**Kyphoplasty**

D 10 Kyphoplasty

Surgeon: Amit Bhandarkar, M.D.

Date 8 th of July 2016

Preoperative Diagnoses:

1. D 10 osteoporotic vertebral compression fracture

Postoperative Diagnoses:

1. D 10osteoporotic vertebral compression fracture

PROCEDURES:

1. D 10 bilateral kyphoplasty

Assistant: None

Complications: None

Specimen: biopsy obtained from the D 10 vertebral body

Blood Loss: Scant

In the preoperative area the diagnosis the pathology the surgical procedure the risks involved, and possible complications were discussed in details. The informed written consent was obtained. Patient's pain was in the midline right at the fracture area. The patient was then taken to the OR. The head nurse and the anesthetic identified the patient. Relevant studies was put on display. Gen. anesthesia was then administered. Patient was also catheterized. All the relevant lines were hooked up. Patient was then turned prone and all bony prominences were padded. Patient was then painted and draped free exposing his lumbar area. After draping a timeout was then performed to confirm his side site patient's name and allergies. The patient was administered 2 g of Ancef.

C-arm was then brought in. the D 10 vertebra was localized and the site of entry for the kyphoplasty needle was marked. Marcaine was then injected locally. The stab knife was then used to make out 3 mm incision on the skin. The kyphoplasty needle was then inserted in the pedicles. C-arm guidance was used throughout.the proper trajectory of the needle to the pedicle into the vertebral body was confirmed using oblique and orthogonal views.

Biopsy needle was then inserted to obtain a core of vertebral body. We will only able to get samples from the left side. Which was sent for histopathological examination.

A drill was used through the needle on both sides to make a track to accomodate the kyphoplasty ballon. The balloon was then inserted on both sides starting first on the left side. The baloon was then slowly inflated under C-arm guidance so as to occupy anterior and middle third of the vertebral body. Care was taken that there is no undue break of the posterior or anterior or the superior endplate. We were able to inflate the ballons to 4 cc. The balloons were then slowly deflated. The catheters were then taken out. There are intact. After the cement mixing was started. we used high viscosity confidence cement. cement was then gradually inserted into the cavity made by loose balloons with a low-pressure technique. The patient was not allowed to exceed beyond 300 at any point of time. C-arm guidance was used throughout. Care was taken that the cement was not crossing anteriorly over the posterior one third or breaching the superior endplate. The left side was inserted first followed by the right side. The endpoint was when the pressure started increasing beyond 200 and the cement started travelling towards the posteriod border. We immidiately decreased the presure by reversing the piston. For the right side it was when he started lifting the superior endplate. After 7 minutes of mixing the cement we had inserted around 9 cc of cement inside the vertebral body and it looked properly placed and we were able to marginally restore the vertebral height. We then withdraw the needle after inserting and were still intact. The cement further flowed to the pedicle. We will able to remove the needle intact. Sterile dressing in the form of Dermabond was then applied along with Steri-Strips.

Patient was then turned supine and then extubated. The surgery was uneventful. The patient was then taken taken to PACU. He was observed for sometimes. He was neurologically intact and his pain was completely gone. He tolerated the procedure really well. He was placed observation and ambulatory care for a few hours. Patient was having throat apain and complaind for Dyspnoes. It was decided to put him under obeservation overnight.