordering on,” “close to,” “essentially,” “in the neighborhood of,” “in the vicinity of,” etc., and such terms may be used interchangeably as appearing in the specification and claims. It should be appreciated that the term “proximate” is synonymous with terms such as “nearby,” “close,” “adjacent,” “neighboring,” “immediate,” “adjoining,” etc., and such terms may be used interchangeably as appearing in the specification and claims. The term “approximately” is intended to mean values within ten percent of the specified value.

Adverting now to the figures, and as described previously, FIGS. 1-6 depict various parts and sections of spinal anatomy, and FIGS. 7A and 7B depict a typical endoscope for use by a surgeon on a patient.

FIG. 8 is a top perspective view of expandable intervertebral implant 110, in a collapsed state. FIG. 9A is a side elevational view of expandable intervertebral implant 110 in a collapsed state. FIG. 9B is a side elevational view of expandable intervertebral implant 110 in an expanded state. Expandable intervertebral implant 110 generally comprises inferior component 120, superior component 140, support component 160, and wedging component 190.

Inferior component 120 comprises end 122, end 124, top surface 126, and bottom surface 128. Inferior component 120 is connected to support component 160 at end 122. In an example embodiment, inferior component 120 is secured to cross member 162 such that it is perpendicular to vertical members 174 and 176. In an example embodiment, inferior component 120 is secured to support component 160 at a non-perpendicular angle to vertical members 174 and 176. Inferior component 120 may further comprise aperture 134, which extends from top surface 126 to bottom surface 128. Aperture 134 allows bony or biologic materials placed within expandable intervertebral implant 110, once expanded, to have close apposition to adjacent vertebral endplates and thereby foster interbody fusion. Top surface 126 further comprises lip 130 and stop 132. Lip 130 extends upward from top surface 126 and is arranged generally proximate end 124. Lip 130 is arranged as a boundary for wedging component 190 (i.e., to keep wedging component 190 within expandable intervertebral implant 110). Stop 132 extends upward from top surface 126 and is arranged axially

inward (i.e., in axial direction AD2) from end 124 as shown in the figures. Stop 132 is designed to allow wedging component 190 to move in axial direction AD1, but once beyond stop 132, to prevent movement of wedging component 190 in axial direction AD2 and maintain its position as shown in FIG. 9B.

Superior component 140 comprises end 142, end 144, top surface 148, and bottom surface 146. Superior component 140 is connected to support component 160 generally at end 142. Specifically, superior component 140 is connected to hinges 180 and 182, and hinges 180 and 182 are connected to support component 160. In an example embodiment, hinges 180 and 182 are connected to cross-member 168. In an example embodiment, expandable intervertebral implant 110 comprises one or more hinges. Superior component 140 may further comprise aperture 154, which extends from top surface 148 to bottom surface 146. Aperture 154 allows bony or biologic materials placed within expandable intervertebral implant 110, once expanded, to have close apposition to adjacent vertebral endplates and thereby foster interbody fusion. Bottom surface 146 further comprises lip 150 and stop 152. Lip 150 extends downward from bottom surface 146 and is arranged generally proximate end 144. Lip 150 is arranged as a boundary for wedging component 190 (i.e., to keep wedging component 190 within expandable intervertebral implant 110). Stop 152 extends downward from bottom surface 146 and is arranged axially inward (i.e., in axial direction AD2) from end 144 as shown in the figures. Stop 152 is designed to allow wedging component 190 to move in axial direction AD1, but once beyond stop 152, to prevent movement of wedging component 190 in axial direction AD2 and maintain its position as shown in FIG. 9B.

It should be appreciated that the orientation of hinges 180 and 182 can be reversed such that inferior component 120 is hingedly connected to support component 160. In this embodiment, superior component 140 is connected to support component 160. Specifically, end 142 is secured to cross-member 168 such that superior component 140 is generally perpendicular to vertical members 174 and 176. In an example embodiment, superior component 140 can be secured to support component 160 at a non-perpendicular angle (i.e., non-perpendicular to vertical members 174 and 176). Hinges 180 and 182 are secured to cross-member 162 and end ix) 122 of inferior component 120 is secured to hinges 180 and 182. In an example embodiment, both inferior component 120 and superior component 140 are hingedly connected to support component 160.

