DECOMPRESSION AND FUSION

Surgeon: Amit Bhandarkar, M.D.

Date: []

Preoperative Diagnosis: []

Postoperative Diagnosis: []

Assistant: []

Complications: []

Specimens: []

Blood Loss: []

Implants: [Gold Standard Orthopaedics]

Procedure:

1. Anterior cervical discectomy for decompression and fusion, [C 5-6]

2. Anterior cervical discectomy for decompression and fusion, [C 6-7]

3. Placement of biomechanical interbody device at [C 5-6]

4. Placement of biomechanical interbody device at [C 6-7]

5. Anterior cervical instrumentation [C 5 to C 7], segmental

6. Use of bone allograft

7. Use of C-arm imagery for localization of incision and assist in placement of implants.

DESCRIPTION OF PROCEDURE: The patient was taken to the operative suite and placed supine on the operating room table and was prepped and draped sterilely. After time out was conducted verifying patient identification and site mark verification, and anesthesia induction, we brought the C-arm in for localization of our incision site. A transverse incision was made over the anterior cervical spine. We then proceeded to dissect sharply through skin down to the platysma, monopolar through platysma and to maintain hemostasis. We then freed up the soft tissue, creating flaps north and south over the sternocleidomastoid. We then dissected bluntly medial to the to the sternocleidomastoid and the carotid sheath down to the prevertebral fascia. The prevertebral fascia was then dissected using Kittners, and then a Caspar pin was placed into what we believed was [C5]. We actually validated this was [C6]. We removed this pin and placed bone wax, and then placed a pin in [C5] and then in [C7]. Once these pins were in place, we confirmed this on a lateral C-arm image. We then used a bipolar along the medial aspect of the longus colli bilaterally to maintain hemostasis, and then we bluntly reflected the musculature laterally to expose the anterior cervical disk area. This was done without a substantial amount of difficulty. We then positioned the self-retaining retractors. The disks were incised anteriorly. The [C 5-6] disk was more difficult to access. We were ultimately able to access both disks, however, removing any anterior osteophyte that was present and removed the disk material out to the posterior longitudinal ligament. We also trimmed bone spurs out through the neural foramina bilaterally to increase space in this area as well. There was also certainly indirect decompression created by performing the distraction and increasing the disk height. This was done as well. All disk material was removed. Decompression was satisfactory. We then roughened up the endplates with our curette so that we would be able to have bone graft infusion occur. Once the endplates were appropriately prepared, we placed cages of appropriate size packed with allograft into the disk spaces. Once these were impacted into the appropriate locations, a plate of appropriate size was selected and placed anteriorly over the cervical spine, then fastened in position using screws.

The screws were tightened down in position, [2] screws at each level- [C5, C6, and C7]. Once the plate was down into position, we took AP and lateral images to determine that the screws were in an appropriate position. They were an excellent length, just to the cortex posteriorly. Seeing these were in good position, we re-verified all screws were tight. We were very happy with the original tightness. I then locked down the cam locking device over all [3] sets of screws.

We then irrigated the wound with copious amounts of saline. Once irrigation was complete and the wound was clean, we noticed a slight amount of bleeding around the [C7] pin site. Bone wax was placed here. The [C5] site was somewhat under the plate. We did not require wax at this site. Given the small amount of drainage we encountered, we elected to place a deep drain. We then closed the wound in layers over the deep drain followed by skin glue and a sterile dressing. The patient tolerated the procedure throughout and was then able to go on a gurney for anesthesia reversal and transport to recovery in stable condition.