## M40.0 Postural kyphosis

1. Operative Note: Patient underwent posterior spinal fusion for severe postural kyphosis. A midline incision was made, followed by extensive soft tissue dissection. Pedicle screws were inserted bilaterally, and rods were secured for stabilization. Correction of kyphosis was achieved by applying controlled distraction forces. The wound was closed meticulously. Patient tolerated the procedure well and was transferred to the recovery unit in stable condition.

2. Operative Note: Posterior spinal osteotomy was performed to address progressive postural kyphosis. A midline incision was made, and the paraspinal muscles were dissected. Multiple osteotomies were carried out to enhance spinal alignment and reduce kyphotic deformity. Careful monitoring of neurological function was performed throughout the procedure. The incision was closed layer by layer, and the patient was transferred to the post-anesthesia care unit for recovery.

3. Operative Note: Anterior vertebral column resection was performed to correct severe postural kyphosis. A transverse incision was made, and the thoracic cavity was accessed through a retroperitoneal approach. Vertebral body resection was performed at multiple levels, followed by reconstruction with expandable cages and bone grafting. The incision was closed in layers, and the patient was extubated and transferred to the intensive care unit for monitoring.

4. Operative Note: Patient underwent kyphoplasty for symptomatic postural kyphosis. Under fluoroscopic guidance, bilateral transpedicular access was obtained. Balloon tamp was inflated to create a cavity, followed by injection of bone cement. Cement distribution and kyphosis reduction were confirmed radiographically. The incisions were closed with sutures, and the patient was transferred to the recovery area in stable condition.

5. Operative Note: Postural kyphosis correction was achieved using a minimally invasive technique. Bilateral small incisions were made, and percutaneous pedicle screws were inserted. A rod was placed and secured to restore spinal alignment. The incisions were closed with adhesive strips, and the patient was transferred to the post-anesthesia care unit for monitoring and pain management.

6. Operative Note: Patient underwent thoracoscopic spinal fusion for postural kyphosis. Three small incisions were made for the introduction of the thoracoscope and instrumentation. Intercostal muscle dissection allowed access to the thoracic spine. Screws and rods were placed to correct the kyphotic deformity. Hemostasis was achieved, and the incisions were closed with absorbable sutures. The patient recovered well and was discharged after an uneventful postoperative period.

7. Operative Note: Open wedge osteotomy was performed to address severe postural kyphosis. A midline incision was made, and the posterior elements were exposed. Multiple osteotomies were performed, and the vertebral bodies were gradually opened using distractors. Adequate correction was achieved, and the alignment was confirmed intraoperatively. The wound was closed in layers, and the patient was transferred to the surgical intensive care unit for monitoring.

8. Operative Note: Patient underwent posterior vertebral column resection for progressive postural kyphosis. A posterior midline incision was made, and the vertebral elements were exposed. Multiple levels of vertebral body resection were performed, followed by reconstruction using expandable cages and posterior instrumentation. Hemostasis was achieved, and the wound was closed meticulously. The patient was transferred to the post-anesthesia care unit in stable condition.

9. Operative Note: Postural kyphosis correction was performed using a combination of anterior and posterior approaches. An anterior thoracotomy was performed to address the thoracic curvature, followed by posterior instrumentation for further stabilization. The necessary osteotomies and corrective measures were performed during the procedure. The incisions were closed meticulously, and the patient was transferred to the intensive care unit for postoperative monitoring.

10. Operative Note: Patient underwent vertebral column decancellation to correct severe postural kyphosis. A posterior midline incision was made, and extensive soft tissue dissection was performed. Multiple vertebral levels were decancelled using osteotomies to restore the normal spinal alignment. Pedicle screws and rods were placed for stabilization. The wound was closed layer by layer, and the patient was transferred to the post-anesthesia care unit for recovery.

1. Operative Note: Minimally invasive lateral lumbar interbody fusion was performed to correct postural kyphosis. Bilateral small incisions were made, and the psoas muscle was dissected. Cage placement and interbody fusion were achieved through a tubular retractor system. Pedicle screws and rods were inserted for additional stability. The incisions were closed, and the patient was transferred to the postoperative recovery area in stable condition.

2. Operative Note: Patient underwent posterior vertebral column resection with anterior release for severe postural kyphosis. A midline incision was made, and the vertebral elements were exposed. Multiple levels of vertebral body resection were performed along with anterior release through a separate incision. Reconstruction was achieved using expandable cages and posterior instrumentation. The wounds were closed meticulously, and the patient was transferred to the surgical intensive care unit.

3. Operative Note: Postural kyphosis correction was performed using a combination of spinal osteotomies and vertebral column resection. Multiple levels of osteotomies were carried out to enhance spinal alignment. Vertebral body resection was performed at specific levels, followed by reconstruction using expandable cages and posterior instrumentation. Hemostasis was achieved, and the incisions were closed in layers. The patient tolerated the procedure well and was transferred to the recovery unit.

4. Operative Note: Patient underwent thoracoscopic anterior spinal fusion for progressive postural kyphosis. Three small incisions were made for the introduction of the thoracoscope and instrumentation. Anterior release and interbody fusion were achieved at multiple levels using a cage and bone graft. Fixation was further augmented with anterior plating. The incisions were closed, and the patient was transferred to the post-anesthesia care unit in stable condition.

5. Operative Note: Postural kyphosis correction was performed using a hybrid approach. An anterior release and interbody fusion were initially performed through an abdominal incision. Subsequently, posterior pedicle screws and rods were inserted for additional stability. Adequate alignment was achieved, and the wounds were closed meticulously. The patient was transferred to the surgical intensive care unit for postoperative monitoring and pain management.

6. Operative Note: Patient underwent posterior vertebral column resection with simultaneous anterior release and fusion for severe postural kyphosis. A midline posterior incision and an anterior approach were utilized. Multiple vertebral body resections were performed, followed by reconstruction with expandable cages and posterior instrumentation. The anterior release and fusion were achieved through a separate anterior incision. The wounds were closed meticulously, and the patient was transferred to the intensive care unit.

7. Operative Note: Patient underwent pedicle subtraction osteotomy for progressive postural kyphosis. A posterior midline incision was made, and the paraspinal muscles were dissected. Multiple osteotomies were performed to enhance spinal alignment. The vertebral body was removed, and the remaining spine was realigned. Posterior instrumentation with pedicle screws and rods was applied. Hemostasis was achieved, and the incisions were closed in layers. The patient recovered well and was transferred to the recovery unit.

8. Operative Note: Patient underwent corrective surgery for postural kyphosis using a magnetically controlled growing rod system. A midline incision was made, and the paraspinal muscles were dissected. The magnetically controlled growing rods were implanted and adjusted using an external remote control device. The incision was closed meticulously, and the patient was transferred to the post-anesthesia care unit for recovery.

9. Operative Note: Postural kyphosis correction was achieved using a combination of vertebral body tethering and posterior instrumentation. A posterior midline incision was made, and the spine was exposed. Vertebral body tethering was performed using polyethylene tethers, followed by posterior pedicle screws and rods for additional stabilization. Hemostasis was achieved, and the wounds were closed layer by layer. The patient tolerated the procedure well and was transferred to the recovery area.

10. Operative Note: Patient underwent posterior spinal fusion with the use of an expandable implant for postural kyphosis. A midline incision was made, and the posterior elements were exposed. Expandable implants were inserted to gradually correct the kyphotic deformity. The implants were expanded intraoperatively to achieve the desired alignment. Posterior instrumentation with pedicle screws and rods was applied for stabilization. The incisions were closed meticulously, and the patient was transferred to the post-anesthesia care unit.

1. Operative Note: Patient underwent posterior spinal fusion for postural kyphosis under general anesthesia. Anesthetic induction was achieved using propofol and remifentanil. Maintenance was carried out with sevoflurane and a balanced infusion of remifentanil and dexmedetomidine. Intraoperative monitoring remained stable throughout the procedure. The anesthesia depth was carefully adjusted to maintain hemodynamic stability and optimal surgical conditions. The patient recovered well and was transferred to the post-anesthesia care unit.

2. Operative Note: Postural kyphosis correction was performed under monitored anesthesia care (MAC). Intravenous sedation was provided with midazolam and fentanyl to maintain patient comfort and cooperation. Local anesthesia was administered at the surgical site for pain control. Throughout the procedure, the patient remained conscious and responsive, and vital signs were closely monitored. The patient tolerated the procedure well and was transferred to the recovery area.

3. Operative Note: Patient underwent posterior vertebral column resection for severe postural kyphosis under combined general and regional anesthesia. General anesthesia was induced with propofol and fentanyl, and endotracheal intubation was performed. A thoracic epidural catheter was placed for postoperative pain control. The anesthesia depth was maintained with sevoflurane and a continuous epidural infusion of local anesthetics. The patient remained stable throughout the procedure and was transferred to the surgical intensive care unit.

4. Operative Note: Minimally invasive kyphoplasty was performed under local anesthesia with intravenous sedation. The surgical site was infiltrated with a local anesthetic agent for pain control. Conscious sedation was achieved using midazolam and fentanyl. The patient remained comfortable and cooperative during the procedure, with vital signs monitored closely. The kyphoplasty was successfully completed, and the patient was transferred to the recovery area in stable condition.

5. Operative Note: Patient underwent thoracoscopic spinal fusion for postural kyphosis under general anesthesia with a balanced technique. Anesthetic induction was achieved using propofol, fentanyl, and rocuronium. Anesthesia was maintained with sevoflurane and a continuous infusion of remifentanil. Intraoperative monitoring of hemodynamics, end-tidal CO2, and oxygen saturation was performed. The patient's anesthesia depth was adjusted to ensure optimal surgical conditions. The patient recovered well and was transferred to the post-anesthesia care unit.

6. Operative Note: Postural kyphosis correction was performed using posterior vertebral column resection under general anesthesia. Anesthetic induction was accomplished with propofol, fentanyl, and rocuronium. Anesthesia was maintained with a combination of sevoflurane, remifentanil infusion, and intermittent boluses of rocuronium. Close monitoring of vital signs, neuromuscular blockade, and depth of anesthesia was maintained throughout the procedure. The patient was transferred to the surgical intensive care unit for postoperative care.

7. Operative Note: Patient underwent kyphoplasty for postural kyphosis under local anesthesia with intravenous sedation. The surgical site was infiltrated with a local anesthetic agent for pain control. Intravenous sedation was achieved with midazolam and remifentanil. The patient remained comfortable and responsive during the procedure, with vital signs closely monitored. Successful kyphoplasty was performed, and the patient was transferred to the recovery area in stable condition.

8. Operative Note: Postural kyphosis correction was performed under general anesthesia with a total intravenous anesthesia (TIVA) technique. Anesthetic induction was achieved using propofol and remifentanil. Anesthesia was maintained with a propofol infusion and remifentanil infusion adjusted based on bispectral index monitoring. Hemodynamic stability and adequate anesthesia depth were ensured throughout the procedure. The patient recovered well and was transferred to the post-anesthesia care unit.

9. Operative Note: Patient underwent posterior spinal fusion with the use of an expandable implant for postural kyphosis under general anesthesia. Anesthetic induction was achieved using propofol and sufentanil. Anesthesia was maintained with sevoflurane and a continuous infusion of remifentanil. The depth of anesthesia was titrated to maintain stable hemodynamics and optimal surgical conditions. The patient's vital signs were closely monitored, and the procedure was completed successfully. The patient was transferred to the post-anesthesia care unit.

10. Operative Note: Patient underwent anterior release and fusion for progressive postural kyphosis under general anesthesia. Anesthetic induction was accomplished using propofol, fentanyl, and rocuronium. Anesthesia was maintained with sevoflurane and remifentanil infusion. Adequate muscle relaxation and optimal anesthesia depth were ensured throughout the procedure. Close monitoring of vital signs, neuromuscular blockade, and depth of anesthesia was performed. The patient recovered well and was transferred to the surgical intensive care unit for postoperative care.

1. Operative Note: Patient underwent posterior vertebral column resection with extensive bone erosion due to severe postural kyphosis. A midline incision was made, and the eroded vertebral bodies were exposed. Multiple levels of vertebral body resection were performed, followed by reconstruction using expandable cages and posterior instrumentation. The eroded bone was carefully removed, and adequate correction of the kyphotic deformity was achieved. The wounds were closed meticulously, and the patient was transferred to the surgical intensive care unit.

2. Operative Note: Patient with postural kyphosis and significant bone erosion underwent anterior release and fusion. A transverse incision was made, and the eroded vertebral bodies were visualized. Extensive debridement was performed to remove the eroded bone and achieve appropriate spinal alignment. An anterior interbody fusion was achieved using cages and bone grafting. Hemostasis was achieved, and the incision was closed. The patient recovered well and was transferred to the post-anesthesia care unit.

3. Operative Note: Patient underwent minimally invasive corrective surgery for postural kyphosis with associated bone erosion. Bilateral small incisions were made, and the eroded vertebral bodies were exposed. Special attention was given to the erosive areas during the correction process. Percutaneous pedicle screws and rods were inserted for stabilization. The eroded bone was carefully managed and removed as necessary. The incisions were closed, and the patient was transferred to the recovery area.

4. Operative Note: Patient underwent posterior spinal fusion for postural kyphosis with severe bone erosion. A midline incision was made, and the eroded vertebral bodies were exposed. Decancellation osteotomies were performed to improve spinal alignment and address the erosive areas. The eroded bone fragments were carefully managed and removed. Posterior instrumentation with pedicle screws and rods was applied. Hemostasis was achieved, and the wounds were closed meticulously. The patient was transferred to the post-anesthesia care unit.

5. Operative Note: Postural kyphosis correction was performed in a patient with significant bone erosion. A midline incision was made, and the eroded vertebral bodies were exposed. Multiple osteotomies were carried out to enhance spinal alignment and address the erosive areas. Attention was given to meticulous removal of the eroded bone fragments. Reconstruction was achieved using expandable cages and posterior instrumentation. The incisions were closed layer by layer, and the patient was transferred to the recovery unit.

6. Operative Note: Patient with severe postural kyphosis and extensive bone erosion underwent anterior vertebral column resection. A transverse incision was made, and the eroded vertebral bodies were accessed. Multiple levels of vertebral body resection were performed, and the erosive bone was meticulously removed. Reconstruction was achieved using expandable cages and anterior plating. Hemostasis was achieved, and the incision was closed. The patient recovered well and was transferred to the surgical intensive care unit.

7. Operative Note: Patient with postural kyphosis and localized bone erosion underwent posterior fusion with bone grafting. A midline incision was made, and the eroded vertebral bodies were exposed. Debridement of the eroded bone was performed to promote bony fusion. Bone grafting was carried out to stimulate healing and stability. Posterior instrumentation was applied using pedicle screws and rods. The incisions were closed meticulously, and the patient was transferred to the recovery area.

8. Operative Note: Patient underwent corrective surgery for severe postural kyphosis with extensive bone erosion. A combined anterior and posterior approach was utilized. The eroded vertebral bodies were exposed through anterior and posterior incisions. Debridement and removal of the eroded bone were performed during the procedure. Reconstruction was achieved using a combination of interbody fusion, expandable cages, and posterior instrumentation. The wounds were closed meticulously, and the patient was transferred to the surgical intensive care unit.

9. Operative Note: Patient with postural kyphosis and significant bone erosion underwent minimally invasive vertebral augmentation. Bilateral small incisions were made, and the eroded vertebral bodies were accessed. Bone cement was injected into the erosive areas to stabilize the spine and relieve pain. The eroded bone was carefully managed during the procedure. The incisions were closed, and the patient was transferred to the post-anesthesia care unit.

10. Operative Note: Patient with progressive postural kyphosis and extensive bone erosion underwent posterior vertebral column resection. A midline incision was made, and the eroded vertebral bodies were exposed. Vertebral column resection was performed at multiple levels to correct the kyphotic deformity and address the erosive areas. The eroded bone was carefully managed and removed. Reconstruction was achieved using expandable cages and posterior instrumentation. The wounds were closed meticulously, and the patient was transferred to the surgical intensive care unit.

1. Operative Note: Patient with severe bone pain due to postural kyphosis underwent posterior spinal fusion. A midline incision was made, and the painful vertebral segments were exposed. Multiple levels of decompression were performed to alleviate nerve compression and relieve bone pain. Posterior instrumentation with pedicle screws and rods was applied for stabilization. The incisions were closed meticulously, and the patient was transferred to the post-anesthesia care unit for pain management.

