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(54) **INTERSPINOUS PROCESS IMPLANT INCLUDING A BINDER AND METHOD OF IMPLANTATION**

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**Publication Classification**

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(57) **ABSTRACT**

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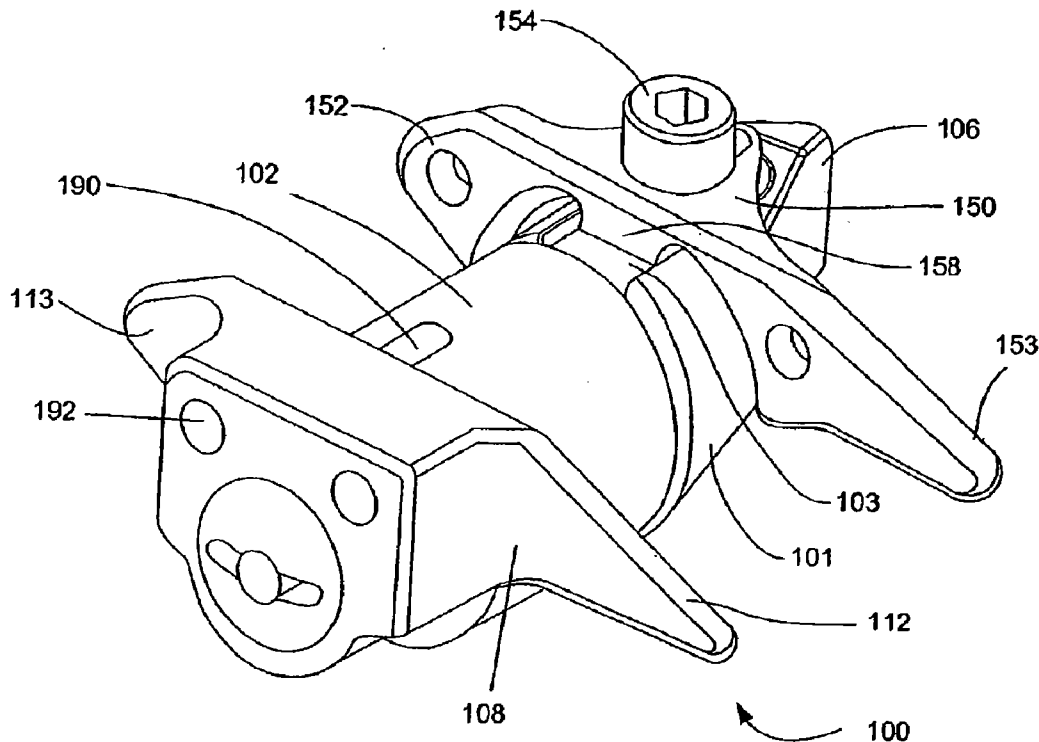
Systems in accordance with embodiments of the present invention can include an implant comprising a spacer for defining a minimum space between adjacent spinous processes, a distraction guide for piercing and distracting an interspinous ligament during implantation, and a binder for limiting or preventing flexion motion of the targeted motion segment. The binder can be secured to a brace associated with the implant during implantation by a capture device. In one embodiment, the capture device includes a fixed piece extending from the brace and a slidable piece associated with the fixed piece. A fastener can be rotated to pinch the binder between the slidable piece and a wall of the brace, securing the binder. A physician need not know the length of the binder prior to implantation, reducing the time required to perform a procedure.

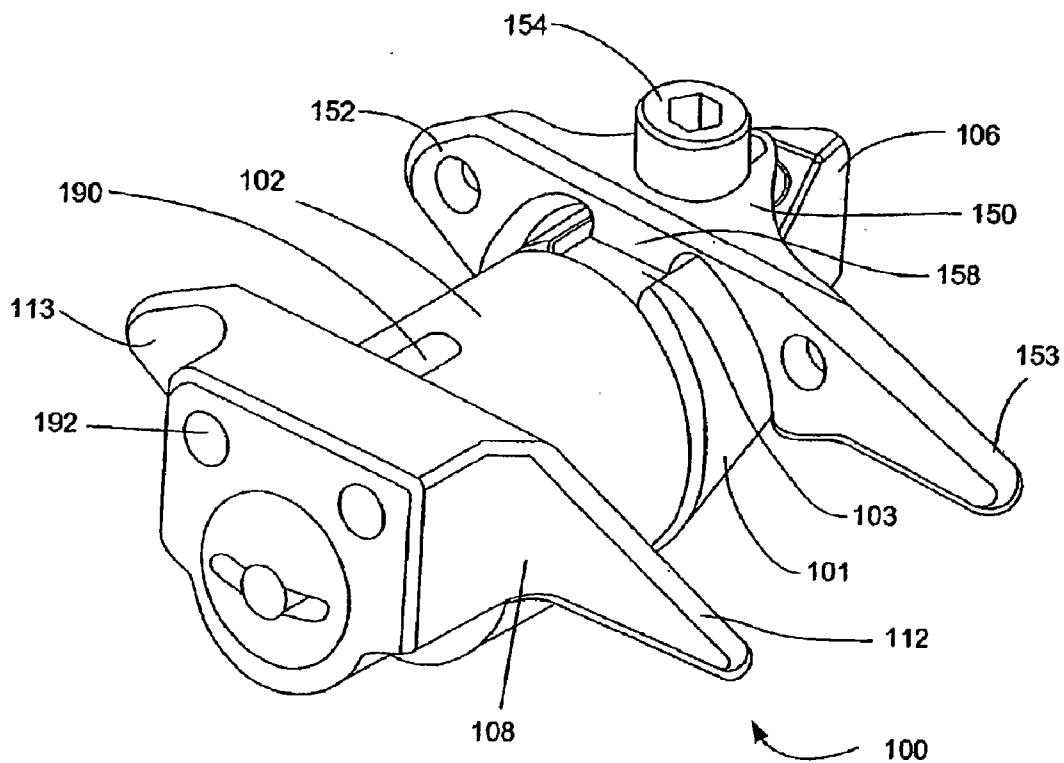
(21) Appl. No.: **11/923,814**

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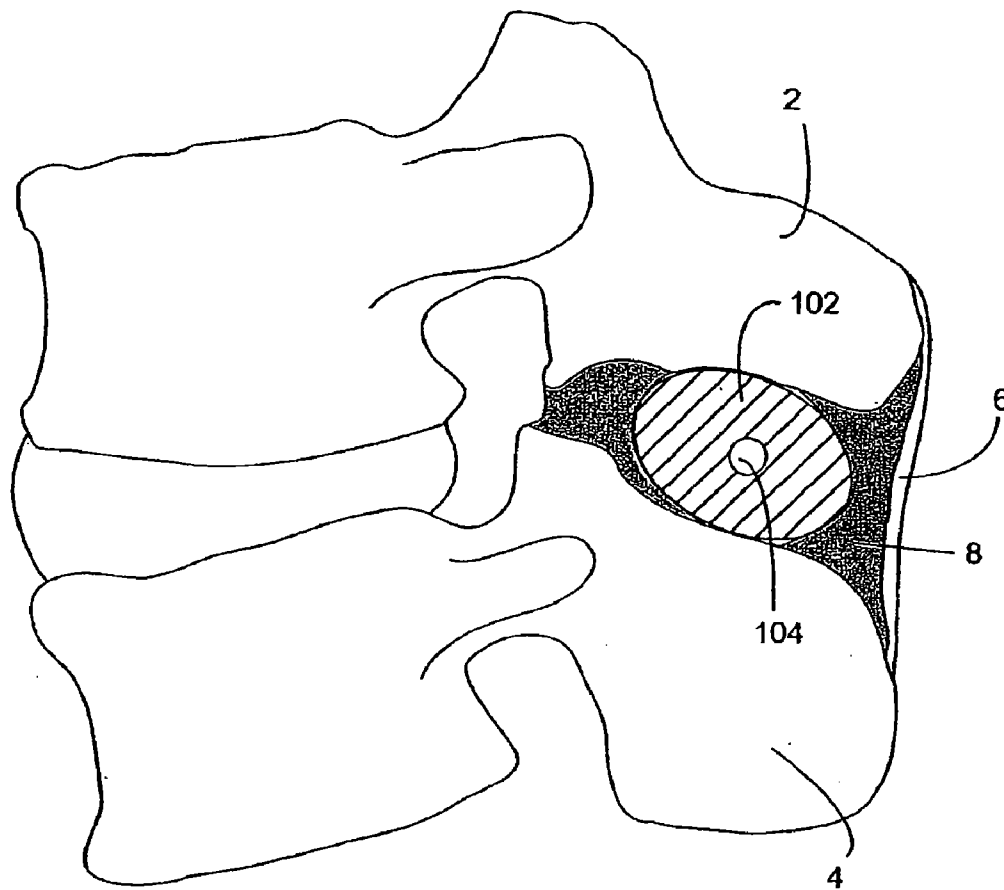
(63) Continuation of application No. 11/095,680, filed on Mar. 31, 2005.





*Fig. 1*





*Fig. 2B*

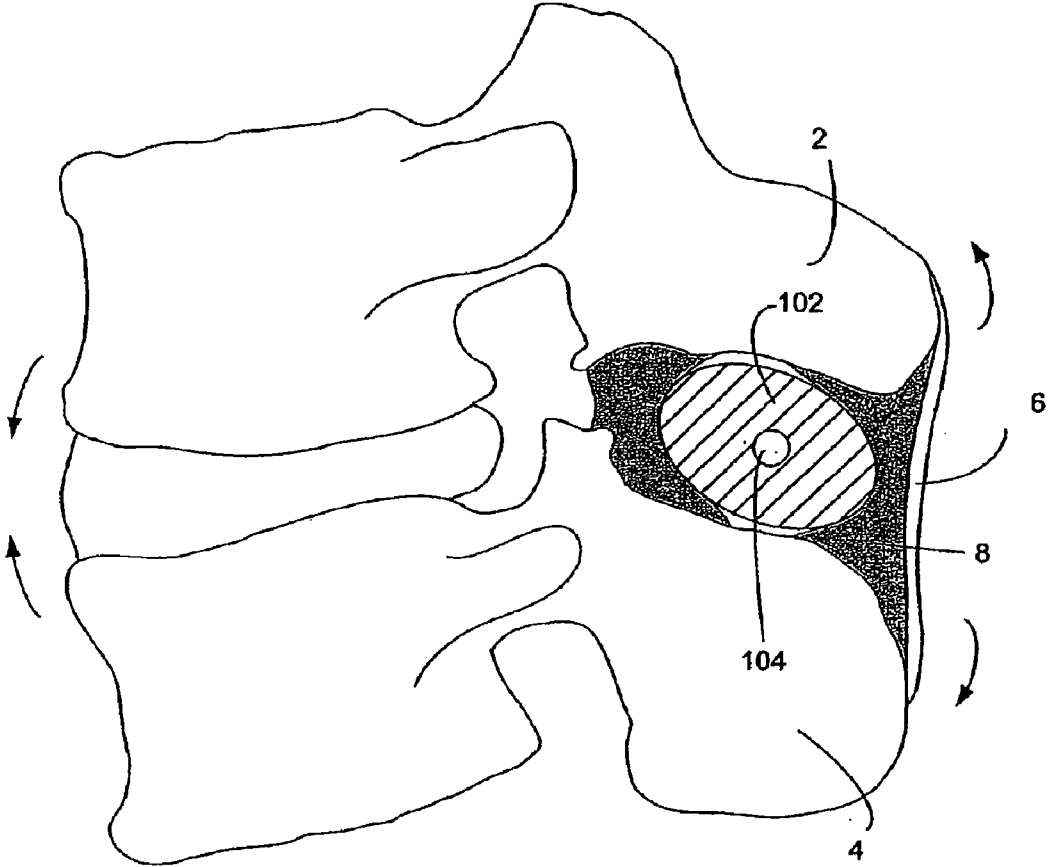


Fig. 2C

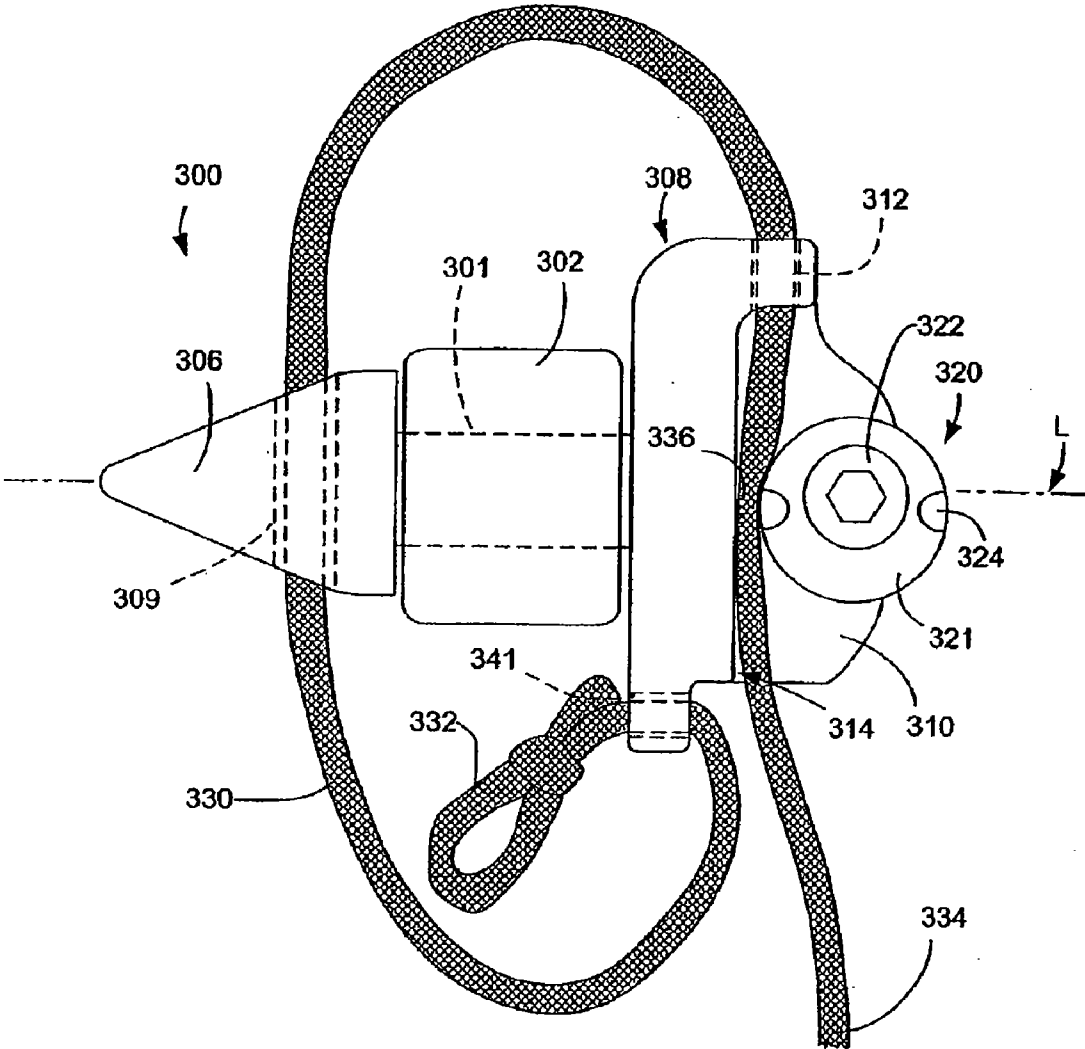
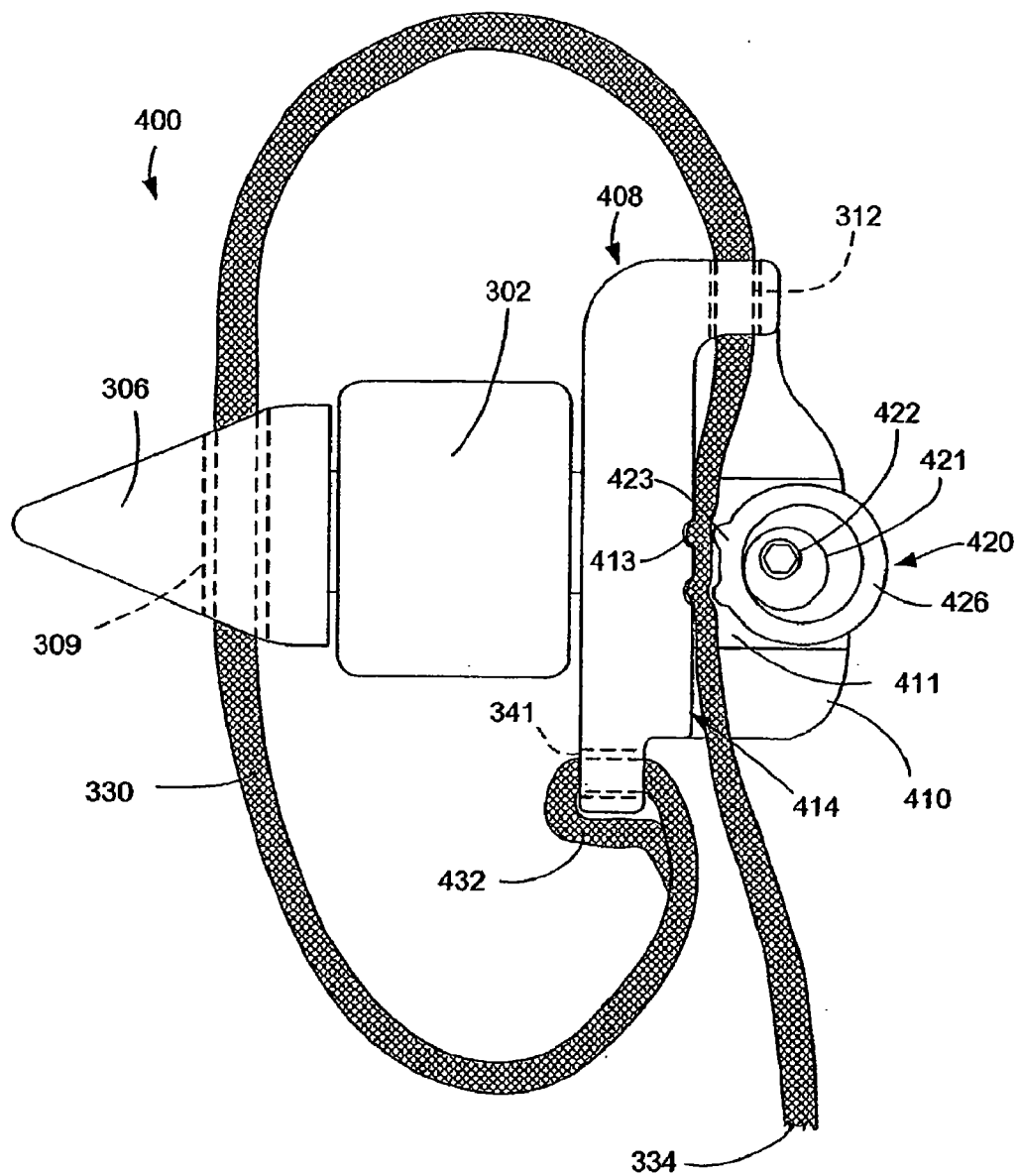
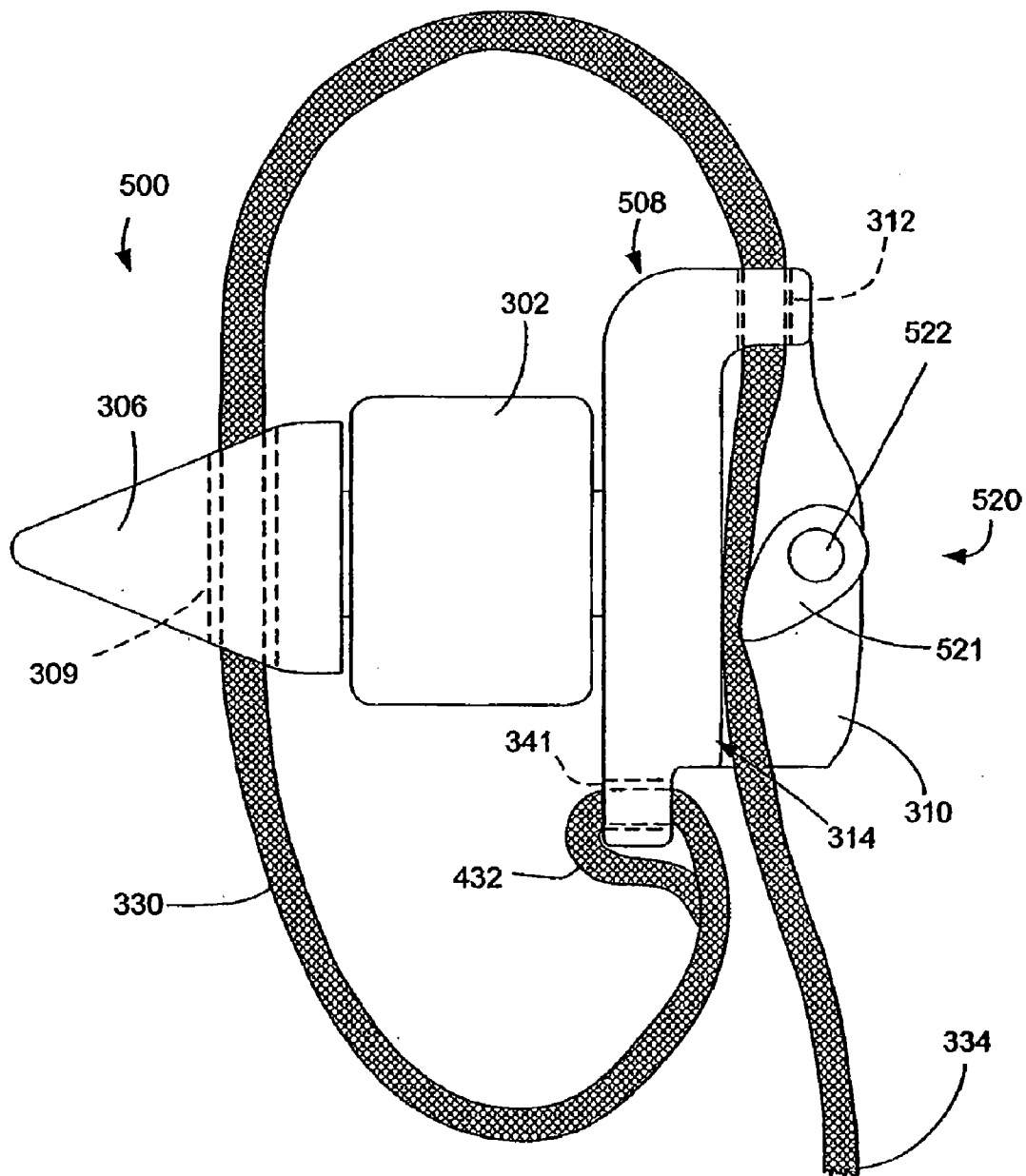


