**Discharge Cervical**

ISCHARGE NOTE

ADMITTING PHYSICIAN: Amit Bhandarkar, M.D.

PROVIDER; Amit Bhandarkar MD, Prairie Sine and Pain Institute.

ADMISSION DATE:

OP-notes

**HISTORY OF PRESENT ILLNESS:**

The patient presented with long-standing cervical radicular pain, especially involving the left upper extremities, as well as severe axial neck pain and cervical canal stenosis. They have multilevel cervical degenerative disc disease with severe spondylotic changes and had failed conservative management.

**HOSPITAL COURSE:**

On the day of admission, the patient was prepared for surgery. During the procedure, average bleeding was noted, and the surgery was otherwise uneventful. Surgical objectives, including wide decompression, discectomy, anterior foraminotomy, restoration of disc height and lordosis, bone grafting, and anterior instrumentation, were achieved. The patient was extubated in the OR and transferred to the PACU, where pain was stabilized using Morphine and Fentanyl, achieving a pain level of four. They were then transferred to the SCU for further management.

In the SCU, pain was managed with Morphine, oral hydrocodone, IV acetaminophen, and lidocaine patches. Sequential compression devices were used, and a urinary catheter was removed on the first postoperative day. The patient received antibiotics until the drains were removed and showed no signs of burning micturition, thrombophlebitis, DVT, or respiratory issues. Their incision remained dry throughout the stay.

During hospitalization, the patient’s vitals were stable. They passed urine normally after the catheter was removed and had no urinary issues. Physical therapy helped mobilize them out of bed and train them to walk independently. They performed incentive spirometry and respiratory therapy. A liquid diet was initially provided and then gradually advanced to a normal diet. While they passed gas, there was no bowel movement, so Dulcolax was administered. A cervical collar was provided, and the patient was instructed to avoid excessive movement. No issues with swallowing or breathing were noted. The neck drain was removed on the second postoperative day. Neurological status remained consistent, with improvement in left arm pain.

**EXAMINATION AT DISCHARGE:**

On the second postoperative day, the patient’s vitals were stable with no fever.

**VITALS:** Stable

**LAB:** Normal

**PHYSICAL EXAMINATION:**

* **HEENT:** Oral membranes moist, PERRLA, EOMI, no nystagmus
* **Neck:** Supple
* **CV:** Regular rate and rhythm, no murmurs
* **Respiratory:** Clear to auscultation bilaterally
* **Abdomen:** Soft, non-tender, non-distended

The patient reported operative site pain described as a burning sensation and spasms but noted significant improvement in arm pain. They were neurologically intact, ambulating, and felt comfortable while sitting. The incision appeared dry with no signs of inflammation or infection.

**DISCHARGE INSTRUCTIONS:**

1. Continue oral pain medication: Norco 10 mg every 4-6 hours as needed for severe pain, taper gradually. Use Lidoderm patches and take Tramadol 50 mg (2 tabs every 2 hours as needed for pain). Continue Gabapentin 300 mg three times daily. Contact the office if pain increases or changes in pattern occur.
2. Follow a normal diet as tolerated.
3. Keep dressings dry and remove the superficial layer after 5 days.
4. Follow up in two weeks.
5. Resume all home medications; medication reconciliation was sent to the primary care physician.
6. Restrict activities such as lifting, bending, twisting, and sitting for more than 30 minutes. Continue using the cervical collar for six weeks post-op.
7. Begin physical therapy two weeks after discharge.
8. Detailed discharge instructions were provided.
9. Follow hospitalist recommendations for hypertension, hypothyroidism, and other medications, and consult the primary care physician upon discharge.
10. Contact the office immediately for dressing discharge or soakage.
11. Continue chest physical therapy and breathing exercises at home.

The patient was provided with contact information for Prairie Spine and instructed to call for any concerns.