2. Operative Note: Patient with debilitating bone pain secondary to postural kyphosis underwent anterior vertebral column resection. A transverse incision was made, and the painful vertebral bodies were accessed. Extensive vertebral body resection was performed to alleviate the source of severe bone pain. Reconstruction was achieved using expandable cages and anterior plating. Hemostasis was achieved, and the incision was closed. The patient recovered well and was transferred to the surgical intensive care unit for pain control.

3. Operative Note: Patient with severe bone pain related to postural kyphosis underwent minimally invasive kyphoplasty. The painful vertebral segments were accessed through small incisions, and the vertebral body was augmented with bone cement. The procedure successfully alleviated the patient's severe bone pain. The incisions were closed, and the patient was transferred to the recovery area for pain management.

4. Operative Note: Patient with intractable bone pain due to postural kyphosis underwent posterior vertebral column resection. A midline incision was made, and the painful vertebral bodies were exposed. Multiple levels of vertebral body resection were performed to alleviate severe bone pain. Reconstruction was achieved using expandable cages and posterior instrumentation. Hemostasis was achieved, and the wounds were closed meticulously. The patient was transferred to the surgical intensive care unit for postoperative pain control.

5. Operative Note: Patient with incapacitating bone pain secondary to postural kyphosis underwent anterior release and fusion. A transverse incision was made, and the painful vertebral bodies were visualized. Extensive debridement and decompression were performed to alleviate severe bone pain. An anterior interbody fusion was achieved using cages and bone grafting. Hemostasis was achieved, and the incision was closed. The patient recovered well and was transferred to the post-anesthesia care unit for pain management.

6. Operative Note: Patient with severe bone pain associated with postural kyphosis underwent posterior spinal fusion. A midline incision was made, and the painful vertebral segments were exposed. Decompression of neural elements was performed to alleviate severe bone pain. Posterior instrumentation with pedicle screws and rods was applied for stabilization. The incisions were closed meticulously, and the patient was transferred to the surgical intensive care unit for comprehensive pain management.

7. Operative Note: Patient with severe bone pain and functional impairment due to postural kyphosis underwent vertebral augmentation. A small incision was made, and bone cement was injected into the painful vertebral bodies to stabilize the spine and relieve bone pain. The procedure successfully alleviated the patient's severe bone pain. The incision was closed, and the patient was transferred to the recovery area for pain management.

8. Operative Note: Patient with incapacitating bone pain related to postural kyphosis underwent posterior vertebral column resection. A midline incision was made, and the painful vertebral bodies were exposed. Extensive resection was performed to alleviate severe bone pain and correct spinal deformity. Reconstruction was achieved using expandable cages and posterior instrumentation. Hemostasis was achieved, and the wounds were closed meticulously. The patient was transferred to the surgical intensive care unit for comprehensive pain control.

9. Operative Note: Patient with intractable bone pain secondary to postural kyphosis underwent anterior vertebral column resection. A transverse incision was made, and the painful vertebral bodies were accessed. Extensive vertebral body resection was performed to alleviate severe bone pain. Reconstruction was achieved using expandable cages and anterior plating. The procedure successfully relieved the patient's severe bone pain. The incision was closed, and the patient was transferred to the surgical intensive care unit for pain management.

10. Operative Note: Patient with debilitating bone pain associated with postural kyphosis underwent minimally invasive kyphoplasty. The painful vertebral segments were accessed through small incisions, and bone cement was injected to stabilize the spine and relieve bone pain. The procedure successfully alleviated the patient's severe bone pain. The incisions were closed, and the patient was transferred to the recovery area for comprehensive pain control.

1. Operative Note: Patient underwent posterior spinal fusion with instrumentation for severe postural kyphosis. A midline incision was made, and the spine was exposed. Pedicle screws and rods were inserted to achieve stabilization and alignment. The deformity was corrected, and interbody fusion was performed. The incision was closed in layers, and the patient was transferred to the recovery area for postoperative care.

2. Operative Note: Patient with postural kyphosis underwent anterior release and fusion surgery. A transverse incision was made, and the anterior spine was accessed. Vertebral bodies were removed, and an interbody fusion was performed. Anterior instrumentation and grafting were employed to achieve stability and alignment. The incision was closed, and the patient was transferred to the surgical intensive care unit for further monitoring.

3. Operative Note: Patient underwent minimally invasive kyphoplasty for postural kyphosis. Small incisions were made, and a balloon catheter was inserted into the vertebrae. The balloon was inflated to create space, followed by the injection of bone cement. The procedure successfully restored vertebral height and reduced pain. The incisions were closed, and the patient was transferred to the recovery area.

4. Operative Note: Patient with severe postural kyphosis underwent posterior vertebral column resection. A midline incision was made, and the affected vertebral levels were exposed. Multiple levels of vertebral body resection were performed, followed by spinal realignment and stabilization. The incision was closed meticulously, and the patient was transferred to the surgical intensive care unit for postoperative management.

5. Operative Note: Patient underwent corrective surgery for postural kyphosis using a combination of anterior and posterior approaches. The anterior release and fusion were performed first, followed by posterior spinal fusion and instrumentation. The deformity was corrected, and stability was achieved. The incisions were closed, and the patient was transferred to the recovery area for postoperative care.

6. Operative Note: Patient with progressive postural kyphosis underwent posterior vertebral column resection and fusion. A midline incision was made, and the affected vertebral levels were exposed. Vertebral column resection was performed, followed by the insertion of pedicle screws and rods for stabilization. Interbody fusion was also achieved. The incision was closed meticulously, and the patient was transferred to the surgical intensive care unit.

7. Operative Note: Patient underwent thoracoscopic spinal fusion for postural kyphosis. The procedure was performed using minimally invasive techniques. Small incisions were made, and a thoracoscope was inserted to visualize the spine. Pedicle screws and rods were placed, and spinal alignment was corrected. The incisions were closed, and the patient was transferred to the post-anesthesia care unit.

8. Operative Note: Patient with severe postural kyphosis underwent posterior vertebral column resection with the aid of neuromonitoring. A midline incision was made, and the affected vertebral levels were exposed. The eroded vertebrae were removed, and the spine was realigned and stabilized with instrumentation. Intraoperative neuromonitoring ensured the safety of neural structures. The incision was closed meticulously, and the patient was transferred to the surgical intensive care unit.

9. Operative Note: Patient with progressive postural kyphosis underwent anterior vertebral column resection with reconstruction. A transverse incision was made, and the affected vertebral levels were accessed. Vertebral body resection was performed, and expandable cages and anterior plating were utilized for stabilization. The incision was closed, and the patient was transferred to the surgical intensive care unit for further management.

10. Operative Note: Patient underwent posterior spinal fusion with bone grafting for postural kyphosis. A midline incision was made, and the spine was exposed. Pedicle screws and rods were inserted to achieve stabilization. Bone graft material was applied to promote fusion. The incision was closed in layers, and the patient was transferred to the post-anesthesia care unit for recovery.

1. Operative Note: Patient with severe postural kyphosis underwent vertebral osteotomy and posterior spinal fusion. A midline incision was made, and the eroded vertebral bodies were accessed. Osteotomy was performed to correct the deformity, followed by the insertion of pedicle screws and rods for stabilization. The incision was closed meticulously, and the patient was transferred to the surgical intensive care unit for postoperative care.

2. Operative Note: Patient underwent anterior cervical discectomy and fusion (ACDF) for postural kyphosis. A transverse incision was made, and the affected cervical levels were accessed. Discectomy was performed, and interbody fusion was achieved using a cage and bone graft. Anterior plating was applied for stability. The incision was closed, and the patient was transferred to the recovery area for further management.

3. Operative Note: Patient with postural kyphosis and severe bone pain underwent vertebral augmentation using a posterior approach. A midline incision was made, and the affected vertebral bodies were accessed. Bone cement was injected to stabilize the spine and relieve pain. The incision was closed, and the patient was transferred to the post-anesthesia care unit for pain management.

4. Operative Note: Patient underwent posterior vertebral column resection with posterior instrumentation for postural kyphosis. A midline incision was made, and the affected vertebral levels were exposed. Vertebral resection was performed, and the spine was realigned using pedicle screws and rods. The incision was closed meticulously, and the patient was transferred to the surgical intensive care unit for postoperative monitoring.

5. Operative Note: Patient with progressive postural kyphosis underwent minimally invasive lateral interbody fusion (MIS-LIF). Bilateral small incisions were made, and the eroded vertebral bodies were accessed. Interbody fusion was achieved using a cage and bone graft material. The procedure successfully corrected the spinal deformity. The incisions were closed, and the patient was transferred to the recovery area for postoperative care.

6. Operative Note: Patient with severe postural kyphosis and spinal instability underwent posterior spinal fusion with segmental fixation. A midline incision was made, and the spine was exposed. Pedicle screws and rods were inserted to achieve stability, and bone grafting was performed to promote fusion. The incision was closed, and the patient was transferred to the surgical intensive care unit for postoperative management.

7. Operative Note: Patient underwent anterior cervical corpectomy and fusion (ACCF) for postural kyphosis. A transverse incision was made, and the affected vertebral levels were accessed. Corpectomy was performed, and the vertebral body was replaced with a cage and bone graft. Anterior plating was applied for stability. The incision was closed, and the patient was transferred to the recovery area for further care.

8. Operative Note: Patient with severe postural kyphosis and spinal cord compression underwent decompressive laminectomy and fusion. A midline incision was made, and the laminae were removed to decompress the spinal cord. Pedicle screws and rods were inserted for stabilization, and bone grafting was performed for fusion. The incision was closed meticulously, and the patient was transferred to the surgical intensive care unit for postoperative monitoring.

9. Operative Note: Patient with postural kyphosis and associated neurologic deficits underwent posterior spinal fusion with spinal cord monitoring. A midline incision was made, and the spine was exposed. Pedicle screws and rods were inserted for stabilization, and bone grafting was performed for fusion. Intraoperative spinal cord monitoring ensured the safety of neural structures. The incision was closed, and the patient was transferred to the surgical intensive care unit for further management.

10. Operative Note: Patient with severe postural kyphosis underwent vertebral column resection and posterior spinal fusion. A midline incision was made, and the affected vertebral levels were exposed. Vertebral column resection was performed to correct the deformity, followed by the insertion of pedicle screws and rods for stabilization. The incision was closed meticulously, and the patient was transferred to the surgical intensive care unit for postoperative care.

1. Operative Note: Patient with severe infection on the extreme moving joint due to postural kyphosis underwent surgical debridement and joint washout. A sterile approach was utilized, and the infected joint was accessed. Thorough debridement was performed, removing infected tissues and debris. The joint was thoroughly irrigated with antibiotic solution. The incision was closed, and the patient was transferred to the surgical intensive care unit for further management of the infection.

2. Operative Note: Patient with postural kyphosis and a severe infection on the extreme moving joint underwent joint arthroplasty. A sterile approach was utilized, and the infected joint was exposed. The diseased joint components were excised, and a prosthesis was implanted to restore joint function. Careful attention was given to thoroughly irrigate and remove infected tissues. The incision was closed, and the patient was transferred to the recovery area for postoperative care and antibiotic therapy.

3. Operative Note: Patient with severe infection on the extreme moving joint due to postural kyphosis underwent joint irrigation and antibiotic spacer placement. A sterile approach was utilized, and the infected joint was accessed. The joint was thoroughly irrigated with antibiotic solution, and an antibiotic-loaded spacer was placed to promote local delivery of antibiotics. The incision was closed, and the patient was transferred to the surgical intensive care unit for further management.

4. Operative Note: Patient with postural kyphosis and a severe infection on the extreme moving joint underwent joint fusion. A sterile approach was utilized, and the infected joint was exposed. The joint surfaces were thoroughly debrided, and bone grafting was performed to achieve fusion. The incision was closed meticulously, and the patient was transferred to the surgical intensive care unit for postoperative management of the infection.

5. Operative Note: Patient with severe infection on the extreme moving joint due to postural kyphosis underwent joint revision surgery. A sterile approach was utilized, and the infected joint was accessed. The prosthetic components were removed, and thorough debridement was performed. New prosthetic components were implanted, and the joint was irrigated with antibiotic solution. The incision was closed, and the patient was transferred to the recovery area for further management.

6. Operative Note: Patient with postural kyphosis and a severe infection on the extreme moving joint underwent joint debridement and external fixation. A sterile approach was utilized, and the infected joint was exposed. Extensive debridement was performed, and an external fixator was applied to stabilize the joint. The incision was closed, and the patient was transferred to the surgical intensive care unit for antibiotic therapy and wound care.

7. Operative Note: Patient with severe infection on the extreme moving joint due to postural kyphosis underwent joint resection arthroplasty. A sterile approach was utilized, and the infected joint was accessed. The joint was completely excised, and the surrounding tissues were debrided. The incision was closed, and the patient was transferred to the recovery area for postoperative care and antibiotic treatment.

8. Operative Note: Patient with postural kyphosis and a severe infection on the extreme moving joint underwent joint irrigation and antibiotic bead placement. A sterile approach was utilized, and the infected joint was exposed. Thorough irrigation was performed, and antibiotic-impregnated beads were placed in the joint space to provide local antibiotic delivery. The incision was closed, and the patient was transferred to the surgical intensive care unit for further management.

9. Operative Note: Patient with severe infection on the extreme moving joint due to postural kyphosis underwent joint resection and arthrodesis. A sterile approach was utilized, and the infected joint was accessed. The joint surfaces were resected, and bone grafting was performed to achieve fusion. The incision was closed meticulously, and the patient was transferred to the surgical intensive care unit for postoperative care and antibiotic therapy.

10. Operative Note: Patient with postural kyphosis and a severe infection on the extreme moving joint underwent joint salvage surgery. A sterile approach was utilized, and the infected joint was accessed. Thorough debridement was performed, removing infected tissues and debris. The joint was meticulously irrigated, and multiple irrigation rounds were conducted. The incision was closed, and the patient was transferred to the surgical intensive care unit for further management of the infection.

1. Operative Note: Patient with postural kyphosis and severe inflammatory response underwent surgical intervention for spinal stabilization. A midline incision was made, and the inflamed tissues surrounding the spine were carefully dissected. Pedicle screws and rods were inserted for stabilization and alignment. The procedure was performed with caution due to the presence of inflammation. The incision was closed meticulously, and the patient was transferred to the recovery area for postoperative care.

2. Operative Note: Patient with postural kyphosis and localized inflammation underwent minimally invasive decompression surgery. Small incisions were made, and the inflamed area was accessed. Decompression was performed to relieve pressure on surrounding structures. Special attention was given to managing the inflammation intraoperatively. The incisions were closed, and the patient was transferred to the post-anesthesia care unit for further observation.

3. Operative Note: Patient with postural kyphosis and significant inflammation underwent anterior release and fusion surgery. A transverse incision was made, and the inflamed vertebral segments were accessed. Complete release of the affected levels was performed, and fusion was achieved using interbody cages and bone grafting. Careful attention was given to the inflamed tissues during the procedure. The incision was closed, and the patient was transferred to the surgical intensive care unit for postoperative management.

4. Operative Note: Patient with postural kyphosis and diffuse inflammation underwent posterior spinal fusion. A midline incision was made, and the spine was exposed. Inflamed tissues were encountered during dissection, and thorough irrigation was performed to reduce inflammation. Pedicle screws and rods were inserted for stabilization. The incision was closed meticulously, and the patient was transferred to the recovery area for postoperative care.

5. Operative Note: Patient with postural kyphosis and severe inflammatory response underwent posterior vertebral column resection. A midline incision was made, and the inflamed vertebral levels were accessed. The affected vertebrae were resected carefully, taking into consideration the presence of inflammation. Stabilization and alignment were achieved using pedicle screws and rods. The incision was closed, and the patient was transferred to the surgical intensive care unit for postoperative monitoring.

6. Operative Note: Patient with postural kyphosis and inflammatory arthritis underwent posterior spinal fusion with instrumentation. A midline incision was made, and the inflamed spine was exposed. Special attention was given to manage the inflammation during the surgical procedure. Pedicle screws and rods were inserted to provide stability. The incision was closed meticulously, and the patient was transferred to the recovery area for postoperative care.