Fig. 3A



*Fig. 3B*



*Fig. 3C*



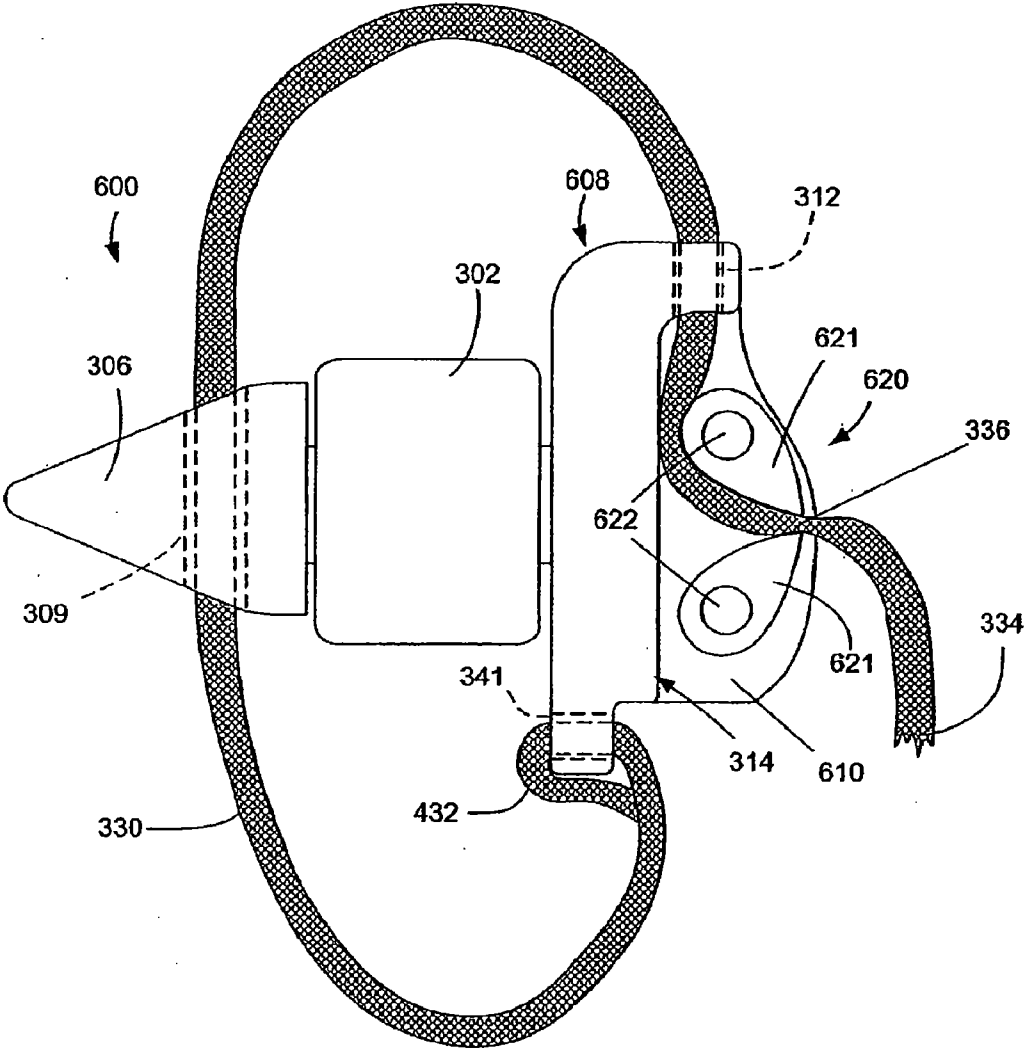


Fig. 3D

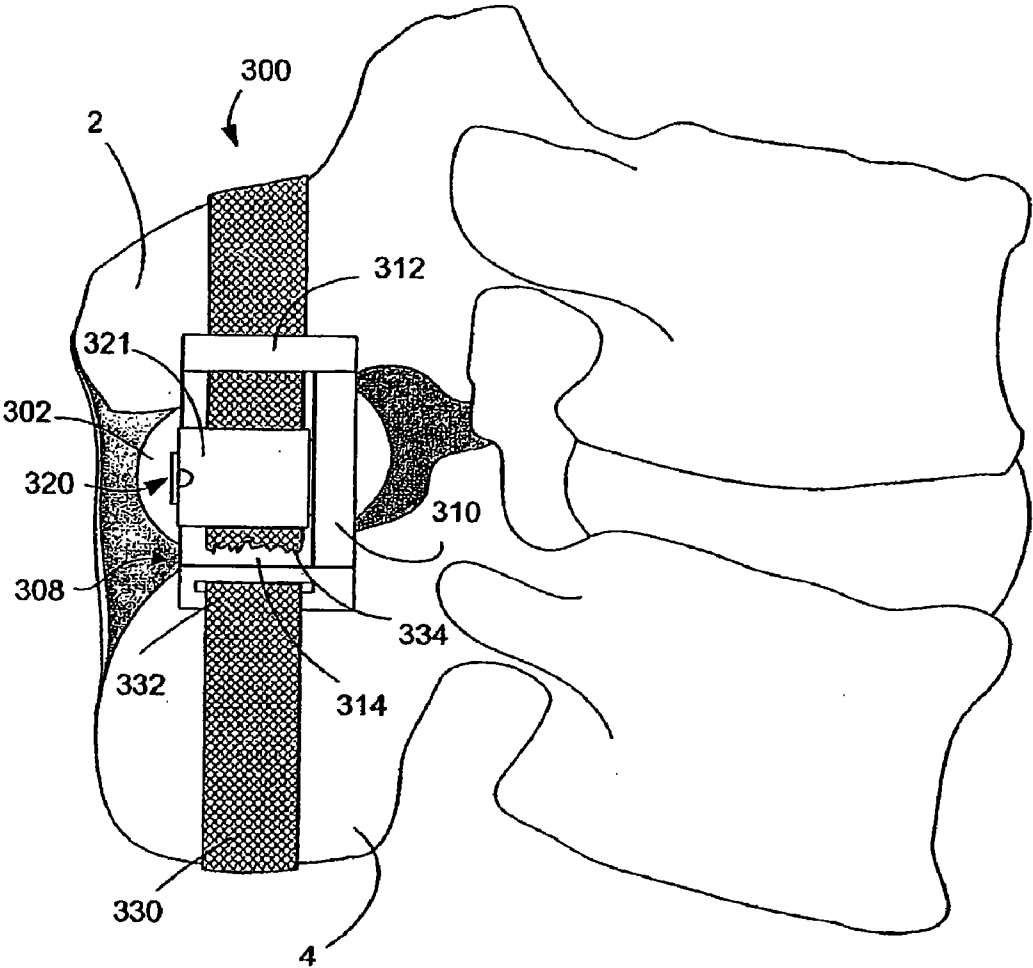
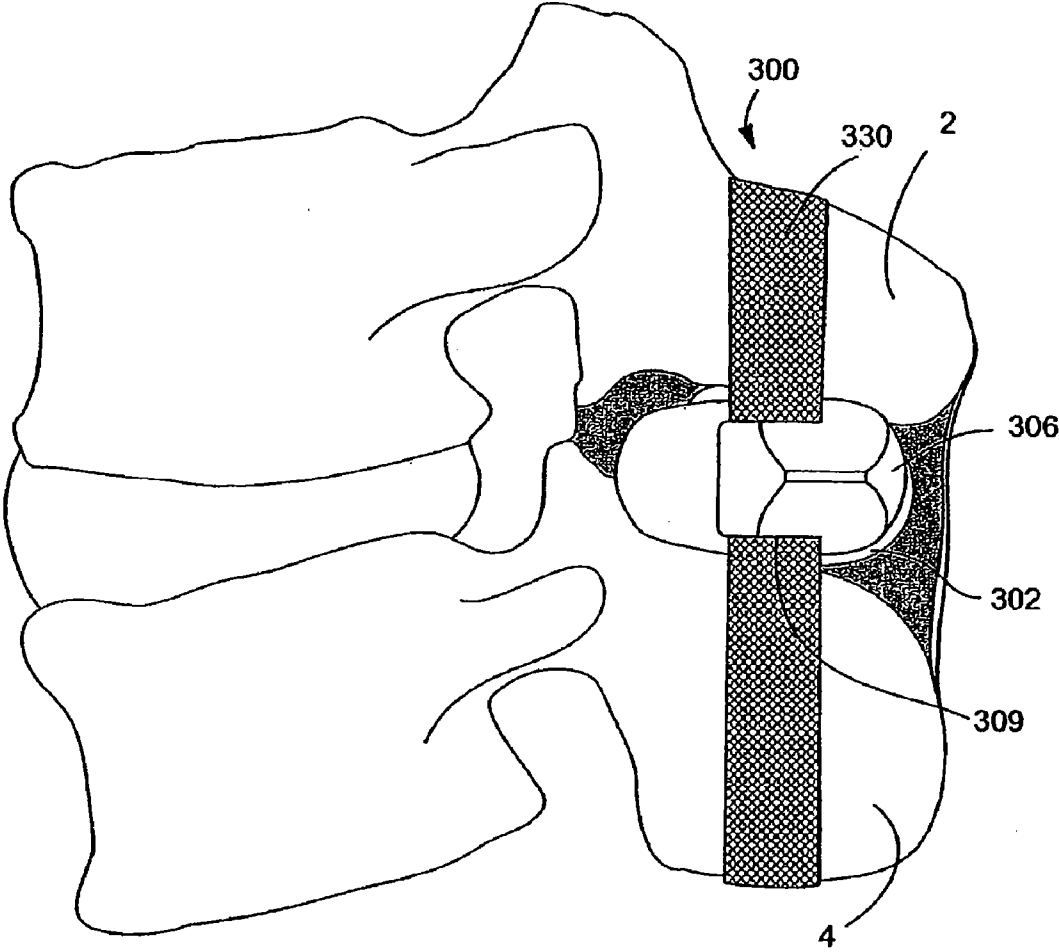
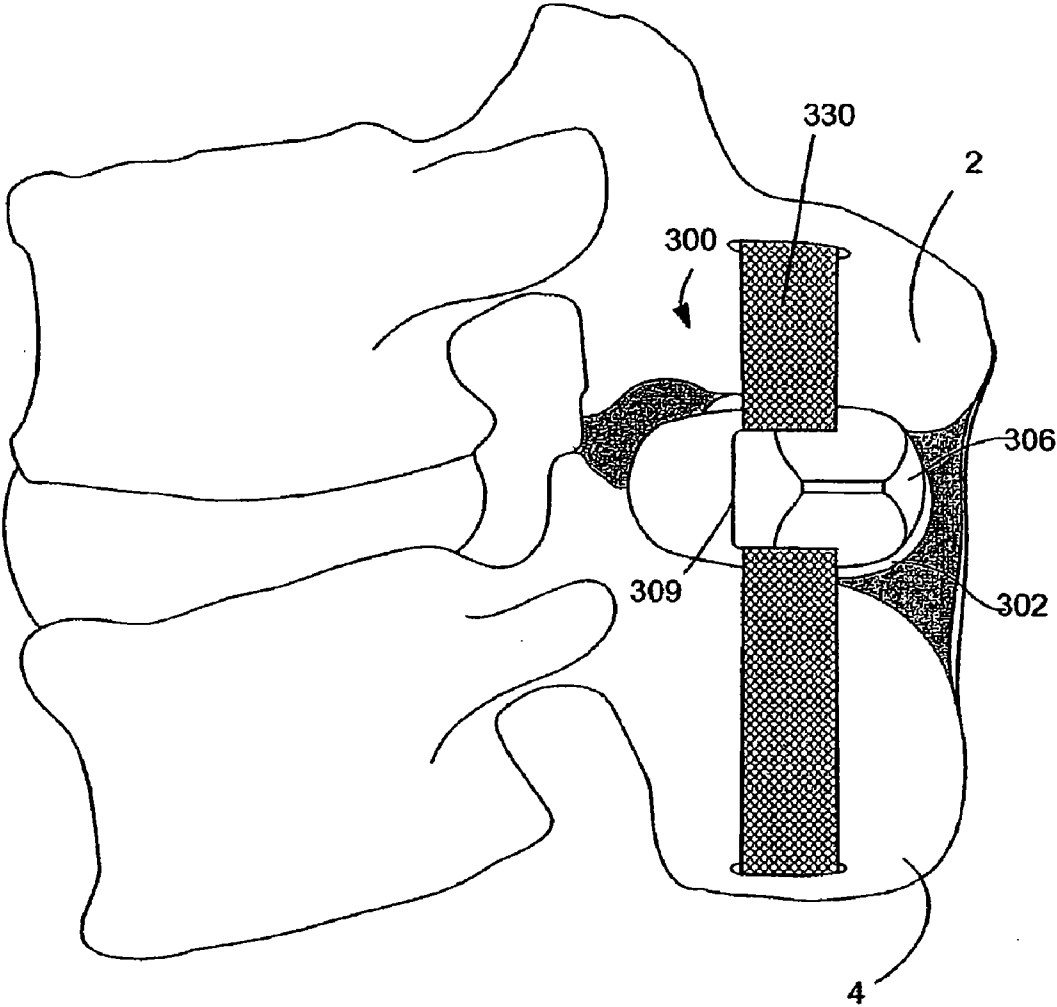