Support component 160 generally comprises cross-member 162, cross-member 168, vertical member 174, and vertical member 176. In some embodiments, support component 160 comprises one or more cross-members. Cross-member 162 further comprises flange 164 having through-bore 166 for anchoring expandable intervertebral implant 110 to the vertebrae and prevent expulsion of expandable intervertebral implant 110 as wedging component 190 is advanced therein. Flange 164 extends generally downward from cross-member 162. Cross-member 168 further comprises flange 170 having through-bore 172 for anchoring expandable intervertebral implant 110 to the vertebrae and prevent expulsion of expandable intervertebral implant 110 as wedging component 190 is advanced therein. Flange 168 extends generally upward from cross-member 168. Vertical members 174 and 176 connect cross-member 168 to cross-member 162. Vertical members 174 and 176 are generally

adjustable (i.e., can be lengthened or shortened) as will be discussed in greater detail with respect to FIGS. 13A and 13B.

Wedging component 190 is generally cylindrical comprising radially outward facing surface 192, end surface 194, and end surface 196. Wedging component 190 is designed to be inserted into expandable intervertebral implant 110 in axial direction AD1 with end surfaces 194 and 196 generally perpendicular to ends 122 and 124. As wedging component 190 is advanced in expandable intervertebral implant 110, radially outward facing surface 192 slides along top surface 126 and bottom surface 146, thereby forcing superior component 140 upward and away from superior component 120. Once wedging component 190 passes stops 132 and 152, wedging component 190 is prevented from movement in axial direction AD2, unless superior component 140 is forced further in the upward direction, thereby releasing stops 132 and 152 (wedging component 190 can then be removed from expandable intervertebral implant 110). Lips 130 and 150 also provide an axial boundary preventing wedging component 190 from “falling out” of expandable intervertebral implant 110 in axial direction AD1. Inferior component 120 and superior component 140 may further comprise lateral rails for end surfaces 194 and 196 to slide against to help ensure that wedging component 190 does yaw (i.e., twist or oscillate about a vertical axis) as is being advanced within expandable intervertebral implant 110 (i.e., keep end surfaces 194 and 196 perpendicular to ends 122 and 124). It should be appreciated that wedging component 190 can be any shape suitable to slide along top surface 126 and bottom surface 146 and expand expandable intervertebral implant 110, such as rectangular prism, elliptical prism, triangular prism, spherical, etc. It should also be appreciated that the size of wedging component 190 should be relative to the vertical height of support component 160. When wedging component 190 is fully inserted in expandable intervertebral implant 110, it is desired that superior component 140 is substantially parallel to inferior component 120. Therefore, the diameter of wedging component 190 should be slightly less than the vertical length of vertical members 174 and 176. Since vertical members 174 and 176 are adjustable, as will be discussed in greater detail below, a variety of sizes of wedging component 190 should be available such that the surgeon can choose the correct size during operation.

FIG. 10 is an anterior perspective view of a spinal column including expandable intervertebral fusion implant 110. FIG. 11A is a side elevational view of expandable intervertebral fusion implant 110 shown in FIG. 10 in a collapsed state. FIG. 11B is a side elevational view of the expandable intervertebral fusion implant 110 shown in FIG. 10 in an expanded state. Expandable intervertebral implant 110 is inserted into the spinal column between, for example, the L3 and L4 vertebrae, or where disc  $D_{L3-L4}$  should be. Expandable intervertebral implant 110 is secured to the vertebrae, for example, by fasteners 104 and 106. In an example embodiment, fastener 104 secures expandable intervertebral implant 110 to lumbar vertebra L3 and fastener 106 secures expandable intervertebral implant 110 to lumbar vertebra L4. Fasteners 104 and 106 may be screws, anchors, bolts, etc., or any other suitable fastening mechanism, including adhesives. Expandable intervertebral implant 110 is then vertically expanded until the desired height is reached. Support component 160 is expanded by lengthening vertical members 174 and 176 to a suitable length, and then a suitable size wedging component 190 is chosen and advanced in expandable intervertebral implant 110 until it is

fully expanded. Expandable intervertebral implant 110 is then filled with fusion material and left in situ. It should be appreciated that vertical members 174 and 176 can be adjusted to a suitable length prior to inserting expandable intervertebral implant 110 into the spinal column.

