**Medial Branch Blocks Cervical Spine**

PREOPERATIVE DIAGNOSIS:----

POSTOPERATIVE DIAGNOSIS: ----

PROCEDURES: ----

1. ----

ASSISTANT: ----

COMPLICATIONS: ----

ESTIMATED BLOOD LOSS:

PREOPERATIVE PAIN LEVEL:

POSTOPERATIVE PAIN LEVEL:

RATIONALE: -----

PREOPERATIVE AREA:

  All the risks of injections were discussed with the patient in the preoperative area. Risks included but not limited to stroke, paralysis, infection, hematoma formation, spinal fluid leak and arachnoiditis were discussed. The temporary nature of the pain relief was also explained to the patient. The alternative options of conservative care were also discussed with the patient. Patient completely understood and consented for the procedure understanding the risks and the benefits. Patient was also appropriately marked for the planned procedure after obtaining full informed consent.  Patient was then transferred to the operating area.

OPERATIVE PROCEDURE: The patient was taken to the operating suite    he/she was identified by the head nurse and was placed in lateral position on a radiolucent table.  Patient’s all bony prominences were padded. Patient is relevant studies were put on display his/ her vitals were being monitored, he/she was administered conscious sedation.  Patient was in correct position with fluoroscopy on the right side. The patient was prepped and draped in the normal sterile fashion. Surgical time out was then performed to confirm the patient's identification, diagnosis, planned procedure and allergies. Surgical site was also properly marked for the planned procedure.

We were able to bring in the C-arm and nicely visualize the end on lateral view of the cervical spine. We were able to make margins of the lateral masses crisp by manipulating the C-arm.   Subsequently we were able to oblique the C-arm to obtain nice end on view of the ipsilateral lateral masses.  We started with the left side first and then proceeded with the right side. The entry point was decided based on the endo on view using a clamp and C-arm guidance. Skin overlying the entry point and was then anesthetized with 2 cc of 1% lidocaine. After adequate anesthesia, a hypodermic needle 25 g which was prebend was slowly inserted towards the target area. I was able to put the needle at the junction of the posterior 1/3rd and anterior 2/3rd of the lateral facet joint projection. I had a nice bony end point at all locations.   Once in that area, I was able to introduce contrast. There was no vascular uptake. I was then able to aspirate the needle with negative aspiration for any fluid. At that point in time, I went and injected all of these areas with 1 mL of solution, which was a mix of 0.3 mL of 0.25% Marcaine, 0.3 mL of 1% lidocaine and 0.4 ml of dexamethasone. I was able to remove the needles and dress the wound with a Band-Aid.

Similarly, the procedure was then carried onto the other side. We had a nice bony feel and then we were able to nicely insert the needle into the right area, and again, the patient had negative aspiration and no vascular uptake on contrast.  I was able to remove the needle and then dress the wound with a Band-Aid. Patient tolerated the procedure really well.

The patient was asked to maintain a pain diary. After injection the patient’s pain went down from --------- to ------------.  He/she was walking comfortably within half an hour after the injection. He/she was neurologically same as before. He/she passed urine. He/she was discharged home after observation. He/she was asked to contact us if any fever, increased pain, tingling, numbness or weakness or any signs of infection.  Discharge instructions were also handed over to him/her.  We will see how he does with this block. He/She understood and verbalized agreement for the present plan. We will see him/her back in 7 days and we will re-evaluate, reassess, and go from there. If any further questions concern in the meantime, they should contact me at pain center.