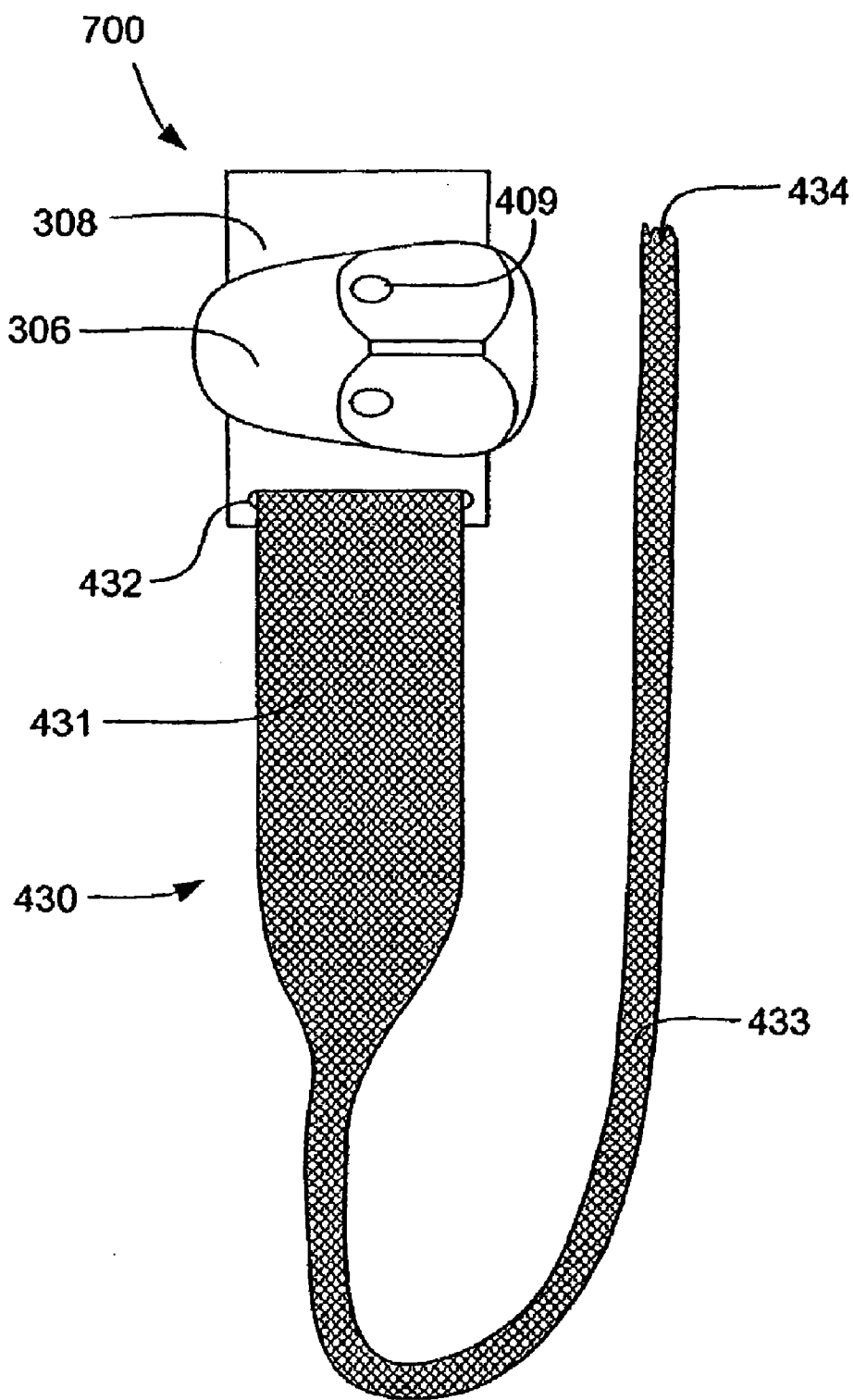
Fig. 4A



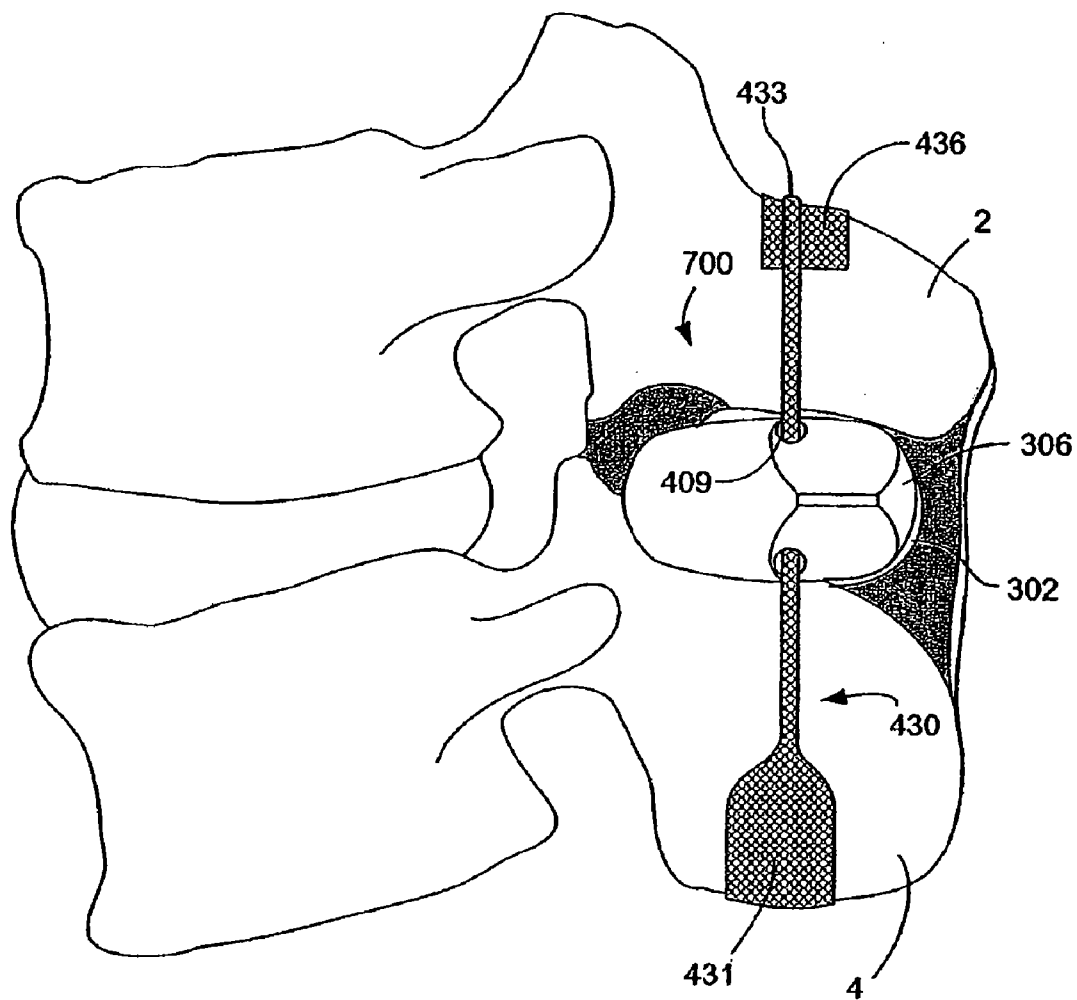
*Fig. 4B*



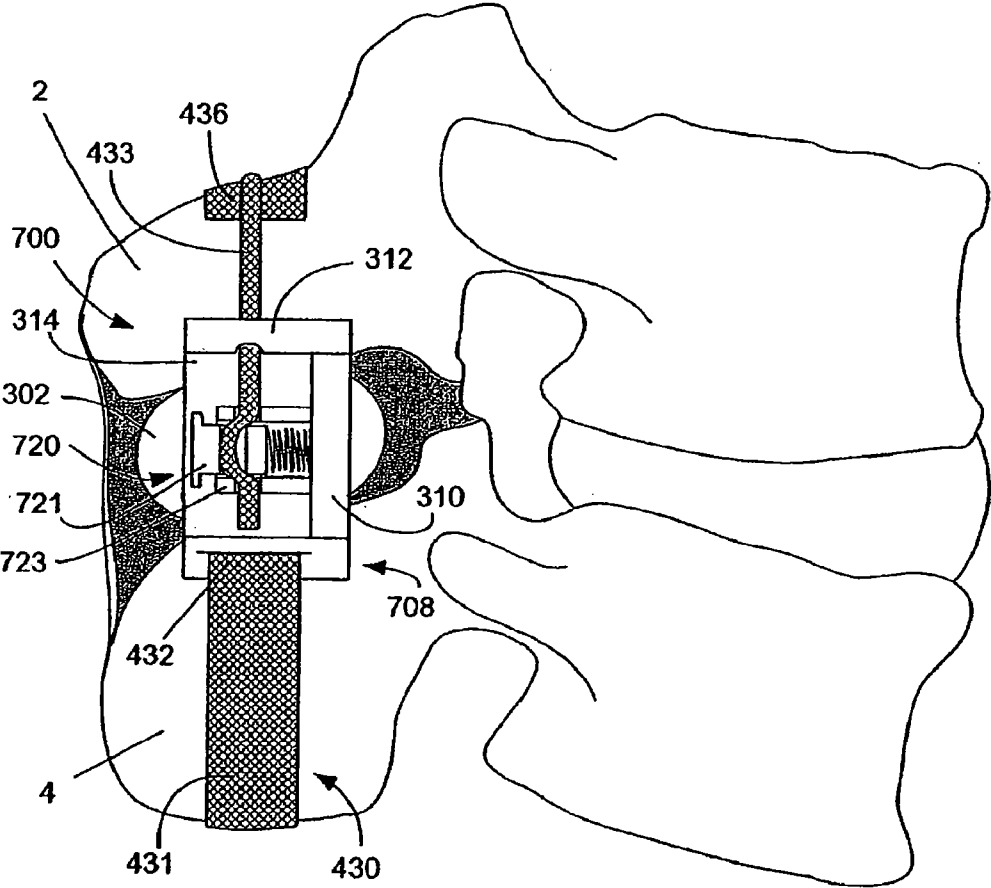
*Fig. 4C*



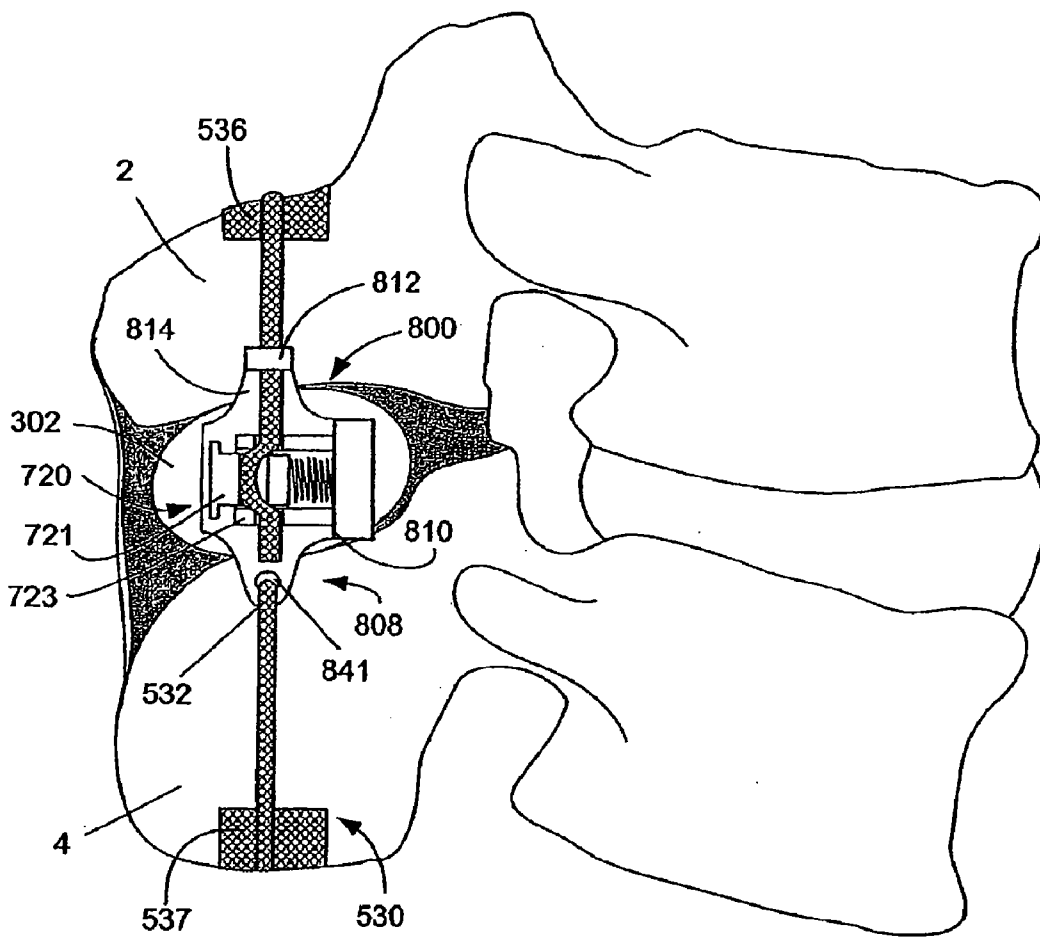
*Fig. 5*



*Fig. 6A*



*Fig. 6B*



*Fig. 6C*