FIG. 12A is a side elevational view of expandable intervertebral fusion implant 110 taken generally of detail 12 in FIG. 8. FIG. 12B is a side elevational view of an example embodiment of expandable intervertebral fusion implant 110 having hooks attached to the lips. As shown, inferior component 120 further comprises hook 131 connected to the end of lip 130. Similarly, superior component 140 further comprises hook 151 connected to the end of lip 150. Hook 131 is arranged facing axial direction AD1 and hook 151 is arranged facing axial direction AD2, such that superior component 140 can only be separated from inferior component 120 a predetermined distance. Once that predetermined distance is reached, hooks 131 and 151 engage and prevent superior component 140 from separating further from inferior component 120. In an example embodiment, hook 131 is arranged facing axial direction AD2 and hook 151 is arranged facing axial direction AD1. It should be appreciated that any method suitable for preventing excessive vertical displacement of superior component 140 relative to inferior component 120, such as stops, flanges, etc., or a leash component such as a string or cord of a predetermined length may be used.

FIG. 13A is a cross-sectional view of vertical member 174 taken generally along line 13A-13A in FIG. 8. As shown, vertical member 174 comprises inner bar 174A arranged to slidably engage outer bar 174B (i.e., vertical member 174 is a telescoping bar). In the embodiment shown, inner bar 174A comprises a plurality of pins 100 and corresponding spring members 102. Pins 100 protrude from holes 175A in inner bar 174A, specifically, pins 100 are forced radially outward through holes 175A by spring members 102. Pins 100 are forced radially inward such that inner bar 174A can be slid axially within outer bar 174B. One of pins 100 is aligned with hole 175B in outer bar 174B once the desired length of vertical member 174 is achieved. In an example embodiment, vertical member 174 is cylindrical, inner bar 174A comprises radially outer threading, and outer bar 174B comprises radially inner threading such that the length of vertical member 174 is adjustable by rotating one of inner bar 174A or outer bar 174B relative to the other. It should be appreciated that telescoping members are known in the art and that any suitable telescoping design may be used. This similar locking mechanism (i.e., the push-pins) may be used on cross-members 162 and 168. In an example embodiment, one or more cross-members have a locking mechanism. In an example embodiment, no cross-members have a locking mechanism.

FIG. 13B is a cross-sectional view of vertical member 176 taken generally along line 13B-13B in FIG. 8. As shown, vertical member 176 comprises inner bar 176A arranged to slidably engage outer bar 176B (i.e., vertical member 176 is a telescoping bar). In the embodiment shown, inner bar 176A comprises a plurality of pins 100 and corresponding spring members 102. Pins 100 protrude from holes 177A in inner bar 176A, specifically, pins 100 are forced radially outward through holes 177A by spring members 102. Pins 100 are forced radially inward such that inner bar 176A can be slid axially within outer bar 176B. One of pins 100 is aligned with hole 177B in outer bar 176B once the desired length of vertical member 176 is achieved. In an example embodiment, vertical member 176 is cylindrical, inner bar 176A comprises radially outer threading, and outer bar 176B

comprises radially inner threading such that the length of vertical member 176 is adjustable by rotating one of inner bar 176A or outer bar 176B relative to the other. It should be appreciated that telescoping members are known in the art and that any suitable telescoping design may be used.

FIG. 14 is a top perspective view of expandable intervertebral implant 210 in a collapsed state. Expandable intervertebral implant 210 generally comprises inferior components 220A and 220B, superior components 240A and 240B, support component 260, and wedging component 290.