7. Operative Note: Patient with postural kyphosis and inflamed spinal structures underwent selective decompression surgery. A limited incision was made, and the inflamed area was accessed. Decompression was performed to alleviate pressure on the affected structures. The procedure was executed with caution due to the presence of inflammation. The incision was closed, and the patient was transferred to the post-anesthesia care unit for further observation.

8. Operative Note: Patient with postural kyphosis and localized inflammation underwent vertebral augmentation with consideration for the inflammatory response. A small incision was made, and the inflamed vertebral body was accessed. Special attention was given to minimize tissue trauma and control inflammation. Bone cement was injected to stabilize the spine. The incision was closed, and the patient was transferred to the recovery area for postoperative care.

9. Operative Note: Patient with postural kyphosis and significant inflammation underwent anterior vertebral column resection. A transverse incision was made, and the inflamed vertebral levels were exposed. The affected vertebrae were carefully resected, taking into account the inflammatory response. Reconstruction was performed using interbody cages and bone grafting. The incision was closed meticulously, and the patient was transferred to the surgical intensive care unit for postoperative management.

10. Operative Note: Patient with postural kyphosis and diffuse inflammation underwent minimally invasive posterior spinal fusion. Small incisions were made, and the inflamed spine was accessed. The procedure was executed with caution to minimize tissue trauma and control inflammation. Pedicle screws and rods were inserted for stabilization. The incisions were closed, and the patient was transferred to the recovery area for postoperative care.

1. Operative Note: Patient with mild postural kyphosis underwent minimally invasive corrective surgery. The procedure was successful, and the patient is expected to have a quick recovery. Postoperative follow-up includes regular clinic visits at 2 weeks, 6 weeks, and 3 months to monitor progress and provide physiotherapy recommendations.

2. Operative Note: Patient with moderate postural kyphosis underwent posterior spinal fusion. The surgery addressed the deformity adequately. Postoperative follow-up includes clinical assessments at 2 weeks, 6 weeks, and 3 months, along with regular X-ray evaluations to monitor fusion progress. Physical therapy sessions will be initiated to aid rehabilitation.

3. Operative Note: Patient with severe postural kyphosis underwent extensive vertebral column resection and fusion. The surgery was challenging due to the severity of the condition. Postoperative follow-up involves close monitoring in the surgical intensive care unit for the initial few days. Subsequent follow-up includes clinic visits at 2 weeks, 6 weeks, 3 months, and 6 months, with regular imaging to assess fusion and overall progress.

4. Operative Note: Patient with mild postural kyphosis underwent non-surgical management with a focus on physical therapy and postural exercises. The patient is expected to show improvement with conservative treatment. Follow-up visits at 6 weeks and 3 months are planned to evaluate progress and determine the need for further intervention.

5. Operative Note: Patient with moderate postural kyphosis underwent a combination of surgical intervention and non-surgical management. The surgery addressed the significant deformity, followed by a comprehensive rehabilitation plan. Postoperative follow-up includes clinic visits at 2 weeks, 6 weeks, 3 months, and 6 months, with regular physiotherapy sessions to monitor progress and ensure optimal recovery.

6. Operative Note: Patient with severe postural kyphosis underwent complex surgical intervention with extensive reconstruction. Given the severity of the condition, an extended period of rehabilitation and monitoring is necessary. Postoperative follow-up includes regular clinic visits at 2 weeks, 6 weeks, 3 months, 6 months, and 1 year, with imaging assessments and close collaboration with physical therapists to optimize outcomes.

7. Operative Note: Patient with mild postural kyphosis underwent a minimally invasive procedure for correction. The surgery was successful, and the patient is expected to resume normal activities soon. Follow-up includes clinic visits at 2 weeks and 6 weeks for assessment of progress and postoperative instructions regarding physical therapy and maintenance of good posture.

8. Operative Note: Patient with moderate postural kyphosis underwent a multi-level spinal fusion. The surgical correction was satisfactory, but close monitoring is essential due to the complexity of the procedure. Postoperative follow-up consists of clinic visits at 2 weeks, 6 weeks, 3 months, and 6 months, with regular imaging studies to assess fusion progression and evaluate patient-reported outcomes.

9. Operative Note: Patient with severe postural kyphosis underwent extensive spinal reconstruction with the aim of improving functional outcomes. Given the complexity and severity of the condition, close postoperative follow-up is crucial. Clinic visits are scheduled at 2 weeks, 6 weeks, 3 months, 6 months, and 1 year to monitor progress, manage complications, and adjust rehabilitation protocols.

10. Operative Note: Patient with mild postural kyphosis underwent conservative management with a focus on postural exercises and bracing. The patient's condition is expected to improve with these measures. Follow-up visits at 6 weeks and 3 months are planned to assess progress and determine the need for further intervention or modification of the treatment plan.

## M40.1 Other secondary kyphosis

1. Operative Note: Patient underwent posterior spinal fusion for other secondary kyphosis. Surgical approach involved a midline incision, followed by meticulous dissection and exposure of the affected spinal segment. The kyphotic deformity was addressed through pedicle screw instrumentation and fusion. Intraoperative monitoring ensured neurological integrity. Hemostasis was achieved, and wound closure performed. Postoperative recovery was uneventful. Patient advised on rehabilitation and follow-up care.

2. Operative Note: Surgical correction of other secondary kyphosis was performed using a minimally invasive technique. A small incision was made, allowing for access to the affected vertebral segment. Through specialized instrumentation, kyphotic deformity was reduced and stabilized with the placement of interbody spacers. Fluoroscopy-guided the procedure. Postoperatively, the patient tolerated the surgery well, and early mobilization was initiated.

3. Operative Note: An anterior approach was employed to address other secondary kyphosis in the patient. A transverse incision was made, and the affected vertebral segment was accessed. The kyphotic deformity was corrected using a combination of vertebral body resection and anterior cage placement. Fusion was achieved using bone graft and anterior plate fixation. The patient recovered smoothly postoperatively, with no complications noted.

4. Operative Note: Patient underwent a thoracoscopic procedure to correct other secondary kyphosis. Several small incisions were made, allowing for the introduction of specialized instruments and a thoracoscope. The kyphotic deformity was addressed through vertebral osteotomies and stabilization using pedicle screw fixation. Intraoperative imaging confirmed proper correction. The patient tolerated the procedure well and was advised on postoperative care and follow-up evaluations.

5. Operative Note: A posterior vertebral column resection was performed to correct other secondary kyphosis. The patient was placed in a prone position, and a midline incision was made. The affected vertebral segments were removed, allowing for deformity correction. Pedicle screw instrumentation and fusion were utilized to stabilize the spine. The procedure was successful, and the patient's postoperative course was uneventful.

6. Operative Note: Patient underwent a hybrid surgical approach to address other secondary kyphosis. An initial anterior procedure involved vertebral body resection, followed by the placement of an expandable cage. Subsequently, a posterior spinal fusion was performed using pedicle screw fixation. The surgical correction achieved satisfactory alignment, and the patient showed signs of improvement during the postoperative period.

7. Operative Note: A posterior osteotomy was performed to correct other secondary kyphosis in the patient. The procedure involved making a midline incision and exposing the affected spinal segments. Multiple osteotomies were carried out to release the kyphotic deformity. Pedicle screw fixation and fusion were performed to stabilize the spine. The patient tolerated the surgery well and exhibited early signs of improvement postoperatively.

8. Operative Note: Patient underwent a vertebral column resection and reconstruction to correct other secondary kyphosis. A posterior approach was employed, involving extensive exposure and osteotomies at the affected vertebral levels. Pedicle screw instrumentation and fusion were performed to achieve spinal stability. Intraoperative monitoring ensured the integrity of the spinal cord. The patient's recovery was uneventful, with improvements observed during the follow-up period.

9. Operative Note: Patient underwent an anterior and posterior spinal fusion to correct other secondary kyphosis. The anterior approach involved a transverse incision, vertebral body resection, and cage placement. The posterior procedure involved pedicle screw fixation and fusion. The spinal alignment was successfully restored, and the patient showed no immediate postoperative complications. Rehabilitation protocols were initiated, emphasizing early mobilization.

10. Operative Note: Patient underwent a posterior vertebral column resection and reconstruction for other secondary kyphosis. A midline incision was made, providing access to the affected vertebral levels. Osteotomies were performed to release the deformity, followed by pedicle screw fixation and fusion. Intraoperative neuromonitoring confirmed the safety of the procedure. The patient recovered well without any significant postoperative issues, and rehabilitation was commenced promptly.

1. Operative Note: Patient underwent a posterior vertebral osteotomy and fusion to correct other secondary kyphosis. The surgical approach involved a midline incision and exposure of the affected spinal segments. Osteotomies were performed to release the kyphotic deformity, followed by pedicle screw fixation and fusion. Intraoperative fluoroscopy confirmed proper alignment. The patient's postoperative course was unremarkable, and they were advised on postoperative care and rehabilitation.

2. Operative Note: An anterior vertebral body tethering procedure was performed to address other secondary kyphosis in the patient. Through a transverse incision, the affected vertebral segments were accessed. A flexible tether was placed along the concave side of the spine to gradually correct the kyphotic deformity. The patient tolerated the procedure well, and postoperative imaging showed improved alignment.

3. Operative Note: Patient underwent a posterior-based osteotomy and pedicle subtraction to correct other secondary kyphosis. A midline incision was made, allowing for exposure of the affected spinal levels. Osteotomies were performed, followed by removal of the posterior elements and vertebral body resection. Pedicle screw fixation and fusion were carried out to stabilize the spine. The patient's postoperative recovery was satisfactory.

4. Operative Note: A posterior vertebral column resection and cage reconstruction were performed to correct other secondary kyphosis. The patient was placed in a prone position, and a midline incision was made. Osteotomies were performed to release the deformity, followed by vertebral body resection and cage placement. Pedicle screw fixation and fusion were performed for stabilization. The patient showed gradual improvement during the postoperative period.

5. Operative Note: Patient underwent a minimally invasive lateral interbody fusion to address other secondary kyphosis. Through a small incision, the affected vertebral level was accessed. A cage filled with bone graft was placed within the intervertebral space, restoring spinal alignment. The procedure was successful, and the patient's postoperative recovery was uneventful.

6. Operative Note: An anterior vertebral column resection and reconstruction were performed to correct other secondary kyphosis. The surgical approach involved a transverse incision and exposure of the affected spinal levels. Vertebral body resection was carried out, followed by the placement of a structural allograft and anterior plate fixation. Intraoperative imaging confirmed proper alignment. The patient's postoperative course was smooth, with early signs of improvement.

7. Operative Note: Patient underwent a combined anterior and posterior spinal fusion to correct other secondary kyphosis. The anterior approach involved a transverse incision, vertebral body resection, and placement of an expandable cage. The posterior procedure involved pedicle screw fixation and fusion. The surgical correction achieved satisfactory alignment, and the patient showed improvement during the postoperative period.

8. Operative Note: A posterior-based osteotomy and vertebral column resection were performed to correct other secondary kyphosis. The surgical approach involved a midline incision, enabling exposure of the affected spinal levels. Osteotomies were performed to release the deformity, followed by vertebral body resection. Pedicle screw fixation and fusion were carried out for spinal stabilization. The patient's recovery was uneventful, with improvements noted on follow-up evaluations.

9. Operative Note: Patient underwent a lateral lumbar interbody fusion to address other secondary kyphosis. Through a minimally invasive approach, the affected vertebral level was accessed. A cage filled with bone graft was inserted, restoring spinal alignment and promoting fusion. The patient tolerated the procedure well, and early postoperative mobilization was initiated.

10. Operative Note: A posterior spinal fusion with instrumentation was performed to correct other secondary kyphosis. The patient was placed in a prone position, and a midline incision was made. Pedicle screws were placed at the affected levels, followed by rod insertion and compression. Fusion was achieved using bone graft. The patient's postoperative course was unremarkable, and they were instructed on postoperative precautions and follow-up care.

1. Operative Note: Patient underwent posterior spinal fusion for other secondary kyphosis under general anesthesia. Anesthesia was induced with propofol and maintained with sevoflurane. Muscle relaxation was achieved using rocuronium. Intraoperative monitoring ensured stable hemodynamics and adequate depth of anesthesia. The surgical procedure was performed without complications, and the patient's postoperative recovery was uneventful.

2. Operative Note: A minimally invasive lateral interbody fusion was performed for other secondary kyphosis under general anesthesia. Anesthesia was induced with propofol and maintained with desflurane. Rocuronium was administered for muscle relaxation. Intraoperative monitoring of vital signs and end-tidal CO2 levels was conducted. The patient tolerated the procedure well, and postoperative pain control was managed effectively.

3. Operative Note: Patient underwent a posterior vertebral column resection and fusion for other secondary kyphosis under monitored anesthesia care (MAC). Conscious sedation was achieved using a combination of midazolam and fentanyl. Local anesthetic infiltration provided additional pain control. The patient remained comfortable and cooperative throughout the procedure, with no intraoperative complications noted.

4. Operative Note: An anterior vertebral body tethering procedure was performed for other secondary kyphosis under regional anesthesia. Spinal anesthesia with bupivacaine was administered, ensuring lower extremity sensory and motor blockade. The patient remained awake and alert during the procedure, reporting minimal discomfort. Intraoperative monitoring included blood pressure and oxygen saturation, which remained stable throughout.

5. Operative Note: Patient underwent a combined anterior and posterior spinal fusion for other secondary kyphosis under general anesthesia with reduced dosage. Anesthesia was induced and maintained using a balanced technique with lower doses of propofol and volatile anesthetics. Rocuronium was administered judiciously for muscle relaxation. The patient's hemodynamic stability was closely monitored throughout the procedure.

6. Operative Note: A posterior-based osteotomy and pedicle subtraction were performed for other secondary kyphosis under general anesthesia. Anesthesia induction included propofol and remifentanil, followed by maintenance with sevoflurane. Rocuronium was used for muscle relaxation. Intraoperative monitoring of vital signs and depth of anesthesia was conducted, ensuring optimal patient comfort and safety.

7. Operative Note: Patient underwent a posterior vertebral osteotomy and fusion for other secondary kyphosis under general anesthesia with increased dosage. Anesthesia was induced and maintained with higher doses of propofol and volatile anesthetics to achieve deeper sedation. Rocuronium was administered for muscle relaxation. Intraoperative monitoring ensured stable anesthesia depth and hemodynamics.

8. Operative Note: An anterior vertebral column resection and reconstruction were performed for other secondary kyphosis under general anesthesia with reduced opioid dosage. Anesthesia induction included propofol and remifentanil, and maintenance was achieved with a lower concentration of volatile anesthetics. A decreased dose of fentanyl was used for intraoperative analgesia. The patient remained hemodynamically stable and responded well to surgical stimulation.

9. Operative Note: Patient underwent a posterior-based osteotomy and vertebral column resection for other secondary kyphosis under general anesthesia with regional analgesia. General anesthesia was induced and maintained with propofol and sevoflurane, while a thoracic epidural catheter provided targeted pain control. The patient remained comfortable throughout the procedure, and intraoperative monitoring ensured optimal anesthesia depth and hemodynamic stability.

10. Operative Note: A lateral lumbar interbody fusion was performed for other secondary kyphosis under monitored anesthesia care (MAC) with conscious sedation. Intravenous midazolam and remifentanil were administered to achieve a moderate sedative state. Local anesthetic infiltration at the incision site provided additional analgesia. The patient remained responsive and cooperative throughout the procedure, with stable vital signs.

1. Operative Note: Patient with other secondary kyphosis and significant bone erosion underwent a posterior spinal fusion. The surgical approach involved a midline incision and extensive exposure of the affected spinal levels. Osteotomies were performed to release the deformity, followed by pedicle screw fixation and fusion. Bone graft substitutes were utilized to address areas of bone erosion. The patient's postoperative recovery was uneventful, and rehabilitation was initiated.

2. Operative Note: A combined anterior and posterior approach was utilized to correct other secondary kyphosis with bone erosion. The anterior procedure involved vertebral body resection and cage placement, addressing areas of bone erosion. The posterior procedure included pedicle screw fixation and fusion. Careful attention was given to the eroded bone regions during instrumentation and fusion. The patient tolerated the surgery well, and postoperative imaging showed improved alignment.

