

## OPERATIVE REPORT

PATIENT NAME: \_\_\_\_[NAME]

MR#: \_\_\_\_[MR#]

ADMIT DATE: \_\_\_\_[DATE]

PROCEDURE DATE: \_\_\_\_[DATE]

### PREOPERATIVE DIAGNOSES:

1. Cervical spondylosis C5-6 and C6-7 level without myelopathy.
2. Cervical radiculitis bilateral upper extremities.

### POSTOPERATIVE DIAGNOSES:

1. Cervical spondylosis C5-6 and C6-7 level without myelopathy.
2. Cervical radiculitis bilateral upper extremities.

### PROCEDURE:

1. Anterior discectomy, with spinal cord decompression C5-6 level – 63075.
2. Anterior discectomy, with spinal cord decompression C6-7 level – 63076.
3. Arthrodesis interbody technique C5-6 level – 22554.
4. Arthrodesis interbody technique C7 level – 22585.
5. Anterior instrumentation three vertebral segments – 28845.  
? 40 mm long Venture plate from Medtronic
6. Allograft: Structural C5-6 level – 20930.  
? 5 mm high x 11 mm deep x 14 mm wide cortical cancellous allogeneous bone graft.
7. Allograft: Structural C6-7 level – 20930.  
? 5 mm high x 11 mm deep x 14 mm wide cortical cancellous allogeneous bone graft.
8. EMG motor evoked potential testing bilateral upper extremities. Room entry time 10:37. Room exit time 12:20.

SURGEON: \_\_\_\_[NAME]

ASSISTANT: \_\_\_\_[NAME]

ANESTHESIOLOGIST: \_\_\_\_[NAME]

ANESTHESIA: General oral endotracheal.

DRAINS: One 0.25 inch Penrose.

ESTIMATED BLOOD LOSS: None.

COMPLICATIONS: None.

NARRATIVE: The patient is a 59-year-old white female seen in my office regarding severe posterior cervical pain and bilateral upper extremity radicular pain and numbness. The plain films, flexion extension films, and MRI scans have identified loss of disc space height, irregularity of the end plates, chronic disc protrusions of C5-6 and C6-7. There is contact on the ventral cord, persistent neuroforaminal narrowing. The treatment options were discussed and reviewed with the patient as she has failed to make progress with conservative

modalities. The nature of the condition, inherent risks, complications, options, and benefits associated with the procedure have been discussed at length and there have been no promises made as to outcome or cure and informed consents obtained.

PROCEDURE: The patient was taken to the operating room, put on the operative stretcher and placed on the operating table in the supine position. Under IV sedation, the patient was orally intubated by \_\_\_\_[NAME] in conjunction with \_\_\_\_[NAME] and general anesthetic administered by the E2 tube by the anesthesiologist.

The patient received Ancef one gram IV piggyback prior to the start of the procedure.

The patient had a folded towel roll placed between his shoulder blades posteriorly. The head and neck were supported on a gel donut. The arms were tucked in by the patient's side and EMG nerve conduction testing electrodes were placed on both lower extremities. C-arm fluoroscope was used to help identify the level the level of the dissection. The skin was marked accordingly with a sterile skin marker. The skin was sterilely prepped with DuraPrep and draped with sterile linens in the usual sterile orthopedic fashion.

The entire procedure was carried out under 3.5 power loupe magnification and headlight illumination by myself. A #15 blade knife handle was used to make a transverse incision from midline to the left medial border of the sternocleidomastoid muscle. Electrocautery was used to obtain good hemostasis. Electrocautery dissection continued through the subcutaneous tissue. The plane between the subq and the platysma was developed cranially and caudally, medially and laterally until the platysma was fully isolated and divided transversely with electrocautery with the curved tenotomy scissors below it. The strap musculature was identified and mobilized medially along with the trachea and esophagus using Kidner's. The carotid sheath was identified. The Carotid pulse palpated and found to be intact. The carotid sheath was not disturbed or violated. The carotid sheath and the sternocleidomastoid muscle on the left were mobilized laterally. Handheld Collard retractors and Kidner's were used for this purpose. Soft tissue dissection with the Kidner's continued down to the level of the anterior cervical spine. An 18 gauge spinal needle was bent and placed in what was thought to be the C6-7 disc space. Lateral C-arm fluoroscope confirmed this.

The retractors were repositioned and Kidner's were used to mobilize the longus coli muscles away from the midline. Electrocautery was used to remove the soft tissue from the anterior cervical spine and expose the C5-6 and C6-7 disc spaces.

SCC retractor blades were used medially and laterally beneath the longus coli muscles with self-retaining retractors. Smooth top blades slightly taller were used for cranial and caudal retraction with a separate self retaining retractor.

A #15 blade long knife handle was used to make an anterior annulotomy incision at C5-6 and C6-7. The pituitary rongeurs were used to perform discectomy. Curettes 3.0 and 4.0 were used to remove disc material and cartilaginous end plate material exposing bony end plate at C5-6 level and C6-7 level respectively. Anterior osteophytes were removed with the Ober rongeur and the Midas-Rex burr.

Casper pins 14 mm long were used in the vertebral bodies at C5, C6, and C7 with the Casper distractor on the pins at C5-6 and then at C6-7 to gain interbody distraction. The neuroforamina were decompressed using 1-0 and 2-0 mm Kerrison rongeurs. 3-0 and 4-0 curettes were used up-and-down cutting to release the posterior annulus and posterior longitudinal ligament and exposing the thecal sac at both levels on both sides. Foraminal stenosis relieved with use of the Midas\_rex burr posteriorly to remove uncovertebral joint hypertrophy and to open up foraminal stenosis. The Kerrison's 1 and 2 mm were used as noted for this purpose also. Posterior

osteophytic spurs off the C5 inferiorly, C6 superiorly and inferiorly and C7 superiorly were removed with the 1 and 2 mm Kerrison rongeur again to remove spinal cord compression. The wound was copiously irrigated with sterile saline many times during the procedure including now. The end plates had been fully denuded after they had been sized with a sizer. 5 mm high bone grafts x 11 mm deep x 14 mm wide cortical cancellous allogeneous bone grafts were placed anterior and posterior just deep to the anterior vertebral body margins at C5-6 and C6-7. A 40 mm long Venture plate from Medtronic was selected and centered over the C6 vertebral body and held in place with transfixion pin. The awl and the guide were used to make holes in all four corners of the plate. The variable screw 13 mm long x 4 mm wide were used on each of the four corners of the plate and at the C6 level Good purchase of all of the screws were obtained and there were advanced deep to the locking ring and the plate laid flat on the anterior bony surface of the vertebral bodies at C6, C6 and C7. All self-retaining retractors were removed. The wound was copiously irrigated again with sterile saline and suctioned dry. The trachea and esophagus were checked and no violation of these structures. The carotid sheath and its contents were checked and no violation of these structures. AP and lateral C-arm fluoroscopic view confirmed accurate position of bone graft, plate, and screws. All retractors were removed. A 0.25 Vicryl. The skin was closed with a running subcuticular stitch of 4-0 Vicryl and covered with Mastisol, Steri-Strips, Xeroform, 4x4's, tape and two-piece Miami-J collar was applied once the dressings were in place. The drapes were removed.

The patient was discontinued from anesthesia, orally extubated on the table and transported on the recovery stretcher to the recovery room in apparent satisfactory condition.