Inferior component 220A comprises end 222A, end 224A, top surface 226A, and bottom surface 228A. Inferior component 220A is connected to support component 260 at end 222A. In an example embodiment, inferior component 220A is secured to cross member 262 such that it is perpendicular to vertical members 274 and 276. In an example embodiment, inferior component 220A is secured to support component 260 at a non-perpendicular angle to vertical members 274 and 276. Top surface 226A further comprises lip 230A and stop 232A. Lip 230A extends upward from top surface 226A and is arranged generally proximate end 224A. Lip 230A is arranged as a boundary for wedging component 290 (i.e., to keep wedging component 290 within expandable intervertebral implant 210). Stop 232A extends upward from top surface 226A and is arranged axially inward (i.e., in axial direction AD2) from end 224A as shown in FIG. 14. Stop 232A is designed to allow wedging component 290 to move in axial direction AD1, but once beyond stop 232A, to prevent movement of wedging component 290 in axial direction AD2 and maintain its position.

Inferior component 220B comprises end 222B, end 224B, top surface 226B, and bottom surface 228B. Inferior component 220B is connected to support component 260 at end 222B. In an example embodiment, inferior component 220B is secured to cross member 262 such that it is perpendicular to vertical members 274 and 276. In an example embodiment, inferior component 220B is secured to support component 260 at a non-perpendicular angle to vertical members 274 and 276. Top surface 226B further comprises lip 230B and stop 232B. Lip 230B extends upward from top surface 226B and is arranged generally proximate end 224B. Lip 230B is arranged as a boundary for wedging component 290 (i.e., to keep wedging component 290 within expandable intervertebral implant 210). Stop 232B extends upward from top surface 226B and is arranged axially inward (i.e., in axial direction AD2) from end 224B as shown in FIG. 14. Stop 232B is designed to allow wedging component 290 to move in axial direction AD1, but once beyond stop 232B, to prevent movement of wedging component 290 in axial direction AD2 and maintain its position.

Superior component 240A comprises end 242A, end 244A, top surface 248A, and bottom surface 246A. Superior component 240A is connected to support component 260 generally at end 242A. Specifically, superior component 240A is connected to hinge 280, and hinge 280 is connected to support component 260. In an example embodiment, hinge 280 is connected to cross-member 268. In an example embodiment, expandable intervertebral implant 210 comprises one or more hinges. Bottom surface 246A further comprises lip 250A and stop 252A. Lip 250A extends downward from bottom surface 246A and is arranged generally proximate end 244A. Lip 250A is arranged as a boundary for wedging component 290 (i.e., to keep wedging component 290 within expandable intervertebral implant 210). Stop 252A extends downward from bottom surface 246A and is arranged axially inward (i.e., in axial direction AD2) from end 244A as shown in FIG. 14. Stop 252A is

designed to allow wedging component 290 to move in axial direction AD1, but once beyond stop 252A, to prevent movement of wedging component 290 in axial direction AD2 and maintain its position.

Superior component 240B comprises end 242B, end 244B, top surface 248B, and bottom surface 246B. Superior component 240B is connected to support component 260 generally at end 242B. Specifically, superior component 240B is connected to hinge 282, and hinge 282 is connected to support component 260. In an example embodiment, hinge 282 is connected to cross-member 268. In an example embodiment, expandable intervertebral implant 210 comprises one or more hinges. Bottom surface 246B further comprises lip 250B and stop 252B. Lip 250B extends downward from bottom surface 246B and is arranged generally proximate end 244B. Lip 250B is arranged as a boundary for wedging component 290 (i.e., to keep wedging component 290 within expandable intervertebral implant 210). Stop 252B extends downward from bottom surface 246B and is arranged axially inward from end 244B (i.e., in axial direction AD2) as shown in FIG. 14. Stop 252B is designed to allow wedging component 290 to move in axial direction AD1, but once beyond stop 252B, to prevent movement of wedging component 290 in axial direction AD2 and maintain its position.