3. Operative Note: Patient underwent a posterior-based osteotomy and vertebral column resection for other secondary kyphosis with significant bone erosion. Osteotomies were performed to release the deformity, taking into consideration the extent of bone erosion. Pedicle screw fixation and fusion were carried out, with careful attention to bone quality. The patient's postoperative recovery was satisfactory, and rehabilitation protocols were initiated.

4. Operative Note: An anterior vertebral column resection and reconstruction were performed to correct other secondary kyphosis with bone erosion. The surgical approach involved a transverse incision and exposure of the affected spinal levels. Vertebral body resection was carried out, addressing areas of bone erosion. Structural allograft and anterior plate fixation were used for reconstruction. The patient's postoperative course was unremarkable, with early signs of improvement.

5. Operative Note: Patient with other secondary kyphosis and extensive bone erosion underwent a posterior vertebral column resection and fusion. The surgical approach involved a midline incision, allowing for exposure of the affected spinal levels. Multiple osteotomies were performed to release the deformity, considering the presence of bone erosion. Pedicle screw fixation and fusion were performed using bone graft substitutes. The patient's postoperative recovery was monitored closely, with no immediate complications observed.

6. Operative Note: A minimally invasive lateral interbody fusion was performed for other secondary kyphosis, addressing areas of bone erosion. Through a small incision, the affected vertebral level was accessed. A cage filled with bone graft substitutes was inserted to restore spinal alignment, specifically targeting eroded bone regions. The patient tolerated the procedure well, and postoperative pain control was managed effectively.

7. Operative Note: Patient with other secondary kyphosis and bone erosion underwent a posterior vertebral osteotomy and fusion. The surgical approach involved a midline incision and exposure of the affected spinal levels. Careful consideration was given to the eroded bone regions during osteotomies and instrumentation. Pedicle screw fixation and fusion were performed, addressing the areas of bone erosion. The patient's postoperative recovery was uneventful, with improvements noted during follow-up evaluations.

8. Operative Note: An anterior vertebral body tethering procedure was performed for other secondary kyphosis with bone erosion. Through a transverse incision, the affected vertebral levels were accessed. The flexible tether was placed to gradually correct the deformity, taking into account the eroded bone regions. The patient tolerated the procedure well, and postoperative imaging showed improved alignment and stabilization of the eroded areas.

9. Operative Note: Patient with other secondary kyphosis and bone erosion underwent a combined anterior and posterior spinal fusion. The anterior approach involved vertebral body re

section and cage placement, addressing the eroded bone regions. The posterior procedure included pedicle screw fixation and fusion, taking care to stabilize the areas of bone erosion. Intraoperative imaging confirmed proper alignment. The patient's postoperative course was satisfactory, with close monitoring of the eroded bone regions.

10. Operative Note: A posterior-based osteotomy and vertebral column resection were performed to correct other secondary kyphosis with significant bone erosion. The surgical approach involved a midline incision and exposure of the affected spinal levels. Special attention was given to the eroded bone regions during osteotomies and resection. Pedicle screw fixation and fusion were carried out to stabilize the spine, considering the areas of bone erosion. The patient's recovery was closely monitored, with appropriate postoperative precautions and rehabilitation.

1. Operative Note: Patient with other secondary kyphosis and severe bone pain underwent a posterior spinal fusion. The surgical approach involved a midline incision and extensive exposure of the affected spinal levels. Osteotomies were performed to release the deformity, alleviating the severe bone pain. Pedicle screw fixation and fusion were carried out to stabilize the spine. The patient's postoperative recovery was uneventful, with a significant reduction in bone pain.

2. Operative Note: A combined anterior and posterior approach was utilized to correct other secondary kyphosis with severe bone pain. The anterior procedure involved vertebral body resection and cage placement, addressing areas of severe bone pain. The posterior procedure included pedicle screw fixation and fusion, providing stability and further pain relief. The patient tolerated the surgery well, with a notable improvement in bone pain postoperatively.

3. Operative Note: Patient underwent a posterior-based osteotomy and vertebral column resection for other secondary kyphosis with severe bone pain. Osteotomies were meticulously performed to release the deformity and alleviate the severe bone pain. Pedicle screw fixation and fusion were carried out, providing stability and support. The patient's postoperative recovery was satisfactory, with significant relief from the previously experienced bone pain.

4. Operative Note: An anterior vertebral column resection and reconstruction were performed to correct other secondary kyphosis with severe bone pain. The surgical approach involved a transverse incision and exposure of the affected spinal levels. Vertebral body resection was carried out, addressing areas of severe bone pain. Structural allograft and anterior plate fixation were used for reconstruction, providing stabilization and alleviating the bone pain. The patient's postoperative course was unremarkable, with notable improvement in bone pain.

5. Operative Note: Patient with other secondary kyphosis and severe bone pain underwent a posterior vertebral column resection and fusion. The surgical approach involved a midline incision, allowing for exposure of the affected spinal levels. Multiple osteotomies were performed to release the deformity and address the severe bone pain. Pedicle screw fixation and fusion were performed using bone graft substitutes, providing stability and significant pain relief. The patient's postoperative recovery was closely monitored, with remarkable reduction in bone pain.

6. Operative Note: A minimally invasive lateral interbody fusion was performed for other secondary kyphosis, targeting severe bone pain. Through a small incision, the affected vertebral level was accessed. A cage filled with bone graft substitutes was inserted to restore spinal alignment and alleviate severe bone pain. The patient tolerated the procedure well, with immediate improvement in bone pain postoperatively.

7. Operative Note: Patient with other secondary kyphosis and severe bone pain underwent a posterior vertebral osteotomy and fusion. The surgical approach involved a midline incision and exposure of the affected spinal levels. Osteotomies were performed with meticulous care to alleviate the severe bone pain. Pedicle screw fixation and fusion were carried out, providing stability and significant relief from bone pain. The patient's postoperative recovery was uneventful, with notable reduction in bone pain.

8. Operative Note: An anterior vertebral body tethering procedure was performed for other secondary kyphosis with severe bone pain. Through a transverse incision, the affected vertebral levels were accessed. The flexible tether was placed to gradually correct the deformity and alleviate severe bone pain. The patient tolerated the procedure well, with immediate relief from the previously experienced severe bone pain.

9. Operative Note: Patient with other secondary kyphosis and severe bone pain underwent a combined anterior and posterior spinal fusion. The anterior approach involved vertebral body resection and cage placement, targeting the severe bone pain. The posterior procedure included pedicle screw fixation and fusion, providing stability and significant relief from bone pain. The patient's postoperative course was satisfactory, with a marked reduction in severe bone pain.

10. Operative Note: A posterior-based osteotomy and vertebral column resection were performed to correct other secondary kyphosis with severe bone pain. The surgical approach involved a midline incision and exposure of the affected spinal levels. Osteotomies were meticulously performed to release the deformity and alleviate severe bone pain. Pedicle screw fixation and fusion were carried out, providing stability and significant pain relief. The patient's recovery was closely monitored, with substantial improvement in severe bone pain.

1. Operative Note: Patient with other secondary kyphosis underwent a posterior spinal fusion with surgical intervention. The surgical approach involved a midline incision and exposure of the affected spinal levels. Osteotomies were performed to release the deformity, followed by pedicle screw fixation and fusion. The surgical intervention successfully corrected the spinal alignment, and the patient's postoperative recovery was uneventful.

2. Operative Note: A surgical intervention, specifically an anterior vertebral column resection and reconstruction, was performed for other secondary kyphosis. The surgical approach involved a transverse incision and exposure of the affected spinal levels. Vertebral body resection was carried out to address the deformity, followed by the placement of structural allograft and anterior plate fixation. The surgical intervention achieved successful realignment, and the patient's postoperative course was satisfactory.

3. Operative Note: Patient with other secondary kyphosis underwent a combined surgical intervention, including a posterior vertebral osteotomy and fusion. The surgical approach involved a midline incision and exposure of the affected spinal levels. Osteotomies were performed to release the deformity, and pedicle screw fixation with fusion was carried out. The surgical intervention effectively corrected the spinal alignment, and the patient's postoperative recovery was unremarkable.

4. Operative Note: A surgical intervention, a minimally invasive lateral interbody fusion, was performed for other secondary kyphosis. The procedure involved a small incision through which the affected vertebral level was accessed. A cage filled with bone graft substitutes was inserted to restore spinal alignment. The surgical intervention successfully addressed the kyphosis, and the patient's postoperative course was uneventful.

5. Operative Note: Patient with other secondary kyphosis underwent a surgical intervention, specifically a posterior vertebral column resection and fusion. The surgical approach involved a midline incision and exposure of the affected spinal levels. Osteotomies were performed to release the deformity, and pedicle screw fixation with fusion was carried out. The surgical intervention resulted in significant improvement in spinal alignment, and the patient's postoperative recovery was satisfactory.

6. Operative Note: A surgical intervention, an anterior vertebral body tethering procedure, was performed for other secondary kyphosis. The procedure involved a transverse incision through which the affected vertebral levels were accessed. The flexible tether was placed to gradually correct the deformity and stabilize the spine. The surgical intervention successfully addressed the kyphosis, and the patient's postoperative course was uneventful.

7. Operative Note: Patient with other secondary kyphosis underwent a combined surgical intervention, including an anterior vertebral column resection and posterior vertebral osteotomy. The surgical approach involved appropriate incisions and exposure of the affected spinal levels. Osteotomies were performed to release the deformity, followed by pedicle screw fixation and fusion. The surgical intervention achieved significant correction of the kyphosis, and the patient's postoperative recovery was satisfactory.

8. Operative Note: A surgical intervention, a posterior-based osteotomy and vertebral column resection, was performed for other secondary kyphosis. The surgical approach involved a midline incision and exposure of the affected spinal levels. Osteotomies were meticulously performed to release the deformity, and pedicle screw fixation with fusion was carried out. The surgical intervention successfully corrected the spinal alignment, and the patient's postoperative recovery was unremarkable.

9. Operative Note: Patient with other secondary kyphosis underwent a surgical intervention, a combined anterior and posterior spinal fusion. The surgical approach involved appropriateincisions and exposure of the affected spinal levels. Vertebral body resection, pedicle screw fixation, and fusion were performed to correct the deformity. The surgical intervention achieved significant improvement in spinal alignment, and the patient's postoperative recovery was satisfactory.

10. Operative Note: A surgical intervention, specifically a posterior spinal fusion, was performed for other secondary kyphosis. The surgical approach involved a midline incision and exposure of the affected spinal levels. Osteotomies were performed to release the deformity, followed by pedicle screw fixation and fusion. The surgical intervention successfully corrected the spinal alignment, and the patient's postoperative recovery was uneventful.

1. Operative Note: Patient with other secondary kyphosis underwent a surgical intervention, a posterior vertebral column resection. The surgical approach involved a midline incision and exposure of the affected spinal levels. Vertebral body resection was performed to address the deformity, followed by pedicle screw fixation and fusion. The surgical intervention successfully corrected the kyphotic alignment, and the patient's postoperative recovery was satisfactory.

2. Operative Note: A surgical intervention, an anterior vertebral body reconstruction, was performed for other secondary kyphosis. The surgical approach involved a transverse incision and exposure of the affected spinal levels. Vertebral body reconstruction was carried out using a cage and structural allograft, followed by anterior plate fixation. The surgical intervention achieved successful realignment, and the patient's postoperative course was unremarkable.

3. Operative Note: Patient with other secondary kyphosis underwent a combined surgical intervention, including a posterior-based osteotomy and anterior interbody fusion. The surgical approach involved appropriate incisions and exposure of the affected spinal levels. Osteotomies were performed to release the deformity, followed by cage placement and anterior plate fixation. The surgical intervention successfully corrected the kyphotic deformity, and the patient's postoperative recovery was satisfactory.

4. Operative Note: A surgical intervention, a posterior vertebral column resection and fusion, was performed for other secondary kyphosis. The surgical approach involved a midline incision and exposure of the affected spinal levels. Vertebral body resection and pedicle screw fixation with fusion were carried out to address the deformity. The surgical intervention achieved significant improvement in spinal alignment, and the patient's postoperative recovery was uneventful.

5. Operative Note: Patient with other secondary kyphosis underwent a surgical intervention, specifically a posterior-based osteotomy and vertebral column resection. The surgical approach involved a midline incision and exposure of the affected spinal levels. Osteotomies were meticulously performed to release the deformity, followed by pedicle screw fixation and fusion. The surgical intervention successfully corrected the spinal alignment, and the patient's postoperative recovery was satisfactory.

6. Operative Note: A surgical intervention, an anterior vertebral body tethering procedure, was performed for other secondary kyphosis. The procedure involved a transverse incision through which the affected vertebral levels were accessed. The flexible tether was placed to gradually correct the deformity and stabilize the spine. The surgical intervention successfully addressed the kyphosis, and the patient's postoperative course was uneventful.

7. Operative Note: Patient with other secondary kyphosis underwent a surgical intervention, a posterior spinal fusion with instrumentation. The surgical approach involved appropriate incisions and exposure of the affected spinal levels. Pedicle screw fixation and fusion were performed to stabilize the spine and correct the deformity. The surgical intervention achieved significant improvement in spinal alignment, and the patient's postoperative recovery was satisfactory.

8. Operative Note: A surgical intervention, a combined anterior and posterior spinal fusion, was performed for other secondary kyphosis. The surgical approach involved appropriate incisions and exposure of the affected spinal levels. Vertebral body resection, pedicle screw fixation, and fusion were performed to correct the deformity and stabilize the spine. The surgical intervention resulted in significant improvement in spinal alignment, and the patient's postoperative recovery was unremarkable.

9. Operative Note: Patient with other secondary kyphosis underwent a surgical intervention, specifically a posterior vertebral osteotomy and fusion. The surgical approach involved a midline incision and exposure of the affected spinal levels. Osteotomies were performed to release the deformity, followed by pedicle screw fixation and fusion. The surgical intervention successfully corrected the spinal alignment, and the patient's postoperative recovery was satisfactory.

10. Operative Note: A surgical intervention, an anterior vertebral column resection, was performed for other secondary kyphosis. The surgical approach involved a transverse incision and exposure of the affected spinal levels. Vertebral body resection was carried out to address the deformity, followed by anterior plate fixation. The surgical intervention achieved successful realignment, and the patient's postoperative course was uneventful.

1. Operative Note: Patient with other secondary kyphosis and severe infection on the extreme moving joint underwent a surgical intervention, specifically a posterior spinal fusion. The surgical approach involved a midline incision and exposure of the affected spinal levels. Osteotomies were performed to release the deformity, followed by extensive debridement and irrigation of the infected joint. Pedicle screw fixation and fusion were carried out, and appropriate antibiotic therapy was administered postoperatively to address the severe infection.

2. Operative Note: A combined surgical intervention was performed for other secondary kyphosis with severe infection on the extreme moving joint. The anterior approach involved vertebral body resection and cage placement, followed by thorough debridement and irrigation of the infected joint. The posterior procedure included pedicle screw fixation and fusion, along with additional debridement and irrigation. The surgical intervention successfully corrected the spinal alignment while addressing the severe infection.

3. Operative Note: Patient with other secondary kyphosis and severe infection on the extreme moving joint underwent a surgical intervention, specifically a posterior vertebral column resection. The surgical approach involved a midline incision and exposure of the affected spinal levels. Osteotomies were performed to release the deformity, followed by extensive debridement and irrigation of the infected joint. Pedicle screw fixation and fusion were carried out, and appropriate measures were taken to control the severe infection.

4. Operative Note: A surgical intervention, a combined anterior and posterior approach, was performed for other secondary kyphosis with severe infection on the extreme moving joint. The anterior procedure involved vertebral body resection and cage placement, followed by meticulous debridement and irrigation of the infected joint. The posterior procedure included pedicle screw fixation and fusion, with additional debridement and irrigation. The surgical intervention successfully corrected the spinal alignment while addressing the severe infection.

5. Operative Note: Patient with other secondary kyphosis and severe infection on the extreme moving joint underwent a surgical intervention, specifically a posterior vertebral osteotomy and fusion. The surgical approach involved a midline incision and exposure of the affected spinal levels. Osteotomies were performed to release the deformity, followed by extensive debridement and irrigation of the infected joint. Pedicle screw fixation and fusion were carried out, and appropriate measures were taken to manage the severe infection.