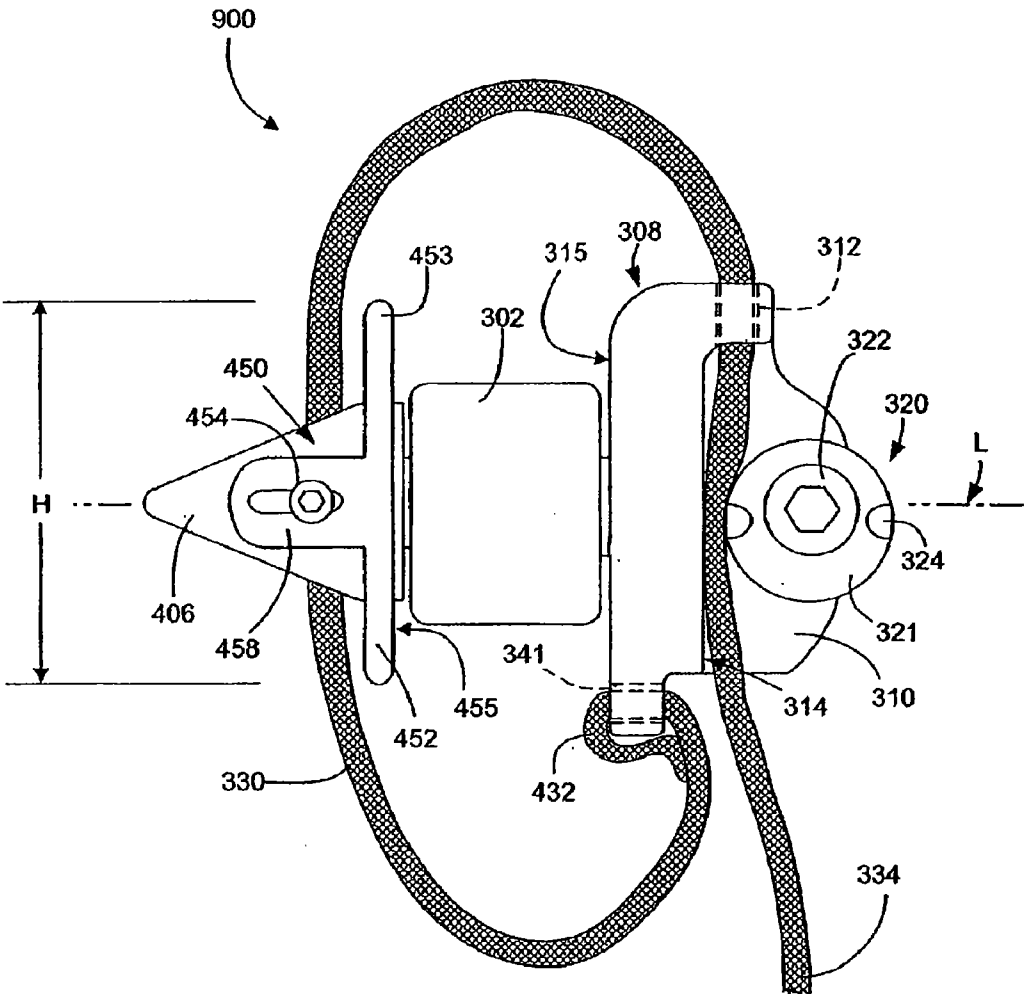


Fig. 7A

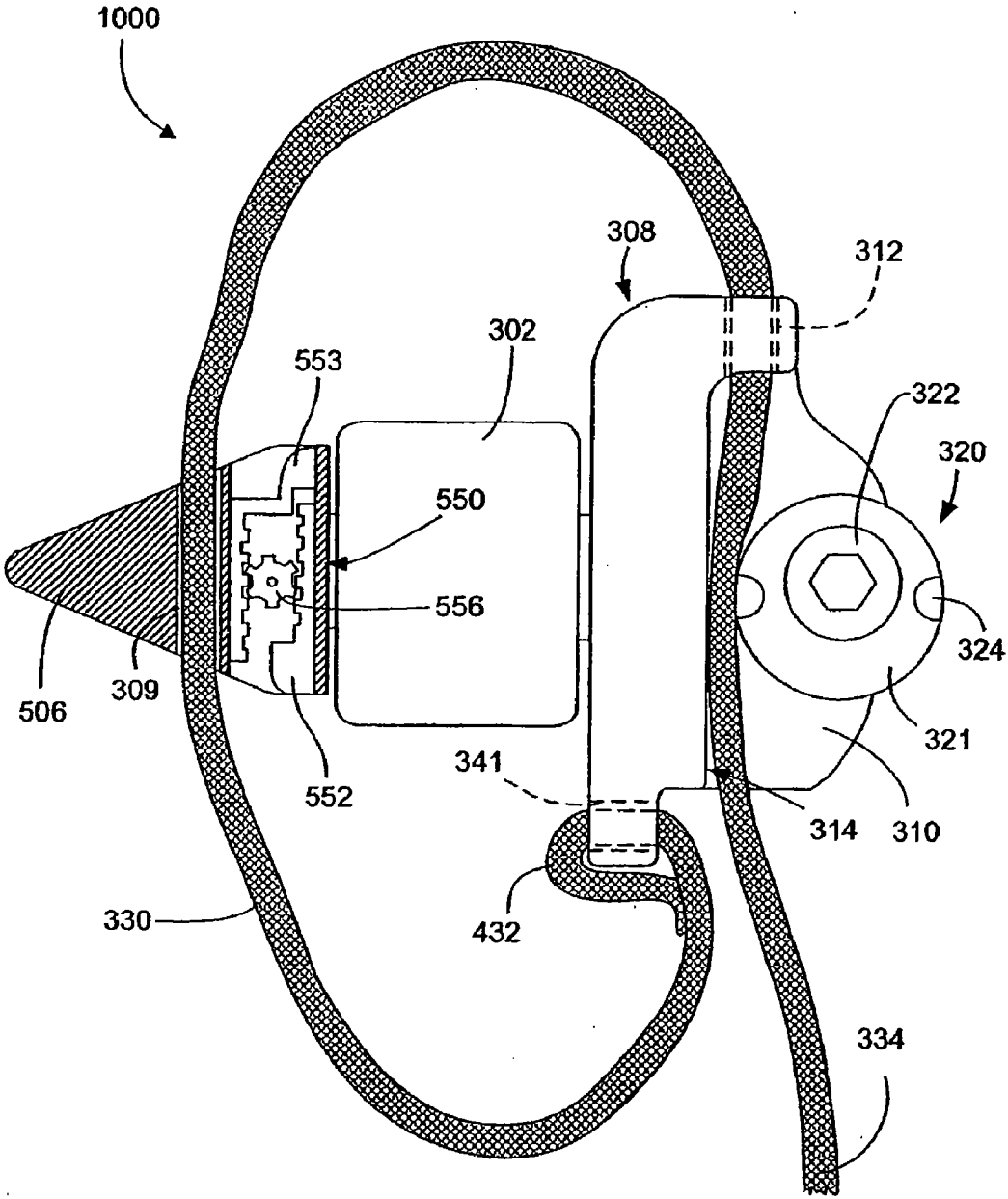


Fig. 7B

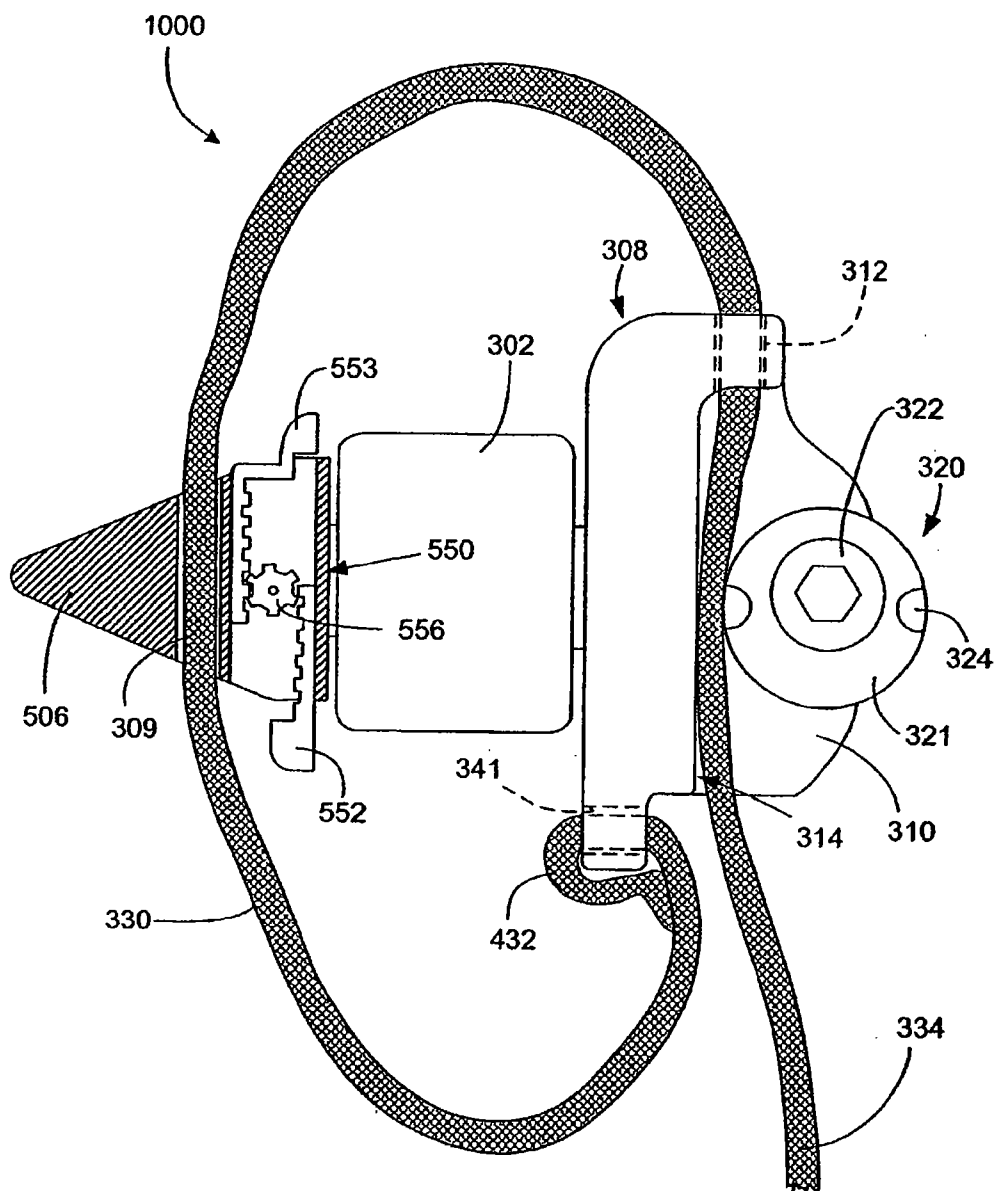


Fig. 7C

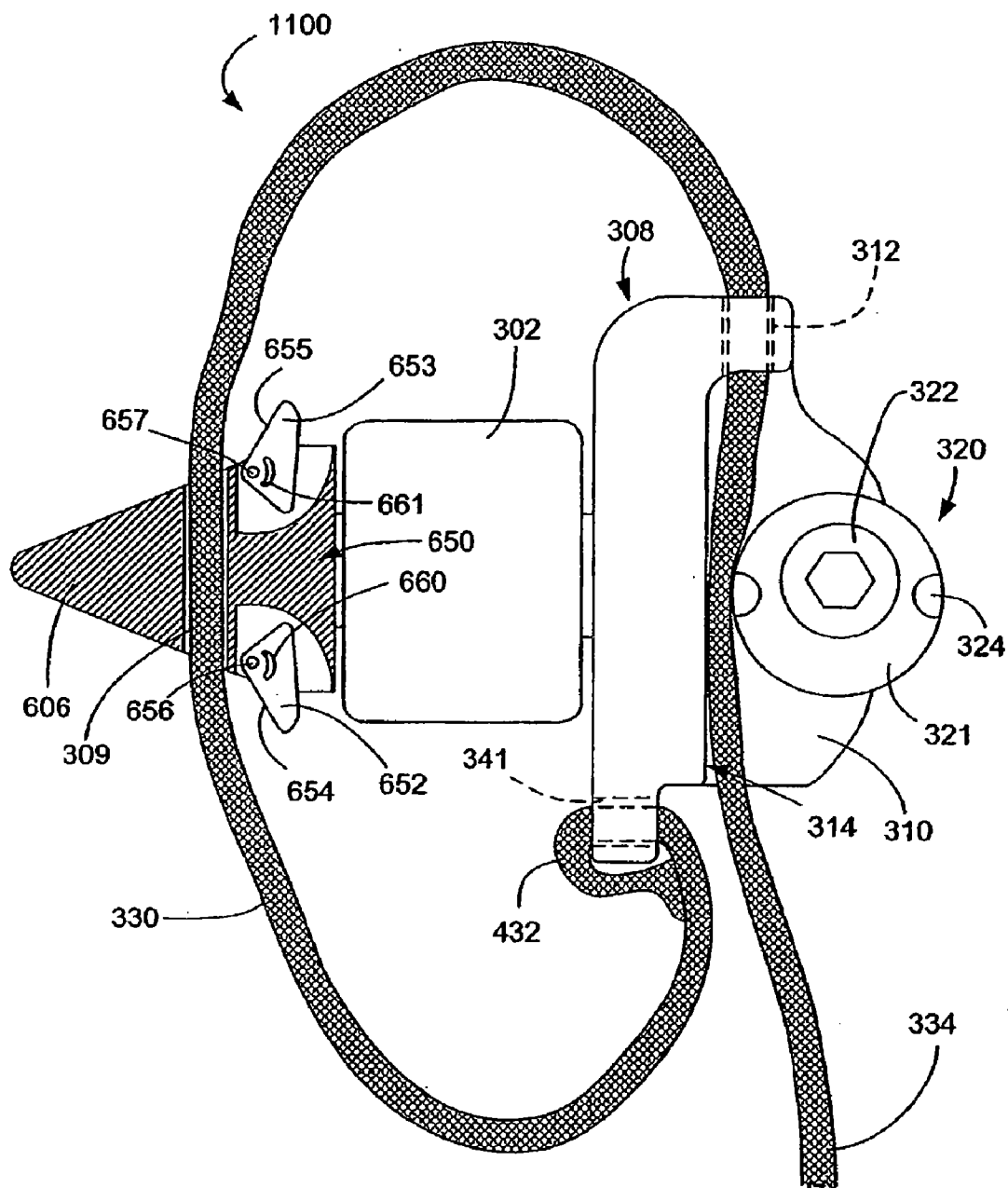


Fig. 7D

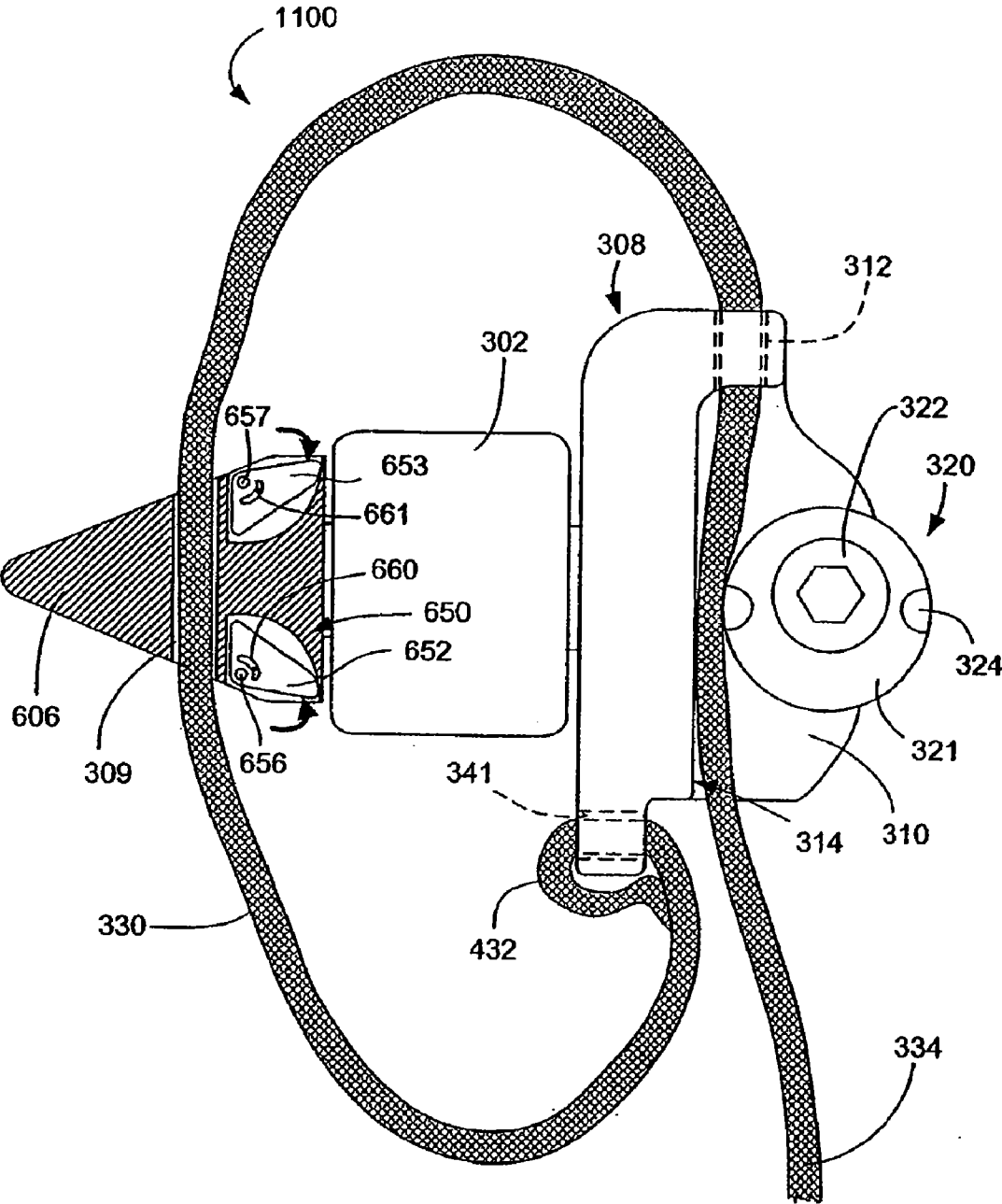
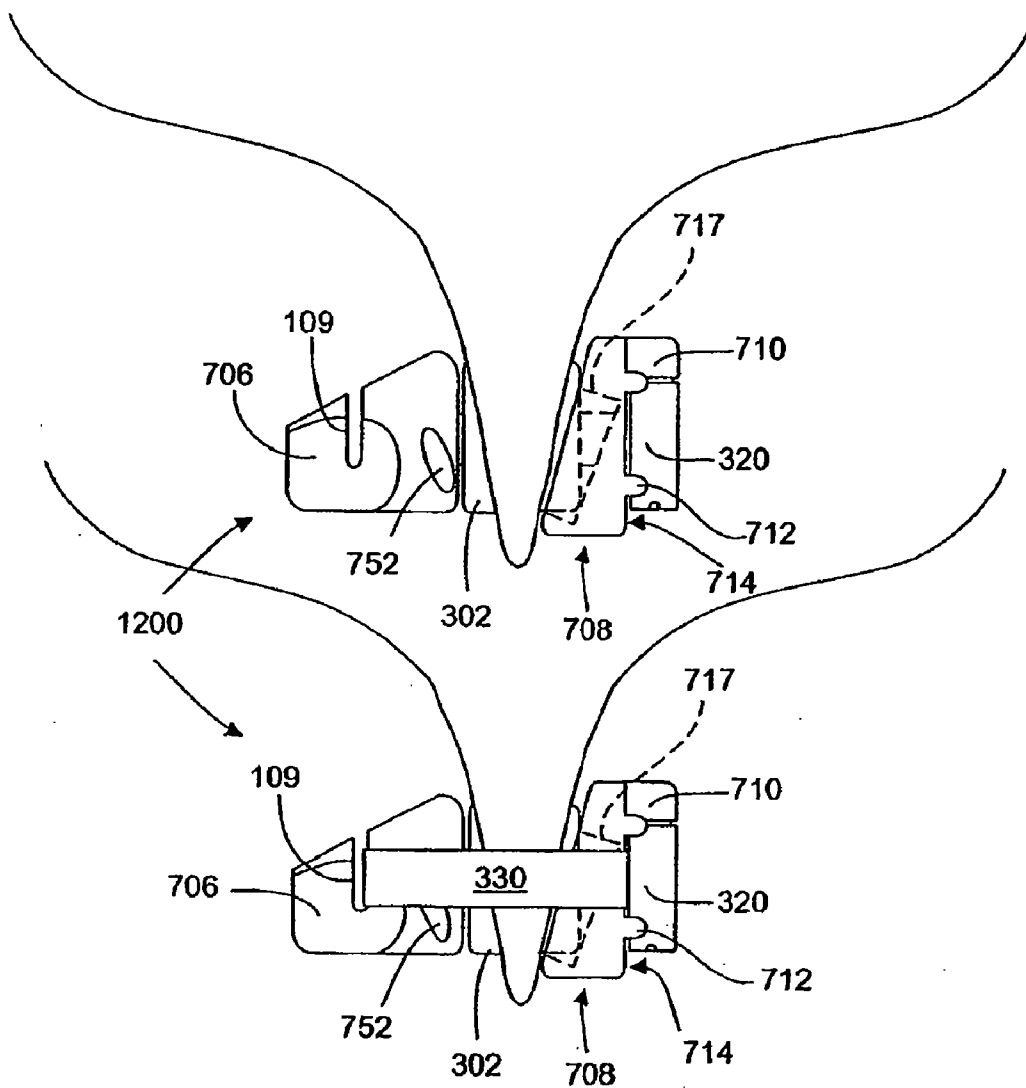