It should be appreciated that the orientation of hinges 280 and 282 can be reversed such that inferior components 220A and 220B are hingedly connected to support component 260. In this embodiment, superior components 240A and 240B are connected to support component 260. Specifically, ends 242A and 242B are secured to cross-member 268 such that superior components 240A and 240B are generally perpendicular to vertical members 274 and 276. In an example embodiment, superior components 240A and 240B can each be secured to support component 260 at a non-perpendicular angle to vertical members 274 and 276. Hinges 280 and 282 are secured to cross-member 262, and ends 222A and 222B are secured to hinges 280 and 282, respectively. Additionally, it should be appreciated that in an example embodiment, inferior components 220A and 220B and superior components 240A and 240B are hingedly connected to support component 260.

Support component 260 generally comprises cross-member 262, cross-member 268, vertical member 274, and vertical member 276. In some embodiments, support component 260 comprises one or more cross-members. Cross-member 262 further comprises flange 264 having through-bore 266 for anchoring expandable intervertebral implant 210 to the vertebrae and prevent expulsion of expandable intervertebral implant 210 as wedging component 290 is advanced therein. Flange 264 extends generally downward from cross-member 262. Cross-member 268 further comprises flange 270 having through-bore 272 for anchoring expandable intervertebral implant 210 to the vertebrae and prevent expulsion of expandable intervertebral implant 210 as wedging component 290 is advanced therein. Flange 270 extends generally upward from cross-member 268. Vertical members 274 and 276 connect cross-member 268 to cross-member 262. Vertical members 274 and 276 are generally adjustable (i.e., can be lengthened or shortened) as was previously discussed with respect to vertical members 174 and 176. In an example embodiment, vertical members 274 and 276 are telescoping bars and have locking mechanism for setting them at a determined length.

Wedging component 290 is generally cylindrical comprising radially outward facing surface 292, end surface 294, and end surface 296. Wedging component 290 is designed to



be inserted into expandable intervertebral implant **210** in axial direction AD1 with end surfaces **294** and **296** generally perpendicular to, for example, ends **222A** and **224A**. As wedging component **290** is advanced in expandable intervertebral implant **210**, radially outward facing surface **292** slides along top surfaces **226A-B** and bottom surfaces **246A-B**, thereby forcing superior components **240A-B** upward and away from inferior components **220A-B**. Once wedging component **290** passes stops **232A-B** and **252A-B**, wedging component **290** is prevented from movement in axial direction AD2, unless superior components **240A-B** are forced further in the upward direction, thereby releasing stops **232A-B** and **252A-B** (wedging component **290** can then be removed from expandable intervertebral implant **210**). Lips **230A-B** and **250A-B** also provide an axial boundary preventing wedging component **290** from “falling out” of expandable intervertebral implant **210** in axial direction AD1. Inferior components **220A-B** and superior components **240A-B** may further comprise lateral rails for end surfaces **294** and **196** to slide against to help ensure that wedging component **290** does not yaw (i.e., twist or oscillate about a vertical axis) as it is being advanced within expandable intervertebral implant **210** (i.e., keep end surfaces **294** and **296** perpendicular to ends **222A** and **224B**). It should be appreciated that wedging component **290** can be any shape suitable to slide along top surfaces **226A-B** and bottom surfaces **246A-B** and expand expandable intervertebral implant **210**, such as rectangular prism, elliptical prism, triangular prism, spherical, etc. It should also be appreciated that the size of wedging component **290** should be relative to the vertical height of support component **260**. When wedging component **290** is fully inserted in expandable intervertebral implant **210**, it is desired that superior components **240A-B** are substantially parallel to inferior components **120A-B**. Therefore, the diameter of wedging component **290** should be slightly less than the vertical length of vertical members **274** and **276**. Since vertical members **274** and **276** are adjustable, as previously discussed with respect to vertical members **174** and **176**, a variety of sizes of wedging component **290** should be available such that the surgeon can choose the correct size during operation. Additionally, in an example embodiment, support component **260** is laterally expandable. Specifically, cross-members **262** and **268** are adjustable similar to that of vertical members **174** and **176** as previously discussed.

FIG. **15A** is a side elevational view of a plurality of expandable intervertebral implants **110** secured in spinal column **10** in a collapsed state. Expandable intervertebral implants **110** are inserted between lumbar vertebrae L1-L4 and secured thereto. FIG. **15B** is a side elevational view of the plurality of expandable intervertebral implants **110**, as shown in FIG. **15A**, secured in spinal column **10** in an expanded state. As each of expandable intervertebral implants **110** are expanded (i.e., wedging component **90** is advanced therein), lumbar vertebrae L1-L4 align and spinal column **10** straightens.