6. Operative Note: A surgical intervention, an anterior vertebral body reconstruction, was performed for other secondary kyphosis with severe infection on the extreme moving joint. The surgical approach involved a transverse incision and exposure of the affected spinal levels. Vertebral body reconstruction was carried out using a cage and structural allograft, accompanied by thorough debridement and irrigation of the infected joint. The surgical intervention successfully corrected the spinal alignment while addressing the severe infection.

7. Operative Note: Patient with other secondary kyphosis and severe infection on the extreme moving joint underwent a surgical intervention, specifically a posterior-based osteotomy and vertebral column resection. The surgical approach involved a midline incision and exposure of the affected spinal levels. Osteotomies were performed to release the deformity, followed by extensive debridement and irrigation of the infected joint. Pedicle screw fixation and fusion were carried out, and appropriate measures were taken to treat the severe infection.

8. Operative Note: A surgical intervention, a posterior spinal fusion with debridement and irrigation, was performed for other secondary kyphosis with severe infection on the extreme moving joint. The surgical approach involved a midline incision and exposure of the affected spinal levels. Osteotomies were performed to release the deformity, followed by meticulous debridement and irrigation of the infected joint. Pedicle screw fixation and fusion were carried out, accompanied by appropriate antibiotic therapy to address the severe infection.

9. Operative Note: Patient with other secondary kyphosis and severe infection on the extreme moving joint underwent a surgical intervention, specifically a combined anterior and posterior spinal fusion with extensive debridement and irrigation. The surgical approach involved appropriate incisions and exposure of the affected spinal levels. Vertebral body resection, pedicle screw fixation, and fusion were performed to correct the deformity while addressing the severe infection. Appropriate antibiotic therapy was administered postoperatively.

10. Operative Note: A surgical intervention, a posterior vertebral column resection with thorough debridement and irrigation, was performed for other secondary kyphosis with severe infection on the extreme moving joint. The surgical approach involved a midline incision and exposure of the affected spinal levels. Osteotomies were performed to release the deformity, followed by extensive debridement and irrigation of the infected joint. Pedicle screw fixation and fusion were carried out, and appropriate measures were taken to manage the severe infection.

1. Operative Note: Patient with other secondary kyphosis and severe inflammation underwent a surgical intervention, specifically a posterior spinal fusion. The surgical approach involved a midline incision and exposure of the affected spinal levels. Osteotomies were performed to release the deformity, followed by meticulous debridement of the inflamed tissues. Pedicle screw fixation and fusion were carried out, providing stability and addressing the underlying inflammation. The patient's postoperative recovery was closely monitored, with significant reduction in inflammation.

2. Operative Note: A surgical intervention, an anterior vertebral body reconstruction, was performed for other secondary kyphosis with significant inflammation. The surgical approach involved a transverse incision and exposure of the affected spinal levels. Vertebral body reconstruction was carried out using a cage and structural allograft, accompanied by meticulous debridement of the inflamed tissues. The surgical intervention successfully corrected the spinal alignment while addressing the inflammation, and the patient's postoperative course was unremarkable.

3. Operative Note: Patient with other secondary kyphosis and chronic inflammation underwent a surgical intervention, specifically a combined anterior and posterior spinal fusion. The anterior approach involved vertebral body resection and cage placement, followed by thorough debridement of the inflamed tissues. The posterior procedure included pedicle screw fixation and fusion, providing stability and addressing the underlying inflammation. The surgical intervention achieved successful realignment and significant reduction in inflammation.

4. Operative Note: A surgical intervention, a posterior-based osteotomy and vertebral column resection, was performed for other secondary kyphosis with persistent inflammation. The surgical approach involved a midline incision and exposure of the affected spinal levels. Osteotomies were meticulously performed to release the deformity, followed by thorough debridement of the inflamed tissues. Pedicle screw fixation and fusion were carried out, providing stability and addressing the underlying inflammation. The patient's postoperative recovery was satisfactory, with notable improvement in inflammation.

5. Operative Note: Patient with other secondary kyphosis and significant inflammation underwent a surgical intervention, specifically a posterior vertebral column resection. The surgical approach involved a midline incision and exposure of the affected spinal levels. Vertebral body resection was performed to address the deformity, accompanied by thorough debridement of the inflamed tissues. Pedicle screw fixation and fusion were carried out, providing stability and addressing the underlying inflammation. The patient's postoperative recovery was uneventful, with notable reduction in inflammation.

6. Operative Note: A surgical intervention, an anterior vertebral body tethering procedure, was performed for other secondary kyphosis with localized inflammation. The procedure involved a transverse incision through which the affected vertebral levels were accessed. The flexible tether was placed to gradually correct the deformity while addressing the localized inflammation. Thorough debridement of the inflamed tissues was carried out. The surgical intervention successfully addressed the kyphosis and led to significant reduction in inflammation.

7. Operative Note: Patient with other secondary kyphosis and moderate inflammation underwent a surgical intervention, specifically a posterior spinal fusion with debridement. The surgical approach involved a midline incision and exposure of the affected spinal levels. Osteotomies were performed to release the deformity, followed by meticulous debridement of the inflamed tissues. Pedicle screw fixation and fusion were carried out, providing stability and addressing the underlying inflammation. The patient's postoperative recovery was satisfactory, with noticeable improvement in inflammation.

8. Operative Note: A surgical intervention, a combined anterior and posterior approach, was performed for other secondary kyphosis with diffuse inflammation. The anterior procedure involved vertebral body resection and cage placement, accompanied by thorough debridement of the inflamed tissues. The posterior procedure included pedicle screw fixation and fusion, providing stability and addressing the underlying inflammation. The surgical intervention successfully corrected the spinal alignment while significantly reducing inflammation.

9. Operative Note: Patient with other secondary kyphosis and chronic inflammation underwent a surgical intervention, specifically a posterior vertebral osteotomy and fusion. The surgical approach involved a midline incision and exposure of the affected spinal levels. Osteotomies were performed to release the deformity, followed by meticulous debridement of the inflamed tissues. Pedicle screw fixation and fusion were carried out, providing stability and addressing the underlying inflammation. The patient's postoperative recovery was uneventful, with notable reduction in inflammation.

10. Operative Note: A surgical intervention, an anterior vertebral body reconstruction, was performed for other secondary kyphosis with severe inflammation. The surgical approach involved a transverse incision and exposure of the affected spinal levels. Vertebral body reconstruction was carried out using a cage and structural allograft, accompanied by meticulous debridement of the inflamed tissues. The surgical intervention successfully corrected the spinal alignment while addressing the inflammation, and the patient's postoperative course was unremarkable, with significant improvement in inflammation.

1. Operative Note: Patient with other secondary kyphosis and mild severity underwent a surgical intervention, specifically a posterior spinal fusion. The surgical approach involved a midline incision and exposure of the affected spinal levels. Pedicle screw fixation and fusion were performed to address the deformity. The patient's postoperative follow-up will include regular outpatient visits for monitoring and rehabilitation exercises to ensure optimal recovery.

2. Operative Note: A surgical intervention, an anterior vertebral body reconstruction, was performed for other secondary kyphosis with moderate severity. The surgical approach involved a transverse incision and exposure of the affected spinal levels. Vertebral body reconstruction using a cage and structural allograft was carried out to correct the deformity. The patient's postoperative follow-up will include periodic imaging and clinical evaluations to assess the progress and manage any potential complications.

3. Operative Note: Patient with other secondary kyphosis and severe severity underwent a surgical intervention, specifically a combined anterior and posterior spinal fusion. The anterior procedure involved vertebral body resection and cage placement, followed by the posterior procedure involving pedicle screw fixation and fusion. The patient's postoperative follow-up will require frequent visits for wound care, pain management, and close monitoring of neurological status to address the severity of the condition.

4. Operative Note: A surgical intervention, a posterior vertebral column resection and fusion, was performed for other secondary kyphosis with moderate severity. The surgical approach involved a midline incision and exposure of the affected spinal levels. Vertebral body resection and pedicle screw fixation with fusion were carried out to address the deformity. The patient's postoperative follow-up will involve regular assessments of spinal alignment, pain management, and rehabilitation to manage the severity of the condition.

5. Operative Note: Patient with other secondary kyphosis and mild severity underwent a surgical intervention, specifically a posterior-based osteotomy and vertebral column resection. The surgical approach involved a midline incision and exposure of the affected spinal levels. Osteotomies were performed to release the deformity, followed by pedicle screw fixation and fusion. The patient's postoperative follow-up will include periodic visits for physical therapy and imaging to monitor the progression and manage the condition's mild severity.

6. Operative Note: A surgical intervention, an anterior vertebral body tethering procedure, was performed for other secondary kyphosis with moderate severity. The procedure involved a transverse incision and exposure of the affected spinal levels. The flexible tether was placed to gradually correct the deformity. The patient's postoperative follow-up will involve regular clinical evaluations, radiographic assessments, and adjustment of the tether to manage the severity of the condition.

7. Operative Note: Patient with other secondary kyphosis and severe severity underwent a surgical intervention, specifically a posterior vertebral osteotomy and fusion. The surgical approach involved a midline incision and exposure of the affected spinal levels. Osteotomies were performed to release the deformity, followed by extensive pedicle screw fixation and fusion. The patient's postoperative follow-up will require frequent visits for pain management, neurological assessments, and close monitoring of fusion progression to address the severity of the condition.

8. Operative Note: A surgical intervention, a combined anterior and posterior spinal fusion, was performed for other secondary kyphosis with mild severity. The surgical approach involved appropriate incisions and exposure of the affected spinal levels. Vertebral body resection, pedicle screw fixation, and fusion were performed to correct the deformity. The patient's postoperative follow-up will include regular check-ups for symptom management and radiographic evaluations to monitor the stability of the mild severity.

9. Operative Note: Patient with other secondary kyphosis and moderate severity underwent a surgical intervention, specifically a posterior vertebral column resection and fusion. The surgical approach involved a midline incision and exposure of the affected spinal levels. Osteotomies were performed to release the deformity, followed by extensive pedicle screw fixation and fusion. The patient's postoperative follow-up will include close monitoring of neurological function, pain management, and regular imaging to manage the moderate severity of the condition.

10. Operative Note: A surgical intervention, an anterior vertebral body reconstruction, was performed for other secondary kyphosis with severe severity. The surgical approach involved a transverse incision and exposure of the affected spinal levels. Vertebral body reconstruction using a cage and structural allograft was carried out to correct the deformity. The patient's postoperative follow-up will require frequent assessments of spinal alignment, pain management, and rehabilitation to address the severe severity of the condition.

## M40.2 Other and unspecified kyphosis

1. Operative Note: Patient underwent posterior spinal fusion for other and unspecified kyphosis. A midline incision was made, followed by extensive soft tissue dissection. Pedicle screws were inserted at multiple levels to provide stability. Posterior fusion was achieved using autograft and allograft materials. Wound closure was performed with absorbable sutures. The patient tolerated the procedure well and was transferred to the recovery room in stable condition.

2. Operative Note: Intraoperative findings revealed other and unspecified kyphosis. Anterior release and osteotomy were performed to correct the deformity. A small retroperitoneal incision was made, and the affected vertebral bodies were exposed. Osteotomy was performed using specialized instruments, and the anterior column was reconstructed with a cage and bone graft. Closure was achieved in layers. The patient's condition remained stable throughout the procedure.

3. Operative Note: Patient underwent minimally invasive surgical correction for other and unspecified kyphosis. A lateral approach was used, and specialized retractors were placed to access the affected vertebral bodies. Kyphoplasty was performed, utilizing balloon inflation and cement augmentation to restore vertebral height and alignment. Hemostasis was achieved, and the incision was closed. The patient's vital signs remained stable, and no intraoperative complications were encountered.

4. Operative Note: Surgical correction was performed for other and unspecified kyphosis. A posterior approach was utilized, and the appropriate levels were exposed. Osteotomies were performed to achieve correction, and pedicle screws were inserted for stabilization. Bone graft was placed to promote fusion. The wound was closed meticulously, and the patient was transferred to the post-anesthesia care unit without any complications. Vital signs remained stable throughout the procedure.

5. Operative Note: Patient underwent endoscopic-assisted correction of other and unspecified kyphosis. A small incision was made, and the endoscope was introduced to visualize the affected vertebral bodies. Specialized instruments were used to perform osteotomies and correct the deformity. Bone graft was placed to enhance fusion. The incision was closed, and the patient was extubated and transferred to the recovery area in stable condition.

6. Operative Note: Posterior spinal fusion was performed to correct other and unspecified kyphosis. The patient was positioned prone, and a midline incision was made over the affected levels. The paraspinal muscles were dissected to expose the laminae. Pedicle screws were inserted bilaterally, followed by decortication of the facets and placement of bone graft. The incision was closed, and the patient's vital signs remained stable throughout the procedure.

7. Operative Note: Patient underwent anterior vertebral column resection for other and unspecified kyphosis. A transabdominal approach was used, and the involved vertebral bodies were identified and resected. Reconstruction was performed using expandable cage and structural graft. The abdomen was closed meticulously in layers. The patient tolerated the procedure well, and postoperative imaging confirmed successful correction of the kyphotic deformity.

8. Operative Note: Surgical correction of other and unspecified kyphosis was performed using a hybrid approach. Initial anterior release was achieved via a thoracotomy incision, allowing for osteotomy and disc removal. Posterior instrumentation and fusion were subsequently performed using pedicle screws and rod constructs. Bone graft was applied to enhance fusion. The incisions were closed, and the patient's condition remained stable throughout the procedure.

9. Operative Note: Patient underwent percutaneous vertebral augmentation for other and unspecified kyphosis. Under fluoroscopic guidance, balloons were inflated within the affected vertebral bodies to restore height. Polymethylmethacrylate cement was then injected into the vertebral bodies for stabilization. Hemostasis was confirmed, and the incision sites were closed. The patient's postoperative course was uneventful, and they were discharged with appropriate pain management.

10. Operative Note: Surgical correction of other and unspecified kyphosis was performed using a posterior-only approach. The patient was positioned prone, and a midline incision was made over the involved levels. Pedicle screws were inserted bilaterally, followed by osteotomies and correction maneuvers. Bone graft was placed for fusion. Closure was performed meticulously, and the patient was transferred to the post-anesthesia care unit without any intraoperative complications.

1. Operative Note: Patient underwent vertebral column resection for correction of other and unspecified kyphosis. A combined anterior and posterior approach was utilized. Anterior release and discectomy were performed, followed by posterior osteotomies and instrumentation. Vertebral column resection was achieved, and anterior column reconstruction was performed using expandable cages and bone graft. Wound closure was performed in layers, and the patient's condition remained stable throughout the procedure.

2. Operative Note: Surgical correction was performed for other and unspecified kyphosis using a minimally invasive lateral approach. A small incision was made, and specialized retractors were used for access to the affected vertebral bodies. Kyphoplasty was performed using balloon inflation and cement augmentation. The incision was closed meticulously, and the patient tolerated the procedure well, without any intraoperative complications.

3. Operative Note: Patient underwent posterior vertebral column resection for correction of other and unspecified kyphosis. A midline incision was made, and the posterior elements were exposed. Osteotomies were performed at multiple levels to achieve correction, followed by placement of pedicle screws for stabilization. Anterior column reconstruction was performed using cages and bone graft. Closure was performed meticulously, and the patient's vital signs remained stable throughout the procedure.

4. Operative Note: Surgical correction of other and unspecified kyphosis was performed using a combination of posterior fusion and osteotomy. The patient was positioned prone, and a midline incision was made. Pedicle screws were inserted bilaterally, followed by facet joint release and correction maneuvers. Fusion was achieved using autograft and allograft materials. The wound was closed, and the patient's postoperative course was uneventful.

5. Operative Note: Patient underwent endoscopic-assisted spinal fusion for correction of other and unspecified kyphosis. A small incision was made, and the endoscope was utilized for visualization. Pedicle screws were inserted bilaterally, followed by decortication and placement of bone graft. The incision was closed meticulously, and the patient tolerated the procedure well, without any complications.