Fig. 7E



*Fig. 8*

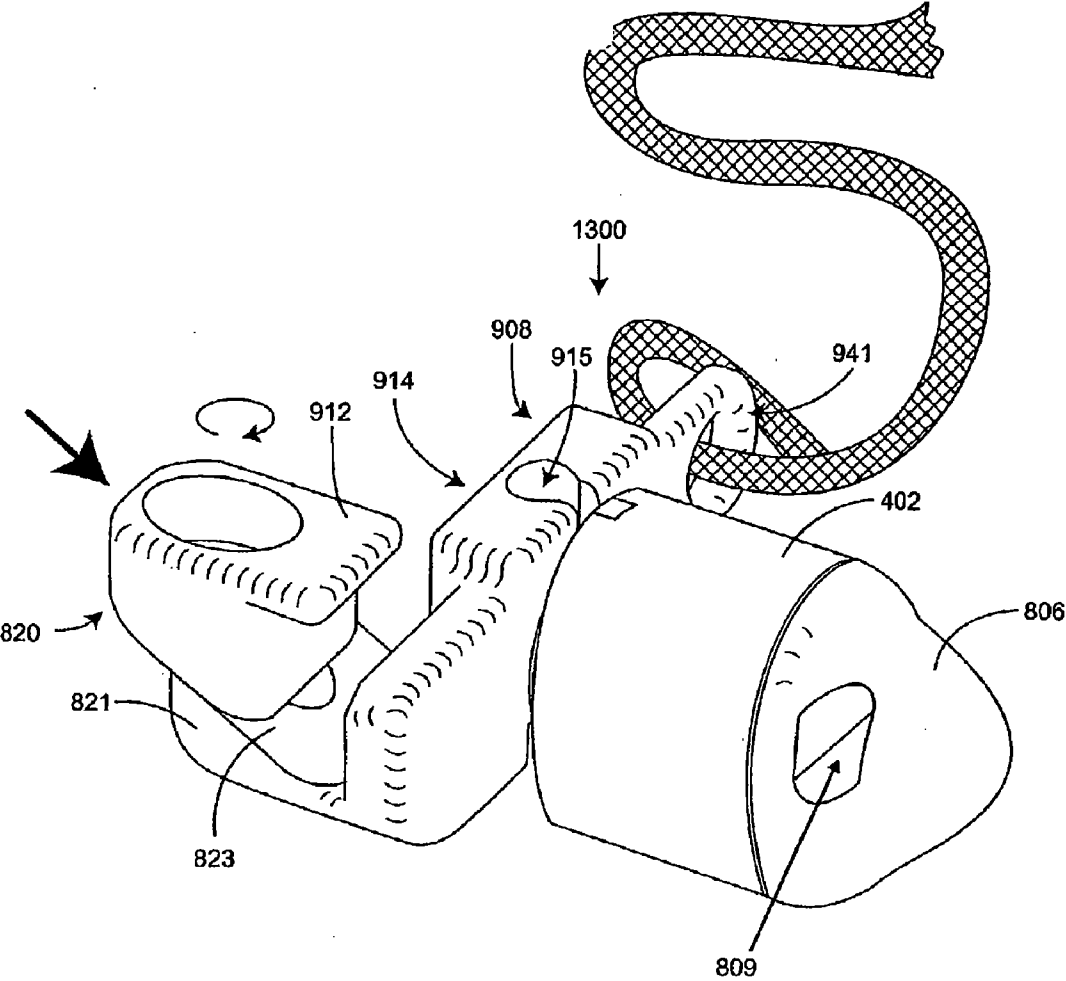
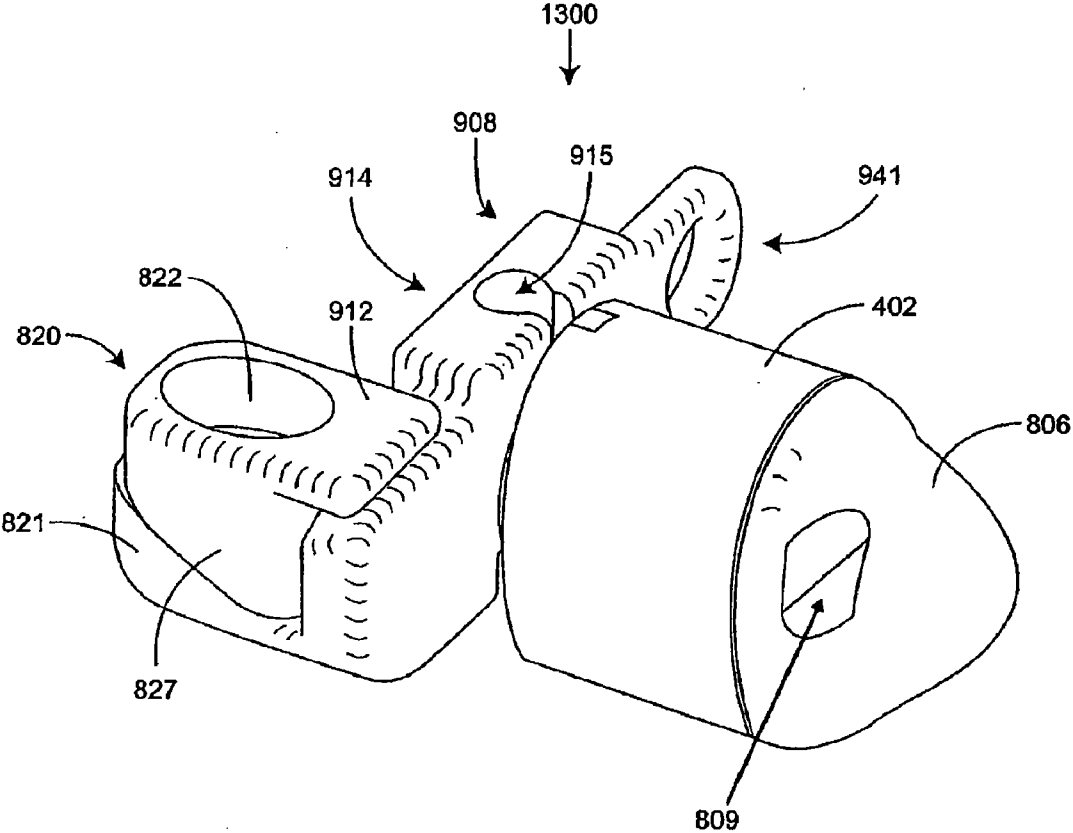
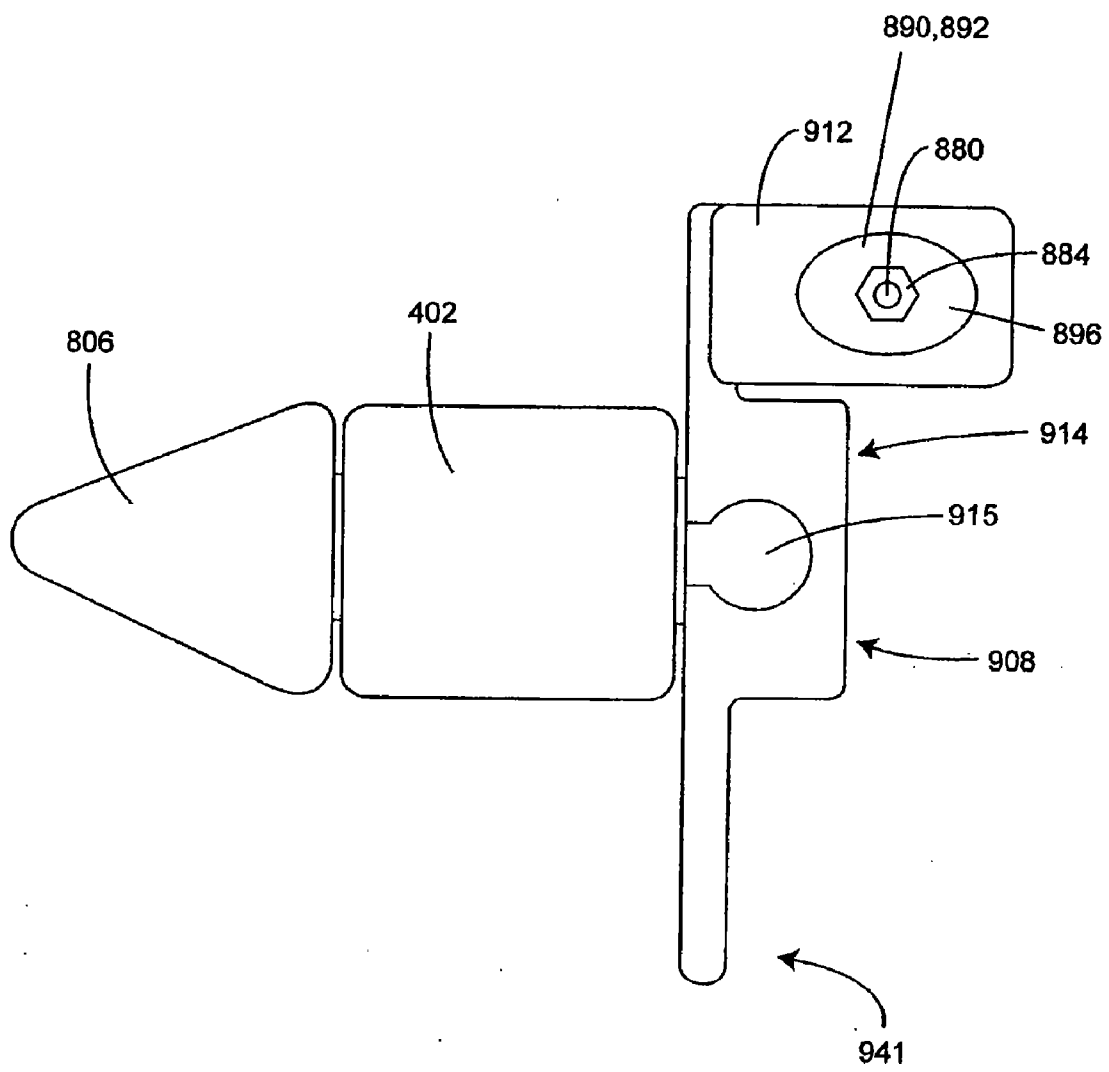


Fig. 9A

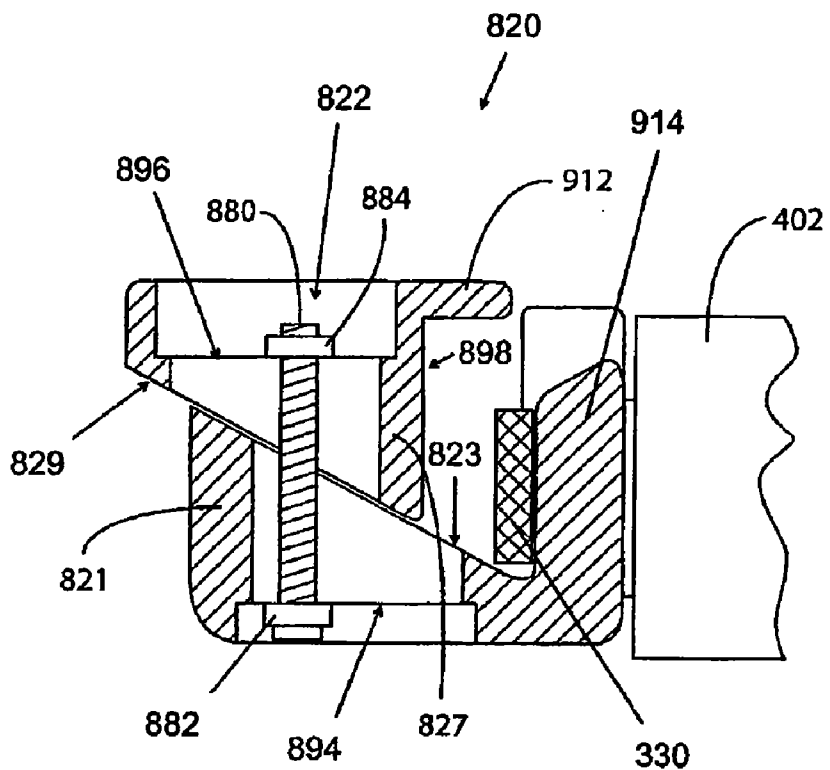


**Fig. 9B**

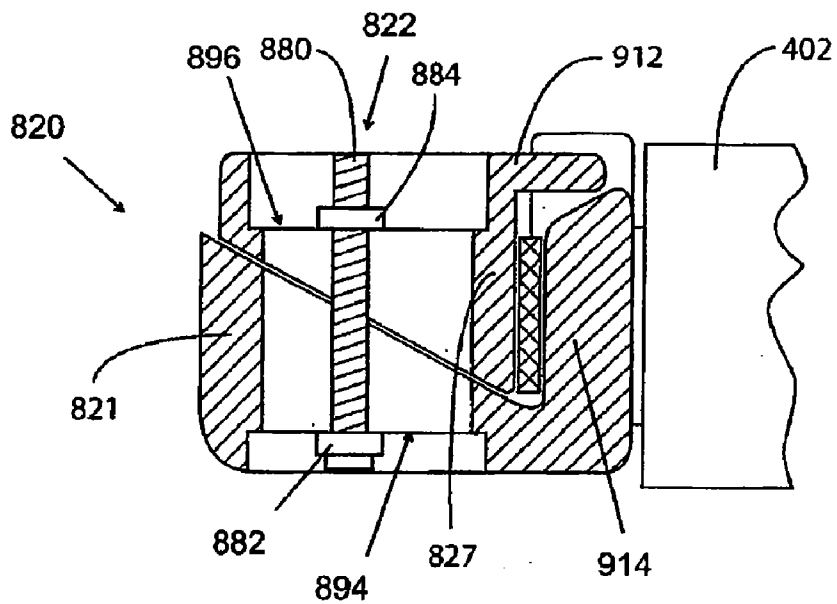




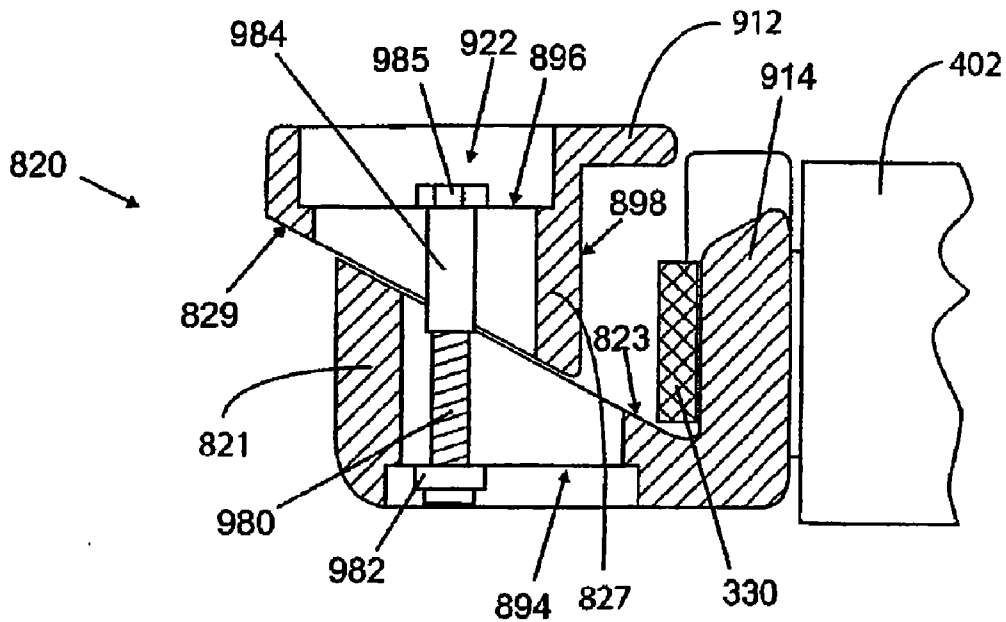
*Fig. 9C*



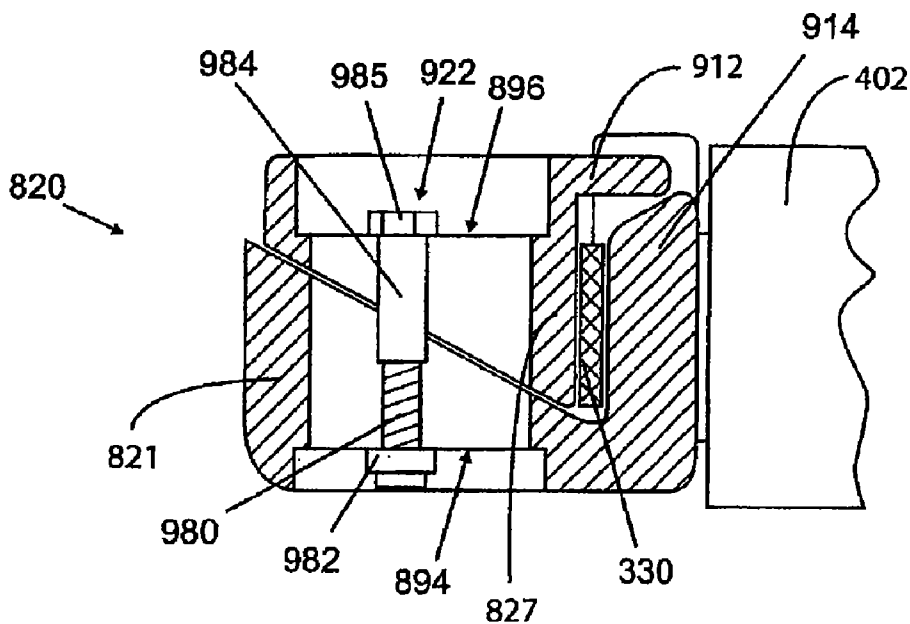
**Fig. 10A**



**Fig. 10B**



**Fig. 10C**



**Fig. 10D**

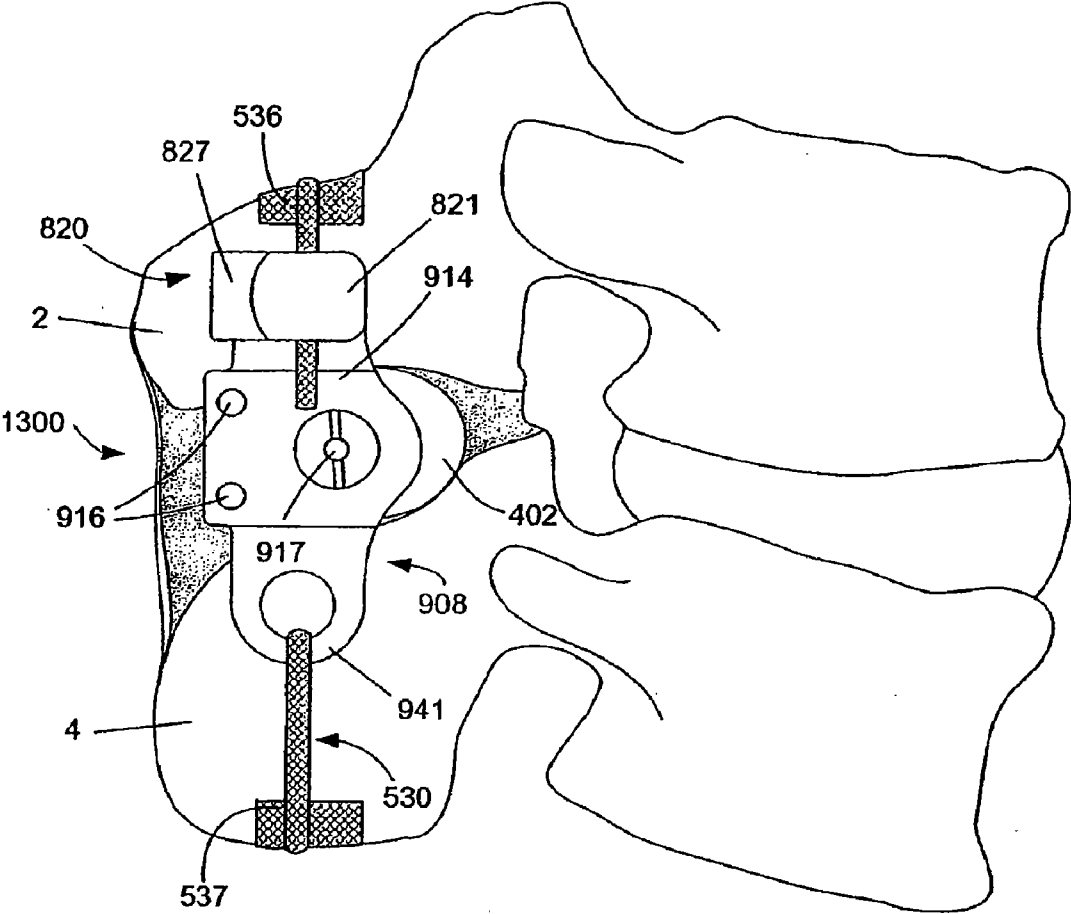
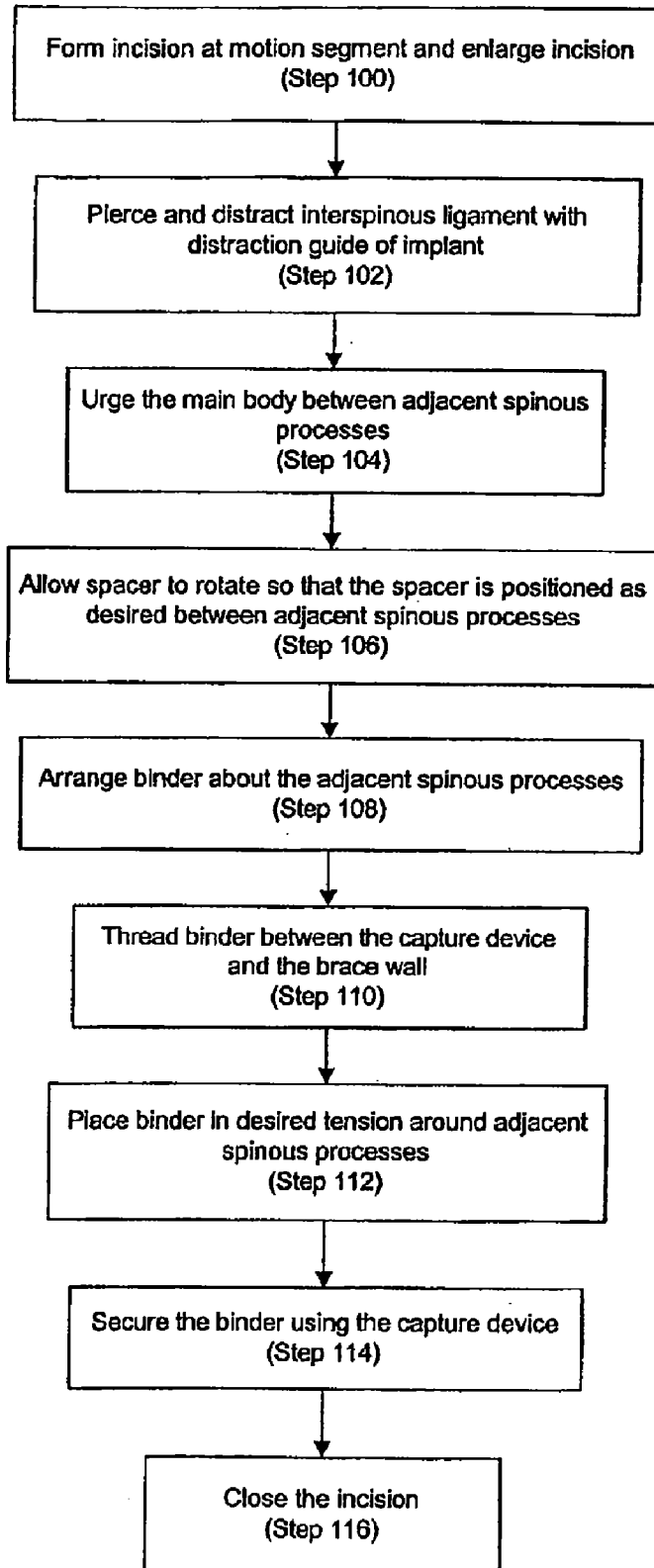


Fig. 11



*Fig. 12*

**INTERSPINOUS PROCESS IMPLANT INCLUDING A BINDER AND METHOD OF IMPLANTATION**

**CROSS-REFERENCE TO RELATED APPLICATIONS**

[0001] This application is a continuation of U.S. patent application Ser. No. 11/095,680, entitled "Interspinous Process Implant Including a Binder and Method of Implantation," filed Mar. 31, 2005, which claims priority to U.S. Provisional Patent Application No. 60/612,465, entitled "Interspinous Process Implant Including a Binder and Method of Implantation," filed Sep. 23, 2004; each of which is incorporated herein by reference in its entirety.

