**Pars block L5 left male**

OPERATIVE PROCEDURE

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Preoperative diagnosis: Spondylolysis with Pars defect With Right sided axial back pain

Postoperative diagnosis:Spondylolysis with Pars defect With Right sided axial back pain

PROCEDURES:

1. L5- pars block

Assistant: None

Complications: None

Specimen: None

Blood Loss: None

DESCRIPTION OF PROCEDURE: All the risk of injections were discussed with the patient in the preop area- risks including but not limited to stroke , paralysis , infection, hematoma formation,arachonditis spinal fluid leak was discussed. The temporary nature of the pain relief and diagnositc nature of the injection was also explained. He was having a pain of 7 in his Back.

The patient was taken to the operating suite and was placed in the prone position on the operating room table. Patient was in correct position with fluoroscopy at Left side. The patient was prepped and draped in the normal fashion. Surgical time-out was taken to confirm the patient's identification, surgical site was properly marked, and planned procedure. Skin overlying the entry point to Pars at the area of maximum pain which was at L 5 was anesthetized with 1/2 cc per level of 1% lidocaine. Following this, 22 gauge needle was directed down using fluoroscopic guidance towards the Right Pard defect identified with the help of C arm. We injected a dye whenthe needl was in appropriate position. There was negative vasculrogram or myelogram. The Pars and surrounding area was injected with. The total injection consisted of 0. 3 cc of lidocaien mixed with 0.5 cc of 0.25% marcaine and 4 mg of dexamethasone. The injection was done after confirming that the patient had no aspiration of any blood or any CSF.

The patient tolerated the procedure well and was taken to the recovery area in stable condition. Patient had partial relief of pain the back pain went down substanatially. He was walking comfortable within half an hour after the injection. He was Neurologically same as before. He was discharged home after observation for 1 hour. He was asked to contact us if any fever, increased pain, wet dresssing. Discharge instructions were handed over. We will see how She does at the end of 2 weeks and proceed from there. He was asked to maintain a pain chart.