6. Operative Note: Surgical correction of other and unspecified kyphosis was performed using a posterior-only approach. A midline incision was made, and the involved levels were exposed. Pedicle screws were inserted bilaterally, and osteotomies were performed to achieve correction. Fusion was achieved using bone graft. The wound was closed, and the patient's vital signs remained stable throughout the procedure.

7. Operative Note: Patient underwent anterior vertebral osteotomy for correction of other and unspecified kyphosis. An anterior approach was utilized, and the involved vertebral bodies were exposed. Osteotomies were performed, and the vertebral column was realigned and stabilized using instrumentation. Bone graft was applied for fusion. The incision was closed meticulously, and the patient's condition remained stable throughout the procedure.

8. Operative Note: Surgical correction was performed for other and unspecified kyphosis using a combined posterior-anterior approach. A midline incision was made, and posterior instrumentation and fusion were performed. An additional anterior incision was made, and the affected vertebral bodies were exposed. Osteotomies were performed, and the vertebral column was corrected and stabilized using cages and bone graft. Closure was performed in layers, and the patient's postoperative course was uneventful.

9. Operative Note: Patient underwent vertebral augmentation for correction of other and unspecified kyphosis. Under fluoroscopic guidance, balloons were inflated within the affected vertebral bodies to restore height and alignment. Cement augmentation using polymethylmethacrylate was then performed. Hemostasis was achieved, and the incision sites were closed meticulously. The patient tolerated the procedure well, without any complications.

10. Operative Note: Surgical correction of other and unspecified kyphosis was performed using a posterior fusion approach. The patient was positioned prone, and a midline incision was made over the involved levels. Pedicle screws were inserted bilaterally, followed by decortication and placement of bone graft. The wound was closed meticulously, and the patient's vital signs remained stable throughout the procedure.

1. Operative Note: Patient underwent posterior spinal fusion for other and unspecified kyphosis under general anesthesia. Induction was achieved with intravenous propofol and fentanyl. Maintenance anesthesia was maintained with sevoflurane and a balanced infusion of remifentanil. The patient remained hemodynamically stable throughout the procedure. Posterior fusion was performed using autograft and allograft materials. The wound was closed meticulously, and the patient recovered well from anesthesia.

2. Operative Note: Surgical correction of other and unspecified kyphosis was performed under monitored anesthesia care (MAC). The patient received a combination of intravenous sedation using midazolam and local anesthesia with lidocaine. The procedure involved posterior fusion and osteotomies. The patient tolerated the procedure well, with minimal discomfort, and no complications were encountered during anesthesia administration.

3. Operative Note: Patient underwent endoscopic-assisted correction of other and unspecified kyphosis under general anesthesia. Induction was achieved with intravenous propofol and remifentanil. Maintenance anesthesia was maintained with a sevoflurane inhalation agent and a continuous infusion of remifentanil. The patient remained stable throughout the procedure, and postoperative recovery was uneventful.

4. Operative Note: Surgical correction of other and unspecified kyphosis was performed under spinal anesthesia. The patient received a spinal block with hyperbaric bupivacaine and opioid supplementation with intravenous fentanyl. The procedure involved anterior release, osteotomy, and fusion. The patient remained comfortable and cooperative throughout the surgery, and there were no intraoperative complications related to anesthesia.

5. Operative Note: Patient underwent posterior vertebral column resection for correction of other and unspecified kyphosis under general anesthesia. Induction was achieved with intravenous propofol and sufentanil. Maintenance anesthesia was maintained with a volatile agent and a continuous infusion of remifentanil. The patient's hemodynamic parameters were well-controlled throughout the procedure, and the anesthesia dosage was adjusted as needed.

6. Operative Note: Surgical correction was performed for other and unspecified kyphosis under regional anesthesia with intravenous sedation. The patient received a thoracic epidural block with a local anesthetic solution. Conscious sedation was achieved with intravenous midazolam and fentanyl. The procedure involved anterior vertebral column reconstruction and posterior stabilization. The patient remained comfortable and responsive, with stable vital signs.

7. Operative Note: Patient underwent anterior vertebral osteotomy for correction of other and unspecified kyphosis under general anesthesia. Induction was achieved with intravenous propofol and remifentanil. Maintenance anesthesia was maintained with a sevoflurane inhalation agent and an infusion of remifentanil. The patient remained hemodynamically stable throughout the procedure, and the anesthesia dosage was carefully titrated to ensure optimal anesthesia depth.

8. Operative Note: Surgical correction of other and unspecified kyphosis was performed under local anesthesia with intravenous sedation. The patient received a tumescent solution containing lidocaine and epinephrine for local infiltration. Intravenous sedation was achieved with midazolam and fentanyl. The procedure involved posterior fusion and osteotomies. The patient tolerated the surgery well, with minimal discomfort and cooperative response during the procedure.

9. Operative Note: Patient underwent minimally invasive surgical correction for other and unspecified kyphosis under general anesthesia. Induction was achieved with intravenous propofol and remifentanil. Maintenance anesthesia was maintained with a sevoflurane inhalation agent and a balanced infusion of remifentanil. The patient's vital signs remained stable throughout the procedure, and anesthesia depth was adjusted accordingly.

10. Operative Note: Surgical correction of other and unspecified kyphosis was performed under general anesthesia with a balanced technique. Induction was achieved with intravenous propofol and remifentanil. Maintenance anesthesia was maintained with a volatile agent and a continuous infusion of remifentanil. The patient's hemodynamic parameters were well-controlled throughout the procedure, and the anesthesia dosage was titrated to maintain an appropriate depth of anesthesia.

1. Operative Note: Patient underwent posterior spinal fusion for other and unspecified kyphosis with associated bone erosion. A midline incision was made, and extensive soft tissue dissection was performed. Pedicle screws were inserted at multiple levels to provide stability in the presence of bone erosion. Posterior fusion was achieved using autograft and allograft materials. Wound closure was performed meticulously. The patient tolerated the procedure well, and steps were taken to address the erosion during the surgery.

2. Operative Note: Intraoperative findings revealed other and unspecified kyphosis with significant bone erosion. Anterior release and osteotomy were performed to correct the deformity and address the bone erosion. A retroperitoneal incision was made to access the affected vertebral bodies. The eroded bone was carefully debrided and reconstructed with cages and structural graft. Closure was performed in layers. The patient's condition remained stable throughout the procedure.

3. Operative Note: Patient underwent minimally invasive surgical correction for other and unspecified kyphosis with associated bone erosion. A lateral approach was used, and specialized retractors were placed to access the affected vertebral bodies. Osteotomies were performed to correct the deformity and address the bone erosion. Bone graft was placed strategically to promote fusion and restore stability. The incision was closed, and the patient's vital signs remained stable throughout the procedure.

4. Operative Note: Surgical correction was performed for other and unspecified kyphosis with significant bone erosion. A posterior approach was utilized, and the appropriate levels were exposed. Osteotomies were performed to address the deformity and erosion. Pedicle screws were inserted for stabilization, considering the presence of bone erosion. Bone graft was applied to enhance fusion. The wound was closed meticulously, and the patient was transferred to the post-anesthesia care unit without any complications.

5. Operative Note: Patient underwent endoscopic-assisted correction of other and unspecified kyphosis with bone erosion. A small incision was made, and the endoscope was introduced to visualize the affected vertebral bodies. Specialized instruments were used to perform osteotomies and correct the deformity while addressing the bone erosion. Bone graft was placed strategically to promote fusion and provide stability. The incision was closed, and the patient's recovery from anesthesia was uneventful.

6. Operative Note: Posterior spinal fusion was performed to correct other and unspecified kyphosis with bone erosion. The patient was positioned prone, and a midline incision was made over the affected levels. The eroded bone was meticulously debrided, and osteotomies were performed to achieve correction while addressing the bone erosion. Pedicle screws were inserted for stabilization. Bone graft was placed strategically to promote fusion. The wound was closed, and the patient's vital signs remained stable throughout the procedure.

7. Operative Note: Patient underwent anterior vertebral column resection for other and unspecified kyphosis with significant bone erosion. A transabdominal approach was used, and the involved vertebral bodies were identified and resected, considering the extent of bone erosion. Reconstruction was performed using expandable cages, structural graft, and bone graft substitutes. The abdomen was closed meticulously in layers. The patient tolerated the procedure well, and postoperative imaging confirmed successful correction of the kyphotic deformity and addressed the bone erosion.

8. Operative Note: Surgical correction of other and unspecified kyphosis was performed using a hybrid approach with consideration for bone erosion. Initial anterior release and osteotomy were achieved via a thoracotomy incision, addressing the bone erosion. Posterior instrumentation and fusion were subsequently performed to provide stability. Careful attention was given to graft placement and fusion in areas of bone erosion. The wounds were closed meticulously, and the patient recovered well from anesthesia.

9. Operative Note: Patient underwent posterior vertebral column resection for correction of other and unspecified kyphosis with significant bone erosion. A midline incision was made, and the involved vertebral bodies were exposed. Extensive bone erosion was noted and meticulously debrided. Vertebral column resection was performed, and posterior stabilization was achieved using pedicle screws. Reconstruction involved the placement of bone graft and cages. The incision was closed, and the patient's postoperative course was uneventful.

10. Operative Note: Surgical correction was performed for other and unspecified kyphosis with associated bone erosion using a combined anterior-posterior approach. The anterior portion involved accessing the affected vertebral bodies, addressing the erosion, and performing osteotomies. Anterior column reconstruction was performed using cages and bone graft. The posterior approach involved pedicle screw insertion and posterior fusion, with careful consideration for bone erosion. The wounds were closed meticulously, and the patient tolerated the procedure well.

1. Operative Note: Surgical correction was performed for other and unspecified kyphosis with severe bone pain. The patient reported significant discomfort preoperatively. A posterior approach was utilized, and the involved vertebral levels were exposed. Osteotomies were performed to correct the deformity and relieve pressure on the affected bones, providing pain relief. Pedicle screws were inserted for stabilization, and posterior fusion was achieved. The patient's pain significantly improved postoperatively.

2. Operative Note: Patient underwent anterior vertebral column resection for correction of other and unspecified kyphosis with severe bone pain. An anterior approach was used to access the affected vertebral bodies. Osteotomies were performed, and the deformed bones causing severe pain were removed. Anterior column reconstruction was performed using cages and bone graft. The procedure successfully alleviated the patient's severe bone pain, and the postoperative course was uneventful.

3. Operative Note: Surgical correction of other and unspecified kyphosis was performed under general anesthesia, primarily to address severe bone pain. A combined anterior and posterior approach was utilized. Anterior release and discectomy were performed to relieve pressure on the affected vertebral bodies, followed by posterior osteotomies and fusion. The patient's severe bone pain was effectively alleviated, and the postoperative recovery was satisfactory.

4. Operative Note: Patient underwent posterior spinal fusion for correction of other and unspecified kyphosis with severe bone pain. The procedure aimed to stabilize the affected vertebrae and alleviate the patient's debilitating bone pain. Pedicle screws were inserted at multiple levels to provide stability and support. Posterior fusion was achieved using autograft and allograft materials. The patient's severe bone pain was significantly reduced postoperatively, leading to improved quality of life.

5. Operative Note: Surgical correction was performed for other and unspecified kyphosis with severe bone pain using a minimally invasive lateral approach. The procedure aimed to alleviate the patient's discomfort caused by bone deformity and compression. Through a small incision, specialized instruments were used to access and correct the affected vertebral bodies. The patient's severe bone pain was successfully relieved, and the procedure was well-tolerated.

6. Operative Note: Patient underwent endoscopic-assisted correction of other and unspecified kyphosis with severe bone pain. The procedure was performed to relieve the patient's significant discomfort caused by bone deformity. The endoscope was utilized to visualize the affected vertebrae, and specialized instruments were used to perform osteotomies and correct the deformity. The patient's severe bone pain was effectively addressed, and postoperative pain management measures were implemented.

7. Operative Note: Surgical correction of other and unspecified kyphosis was performed under general anesthesia, primarily to alleviate severe bone pain. A posterior approach was used, and the involved vertebral levels were exposed. Osteotomies were performed to correct the deformity and relieve pressure on the affected bones, resulting in immediate reduction of severe bone pain. Pedicle screws were inserted for stabilization, and posterior fusion was achieved successfully.

8. Operative Note: Patient underwent anterior vertebral osteotomy for correction of other and unspecified kyphosis with severe bone pain. The procedure aimed to alleviate the patient's significant discomfort caused by bone deformity and compression. An anterior approach was utilized, and the involved vertebral bodies were exposed. Osteotomies were performed to correct the deformity and relieve pressure on the affected bones, providing immediate relief from severe bone pain. Anterior column reconstruction was performed using cages and bone graft.

9. Operative Note: Surgical correction was performed for other and unspecified kyphosis with severe bone pain. The patient reported debilitating discomfort preoperatively. A hybrid approach combining anterior and posterior techniques was used. Anterior release and osteotomy were performed to relieve pressure on the affected vertebrae, followed by posterior instrumentation and fusion for stabilization. The patient's severe bone pain significantly diminished following the procedure, leading to improved functional capacity.

10. Operative Note: Patient underwent posterior vertebral column resection for correction of other and unspecified kyphosis with severe bone pain. The procedure aimed to alleviate the patient's significant discomfort and improve quality of life. A midline incision was made, and the involved vertebral bodies were exposed. Vertebral column resection was performed, relieving pressure on the affected bones and providing pain relief. Posterior stabilization was achieved using pedicle screws, and bone graft was placed for fusion. The patient's severe bone pain was effectively addressed, and the postoperative course was uneventful.:

1. Operative Note: Surgical correction of other and unspecified kyphosis was performed using a posterior spinal fusion approach. The patient was positioned prone, and a midline incision was made over the affected levels. Pedicle screws were inserted bilaterally, followed by extensive decompression and osteotomies to correct the deformity. Bone graft was applied for fusion. The wound was closed meticulously, and the patient tolerated the procedure well, with anticipated improvement in alignment.

2. Operative Note: Patient underwent anterior vertebral column resection for correction of severe other and unspecified kyphosis. A thoracotomy incision was made to access the affected vertebral bodies. The anterior release was performed, followed by osteotomies to allow for correction of the deformity. Anterior column reconstruction was achieved using expandable cages and structural graft. The patient's spine was stabilized, and the incision was closed meticulously. The procedure was successful in addressing the kyphotic deformity.

3. Operative Note: Surgical correction was performed for other and unspecified kyphosis using a combination of anterior and posterior approaches. Anterior release and discectomy were performed to address the deformity, followed by posterior fusion and instrumentation for stabilization. The patient tolerated the procedure well, and intraoperative imaging confirmed satisfactory correction. The wounds were closed meticulously, and postoperative management included pain control and appropriate physical therapy.

4. Operative Note: Patient underwent minimally invasive surgical correction for other and unspecified kyphosis using a lateral approach. The affected vertebral levels were accessed through a small incision, and specialized instruments were used to perform osteotomies and correct the deformity. Bone graft was applied to promote fusion. The patient tolerated the procedure well, with minimal blood loss and postoperative pain. The incision was closed, and the patient was advised on postoperative care.

5. Operative Note: Surgical intervention was performed for severe other and unspecified kyphosis using a combined anterior and posterior approach. Anterior release, discectomy, and osteotomies were performed to address the deformity, followed by posterior instrumentation and fusion for stabilization. The patient's spine was realigned, and bone graft was placed to promote fusion. The procedure was successful, and the patient's postoperative course was uneventful.

6. Operative Note: Patient underwent posterior vertebral column resection as a surgical intervention for other and unspecified kyphosis. A midline incision was made, and the involved vertebral levels were exposed. Vertebral column resection was performed to correct the deformity and restore alignment. Pedicle screws were inserted for stabilization, and bone graft was placed for fusion. The wound was closed meticulously, and the patient's postoperative recovery was satisfactory.

7. Operative Note: Surgical correction was performed for other and unspecified kyphosis using a posterior fusion approach. A midline incision was made, and the affected vertebral levels were exposed. Pedicle screws were inserted bilaterally, and extensive osteotomies were performed to correct the deformity. Posterior fusion was achieved using bone graft and instrumentation. The wound was closed meticulously, and the patient's postoperative course was unremarkable.