[0002] This U.S. Patent Application incorporates by reference all of the following co-pending applications and issued patents:

[0003] U.S. patent application Ser. No. 10/850,267 (now Publication No. 2005-0010293), entitled "Distractible Interspinous Process Implant and Method of Implantation," filed May 20, 2004;

[0004] U.S. Pat. No. 6,419,676, entitled "Spine Distraction Implant and Method," issued Jul. 16, 2002 to Zucherman, et al.;

[0005] U.S. Pat. No. 6,451,019, entitled "Supplemental Spine Fixation Device and Method," issued Sep. 17, 2002 to Zucherman, et al.;

[0006] U.S. Pat. No. 6,582,433, entitled "Spine Fixation Device and Method," issued Jun. 24, 2003 to Yun;

[0007] U.S. Pat. No. 6,652,527, entitled "Supplemental Spine Fixation Device and Method," issued Nov. 25, 2003 to Zucherman, et al.;

[0008] U.S. Pat. No. 6,695,842, entitled "Interspinous Process Distraction System and Method with Positionable Wing and Method," issued Feb. 24, 2004 to Zucherman, et al.;

[0009] U.S. Pat. No. 6,699,246, entitled "Spine Distraction Implant," issued Mar. 2, 2004 to Zucherman, et al.;

[0010] U.S. Pat. No. 6,712,819, entitled "Mating Insertion Instruments for Spinal Implants and Methods of Use," issued Mar. 30, 2004 to Zucherman, et al.

**BACKGROUND**

[0011] This invention relates to interspinous process implants. As the present society ages, it is anticipated that there will be an increase in adverse spinal conditions which are characteristic of older people. Certain biochemical changes can occur with aging, affecting tissue found throughout the body. In the spine, the structure of the intervertebral disks can be compromised, in part as the structure of the annulus fibrosus of the intervertebral disk weakens due to degenerative effects. Spondylosis (also referred to as spinal osteoarthritis) is one example of a degenerative disorder that can cause loss of normal spinal structure and function. The degenerative process can impact the cervical, thoracic, and/or lumbar regions of the spine, affecting the intervertebral disks and the facet joints. Pain associated with degenerative disorders is often triggered by one or both of forward flexion and hyperextension. Spondylosis in the thoracic region of the spine can cause disk pain

during flexion and facet pain during hyperextension. Spondylosis can affect the lumbar region of the spine, which carries most of the body's weight, and movement can stimulate pain fibers in the annulus fibrosus and facet joints.

[0012] Over time, loss of disk height can result in a degenerative cascade with deterioration of all components of the motion segment resulting in segment instability and ultimately in spinal stenosis (including, but not limited to, central canal and lateral stenosis). Spinal stenosis results in a reduction in foraminal area (i.e., the available space for the passage of nerves and blood vessels) which compresses the nerve roots and causes radicular pain. Another symptom of spinal stenosis is myelopathy. Extension and ipsilateral rotation further reduces the foraminal area and contributes to pain, nerve root compression and neural injury. During the process of deterioration, disks can become herniated and/or become internally torn and chronically painful. When symptoms seem to emanate from both anterior (disk) and posterior (facets and foramen) structures, patients cannot tolerate positions of extension or flexion.

[0013] A common procedure for handling pain associated with degenerative spinal disk disease is the use of devices for fusing together two or more adjacent vertebral bodies. The procedure is known by a number of terms, one of which is interbody fusion. Interbody fusion can be accomplished through the use of a number of devices and methods known in the art. These include screw arrangements, solid bone implant methodologies, and fusion devices which include a cage or other mechanism which is packed with bone and/or bone growth inducing substances. All of the above are implanted between adjacent vertebral bodies in order to fuse the vertebral bodies together, alleviating associated pain.

[0014] Depending on the degree of slip and other factors, a physician may fuse the vertebra "as is," or fuse the vertebrae and also use a supplemental device. Supplemental devices are often associated with primary fusion devices and methods, and assist in the fusion process. Supplemental devices assist during the several month period when bone from the adjacent vertebral bodies is growing together through the primary fusion device in order to fuse the adjacent vertebral bodies. During this period it is advantageous to have the vertebral bodies held immobile with respect to each other so that sufficient bone growth can be established. Supplemental devices can include hook and rod arrangements, screw arrangements, and a number of other devices which include straps, wires, and bands, all of which are used to immobilize one portion of the spine relative to another. Supplemental devices have the disadvantage that they generally require extensive surgical procedures in addition to the extensive procedure surrounding the primary fusion implant. Such extensive surgical procedures include additional risks, including risk of causing damage to the spinal nerves during implantation. Spinal fusion can include highly invasive surgery requiring use of a general anesthetic, which itself includes additional risks. Risks further include the possibility of infection, and extensive trauma and damage to the bone of the vertebrae caused either by anchoring of the primary fusion device or the supplemental device. Finally, spinal fusion can result in an absolute loss of relative movement between vertebral bodies.

[0015] U.S. Pat. No. 5,496,318 to Howland, et al. teaches supplemental devices for the stabilization of the spine for

use with surgical procedures to implant a primary fusion device. Howland '318 teaches an H-shaped spacer having two pieces held together by a belt, steel cable, or polytetrafluoroethane web material, one or both ends of which includes an attachment device fixedly connected with the respective end. Howland '318 teaches that the vertebra are preferably surgically modified to include a square notch to locate the fixation device in a preferred location. Howland '318 has the further disadvantage that the belt, cable or web material must be sized before implantation, increasing the procedure time to include sizing time and reducing the precision of the fit where both ends of the belt, cable or web material include attachment devices (and as such are incrementally sized).

[0016] U.S. Pat. No. 5,609,634 to Voydeville teaches a prosthesis including a semi-flexible interspinous block positioned between adjacent spinous processes and a ligament made from the same material. A physician must lace the ligament through the interspinous block and around the spinous processes in a figure of eight, through the interspinous block and around the spinous processes in an oval, and suture the ligament to itself to fix the interspinous block in place. Voydeville has the disadvantage of requiring significant displacement and/or removal of tissue associated with the spinous processes, potentially resulting in significant trauma and damage. Voydeville has the further disadvantage of requiring the physician to lace the interspinous ligament through the interspinous block. Such a procedure can require care and time, particularly because a physician's ability to view the area of interest is complicated by suffusion of blood in the area of interest.

[0017] It would be advantageous if a device and procedure for limiting flexion and extension of adjacent vertebral bodies were as simple and easy to perform as possible, and would preferably (though not necessarily) leave intact all bone, ligament, and other tissue which comprise and surround the spine. Accordingly, there is a need for procedures and implants which are minimally invasive and which can supplement or substitute for primary fusion devices and methods, or other spine fixation devices and methods. Accordingly, a need exists to develop spine implants that alleviate pain caused by spinal stenosis and other such conditions caused by damage to, or degeneration of, the spine. Such implants would distract (increase) or maintain the space between the vertebrae to increase the foraminal area and reduce pressure on the nerves and blood vessels of the spine, and limit or block flexion to reduce pain resulting from spondylosis and other such degenerative conditions.

[0018] A further need exists for development of a minimally invasive surgical implantation method for spine implants that preserves the physiology of the spine. A still further need exists for an implant that accommodates the distinct anatomical structures of the spine, minimizes further trauma to the spine, and obviates the need for invasive methods of surgical implantation. Additionally, a need exists to address adverse spinal conditions that are exacerbated by spinal extension and flexion.

#### BRIEF DESCRIPTION OF THE DRAWINGS

[0019] Further details of embodiments of the present invention are explained with the help of the attached drawings in which:

[0020] FIG. 1 is a perspective view of an interspinous implant capable of limiting or blocking relative movement of adjacent spinous processes during extension of the spine.

[0021] FIG. 2A is a posterior view of the implant of FIG. 1 positioned between adjacent spinous processes.

[0022] FIG. 2B is a cross-sectional side view of a spacer of the interspinous implant of FIGS. 1 and 2A positioned between spinous processes.

[0023] FIG. 2C is a cross-sectional view of the spacer of FIG. 2B during flexion of the spine.

[0024] FIG. 3A is a side view of an embodiment of an implant in accordance with the present invention having a distraction guide, a spacer, a brace, and a binder associated with the brace and fixable in position by a capture device.

[0025] FIG. 3B is a side view of an alternative embodiment of an implant in accordance with the present invention including a brace wall having recesses for receiving lobes of a capture device.

[0026] FIG. 3C is a side view of still another embodiment of an implant in accordance with the present invention including a capture device having a spring-loaded cam for securing a binder against a brace wall.

[0027] FIG. 3D is a side view of a still further embodiment of an implant in accordance with the present invention including a capture device having dual spring-loaded cams for securing a binder in position.

[0028] FIG. 4A is an end view of the implant of FIG. 3A positioned between adjacent spinous processes.

[0029] FIG. 4B is an end view of the implant of FIG. 3A positioned between adjacent spinous processes.

[0030] FIG. 4C is an end view of the implant of FIG. 3A positioned between adjacent spinous processes wherein the spinous processes are surgically modified to receive a binder.

[0031] FIG. 5 is an end view of an alternative embodiment of an implant in accordance with the present invention having a binder that varies in shape along the binder's length.

[0032] FIG. 6A is an end view of the implant of FIG. 5 positioned between adjacent spinous processes.

[0033] FIG. 6B is an opposite end view of the implant of FIG. 6A.

[0034] FIG. 6C is an end view of still another embodiment of an implant in accordance with the present invention having a cord for a binder.

[0035] FIG. 7A is a side view of an embodiment of an implant in accordance with the present invention including a wing associated with the distraction guide to further limit or block movement of the implant.

[0036] FIG. 7B is a partial cross-sectional side view of an alternative embodiment of an implant in accordance with the present invention include an extendable wing associated with the distraction guide, the extendable wing being in a retracted position.

[0037] FIG. 7C is a partial cross-sectional side view of the implant of FIG. 7B wherein the extendable wing is in an extended position.

[0038] FIG. 7D is a partial cross-sectional side view of still another embodiment of an implant in accordance with the present invention including a spring-loaded wing associated with the distraction guide, the wing being in an extended position.

[0039] FIG. 7E is a partial cross-sectional side view of the implant of FIG. 7D wherein the spring-loaded wing is in a collapsed position.

[0040] FIG. 8 is a top view of two implants in accordance with an embodiment of the present invention positioned between the spinous processes of adjacent vertebrae, one of the implants having a binder arranged around the adjacent spinous processes.

[0041] FIG. 9A is a perspective view of a further embodiment of an implant in accordance with the present invention having a distraction guide, a spacer, a brace, and a binder associated with the brace and fixable in position by a capture device.

[0042] FIG. 9B is a perspective view the implant of FIG. 9A wherein the capture device is arranged to secure a binder between the capture device and the brace.

[0043] FIG. 9C is a side view of the implant of FIGS. 9A and 9B.

[0044] FIG. 10A is a cross-sectional top view of a binder loosely positioned within the capture device of the implant of FIGS. 9A and 9B.

[0045] FIG. 10B is a cross-sectional top view of the binder secured to the brace by the capture device of the implant of FIGS. 9A and 9B.

[0046] FIG. 10C is a cross-sectional top view of a binder loosely positioned within an alternative embodiment of a capture device of the implant of FIGS. 9A and 9B.

[0047] FIG. 10D is a cross-sectional top view of the binder and capture device of FIG. 10C wherein the binder is secured to the brace

[0048] FIG. 11 is an end view of the implant of FIGS. 9A and 9B positioned between adjacent spinous processes.

[0049] FIG. 12 is a flow chart of a method of inserting an implant according to an embodiment of the invention.

#### DETAILED DESCRIPTION

[0050] FIG. 1 is a perspective view of an implant as described in U.S. Pat. No. 6,695,842 to Zucherman, et al., incorporated herein by reference. The implant 100 has a main body 101. The main body 101 includes a spacer 102, a first wing 108, a lead-in tissue expander 106 (also referred to herein as a distraction guide) and an alignment track 103. The main body 101 is inserted between adjacent spinous processes. Preferably, the main body 101 remains (where desired) in place without attachment to the bone or ligaments.

[0051] The distraction guide 106 includes a tip from which the distraction guide 106 expands, the tip having a diameter sufficiently small such that the tip can pierce an opening in

an interspinous ligament and/or can be inserted into a small initial dilated opening. The diameter and/or cross-sectional area of the distraction guide 106 then gradually increases until it is substantially similar to the diameter of the main body 101 and spacer 102. The tapered front end eases the ability of a physician to urge the implant 100 between adjacent spinous processes. When urging the main body 101 between adjacent spinous processes, the front end of the distraction guide 106 distracts the adjacent spinous processes and dilates the interspinous ligament so that a space between the adjacent spinous processes is approximately the diameter of the spacer 102.

[0052] The shape of the spacer 102 is such that for purposes of insertion between the spinous processes, the spinous processes need not be altered or cut away in order to accommodate the spacer 102. Additionally, associated ligaments need not be cut away and there is little or no damage to the adjacent or surrounding tissues. As shown in FIG. 1, the spacer 102 is elliptically shaped in cross-section, and can swivel about a central body (also referred to herein as a shaft) extending from the first wing 108 so that the spacer 102 can self-align relative to the uneven surfaces of the spinous processes. Self-alignment can ensure that compressive loads are distributed across the surface of the bone. As contemplated in Zucherman '842, the spacer 102 can have, for example, a diameter of six millimeters, eight millimeters, ten millimeters, twelve millimeters and fourteen millimeters. These diameters refer to the height by which the spacer distracts and maintains apart the spinous process. For an elliptically shaped spacer, the selected height (i.e., diameter) is the minor dimension measurement across the ellipse. The major dimension is transverse to the alignment of the spinous process, one above the other.

[0053] The first wing 108 has a lower portion 113 and an upper portion 112. As shown in FIG. 1, the upper portion 112 is shaped to accommodate the anatomical form or contour of spinous processes (and/or laminae) of the L4 (for an L4-L5 placement) or L5 (for an L5-S1 placement) vertebra. The same shape or variations of this shape can be used to accommodate other motion segments. The lower portion 113 can also be rounded to accommodate the spinous processes. The lower portion 113 and upper portion 112 of the first wing 108 act as a stop mechanism when the implant 100 is inserted between adjacent spinous processes. The implant 100 cannot be inserted beyond the surfaces of the first wing 108. Additionally, once the implant 100 is inserted, the first wing 108 can prevent side-to-side, or posterior-to-anterior movement of the implant 100.

[0054] The implant 100 further includes an adjustable wing 150 (also referred to herein as a second wing). The adjustable wing 150 has a lower portion 152 and an upper portion 153. Similar to the first wing 108, the adjustable wing 150 is designed to accommodate the anatomical form or contour of the spinous processes and/or lamina. The adjustable wing 150 is secured to the main body 101 with a fastener 154. The adjustable wing 150 also has an alignment tab 158. When the adjustable wing 150 is initially placed on the main body 101, the alignment tab 158 engages the alignment track 103. The alignment tab 158 slides within the alignment track 103 and helps to maintain the adjustable wing 150 substantially parallel with the first wing 108. When the main body 101 is inserted into the patient and the



adjustable wing **150** has been attached, the adjustable wing **150** also can prevent side-to-side, or posterior-to-anterior movement.

[0055] FIG. 2A illustrates an implant **100** positioned between adjacent spinous processes extending from vertebrae of the lumbar region. The implant **100** is positioned between inferior articular processes **10** associated with the upper vertebrae and superior articular processes **12** associated with the lower vertebrae. The supraspinous ligament **6** connects the upper and lower spinous processes **2,4**. The implant **100** can be positioned without severing or otherwise destructively disturbing the supraspinous ligament **6**.

[0056] Referring to FIG. 2B, the spacer **102** of the implant **100** of FIG. 2A is shown in cross-section. The spacer **102** defines a minimum space between adjacent spinous processes **2,4**. During extension the spacer **102** limits or blocks relative movement between the adjacent spinous processes **2,4**, limiting or blocking the collapse of the space between the spinous processes **2,4**. Such support can alleviate symptoms of degenerative disorders by preventing a reduction of the foraminal area and compression of the nerve roots, or by avoiding aggravation of a herniated disk, or by relieving other problems. However, as shown in FIG. 2C, the implant **100** permits flexion, which in some degenerative disorders (for example in cases of spinal stenosis) can relieve some symptoms. As can be seen, during flexion the spacer **102** can float between the spinous processes, held in position by the interspinous ligament **8**, and/or other tissues and structures associated with the spine. The ability to float between the spinous processes **2,4** also permits varying degrees of rotation, as well as flexion. Implants as described in Zucherman '842 thus have the advantage that they permit a greater degree of movement when compared with primary and supplementary spinal fusion devices.

[0057] In some circumstances, for example where a patient develops spondylosis or other degenerative disorder that makes both flexion and extension painful and uncomfortable, it can be desired that the spinous processes be further immobilized, while providing the same ease of implantation as provided with implants described above. Referring to FIG. 3A, an embodiment of an implant **300** in accordance with the present invention is shown. The implant **300** includes a distraction guide **306**, a spacer **302**, and a brace **308**. As shown, the spacer **302** is rotatable about a central body **301** extending from the brace **302**, although in other embodiments the spacer **302** can be fixed in position. A binder **330** can be fixedly connected with the brace **308** at a proximal end **332** of the binder **330**. The binder **330** is flexible, or semi-flexible, and can be positioned around adjacent spinous processes so that the binder **308** engages the spinous processes during flexion of the spine. Once positioned around adjacent spinous processes, tension of the binder **330** can be set when the binder **330** is secured to the brace **308** so that relative movement of the adjacent spinous processes during flexion is limited or prevented, as desired.

[0058] As can be seen in FIG. 3A, in an embodiment the brace **308** can include a first end having a slot **341** through which the proximal end **332** of the binder **330** can be threaded and subsequently sutured, knotted or otherwise bound so that the proximal end **332** of the binder **330** cannot be drawn through the slot **341**. In other embodiments (not shown), the proximal end **332** can be looped or can include

a connector, such as a clasp or other device, and can be fixed to the brace **308** via a fastener that engages the connector. One of ordinary skill in the art can appreciate the myriad different ways in which the proximal end **332** of the binder **330** can be associated with the brace **308** so that tension can be applied to the binder **330**, and implants in accordance with the present invention are not intended to be limited to those schemes described in detail herein.

