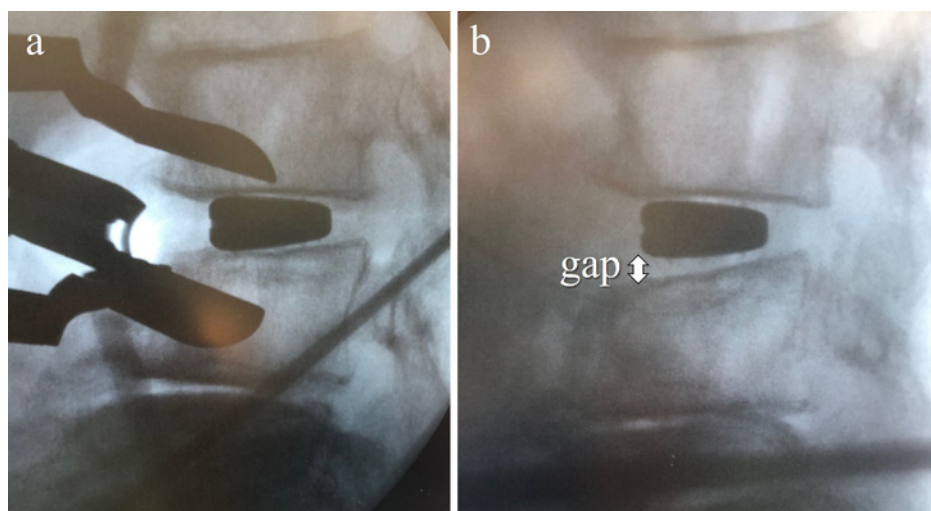
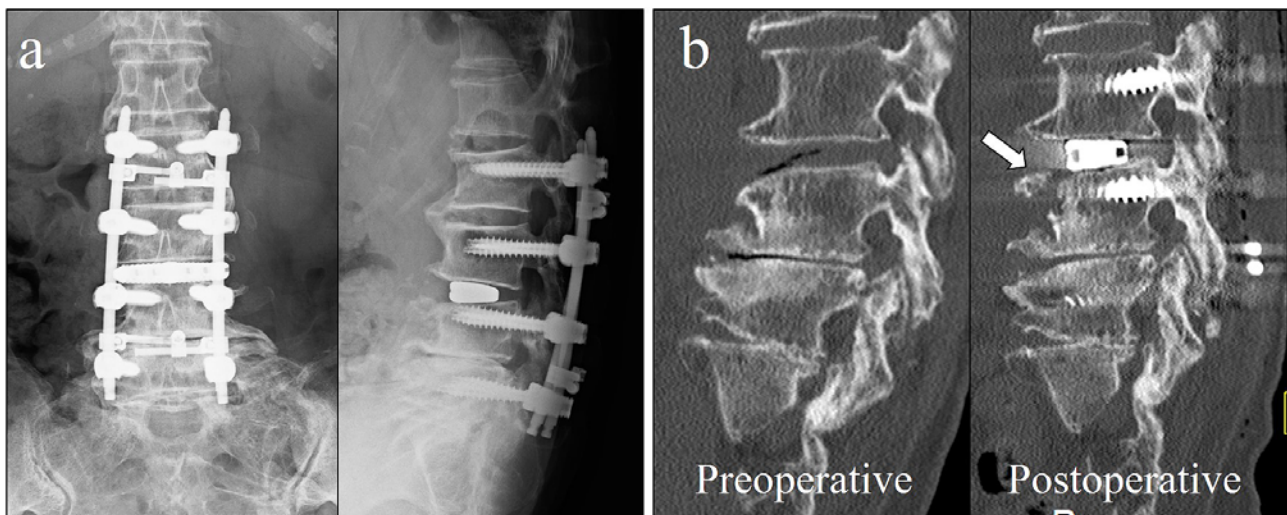


**Figure 1.** Preoperative plain X-ray images: (a) anteroposterior view and (b) lateral view in flexion, neutral, and extension, with a 3° L3/4 lateral disc mobility between flexion and extension; (c) computed tomography scans showing osseous bridging of the vertebrae from L2 to L3 and from L4 to the sacrum; (d) preoperative sagittal T2-weighted magnetic resonance images, showing lumbar spinal canal stenosis at L3/4, and magnetic resonance imaging in the axial plane, showing lateral recess stenosis on the right side (arrow).



**Figure 2.** (a) The image acquired when the intervertebral cage was inserted before changing the patient’s position. No anterior opening at L3/4 is evident. (b) The image obtained after changing the patient’s position from lateral to prone reveals anterior opening at L3/4 and a gap between the intervertebral cage and endplate.



**Figure 3.** (a) Postoperative radiographs confirming that adequate compression was applied at L3/4 and that there was contact between the intervertebral cage and the endplate. (b) Preoperative and postoperative sagittal computed tomography images, with the postoperative image showing an avulsion fracture of the anterior longitudinal ligament (arrow).

pated that decompression alone would be insufficient; thus, XLIF at L3/4 and lumbar fixation from L2 to L5 was planned. As in most facilities, we routinely insert the PPS with the patient in the prone position because insertion is easier. However, retrospectively, we believe that the ALL injury in this case could have been avoided by inserting the PPS with the patient in the lateral position. Furthermore, sufficient attention should be given to the selection of cage size and installation position. In this case, 9 mm may have been too large for the patient. Surgeons should be aware that such complications can occur and check the fluoroscopic images very carefully when repositioning the patient.

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**Ethical Approval:** Not applicable.

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