8. Operative Note: Patient underwent anterior vertebral osteotomy as a surgical intervention for other and unspecified kyphosis. An anterior approach was utilized, and the involved vertebral bodies were exposed. Osteotomies were performed to correct the deformity, followed by anterior column reconstruction using cages and bone graft. The patient's spine was realigned, and stability was achieved. The incision was closed meticulously, and the patient's postoperative recovery was satisfactory.

9. Operative Note: Surgical intervention was performed for severe other and unspecified kyphosis using a posterior approach. The involved vertebral levels were exposed through a midline incision. Osteotomies were performed to correct the deformity, and pedicle screws were inserted for stabilization. Posterior fusion was achieved using bone graft and instrumentation. The patient tolerated the procedure well, and immediate postoperative imaging confirmed satisfactory alignment correction.

10. Operative Note: Patient underwent endoscopic-assisted surgical correction for other and unspecified kyphosis. A small incision was made, and an endoscope was used to visualize the affected vertebral bodies. Osteotomies were performed to correct the deformity, followed by placement of bone graft and instrumentation to stabilize the spine. The procedure was successful in achieving realignment, and the incision was closed meticulously. The patient's postoperative recovery was uneventful, with expected improvement in kyphotic alignment.

1. Operative Note: Surgical correction was performed for other and unspecified kyphosis with a severe infection on the extreme moving joint. The patient presented with significant pain and signs of joint inflammation. After careful evaluation and consultation with infectious disease specialists, a two-stage procedure was planned. The initial stage involved thorough debridement and irrigation of the infected joint, followed by temporary stabilization. The subsequent stage aimed at definitive correction and fusion once the infection was controlled.

2. Operative Note: Patient underwent extensive debridement and corrective surgery for other and unspecified kyphosis with a severe infection involving the extreme moving joint. Intraoperatively, the infected joint was meticulously irrigated and debrided to remove the infected tissues. Adequate stabilization and correction of the kyphotic deformity were achieved using specialized instrumentation and fusion techniques. Antibiotic therapy was administered, and the patient was closely monitored postoperatively for infection control.

3. Operative Note: Surgical intervention was performed for severe other and unspecified kyphosis, complicated by a deep infection in the extreme moving joint. The infected joint was carefully approached, and extensive debridement was carried out to remove the infected tissues. Antibiotic-loaded cement spacers were placed temporarily to maintain joint space and provide local antimicrobial therapy. The kyphotic deformity was addressed through a separate posterior fusion procedure. The patient's postoperative course was managed in collaboration with infectious disease specialists.

4. Operative Note: Patient underwent surgical correction for other and unspecified kyphosis with a severe infection involving the extreme moving joint. Intraoperatively, the infected joint was thoroughly debrided and irrigated. The joint surfaces were carefully inspected, and any necrotic or infected tissue was excised. Subsequently, a fusion procedure was performed to correct the kyphotic deformity and provide stability. Intravenous antibiotic therapy was initiated postoperatively to target the infection.

5. Operative Note: Surgical intervention was performed for other and unspecified kyphosis complicated by a severe infection in the extreme moving joint. The infected joint was approached, and extensive debridement was performed to remove the infected tissues. The kyphotic deformity was addressed through a separate procedure, involving osteotomies and posterior instrumentation. Antibiotic therapy was administered, and meticulous wound care was ensured postoperatively to facilitate infection control and promote healing.

6. Operative Note: Patient underwent surgical correction for other and unspecified kyphosis with a severe infection affecting the extreme moving joint. Intraoperatively, the infected joint was meticulously debrided, and all necrotic or infected tissue was excised. Temporary joint stabilization was achieved, and the kyphotic deformity was addressed through a separate procedure. Antibiotic therapy was initiated to target the infection, and close follow-up was planned to monitor the patient's response.

7. Operative Note: Surgical correction was performed for other and unspecified kyphosis with a severe infection involving the extreme moving joint. The infected joint was accessed, and thorough debridement was performed to remove all infected tissues. Temporary stabilization was achieved, and a separate procedure was performed to correct the kyphotic deformity. Appropriate intravenous antibiotics were administered, and the patient's postoperative course was closely monitored for infection control.

8. Operative Note: Patient underwent extensive debridement and corrective surgery for other and unspecified kyphosis with a severe infection affecting the extreme moving joint. Intraoperatively, the infected joint was meticulously irrigated and debrided, and all infected tissues were removed. Temporary stabilization was accomplished, and the kyphotic deformity was addressed through a separate procedure. Antibiotic therapy was initiated to target the infection, and close collaboration with infectious disease specialists was maintained.

9. Operative Note: Surgical intervention was performed for severe other and unspecified kyphosis with a severe infection in the extreme moving joint. The infected joint was approached, and extensive debridement was carried out to remove all infected tissues. Temporary stabilization was achieved, and the kyphotic deformity was corrected through a separate procedure. Postoperatively, intravenous antibiotics were administered, and the patient's progress was closely monitored to ensure infection control.

10. Operative Note: Patient underwent surgical correction for other and unspecified kyphosis with a severe infection involving the extreme moving joint. Intraoperatively, the infected joint was meticulously debrided, and all infected tissues were excised. Temporary stabilization was achieved, and the kyphotic deformity was addressed through a separate procedure. Antibiotic therapy was initiated, and wound care protocols were followed diligently to promote healing and control the infection.

1. Operative Note: Surgical correction was performed for other and unspecified kyphosis with severe inflammation affecting the surrounding tissues. The patient presented with significant pain, redness, and swelling. Intraoperatively, meticulous dissection was performed to minimize tissue trauma. The kyphotic deformity was addressed through a posterior fusion procedure, taking care to avoid further irritation to the inflamed tissues. Anti-inflammatory measures were implemented postoperatively to manage the inflammatory response.

2. Operative Note: Patient underwent surgical intervention for severe other and unspecified kyphosis complicated by marked inflammation in the surrounding tissues. Intraoperatively, meticulous tissue handling was employed to minimize the inflammatory response. The kyphotic deformity was addressed through a combined anterior and posterior approach, with careful consideration given to the inflamed tissues. Postoperative management included anti-inflammatory medications to control the inflammatory process.

3. Operative Note: Surgical correction was performed for other and unspecified kyphosis with inflammation of the surrounding tissues. Intraoperatively, careful attention was given to minimize tissue manipulation and trauma, considering the inflammatory response. The kyphotic deformity was addressed through a posterior fusion procedure, with additional measures taken to reduce inflammation in the surgical field. Postoperatively, anti-inflammatory medications were prescribed to manage the inflammatory symptoms.

4. Operative Note: Patient underwent surgical intervention for other and unspecified kyphosis with significant inflammation involving the surrounding tissues. Intraoperatively, gentle tissue handling was employed to minimize the inflammatory response. The kyphotic deformity was addressed through a combined anterior and posterior approach, with particular attention paid to the inflamed tissues. Postoperatively, anti-inflammatory measures were implemented to control the inflammatory process and aid in the patient's recovery.

5. Operative Note: Surgical correction was performed for other and unspecified kyphosis with inflammation of the surrounding tissues. Intraoperatively, meticulous tissue dissection was performed to minimize further inflammation. The kyphotic deformity was addressed through a posterior fusion procedure, with careful consideration given to the inflamed tissues. Postoperatively, anti-inflammatory medications were administered to manage the inflammatory response and facilitate the patient's healing.

6. Operative Note: Patient underwent surgical intervention for severe other and unspecified kyphosis with significant inflammation in the surrounding tissues. Intraoperatively, measures were taken to minimize tissue trauma and avoid exacerbation of the inflammatory response. The kyphotic deformity was addressed through a combined anterior and posterior approach, with meticulous attention given to the inflamed tissues. Postoperatively, anti-inflammatory strategies were implemented to manage the inflammatory symptoms.

7. Operative Note: Surgical correction was performed for other and unspecified kyphosis with inflammation affecting the surrounding tissues. Intraoperatively, gentle tissue handling was employed to minimize the inflammatory response. The kyphotic deformity was addressed through a posterior fusion procedure, with additional precautions taken to reduce inflammation in the surgical field. Postoperatively, anti-inflammatory medications were administered to control the inflammatory symptoms and support the patient's recovery.

8. Operative Note: Patient underwent surgical intervention for other and unspecified kyphosis with significant inflammation in the surrounding tissues. Intraoperatively, meticulous tissue dissection and careful handling techniques were employed to minimize the inflammatory response. The kyphotic deformity was addressed through a combined anterior and posterior approach, with specific attention given to the inflamed tissues. Postoperatively, anti-inflammatory measures were implemented to manage the inflammation and promote healing.

9. Operative Note: Surgical correction was performed for other and unspecified kyphosis with inflammation affecting the surrounding tissues. Intraoperatively, careful tissue dissection was carried out to minimize the inflammatory response. The kyphotic deformity was addressed through a posterior fusion procedure, with additional measures taken to reduce inflammation in the surgical field. Postoperatively, anti-inflammatory medications were prescribed to control the inflammatory symptoms and optimize the patient's recovery.

10. Operative Note: Patient underwent surgical intervention for severe other and unspecified kyphosis with marked inflammation in the surrounding tissues. Intraoperatively, meticulous tissue handling techniques were employed to minimize the inflammatory response. The kyphotic deformity was addressed through a combined anterior and posterior approach, with special attention given to the inflamed tissues. Postoperatively, anti-inflammatory strategies were implemented to manage the inflammatory symptoms and support the patient's postoperative course.

1. Operative Note: Surgical intervention was performed for other and unspecified kyphosis, which was determined to be of moderate severity. The patient's postoperative course will be followed up with periodic clinical evaluations and imaging assessments at regular intervals to monitor the progression of the kyphotic deformity. Additional interventions or conservative management will be considered based on the patient's symptoms and radiographic findings during follow-up visits.

2. Operative Note: Patient underwent surgical correction for severe other and unspecified kyphosis. The postoperative follow-up plan includes close monitoring of the patient's neurologic status, pain levels, and overall functional improvement. Frequent clinical evaluations and radiographic assessments will be conducted to assess the success of the surgical intervention and determine the need for additional treatments or rehabilitation measures.

3. Operative Note: Surgical correction was performed for mild other and unspecified kyphosis. The patient's postoperative follow-up will include regular clinical assessments to evaluate pain levels, functional outcomes, and the stability of the corrected spine. Imaging studies will be conducted at specific intervals to assess the progression of the kyphotic deformity and determine the necessity for further interventions or conservative management.

4. Operative Note: Patient underwent surgical intervention for moderate other and unspecified kyphosis. The postoperative follow-up plan involves frequent clinical evaluations to assess the patient's pain, range of motion, and overall functional improvement. Radiographic assessments will be performed at scheduled intervals to monitor the alignment of the spine and determine the need for additional interventions or therapeutic measures based on the severity of the residual deformity.

5. Operative Note: Surgical correction was performed for severe other and unspecified kyphosis. The postoperative follow-up plan includes close monitoring of the patient's neurologic function, pain levels, and quality of life. Serial radiographic evaluations will be conducted to assess the success of the surgical intervention and determine the need for additional treatments or interventions based on the severity of the residual kyphotic deformity.

6. Operative Note: Patient underwent surgical intervention for mild other and unspecified kyphosis. The postoperative follow-up plan includes regular clinical assessments to evaluate pain levels, functional outcomes, and the stability of the corrected spine. Imaging studies will be conducted at specific intervals to assess the progression of the kyphotic deformity and determine the necessity for further interventions or conservative management based on the severity of the residual deformity.

7. Operative Note: Surgical correction was performed for moderate other and unspecified kyphosis. The postoperative follow-up plan involves frequent clinical evaluations to assess the patient's pain, range of motion, and overall functional improvement. Radiographic assessments will be performed at scheduled intervals to monitor the alignment of the spine and determine the need for additional interventions or therapeutic measures based on the severity of the residual deformity.

8. Operative Note: Patient underwent surgical intervention for severe other and unspecified kyphosis. The postoperative follow-up plan includes close monitoring of the patient's neurologic function, pain levels, and quality of life. Serial radiographic evaluations will be conducted to assess the success of the surgical intervention and determine the need for additional treatments or interventions based on the severity of the residual kyphotic deformity.

9. Operative Note: Surgical correction was performed for mild other and unspecified kyphosis. The postoperative follow-up plan includes regular clinical assessments to evaluate pain levels, functional outcomes, and the stability of the corrected spine. Imaging studies will be conducted at specific intervals to assess the progression of the kyphotic deformity and determine the necessity for further interventions or conservative management based on the severity of the residual deformity.

10. Operative Note: Patient underwent surgical intervention for moderate other and unspecified kyphosis. The postoperative follow-up plan involves frequent clinical evaluations to assess the patient's pain, range of motion, and overall functional improvement. Radiographic assessments will be performed at scheduled intervals to monitor the alignment of the spine and determine the need for additional interventions or therapeutic measures based on the severity of the residual deformity.

## M40.3 Flatback syndrome

1. Operative Note: Patient with Flatback Syndrome underwent a posterior spinal fusion procedure. Laminectomy and pedicle screw instrumentation were performed to correct sagittal imbalance. Posterior spinal elements were decorticated, and bone graft material was inserted to promote fusion. Intraoperative neuromonitoring was utilized to ensure spinal cord safety. Surgical wounds were closed, and the patient was transferred to the recovery unit in stable condition.

2. Operative Note: A patient diagnosed with Flatback Syndrome underwent a posterior osteotomy and vertebral column resection. Posterior spinal elements were removed to address spinal alignment. Pedicle screws were inserted for stabilization, and bone graft material was placed for fusion. The surgical site was closed in layers, and the patient was transferred to the intensive care unit for close monitoring.

3. Operative Note: Patient presented with Flatback Syndrome and underwent an anterior release and fusion procedure. The anterior approach was utilized to access the thoracolumbar spine. The intervertebral disc spaces were cleared, and bone graft material was placed to promote fusion. Anterior instrumentation was applied for spinal stability. The surgical incision was closed, and the patient was moved to the post-anesthesia care unit.

4. Operative Note: A patient with Flatback Syndrome underwent a pedicle subtraction osteotomy. The posterior spinal elements were resected to correct sagittal imbalance. Pedicle screws were inserted, and the vertebral column was mobilized and realigned. Bone graft material was placed, and posterior instrumentation was applied. Hemostasis was achieved, and the incision was closed meticulously.

5. Operative Note: Patient diagnosed with Flatback Syndrome underwent a posterior column osteotomy. The vertebral column was approached posteriorly, and osteotomies were performed at multiple levels. Pedicle screws and rods were inserted for stabilization. Bone graft material was packed to promote fusion. The incision was closed in layers, and the patient was transferred to the postoperative recovery area.

6. Operative Note: A patient with Flatback Syndrome underwent a spinal osteotomy and posterior fusion. The posterior approach was utilized to access the spine. Osteotomies were performed to correct spinal alignment. Pedicle screws and rods were placed for stabilization. Bone graft material was packed into the osteotomy sites for fusion. The incision was closed, and the patient was transferred to the neurosurgical ward.

7. Operative Note: Patient diagnosed with Flatback Syndrome underwent a posterior spinal fusion with instrumentation. Pedicle screws and rods were placed to correct spinal alignment. The posterior spinal elements were decorticated, and bone graft material was inserted into the intervertebral spaces. Hemostasis was achieved, and the incision was closed in layers. The patient was extubated and transferred to the post-anesthesia care unit.

8. Operative Note: A patient with Flatback Syndrome underwent a vertebral column resection and posterior spinal fusion. The posterior approach was utilized, and resection of the vertebral column was performed to correct spinal alignment. Pedicle screws and rods were inserted for stabilization. Bone graft material was packed into the surgical site. The incision was closed meticulously, and the patient was taken to the recovery room.

9. Operative Note: Patient diagnosed with Flatback Syndrome underwent a posterior lumbar osteotomy. The vertebral column was approached posteriorly, and osteotomies were performed to correct sagittal imbalance. Pedicle screws and rods were inserted for stabilization. Bone graft material was packed into the osteotomy sites. Hemostasis was achieved, and the incision was closed in layers. The patient was transported to the postoperative intensive care unit.

10. Operative Note: A patient with Flatback Syndrome underwent a posterior spinal fusion with vertebral column resection. The vertebral column was accessed posteriorly, and resection was performed to correct spinal alignment. Pedicle screws and rods were inserted for stabilization. Bone graft material was placed for fusion. The surgical site was closed meticulously, and the patient was transferred to the orthopedic ward for postoperative care.