[0059] The brace **308** can include a height along the spine greater than a height of the spacer **302** so that movement along a longitudinal axis L in the direction of insertion is limited or blocked by the brace **308** when the brace **308** contacts the lateral surfaces of the spinous processes. In this way, the brace **308** can function similarly to the wing **108** of the above described implant **100**. In other embodiments, the brace **308** can have a height greater or smaller than as shown. Once the binder **330** is positioned around the spinous processes and secured, movement of the implant **300** relative to the spinous processes is limited by the binder **330** along the longitudinal axis as well as along the spinous processes (i.e., anterior-to-posterior movement).

[0060] A free end of the binder **330** can be secured to the brace **308** by a capture device **320** associated with the brace **308**. The brace **308** can include a flange **310** from which the capture device **320** can extend. In the embodiment shown in FIG. 3A, the capture device **320** comprises a rotatable cam **321** having a fastener **322** and one or more cut-outs **324**. A tool can be mated with the cut-outs **324** and rotated to pivot the rotatable cam **321**. When the cam **321** is rotated, the eccentric shape of the cam **321** causes a gap to close between the cam **321** and a wall **314** of the brace **330** from which the flange **310** extends. When the binder **330** is positioned between the cam **321** and the wall **314**, the rotation of the cam **321** can pinch the binder **330** between the cam **321** and the wall **314**, defining a secured end **336** of the binder **330**. Optionally, the fastener **322** can be screwed (i.e., rotated) so that the fastener **322** is further seated, tightening against the cam **321** to fix the cam **321** in position. Further, optionally, one or both of the wall **314** and the rotatable cam **321** can include knurls, or some other texture (e.g., teeth) to prevent slippage (i.e., the slipping of the binder **330** between the cam **321** and the wall **314**). The brace **308** can further include a guide **312**, such as a channel or slot (a slot as shown) at a second end of the brace **308** to align the binder **330** with the capture device **320**.

[0061] The binder **330** can comprise a strap, ribbon, tether, cord, or some other flexible (or semi-flexible), and preferably threadable structure. The binder **330** can be made from a biocompatible material. In an embodiment, the binder **330** can be made from a braided polyester suture material. Braided polyester suture materials include, for example, Ethibond, Ethiflex, Mersilene, and Dacron, and are nonabsorbable, having high tensile strength, low tissue reactivity and improved handling. In other embodiments, the binder **330** can be made from stainless steel (i.e., surgical steel), which can be braided into a tether or woven into a strap, for example. In still other embodiments, the binder **330** can be made from some other material (or combination of materials) having similar properties.

[0062] The distraction guide **306** can optionally include a slot, bore, cut-out or other cavity **309** formed in the distraction guide **306** through which the binder **330** can be threaded

or positioned. Such a cavity can allow on-axis positioning of the binder 330 (i.e., the binder can be substantially aligned with the longitudinal axis L of the implant 300). Further, capturing the binder 330 within a slot or bore can prevent or limit shifting of the distraction guide 306 relative to the binder 330 to further secure the implant 300 between the spinous processes.

[0063] As will be readily apparent to one of skill in the art, implants in accordance with the present invention provide significant benefits to a physician by simplifying an implantation procedure and reducing procedure time, while providing an implant that can limit or block flexion and extension of the spine. A physician can position an implant between adjacent spinous processes and can position a binder 330 connected with the brace 308 around the spinous processes without requiring the physician to measure an appropriate length of the binder 330 prior to implantation. The capture device 320 allows the binder 330 to be secured to the brace 308 anywhere along a portion of the binder 330, the portion being between a distal end 334 of the binder 330 and the proximal end 332. The physician can secure the binder 330 to the brace 308 to achieve the desired range of movement (if any) of the spinous processes during flexion.

[0064] The capture device 320 and brace 308 can have alternative designs to that shown in FIG. 3A. A side view of an implant 400 in accordance with an alternative embodiment of the present invention is shown in FIG. 3B, the implant 400 including a capture device 420 comprising a cam 421 positioned within a ring 426 having one or more lobes 423 corresponding with one or more recesses 413 in a wall 414 of the brace 408. The binder 330 is positioned between the capture device 420 and the brace 408. Once the binder 330 is positioned as desired, the fastener 422 and cam 421 can be rotated using an appropriate tool, with the cam 421 forcing the lobes 423 of the ring 426 to mate with the recesses 413 of the brace 408, preventing the ring 426 from shifting in position and defining a secure end 336 of the binder 330. Rotating the fastener 422 rotates and optionally tightens down the cam 421. Such a capture device 420 can provide a physician a visual indication that the binder 330 is properly secured to the brace 408, as well as preventing slippage.

[0065] Referring to FIGS. 3C and 3D, in still other embodiments, the implant can include a capture device comprising a spring-loaded mechanism. FIG. 3C illustrates an implant 500 including a capture device 520 comprising a single spring-loaded cam 521 pivotally connected with the flange 310 and biased to rotate in one direction. The distance between the pivot point of the cam 521 and the wall 314 is sufficiently narrow that the rotation of the cam 521 in the direction of bias is blocked (or nearly blocked) by the wall 314. The eccentricity of the cam 521 is large enough that a maximum gap between the wall 314 and the cam 521 is sufficiently wide as to allow the binder 330 to be threaded between the cam 521 and the wall 314. A physician can position the binder 330 between the cam 521 and the wall 314 by overcoming the spring-force of the spring-loaded cam 521. Once the binder 330 is positioned as desired, the physician need only allow the bias force of the spring-loaded cam 520 to force the cam 521 against the wall 314, so that the cam 521 pinches and secures the binder 330 between the cam 521 and the wall 314. Optionally, one or both of the cam 521 and the wall 314 can be knurled or otherwise textured

to limit or prevent slippage. Further, the wall 314 can optionally include a recess (not shown) to receive the cam 521 so that the binder 330 is pinched within the recess (similar to the lobe and recess arrangement of FIG. 3B), thereby further limiting slippage.

[0066] FIG. 3D illustrates an implant 600 including a capture device 620 comprising dual spring-loaded cams 621, the dual spring-loaded cams 621 being pivotally connected with the flange 310. The dual spring-loaded cams 621 are biased in opposition to one another so that the cams 621 abut one another, similar to cam cleats commonly used for securing rope lines on boats. During surgery, the binder 330 can be loosely positioned around the adjacent spinous processes and threaded between the cams 621. Tension can be applied to the binder 330, as desired, by drawing the binder 330 through the cams 621. The force of the binder 330 being pulled through the cams 621 can overcome the bias force to allow the binder 330 to be tightened, while releasing the binder 330 can define a secure end 336 of the binder 330 as the cams 621 swivel together. As above, one or both of the cams 621 can be knurled or otherwise textured to limit or prevent slippage.

[0067] Embodiments of implants have been described in FIGS. 3A-3D with some level of specificity; however, implants in accordance with the present invention should not be construed as being limited to such embodiments. Any number of different capture devices can be employed to fix a binder to a brace by defining a secure end of the binder, and such capture devices should not be construed as being limited to capture devices including cams, as described above. The capture device need only be a device that allows a physician to fit a binder having a generic size, or estimated size, around adjacent spinous processes with a desired level of precision in tension.

[0068] FIGS. 4A and 4B are an opposite end views of the implant of FIG. 3A positioned between adjacent spinous processes extending from vertebrae of the lumbar region. The contours of a space between adjacent spinous processes can vary between patients, and between motion segments. A rotatable spacer 302 can rotate to best accommodate the shape of the space so that the implant 300 can be positioned as desired along the spinous processes. For example, it can be desirable to position the spacer 302 as close to the vertebral bodies as possible (or as close to the vertebral bodies as practicable) to provide improved support. Once the implant 300 is positioned as desired, the binder 330 can be threaded through interspinous ligaments associated with motion segments (i.e., pairs of adjacent vertebrae and associated structures and tissues) above and below the targeted motion segment so that the binder 330 is arranged around the upper and lower spinous processes 2,4. The binder 330 can then be threaded through the slot 312 of the brace 308 and positioned between the capture device 320 and the brace wall 314. A first tool (not shown) can be inserted into the incision formed to insert the implant 300 between the spinous processes 2,4. Though not shown, the spacer 302 can include a notch, similar to a notch 190 of the spacer 102 of FIG. 1, and the brace 308 can include recesses, similar to recesses 192 of the first wing 108 of FIG. 1, that can be engaged by the first tool for grasping and releasing the implant 300 during insertion. (See U.S. Pat. No. 6,712,819, which is incorporated herein by reference.) Alternatively, some other technique for grasping and releasing the implant

**300** can be employed. Once the implant **300** is positioned and the binder **330** is arranged as desired, a second tool (not shown), such as a forked tool having spaced apart tines, can engage the cam **321** of the capture device **320** to rotate the cam **321**, thereby securing the binder **330** to the brace **308**. A hex wrench can tighten down the fastener **322** if desired. Alternatively, a single tool can be employed to perform both the function of insertion of the implant **300** and rotation of the cam **321**, as depicted in the above referenced patent. Optionally, the binder **330** can then be trimmed so that the distal end **334** of the binder **330** does not extend undesirably away from the brace **308**. As can be seen, the spacer **302** is rotated relative to the distraction guide **306** and the brace **308**. Because the spacer **302** can rotate relative to the distraction guide **306** and the brace **308**, the brace **308** can be positioned so that the binder **330** can be arranged around the upper and lower spinous processes **2,4** without twisting the binder **330**. The binder **330** is positioned around the lower spinous process **4**, threaded or positioned at least partially within a slot **309** of the distraction guide **306**, and positioned around the upper spinous process **2** so that the binder **330** can be secured to the brace **308**, as described above.

[0069] Implants in accordance with the present invention can enable a physician to limit or block flexion and extension in a targeted motion segment while minimizing invasiveness of an implantation procedure (relative to implantation procedures of the prior art). However, such implants can also be used where more extensive implantation procedures are desired. For example, as shown in FIG. 4C, it can be desired that the adjacent spinous processes **2,4** be surgically modified to receive the binder **330**, thereby insuring that the binder **330** does not shift or slide relative to the spinous processes **2,4**. The binder **330** is threaded directly through the respective spinous processes **2,4** rather than through the interspinous ligaments of adjacent motion segments. The amount of bone removed from the spinous processes **2,4** can be reduced where a cord or tether is used as a binder **330** rather than a strap. While such applications fall within the contemplated scope of implants and methods of implantation of the present invention, such application may not realize the full benefit that can be achieved using such implants due to the modification of the bone.

[0070] Still another embodiment of an implant **700** in accordance with the present invention is shown in the end view of FIG. 5. In such an embodiment the binder **430** can comprise a first portion **431** formed as a strap for arrangement around one of the upper and lower spinous processes **2,4**, and that tapers to a second portion **433** formed as a cord. The distraction guide **406** can include a bore **409** or other cavity for receiving the second portion **433**. As can be seen in FIG. 6A, once the binder **430** is threaded through the distraction guide **406**, a pad **436** of biocompatible material can be associated with the binder **430**, for example by slidably threading the binder **430** through a portion of the pad **436**, and the pad **436** can be arranged between the binder **430** and the respective spinous process **2** so that a load applied by the binder **430** is distributed across a portion of the surface of the spinous process **2**. Referring to FIG. 6B, once the binder **430** is arranged as desired relative to the adjacent spinous processes **2,4**, the binder **330** can be secured by the brace **708**. The brace **708** as shown is still another embodiment of a brace for use with implants of the present invention. In such an embodiment, the brace **708**

includes a capture device **720** comprising a clip including a spring-loaded button **721** having a first hole therethrough and a shell **723** in which the button **721** is disposed, the shell **723** having a second hole. A physician depresses the button **721** so that the first and second holes align. The binder **430** can then be threaded through the holes, and the button **721** can be released so that the spring forces the holes to misalign, pinching the binder **430** and defining a secure end of the binder **430**.

[0071] FIG. 6C is an end view of a still further embodiment of an implant **800** in accordance with the present invention. In such an embodiment the binder **530** can comprise a cord. An upper pad **536** and a lower pad **538** can be slidably associated with the binder **530** and arranged so that a load applied by the binder **530** is distributed across a portion of the upper and lower spinous processes **2,4**. As can be seen, such an embodiment can include a brace **808** having a substantially different shape than braces previously described. It should be noted that the brace **808** of FIG. 6C is shown, in part, to impress upon one of ordinary skill in the art that a brace and capture device for use with implants of the present invention can include myriad different shapes, mechanisms and arrangements, and that the present invention is meant to include all such variations. As shown, the footprint of the brace **808** is reduced by shaping the wall **814** of the brace **808** to taper at an upper end to form a guide **812** for aligning the binder **530** and to taper at a lower end to an eyelet **841** for capturing a proximal end **532** of the binder **530**. The brace **808** includes a height from eyelet **841** to guide **812** such that movement of the implant **800** in the direction of insertion is blocked or limited by the brace **808**.

[0072] Use of a binder to limit or prevent flexion can provide an additional benefit of limiting movement along the longitudinal axis L (shown in FIG. 3A). However, implants in accordance with the present invention can optionally further include a second wing for limiting or blocking movement in the direction opposite insertion. Inclusion of such a structure can ensure that the implant remains in position, for example where the binder slips out of a slot of the distraction guide, or where the binder becomes unsecured.

[0073] Referring to FIG. 7A, an implant in accordance with an embodiment can include a second wing **450** connected with the distraction guide **406** of the implant **900** by a fastener **454**. The second wing **450** is similar to the second wing **150** described above in reference to FIG. 1. The second wing **450** can include an alignment tab **458** allowing a position of the second wing **450** to be adjusted along a longitudinal axis L of the implant **900**, and a fastener **454** (for example a hex headed bolt) for affixing the second wing **450** to the implant **900** in the position along the longitudinal axis L desired. The distraction guide **406** can include an alignment groove (not shown) corresponding to the alignment tab **458**. The alignment tab **458** fits within, and is movable along, the alignment groove so that a contact surface **455** of the second wing **450** can be arranged as desired. As shown, the second wing **450** includes a substantially planar contact surface arranged so that the contact surface **455** of the second wing **450** is perpendicular to the longitudinal axis L. However, in other embodiments, the contact surface **455** need not be planar, and can be shaped and oriented to roughly correspond with a contact surface of the upper and lower spinous processes. Likewise, a contact

surface **315** of the binder **308** can be shaped and oriented to roughly correspond with a contact surface of the upper and lower spinous processes. As shown, the upper portion **453** and the lower portion **452** of the second wing **450** do not extend from the distraction guide **406** as substantially as the upper portion **153** and lower portion **152** of the second wing **150** of FIG. 1. As such, the second wing **450** includes a height H along the spine smaller than that of the second wing **150** of FIG. 1. It has been observed that benefits can be gained by including a wing **450**, though the wing **450** does not extend from the distraction guide **406** as significantly as shown in FIG. 1 (i.e., the wing **450** includes “nubs” extending above and/or below the height of the spacer **302**). Such wings **450** will also be referred to herein as winglets. Including a second wing **450** having an overall height along the spine smaller than that of FIG. 1 can limit movement along the longitudinal axis without interfering with (or being interfered by) the arrangement of the binder **330**.

[0074] In other embodiments, implants in accordance with the present invention can include a second wing (or an upper portion and/or lower portion) extendable from the distraction guide. In this way an implant and a device for limiting or blocking movement along a longitudinal axis of the implant can be included in a single piece, possibly simplifying implantation. Referring to FIGS. 7B and 7C, implants **1000** in accordance with the present invention can include a distraction guide **506** having a selectably extendable upper portion **553** and lower portion **552** disposed within a cavity of the distraction guide **506**. The upper and lower portions **553,552** can be extended by actuating a nut, knob or other mechanism operably associated with a gear **556** so that the gear **556** rotates. The teeth of the gear **556** engage teeth of the upper and lower portions **553,552**, causing the upper and lower portions **553,552** to extend sufficiently that the upper and lower portions **553,552** form winglets for preventing motion of the implant **1000** in a direction opposite insertion (shown in FIG. 7C). Rotating the gear **556** in an opposite direction can retract the upper and lower portions **553,552**.

[0075] In an alternative embodiment, implants **1100** in accordance with the present invention can include spring-loaded upper and/or lower portions **653,652** such as shown in FIGS. 7D and 7E. In such an embodiment the upper and lower portions **653,652** can be fin-shaped, having sloping forward surfaces **655,654** and being spring-biased to an extended position, as shown in FIG. 7D. As the implant **1100** is positioned between adjacent spinous processes, the spinous processes and/or related tissues can contact the forward surface **655,654** of the upper and lower portions **653,652**, causing the upper and lower portions **653,652** to pivot about respective hinge points **657,656** and collapse into cavities disposed within the distraction guide **606**, as shown in FIG. 7E. Once the implant **1100** clears the obstruction, the upper and lower portions **653,652** re-extend out of the distraction guide **650**. A slot and pin mechanism **660,661** or other mechanism can lock the upper and lower portion **653,652** in place once extended, disallowing over-extension of the upper and lower portion **653,652** in the direction of bias. The extended upper and lower portions **653,652** limit or block movement of the implant **1100** in a direction opposite insertion.

[0076] In still further embodiments, implants in accordance with the present invention can optionally employ some other additional mechanism for limiting or blocking

motion along the longitudinal axis of the implant. Mechanisms shown and described in FIGS. 7A-7E are merely provided as examples of possible mechanisms for use with such implants, and are not intended to be limiting.

[0077] FIG. 8 is a top-down view of still another embodiment of an implant in accordance with the present invention including a brace **708** arranged at an angle along the spinous process relative to the longitudinal axis L of the implant **1200**. The brace **708** is arranged at such an angle to roughly correspond to a general shape of the adjacent spinous processes. Such a general shape can commonly be found in spinous processes extending from vertebrae of the cervical and thoracic region, for example. The implant **1200** further includes a second wing **752** extending from distraction guide **706** at an angle roughly corresponding to a general shape of the adjacent spinous processes. Identical implants **1200**, one above the other, are shown. The lower implant **1200** includes a binder **330** arranged around the adjacent spinous processes (only the upper spinous process is shown) and positioned in a slot **309** of the distraction guide **706**. The binder **330** includes a capture device **320** for securing the binder **330** to the brace **708**, and a channel formed by guides **712** on the brace **708** for aligning the binder **330** with the capture device **320**. Unlike previously illustrated embodiments, the brace wall includes a recess **717** to accommodate rotation of the rotatable spacer **302**. Alternatively, the implants can include fixed spacers, for example integrally formed with the brace **708** and the distraction guide **706**.

[0078] FIGS. 9A and 9B are perspective views, and FIG. 9C is a side view of a still further embodiment of an implant in accordance with the present invention. The implant **1300** includes a distraction guide **806**, a rotatable spacer **302**, and a brace **908**. As above, a binder **330** can be fixedly connected with the brace **908** at a proximal end **332** of the binder **330**. Once positioned around adjacent spinous processes, tension of the binder **330** can be set when the binder **330** is secured to the brace **908** so that relative movement of the adjacent spinous processes during flexion is limited or prevented, as desired.