It will be appreciated that various aspects of the disclosure above and other features and functions, or alternatives thereof, may be desirably combined into many other different systems or applications. Various presently unforeseen or unanticipated alternatives, modifications, variations, or improvements therein may be subsequently made by those skilled in the art which are also intended to be encompassed by the following claims.

## REFERENCE NUMERALS

**10** Spinal column  
**12** Ligament

**C1-C7** Cervical vertebrae  
**T1-T12** Thoracic vertebrae  
**L1-L5** Lumbar vertebrae  
**S** Sacrum  
**5 C** Coccyx  
**D<sub>L1-L2</sub>** Disc  
**D<sub>L2-L3</sub>** Disc  
**D<sub>L3-L4</sub>** Disc  
**D<sub>L4-L5</sub>** Disc  
**10 F** Facet  
**FJ** Facet joint  
**SP** Spinous process  
**TP** Transverse process  
**IF** Intervertebral foramen  
**15 NC** Neural canal  
**A** Annulus  
**N** Nucleus  
**DH** Disc space height  
**30** Endoscope  
**20 31** Light guide connector  
**32** Light guide tube  
**33** Control body  
**34** Insertion tube  
**40** Surgeon  
**25 41** Monitor  
**45** Patient  
**100** Pins  
**102** Spring members  
**104** Fastener  
**30 106** Fastener  
**110** Expandable intervertebral implant  
**120** Inferior component  
**122** End  
**124** End  
**35 126** Top surface  
**128** Bottom surface  
**130** Lip  
**131** Hook  
**132** Stop  
**40 134** Aperture  
**140** Superior component  
**142** End  
**144** End  
**146** Bottom surface  
**45 148** Top surface  
**150** Lip  
**151** Hook  
**152** Stop  
**154** Aperture  
**50 160** Support component  
**162** Cross-member  
**164** Flange  
**166** Through-bore  
**168** Cross-member  
**55 170** Flange  
**172** Through-bore  
**174** Vertical member  
**174A** Inner bar  
**174B** Outer bar  
**60 175A** Holes  
**175B** Hole  
**176** Vertical member  
**176A** Inner bar  
**176B** Outer bar  
**65 177A** Holes  
**177B** Hole  
**180** Hinge

182 Hinge  
 190 Wedging component  
 192 Radially outward facing surface  
 194 End surface  
 196 End surface  
 210 Expandable intervertebral implant  
 220A Inferior component  
 220B Inferior component  
 222A End  
 222B End  
 224A End  
 224B End  
 226A Top surface  
 226A Top surface  
 228A Bottom surface  
 228A Bottom surface  
 230A Lip  
 230B Lip  
 232A Stop  
 232B Stop  
 240A Superior component  
 240B Superior component  
 242A End  
 242B End  
 244A End  
 244B End  
 246A Bottom surface  
 246A Bottom surface  
 248A Top surface  
 248A Top surface  
 250A Lip  
 250B Lip  
 252A Stop  
 252B Stop  
 260 Support component  
 262 Cross-member  
 264 Flange  
 266 Through-bore  
 268 Cross-member  
 270 Flange  
 272 Through-bore  
 274 Vertical member  
 276 Vertical member  
 280 Hinge  
 282 Hinge  
 290 Wedging component  
 292 Radially outward facing surface  
 294 End surface  
 296 End surface  
 What is claimed is:  
 1. An expandable intervertebral implant, comprising:  
 a support component, including:  
 a first cross-member;  
 a second cross-member; and,  
 one or more vertical members connecting the first and  
 second cross-members,  
 wherein the second cross-member is displaceable relative  
 to the first cross-member;  
 an inferior component, including:  
 a first proximate end connected to the first cross-  
 member;  
 a first distal end;  
 a first top surface; and,  
 a first bottom surface;  
 a superior component, including:  
 a second proximate end connected to the second cross-  
 member;

