**ACDF 2 level female**

OPERATIVE PROCEDURE

Anterior Cervical Decompression and Fusion.

Date: 03/22/2016

Preoperative Diagnoses: Cervical spondylosis with bilateral C5-6-7 radiculopathy, axial neck pain , cervical canal stenosis

Postoperative Diagnoses: Same

Surgeon: Amit Bhandarkar, M.D.

Assistant: Rubein

Complications: None

Specimen: None

Blood Loss: 100

Implants: Plate and screws Synthes

PROCEDURES:

1. Anterior cervical discectomy with decompression.

2. Anterior Cervical fusion C5-6

3. Placement of Biomechanical Device C5-6

4. Use of bone allograft

5. Anterior cervical instrumentation, C5-6

6. Use of C arm imagery, AP and Lateral cervical spine images- for proper positioning of implants

7. Use of operative microscope for assistance in dissection

Patient was brought to the operating room was identified by the anesthetist and the chief nurse. IV access lines were established anesthesia was then administered. Arterial lines were secured SCDs were placed. Foley's catheter was then placed. Patient was then positioned supine. All bony prominences were padded. Monitoring baseline was then carried out all looked okay. Patient was then prepped and draped in routine fashion. ChloraPrep was used for Prepping she was draped free exposing her cervical spine on the anterior side. .

A formal timeout was then carried out and everything including but not limited to her name, type of surgery, duration of surgery site and side was confirmed for midline incision. Using C- arm appropriate incision site was marked on the skin.

We used an anterolateral approach to the cervical spine through a transverse incision. We approached the patient from the left side. Sharp dissection through skin subcutaneous down to the platysma. Using Monopolar for hemostasis, I bluntly dissected under the platymsa, over the sternocleidomastoid north and south freeing up the soft tissue plane and then bluntly dissected medial to the sternocleidomastoid and the carotid sheath down to the prevertebral fascia. I used kittners to bluntly dissect the prevertebral fascia away from the disc, and Then I placed a Caspar pin at C5, confirming this on lateral C-arm image. I then placed and additional pin at C6. I then took the bipolar along the medial aspect of the longus colli bilaterally bluntly reflected this and we were able to place our retractors in to the position.

Once the retractors were placed I then incised the disc anteriorly and removed disc material going out all the way to the posterior aspect of the disc doing a through decompression. The endplate was scraped to bleeding bone using curettes. The Microscope was then brought in the field for appropriate visualization with illumination. The uncinate process and disc osteophyte complex was slowly thinned out using 3 mm diamond burr and was then removed using a 1 mm 45 angled kerrision roungers. A small blunt hook was used to confirm the adequacy of the decompression. The PLL Was slowly scarped out of the disc material and was thin and floating. There was no signs of extrusion of any disc material posteriorly and hence PLL was not removed.

Once that was complete I then took a cage of appropriate size and did some trials, and the packed a cage with bone graft material-consisting of DBM and local bone graft harvested from the osteophyte and impacted that into position at C5-6.

The C5 Caspar pin was then moved To C7 and similar decompression procedure and cage placement after bed preparation was carried out at C6-7 level after confirming adequate decompression.

The patients EMG motors and sensory never changed from baseline throught out the procedure.

Once completed, I them trimmed the anterior osteophyte to create a nice space for the plate. I used a plate of appropriate size and screw, which were put into position. The length and positon of the screws were ascertained using a C arm. All screws were in good position and were wrist tight.

X-ray

AP and lateral cervical spine images demonstrated good position of the plate anteriorly in the coronal plane and also good position into the sagittal plane. There was good disc height restoration, minimal facet distraction at the level. It appeared to be in good positon with good cervical lordosis.