[0079] As can be seen in FIG. 9A, the brace **908** can include a first end having an eyelet **941** through which the proximal end **332** of the binder **330** can be threaded and subsequently sutured, knotted or otherwise bound, or alternatively looped through the eyelet **941** and secured to itself (e.g., using a clasp) so that the proximal end **332** of the binder **330** cannot be drawn through the eyelet **941**. One of ordinary skill in the art can appreciate the myriad different ways in which the proximal end **332** of the binder **330** can be associated with the brace **908** so that tension can be applied to the binder **330**. As in previous embodiments, a free end of the binder **330** can be secured to the brace **908** by a capture device **820** associated with the brace **908**. The capture device **820** of FIGS. 9A-11 is arranged at a second end of the brace **908** opposite the eyelet **941**, rather than approximately centered along the brace wall **914**. The brace **908** can optionally include a locking pin hole **915** that can be engaged by a locking pin of an insertion instrument (not shown), for example as described in U.S. Pat. No. 6,712,819 to Zucherman, et al., incorporated herein by reference. Further, similar to implants described in Zucherman '819, the brace wall **914** can optionally include one or more holes **916** (shown in FIG. 11) adapted to receive alignment pins of such an insertion instrument, and the spacer **402** can include

a spacer engagement hole 403 adapted to receive a spacer engagement pin of such an insertion instrument. When a spacer engagement pin engages the spacer engagement hole 403, rotation of the spacer 402 can be limited or blocked. Once the spacer engagement pin is released from the spacer engagement hole 403, the spacer 402 can rotate and/or swivel about a central body 917 without impediment from the spacer engagement pin. Such an arrangement can provide a physician additional control over the positioning of the implant 1300, although in other embodiments the spacer 402 need not include an engagement hole 403. Arranging the captured device 820 at a second end of the brace 908 can allow an insertion instrument, having a configuration as described in Zucherman '819 or having some other configuration, to releasably engage the implant 1300 to assist in implantation without interference from the capture device 820.

[0080] The distraction guide 806 of the implant 1300 can be wedge-shaped, as described above, or approximately conical, as shown in FIGS. 9A-9C, and can include a slot 809 disposed through the distraction guide 806 and adapted to receive the binder 330 during implantation. Also as described above, the rotatable spacer 402 can be elliptical in cross-section, or otherwise shaped, and can rotate relative to the distraction guide 806 to roughly conform with a contour of a space between the targeted adjacent spinous processes.

[0081] The capture device 820 is shown in cross-section in FIGS. 10A and 10B. The capture device 820 can comprise, for example, two pieces slidably associated with one another by an adjustable fastener 822 (as shown, the adjustable fastener is a hex screw). A fixed piece 821 of the capture device can extend from the brace wall 914. The fixed piece 821 can include a beveled surface 823 that can function as a ramp. A slidable piece 827 of the capture device can be slidably associated with the fixed piece 821, and can likewise include a beveled surface 829 positioned in opposition to the beveled surface 823 of the fixed piece 821. As shown, the slidable piece 827 is associated with the fixed piece 821 via an adjustable fastener 822. The fastener 822 can be positioned within slots 890, 892 of the fixed piece 821 and the slidable piece 827 and can include a threaded shaft 880, a head 882, and a nut 884. The head 882 of the fastener 822 can engage an anterior surface 894 of the fixed piece 821 and the nut 884 can be threaded onto the threaded shaft 880 so that the nut 884 can engage a posterior surface 896 of the slidable piece 827. The slidable piece 827 is free to slide along the beveled surface 823 of the fixed piece 821 until both the nut 884 engages the posterior surface 896 and the head 882 engages the anterior surface 894, blocking further movement in one direction. The distance between the anterior surface 894 and the posterior surface 896 increases or decreases as the slidable piece 827 slides along the beveled surface 823 and a distance between a capture surface 898 of the slidable piece 827 and the brace wall 914 likewise increases or decreases. The maximum distance the slidable piece 827 can travel can be defined by the distance between the nut 884 and the head 882. A physician can adjust the maximum distance by rotating the nut 884 so that the nut 884 travels closer to, or farther from the head 882 along the threaded shaft 880, possibly urging the capture surface 898 toward the brace wall 914. Thus, when the implant 1300 is positioned between spinous processes, the physician can set the maximum distance so that the free end of the binder 330 can be threaded between the capture surface 898 and the

brace wall 914. As shown in FIG. 10B, the physician can then adjust the fastener 822 so that the posterior surface 896 and the anterior surface 894 are urged together, the maximum distance decreases and the distance between the capture surface 898 and the brace wall 914 decreases, thereby pinching the binder 330 between the capture surface 898 and the brace wall 914 and defining a secure end of the binder 330. In some embodiments, one or both of the capture surface 898 and the brace wall 914 can include texture so that the binder 330 is further prevented from sliding when the binder 330 is placed under increasing tension (e.g., during flexion).

[0082] The slidable piece 827 can optionally further include a guide 912 extending from the slidable piece 827 so that the guide 912 overlaps a portion of the brace 908. The guide 912 can extend, for example, a distance roughly similar to the maximum distance between the capture surface 898 and the brace wall 914, and can help ensure that the binder 330 is captured between the capture surface 898 and the brace wall 914. In other embodiments, the capture device 820 of FIGS. 9A-10B can include some other shape or configuration and still fall within the contemplated scope of the invention. For example, the fastener need not include a nut. In one embodiment, shown in FIGS. 10C and 10D, the fastener 922 can include a threaded shaft 980 associated with a sleeve 984. As one of the threaded shaft 980 and the sleeve 984 is rotated, the distance between a head 982 of the threaded shaft 980 and the head 985 of the sleeve 984 can decrease or increase. In still other embodiments, the fastener need not include a threaded shaft, but rather can include a smooth shaft having a retaining clip frictionally associated with the smooth shaft. One of ordinary skill in the art will appreciate the myriad different devices that can be employed to selectively close a gap between a capture surface 898 and the brace wall 914.

[0083] FIG. 11 is an end view of the implant 1300 of FIGS. 9A-10D positioned between adjacent spinous processes. As shown, the binder 530 is a cord, but in other embodiments can have some other geometry. As described above in reference to previous embodiments, where a cord, a tether, or the like is used as a binder, a pad 536 can be arranged along a contact surface of the respective spinous process so that a load applied to the contact surface by the tension in the binder 530 can be distributed across a portion of the contact surface wider than the binder 530, thereby reducing stress on the portion. The capture device 820 is arranged so that the slidable piece 827 is posteriorly located relative to the fixed piece 821. A fastener 822 can be accessed by the physician using a substantially posterior approach.

[0084] A method of surgically implanting an implant 1300 in accordance with an embodiment as described above in FIGS. 9A-11 of the present invention is shown as a block diagram in FIG. 12. The method can include forming an incision at the target motion segment, and enlarging the incision to access the target motion segment (Step 100). The interspinous ligament between targeted adjacent spinous processes can then be distracted by piercing or displacing the interspinous ligament with the distraction guide 106 (Step 102) and urging the implant 1300 between the adjacent spinous processes (Step 104). As the interspinous ligament is displaced, the spacer 302 can be positioned between the spinous processes such that the spacer 302 can rotate to

assume a preferred position between the spinous processes (Step 106). Once the implant 1300 is positioned, the binder 330 can be threaded between interspinous ligaments of adjacent motion segments so that the targeted adjacent spinous processes are disposed within a loop formed by the binder 330 (Step 108). The physician can then thread the binder 330 between the capture surface 898 of the capture device 820 and the brace wall 914 (Step 110). Once a desired tension of the binder 330 is applied (Step 112), the physician can adjust the fastener 822 of the capture device 820 so that the binder 330 is secured between the captured surface 898 and the brace wall 914 (Step 114). The incision can subsequently be closed (Step 116).

#### Materials For Use in Implants of The Present Invention

[0085] In some embodiments, the implant can be fabricated from medical grade metals such as titanium, stainless steel, cobalt chrome, and alloys thereof, or other suitable implant material having similar high strength and biocompatible properties. Additionally, the implant can be at least partially fabricated from a shape memory metal, for example Nitinol, which is a combination of titanium and nickel. Such materials are typically radiopaque, and appear during x-ray imaging, and other types of imaging. Implants in accordance with the present invention, and/or portions thereof can also be fabricated from somewhat flexible and/or deflectable material. In these embodiments, the implant and/or portions thereof can be fabricated in whole or in part from medical grade biocompatible polymers, copolymers, blends, and composites of polymers. A copolymer is a polymer derived from more than one species of monomer. A polymer composite is a heterogeneous combination of two or more materials, wherein the constituents are not miscible, and therefore exhibit an interface between one another. A polymer blend is a macroscopically homogeneous mixture of two or more different species of polymer. Many polymers, copolymers, blends, and composites of polymers are radiolucent and do not appear during x-ray or other types of imaging. Implants comprising such materials can provide a physician with a less obstructed view of the spine under imaging, than with an implant comprising radiopaque materials entirely. However, the implant need not comprise any radiolucent materials.

[0086] One group of biocompatible polymers is the polyaryletherketone group which has several members including polyetheretherketone (PEEK), and polyetherketoneketone (PEKK). PEEK is proven as a durable material for implants, and meets the criterion of biocompatibility. Medical grade PEEK is available from Victrex Corporation of Lancashire, Great Britain under the product name PEEK-OPTIMA. Medical grade PEKK is available from Oxford Performance Materials under the name OXPEKK, and also from CoorsTek under the name BioPEKK. These medical grade materials are also available as reinforced polymer resins, such reinforced resins displaying even greater material strength. In an embodiment, the implant can be fabricated from PEEK 450 G, which is an unfilled PEEK approved for medical implantation available from Victrex. Other sources of this material include Gharda located in Panoli, India. PEEK 450 G has the following approximate properties:

Property	Value
Density	1.3 g/cc
Rockwell M	99
Rockwell R	126
Tensile Strength	97 MPa
Modulus of Elasticity	3.5 GPa
Flexural Modulus	4.1 GPa

[0087] PEEK 450 G has appropriate physical and mechanical properties and is suitable for carrying and spreading a physical load between the adjacent spinous processes. The implant and/or portions thereof can be formed by extrusion, injection, compression molding and/or machining techniques.

[0088] It should be noted that the material selected can also be filled. Fillers can be added to a polymer, copolymer, polymer blend, or polymer composite to reinforce a polymeric material. Fillers are added to modify properties such as mechanical, optical, and thermal properties. For example, carbon fibers can be added to reinforce polymers mechanically to enhance strength for certain uses, such as for load bearing devices. In some embodiments, other grades of PEEK are available and contemplated for use in implants in accordance with the present invention, such as 30% glass-filled or 30% carbon-filled grades, provided such materials are cleared for use in implantable devices by the FDA, or other regulatory body. Glass-filled PEEK reduces the expansion rate and increases the flexural modulus of PEEK relative to unfilled PEEK. The resulting product is known to be ideal for improved strength, stiffness, or stability. Carbon-filled PEEK is known to have enhanced compressive strength and stiffness, and a lower expansion rate relative to unfilled PEEK. Carbon-filled PEEK also offers wear resistance and load carrying capability.

[0089] As will be appreciated, other suitable similarly biocompatible thermoplastic or thermoplastic polycondensate materials that resist fatigue, have good memory, are flexible, and/or deflectable, have very low moisture absorption, and good wear and/or abrasion resistance, can be used without departing from the scope of the invention. As mentioned, the implant can be comprised of polyetherketoneketone (PEKK). Other material that can be used include polyetherketone (PEK), polyetherketoneetherketoneketone (PEKEKK), polyetheretherketoneketone (PEEKK), and generally a polyaryletheretherketone. Further, other polyketones can be used as well as other thermoplastics. Reference to appropriate polymers that can be used in the implant can be made to the following documents, all of which are incorporated herein by reference. These documents include: PCT Publication WO 02/02158 A1, dated Jan. 10, 2002, entitled "Bio-Compatible Polymeric Materials;" PCT Publication WO 02/00275 A1, dated Jan. 3, 2002, entitled "Bio-Compatible Polymeric Materials;" and, PCT Publication WO 02/00270 A1, dated Jan. 3, 2002, entitled "Bio-Compatible Polymeric Materials." Other materials such as Bionate®, polycarbonate urethane, available from the Polymer Technology Group, Berkeley, Calif., may also be appropriate because of the good oxidative stability, biocompatibility, mechanical strength and abrasion resistance. Other thermoplastic materials and other high molecular weight polymers can be used.

[0090] As described above, the binder can be made from a biocompatible material. In an embodiment, the binder can be made from a braided polyester suture material. Braided polyester suture materials include, for example, Ethibond, Ethiflex, Mersilene, and Dacron, and are nonabsorbable, having high tensile strength, low tissue reactivity and improved handling. In other embodiments, the binder can be made from stainless steel (i.e., surgical steel), which can be braided into a tether or woven into a strap, for example. In still other embodiments, the binder can be made from some other material (or combination of materials) having similar properties.

[0091] The foregoing description of the present invention have been presented for purposes of illustration and description. It is not intended to be exhaustive or to limit the invention to the precise forms disclosed. Many modifications and variations will be apparent to practitioners skilled in this art. The embodiments were chosen and described in order to best explain the principles of the invention and its practical application, thereby enabling others skilled in the art to understand the invention for various embodiments and with various modifications as are suited to the particular use contemplated. It is intended that the scope of the invention be defined by the following claims and their equivalents.

What is claimed is:

1. A method, comprising:
  - disposing an elongated member substantially around a pair of adjacent spinous processes; and
  - rotating a distal end portion of a tool to couple a first end portion of the elongated member to a second end portion of the elongated member after the disposing.
2. The method of claim 1, further comprising:
  - adjusting, before the rotating, a length of the elongated member substantially around the pair of adjacent spinous processes such that an amount of flexion associated with the pair of adjacent spinous processes is limited.
3. The method of claim 1, further comprising:
  - adjusting, before the rotating, a tension of the elongated member substantially around the pair of adjacent spinous processes such that an amount of flexion associated with the pair of adjacent spinous processes is limited.
4. The method of claim 1, wherein the tool is a first tool, the method further comprising:
  - inserting, before the disposing, the elongated member into a patient's body via a second tool.
5. The method of claim 1, wherein the disposing include threading the elongated member between interspinous ligaments of the pair of adjacent spinous processes so that the pair of adjacent spinous processes are disposed within a loop defined by the elongated member.
6. The method of claim 1, wherein the rotating includes rotating a capture device such that the second end portion of the elongated member is coupled to a brace, the first end portion of the elongated member is fixedly coupled to the brace.
7. The method of claim 1, further comprising:
  - forming, before the inserting, an incision in the patient's body; and

inserting, before the disposing, the elongated member into the patient's body through the incision.

8. The method of claim 1, further comprising:

forming, before the inserting, an incision in the patient's body;

inserting, before the disposing, the elongated member into the patient's body through the incision; and

inserting, before the rotating, a distal end portion of the tool into the patient's body through the incision such that a proximal end portion of the tool is disposed outside of the patient's body.

9. The method of claim 1, wherein the tool is a first tool, further comprising:

forming, before the inserting, the incision in the patient's body;

inserting, before the disposing, the elongated member into the patient's body through the incision via a second tool; and

inserting, before the actuating, a distal end portion of the first tool into the patient's body through the incision such that a proximal end portion of the first tool is disposed outside of the patient's body.

10. A method, comprising:

inserting an elongated member into a patient's body through an incision in the body;

disposing, after the inserting, the elongated member substantially around a pair of adjacent spinous processes; and

actuating, after the disposing, a tool through the incision to couple a first end portion of the elongated member to a second end portion of the elongated member.

11. The method of claim 10, further comprising:

adjusting, before the actuating, a length of the elongated member substantially around the pair of adjacent spinous processes such that an amount of flexion associated with the pair of adjacent spinous processes is limited.

12. The method of claim 10, further comprising:

adjusting, before the actuating, a tension of the elongated member substantially around the pair of adjacent spinous processes such that an amount of flexion associated with the pair of adjacent spinous processes is limited.

13. The method of claim 10, wherein the disposing include threading the elongated member between interspinous ligaments of the pair of adjacent spinous processes so that the pair of adjacent spinous processes are disposed within a loop defined by the elongated member.

14. The method of claim 10, wherein the actuating includes rotating a distal end portion of the tool such that a capture device couples the second end portion of the elongated member to a brace, the first end portion of the elongated member is fixedly coupled to the brace.

15. The method of claim 10, further comprising:

forming, before the inserting, the incision in the patient's body; and

inserting, before the disposing, the elongated member into the patient's body through the incision.

**16.** The method of claim 10, further comprising:  
forming, before the inserting, the incision in the patient's body;  
inserting, before the disposing, the elongated member into the patient's body through the incision; and  
inserting, before the actuating, a distal end portion of the tool into the patient's body through the incision such that a proximal end portion of the tool is disposed outside of the patient's body.

**17.** A kit, comprising:  
a coupler;  
an elongated member, a first end portion of the elongated member being fixedly coupled to the coupler; and  
a tool configured to couple a second end portion of the elongated member to the coupler while the elongated member is disposed substantially around a pair of adjacent spinous processes.

**18.** The kit of claim 17, wherein:  
the coupler includes a brace and a capture device;  
the first end portion of the elongated member fixedly coupled to the brace, the second end portion of the elongated member removably coupleable to the brace via the capture device; and  
the tool configured to rotate the capture device while the elongated member is disposed around the pair of adjacent spinous processes.

**19.** The kit of claim 17, wherein the tool is a first tool, the kit further comprising:  
a second tool configured to insert the coupler and the elongated member into a patient's body through an incision.

**20.** The kit of claim 17, wherein the tool is a first tool, the kit further comprising:  
a second tool configured to insert the coupler and the elongated member into a patient's body through an incision,

a distal end portion of the first tool is configured to be inserted into the patient's body through the incision and couple the second end portion of the elongated member to the coupler.

**21.** A method, comprising:  
placing an elongated member around a pair of adjacent spinous processes in a patient's body, the elongated member having a distal end and a proximal end; and  
coupling a distal portion of the elongated member to a proximal portion of the elongated member, via a tool, such that a displacement of the two adjacent spinous processes away from each other is limited.

**22.** The method of claim 21, further comprising:  
adjusting a coupling member, the coupling member engaging the distal portion and the proximal portion of the elongated member, such that the displacement of the two adjacent spinous processes away from each other is further limited.

**23.** The method of claim 21, further comprising:  
adjusting a coupling member via tool, the coupling member moveably engaged with the distal portion and the proximal portion of the elongated member, such that a displacement of the two adjacent spinous processes away from each other after the adjusting is greater than the displacement of the two adjacent spinous processes before the adjusting.

**24.** The method of claim 21, further comprising:  
positioning a spacer between the pair of adjacent spinous processes.

**25.** The method of claim 21, further comprising:  
positioning, before the coupling, a spacer between the pair of adjacent spinous processes, the spacer being coupled to the elongated member.

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