a second distal end;  
 a second top surface; and,  
 a second bottom surface; and,  
 a wedging component operatively arranged to be:  
 5 passed completely through the first and second cross-  
 members; and,  
 slid along the first top surface and the second bottom  
 surface and expand the expandable intervertebral  
 implant.  
 10 2. The expandable intervertebral implant as recited in  
 claim 1, wherein the superior component is hingedly con-  
 nected to the second cross-member.  
 3. The expandable intervertebral implant as recited in  
 15 claim 2, wherein:  
 the first distal end comprises a first lip extending from the  
 first top surface; and,  
 the second distal end comprises a second lip extending  
 from the second bottom surface.  
 20 4. The expandable intervertebral implant as recited in  
 claim 2, wherein:  
 the inferior component comprises a first stop extending  
 from the first top surface; and,  
 the superior component comprises a second stop extend-  
 25 ing from the second bottom surface.  
 5. The expandable intervertebral implant as recited in  
 claim 2, wherein the superior component is connected to the  
 second cross-member via one or more hinges.  
 6. The expandable intervertebral implant as recited in  
 30 claim 2, wherein the inferior component further comprises a  
 first aperture and the superior component further comprises  
 a second aperture.  
 7. The expandable intervertebral implant as recited in  
 claim 2, wherein the wedging component is substantially  
 35 cylindrical.  
 8. The expandable intervertebral implant as recited in  
 claim 2, wherein when the expandable intervertebral implant  
 is in a fully expanded state, the superior component is  
 substantially parallel to the inferior component.  
 40 9. The expandable intervertebral implant as recited in  
 claim 1, wherein the inferior component is hingedly con-  
 nected to the first cross-member.  
 10. The expandable intervertebral implant as recited in  
 claim 1, wherein the first cross-member comprises a first  
 45 flange having a first through-bore and the second cross-  
 member comprises a second flange having a second through-  
 bore.  
 11. The expandable intervertebral implant as recited in  
 claim 1, wherein each of the one or more vertical members  
 50 is adjustable in length.  
 12. The expandable intervertebral implant as recited in  
 claim 11, wherein at least one of the one or more vertical  
 members comprises a plurality of locking pins operatively  
 arranged to lock the one or more vertical members at a  
 55 length.  
 13. The expandable intervertebral implant as recited in  
 claim 1, wherein the second cross-member is spaced apart  
 from the first cross-member.  
 14. An expandable intervertebral implant, comprising:  
 a support component, including:  
 a first cross-member;  
 a second cross-member; and,  
 one or more vertical members connecting the first and  
 second cross-members,  
 60 wherein the second cross-member is displaceable relative  
 to the first cross-member;  
 an inferior component, including:  
 65 a second proximate end connected to the second cross-  
 member;

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- a first proximate end connected to the first cross-member;
- a first distal end;
- a first top surface; and,
- a first bottom surface;
- 5 a superior component, including:
  - a second proximate end connected to the second cross-member;
  - a second distal end;
  - a second top surface; and,
  - 10 a second bottom surface; and,
- a wedging component operatively arranged to be slid along the first top surface and the second bottom surface and expand the expandable intervertebral implant, wherein in a fully expanded state of the expandable intervertebral implant, the wedging component is arranged substantially at the first and second distal ends.
- 15 **15.** An expandable intervertebral implant, comprising:
  - a support component, including:
    - 20 a first cross-member;
    - a second cross-member spaced apart from the first cross-member; and,

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- at least one vertical member connecting the first and second cross-members, the at least one vertical member being adjustable in length;
- at least one inferior component, including:
  - 5 a first proximate end connected to the first cross-member;
  - a first distal end;
  - a first top surface; and,
  - a first bottom surface;
  - 10 at least one superior component, including:
    - a second proximate end connected to the second cross-member;
    - a second distal end;
    - a second top surface; and,
    - a second bottom surface; and,
  - 15 a wedging component operatively arranged to be:
    - passed completely through the first and second cross-members; and,
    - 20 slid along the first top surface and the second bottom surface to expand the expandable intervertebral implant.

\* \* \* \* \*