1. Operative Note: Patient with Flatback Syndrome underwent a posterior spinal osteotomy and fusion. The posterior approach was utilized to access the spine. Osteotomies were performed to correct spinal alignment, followed by insertion of pedicle screws and rods for stabilization. Bone graft material was packed into the osteotomy sites. Hemostasis was achieved, and the incision was closed in layers. The patient was transferred to the surgical recovery area for monitoring.

2. Operative Note: A patient diagnosed with Flatback Syndrome underwent a vertebral column resection and anterior spinal fusion. The anterior approach was used to access the thoracolumbar spine. Vertebral column resection was performed to correct spinal alignment. Anterior instrumentation and bone graft material were utilized for stabilization and fusion. The surgical incision was closed meticulously, and the patient was transferred to the post-anesthesia care unit.

3. Operative Note: Patient with Flatback Syndrome underwent a posterior spinal fusion with pedicle subtraction osteotomy. The posterior approach was utilized to access the spine. Pedicle subtraction osteotomy was performed to correct sagittal imbalance. Pedicle screws and rods were inserted for stabilization, and bone graft material was packed into the osteotomy sites. The surgical incision was closed, and the patient was transferred to the neurosurgical intensive care unit.

4. Operative Note: A patient diagnosed with Flatback Syndrome underwent a spinal osteotomy and anterior release procedure. The anterior approach was used to access the thoracolumbar spine. Osteotomies were performed to correct spinal alignment, followed by an anterior release to release the contracted anterior structures. Anterior instrumentation and bone graft material were utilized for stabilization and fusion. The surgical incision was closed meticulously, and the patient was transferred to the orthopedic ward.

5. Operative Note: Patient with Flatback Syndrome underwent a posterior spinal fusion with vertebral column resection. The posterior approach was utilized to access the spine. Vertebral column resection was performed to correct spinal alignment, followed by insertion of pedicle screws and rods for stabilization. Bone graft material was packed into the surgical site. The incision was closed in layers, and the patient was transferred to the intensive care unit for postoperative monitoring.

6. Operative Note: A patient diagnosed with Flatback Syndrome underwent a spinal osteotomy and posterior release procedure. The posterior approach was used to access the thoracolumbar spine. Osteotomies were performed to correct spinal alignment, followed by a posterior release to release the contracted posterior structures. Posterior instrumentation and bone graft material were utilized for stabilization and fusion. The surgical incision was closed meticulously, and the patient was transferred to the neurosurgical intensive care unit.

7. Operative Note: Patient with Flatback Syndrome underwent a posterior spinal fusion with anterior column realignment. The posterior approach was utilized to access the spine. Realignment of the anterior column was performed to correct spinal alignment, followed by insertion of pedicle screws and rods for stabilization. Bone graft material was packed into the surgical site. The incision was closed in layers, and the patient was transferred to the post-anesthesia care unit.

8. Operative Note: A patient diagnosed with Flatback Syndrome underwent a vertebral column resection and posterior release procedure. The posterior approach was used to access the thoracolumbar spine. Vertebral column resection was performed to correct spinal alignment, followed by a posterior release to release the contracted posterior structures. Posterior instrumentation and bone graft material were utilized for stabilization and fusion. The surgical incision was closed meticulously, and the patient was transferred to the orthopedic ward.

9. Operative Note: Patient with Flatback Syndrome underwent a posterior spinal fusion with pedicle subtraction osteotomy. The posterior approach was utilized to access the spine. Pedicle subtraction osteotomy was performed to correct sagittal imbalance. Pedicle screws and rods were inserted for stabilization, and bone graft material was packed into the osteotomy sites. The surgical incision was closed, and the patient was transferred to the intensive care unit for postoperative monitoring.

10. Operative Note: A patient diagnosed with Flatback Syndrome underwent a spinal osteotomy and anterior column realignment. The anterior approach was used to access the thoracolumbar spine. Osteotomies were performed to correct spinal alignment, followed by realignment of the anterior column. Anterior instrumentation and bone graft material were utilized for stabilization and fusion. The surgical incision was closed meticulously, and the patient was transferred to the neurosurgical intensive care unit.

1. Operative Note: Patient with Flatback Syndrome underwent a posterior spinal fusion with pedicle subtraction osteotomy under general anesthesia. Total intravenous anesthesia was administered with propofol at a rate of 100 mcg/kg/min and remifentanil at 0.1 mcg/kg/min. Hemodynamic parameters were stable throughout the procedure. The surgical steps were performed as planned, and the patient tolerated the procedure well. The anesthesia was discontinued smoothly, and the patient was transferred to the post-anesthesia care unit for recovery.

2. Operative Note: A patient diagnosed with Flatback Syndrome underwent a spinal osteotomy and anterior release procedure under regional anesthesia. Spinal anesthesia was induced using 10 mL of 0.5% hyperbaric bupivacaine. Sedation was provided with intravenous midazolam and fentanyl as needed. The patient remained comfortable and cooperative throughout the surgery. Adequate muscle relaxation was achieved with rocuronium. The procedure was completed without complications, and the patient was transferred to the recovery area in stable condition.

3. Operative Note: Patient with Flatback Syndrome underwent a posterior spinal fusion with vertebral column resection under general anesthesia. Inhalation anesthesia was maintained using sevoflurane with a MAC value of 1.0. Intravenous analgesia was provided with fentanyl at a total dose of 100 mcg. The patient remained hemodynamically stable throughout the procedure. The anesthesia was smoothly reversed, and the patient was transferred to the postoperative care unit for monitoring.

4. Operative Note: A patient diagnosed with Flatback Syndrome underwent a spinal osteotomy and posterior release procedure under monitored anesthesia care (MAC). The patient received intravenous sedation with propofol and analgesia with remifentanil via patient-controlled analgesia (PCA) device. The anesthesia was titrated to maintain a moderate level of sedation and pain control. The procedure was performed successfully, and the patient was transferred to the recovery area in a comfortable state.

5. Operative Note: Patient with Flatback Syndrome underwent a posterior spinal fusion with pedicle subtraction osteotomy under combined epidural and general anesthesia. Epidural anesthesia was induced using 10 mL of 0.5% ropivacaine with fentanyl 100 mcg added. General anesthesia was maintained with sevoflurane and remifentanil infusion. The patient remained stable hemodynamically, and adequate intraoperative analgesia was achieved. The anesthesia was discontinued, and the patient was transferred to the post-anesthesia care unit for further monitoring.

6. Operative Note: A patient diagnosed with Flatback Syndrome underwent a vertebral column resection and anterior spinal fusion under general anesthesia. Total intravenous anesthesia was administered with propofol at a rate of 150 mcg/kg/min and remifentanil at 0.2 mcg/kg/min. The patient's hemodynamic parameters were closely monitored and maintained within normal limits throughout the procedure. The surgery was completed successfully, and the patient was transferred to the intensive care unit for postoperative management.

7. Operative Note: Patient with Flatback Syndrome underwent a posterior spinal fusion with pedicle subtraction osteotomy under general anesthesia. Balanced anesthesia was maintained using a combination of sevoflurane, remifentanil, and intravenous fentanyl. The anesthetic agents were titrated to ensure optimal depth of anesthesia and adequate analgesia. The patient remained stable throughout the procedure, and the anesthesia was smoothly reversed. The patient was transferred to the postoperative recovery area for observation.

8. Operative Note: A patient diagnosed with Flatback Syndrome underwent a spinal osteotomy and anterior release procedure under general anesthesia. Anesthesia was induced with propofol and maintained with a sevoflurane and remifentanil infusion. Intermittent boluses of fentanyl were administered for analgesia. The patient's vital signs were stable throughout the surgery. The procedure was completed successfully, and the patient was transferred to the post-anesthesia care unit for recovery.

9. Operative Note: Patient with Flatback Syndrome underwent a posterior spinal fusion with vertebral column resection under general anesthesia. Anesthesia was induced with intravenous propofol and maintained with a combination of sevoflurane and remifentanil infusion. The patient received additional analgesia with intravenous morphine as needed. Hemodynamic stability was maintained throughout the procedure. The anesthesia was discontinued, and the patient was transferred to the surgical ward for postoperative care.

10. Operative Note: A patient diagnosed with Flatback Syndrome underwent a spinal osteotomy and posterior release procedure under regional anesthesia. Spinal anesthesia was achieved using 15 mL of 0.5% hyperbaric bupivacaine. Sedation was provided with intravenous midazolam and remifentanil infusion. The patient remained comfortable and cooperative during the surgery. The procedure was completed successfully, and the patient was transferred to the recovery area for close monitoring.

1. Operative Note: Patient with Flatback Syndrome and significant bone erosion underwent a posterior spinal fusion with vertebral column resection. The posterior approach was utilized to access the spine. Vertebral column resection was performed to correct spinal alignment and address the bone erosion. Pedicle screws and rods were inserted for stabilization, and bone graft material was packed into the osteotomy sites to promote fusion. The surgical incision was closed meticulously, and the patient was transferred to the intensive care unit for postoperative care.

2. Operative Note: A patient diagnosed with Flatback Syndrome and severe bone erosion underwent a spinal osteotomy and anterior release procedure. The anterior approach was used to access the thoracolumbar spine. Osteotomies were performed to correct spinal alignment and address the bone erosion. Anterior instrumentation and bone graft material were utilized for stabilization and fusion. The surgical incision was closed carefully, and the patient was transferred to the post-anesthesia care unit for recovery and monitoring.

3. Operative Note: Patient with Flatback Syndrome and extensive bone erosion underwent a posterior spinal fusion with pedicle subtraction osteotomy. The posterior approach was utilized to access the spine. Pedicle subtraction osteotomy was performed to correct sagittal imbalance and address the bone erosion. Pedicle screws and rods were inserted for stabilization, and bone graft material was packed into the osteotomy sites. The surgical incision was closed, and the patient was transferred to the neurosurgical intensive care unit for postoperative management.

4. Operative Note: A patient diagnosed with Flatback Syndrome and bone erosion underwent a vertebral column resection and posterior release procedure. The posterior approach was used to access the thoracolumbar spine. Vertebral column resection was performed to correct spinal alignment and address the bone erosion. Posterior instrumentation and bone graft material were utilized for stabilization and fusion. The surgical incision was closed meticulously, and the patient was transferred to the orthopedic ward for further observation.

5. Operative Note: Patient with Flatback Syndrome and significant bone erosion underwent a posterior spinal fusion with pedicle subtraction osteotomy. The posterior approach was utilized to access the spine. Pedicle subtraction osteotomy was performed to correct sagittal imbalance and address the extensive bone erosion. Pedicle screws and rods were inserted for stabilization, and bone graft material was packed into the osteotomy sites. The surgical incision was closed, and the patient was transferred to the intensive care unit for close monitoring.

6. Operative Note: A patient diagnosed with Flatback Syndrome and bone erosion underwent a spinal osteotomy and anterior column realignment procedure. The anterior approach was used to access the thoracolumbar spine. Osteotomies were performed to correct spinal alignment and address the bone erosion. Anterior instrumentation and bone graft material were utilized for stabilization and fusion. The surgical incision was closed meticulously, and the patient was transferred to the neurosurgical intensive care unit for postoperative management.

7. Operative Note: Patient with Flatback Syndrome and extensive bone erosion underwent a posterior spinal fusion with vertebral column resection. The posterior approach was utilized to access the spine. Vertebral column resection was performed to correct spinal alignment and address the bone erosion. Pedicle screws and rods were inserted for stabilization, and bone graft material was packed into the osteotomy sites. The surgical incision was closed, and the patient was transferred to the orthopedic ward for postoperative care.

8. Operative Note: A patient diagnosed with Flatback Syndrome and bone erosion underwent a spinal osteotomy and posterior release procedure. The posterior approach was used to access the thoracolumbar spine. Osteotomies were performed to correct spinal alignment and address the bone erosion. Posterior instrumentation and bone graft material were utilized for stabilization and fusion. The surgical incision was closed meticulously, and the patient was transferred to the neurosurgical intensive care unit for postoperative management.

9. Operative Note: Patient with Flatback Syndrome and significant bone erosion underwent a posterior spinal fusion with pedicle subtraction osteotomy. The posterior approach was utilized to access the spine. Pedicle subtraction osteotomy was performed to correct sagittal imbalance and address the bone erosion. Pedicle screws and rods were inserted for stabilization, and bone graft material was packed into the osteotomy sites. The surgical incision was closed, and the patient was transferred to the orthopedic ward for further observation.

10. Operative Note: A patient diagnosed with Flatback Syndrome and bone erosion underwent a vertebral column resection and anterior release procedure. The anterior approach was used to access the thoracolumbar spine. Vertebral column resection was performed to correct spinal alignment and address the bone erosion. Anterior instrumentation and bone graft material were utilized for stabilization and fusion. The surgical incision was closed meticulously, and the patient was transferred to the post-anesthesia care unit for recovery and monitoring.

1. Operative Note: Patient with Flatback Syndrome and severe bone pain underwent a posterior spinal fusion with vertebral column resection. The posterior approach was utilized to access the spine. Vertebral column resection was performed to correct spinal alignment and alleviate the severe bone pain. Pedicle screws and rods were inserted for stabilization, and bone graft material was packed into the osteotomy sites. The surgical incision was closed meticulously, and the patient was transferred to the intensive care unit for postoperative pain management.

2. Operative Note: A patient diagnosed with Flatback Syndrome and intractable bone pain underwent a spinal osteotomy and anterior release procedure. The anterior approach was used to access the thoracolumbar spine. Osteotomies were performed to correct spinal alignment and address the severe bone pain. Anterior instrumentation and bone graft material were utilized for stabilization and fusion. The surgical incision was closed carefully, and the patient was transferred to the post-anesthesia care unit for pain control and recovery.

3. Operative Note: Patient with Flatback Syndrome and debilitating bone pain underwent a posterior spinal fusion with pedicle subtraction osteotomy. The posterior approach was utilized to access the spine. Pedicle subtraction osteotomy was performed to correct sagittal imbalance and relieve the severe bone pain. Pedicle screws and rods were inserted for stabilization, and bone graft material was packed into the osteotomy sites. The surgical incision was closed, and the patient was transferred to the neurosurgical intensive care unit for postoperative pain management.

4. Operative Note: A patient diagnosed with Flatback Syndrome and excruciating bone pain underwent a vertebral column resection and posterior release procedure. The posterior approach was used to access the thoracolumbar spine. Vertebral column resection was performed to correct spinal alignment and address the severe bone pain. Posterior instrumentation and bone graft material were utilized for stabilization and fusion. The surgical incision was closed meticulously, and the patient was transferred to the orthopedic ward for pain control and recovery.

5. Operative Note: Patient with Flatback Syndrome and severe bone pain refractory to conservative measures underwent a posterior spinal fusion with pedicle subtraction osteotomy. The posterior approach was utilized to access the spine. Pedicle subtraction osteotomy was performed to correct sagittal imbalance and alleviate the severe bone pain. Pedicle screws and rods were inserted for stabilization, and bone graft material was packed into the osteotomy sites. The surgical incision was closed, and the patient was transferred to the intensive care unit for postoperative pain management.

6. Operative Note: A patient diagnosed with Flatback Syndrome and debilitating bone pain underwent a spinal osteotomy and anterior column realignment procedure. The anterior approach was used to access the thoracolumbar spine. Osteotomies were performed to correct spinal alignment and address the severe bone pain. Anterior instrumentation and bone graft material were utilized for stabilization and fusion. The surgical incision was closed meticulously, and the patient was transferred to the neurosurgical intensive care unit for comprehensive pain management.

7. Operative Note: Patient with Flatback Syndrome and incapacitating bone pain underwent a posterior spinal fusion with vertebral column resection. The posterior approach was utilized to access the spine. Vertebral column resection was performed to correct spinal alignment and alleviate the severe bone pain. Pedicle screws and rods were inserted for stabilization, and bone graft material was packed into the osteotomy sites. The surgical incision was closed, and the patient was transferred to the orthopedic ward for diligent pain control and recovery.

8. Operative Note: A patient diagnosed with Flatback Syndrome and severe bone pain underwent a spinal osteotomy and posterior release procedure. The posterior approach was used to access the thoracolumbar spine. Osteotomies were performed to correct spinal alignment and address the severe bone pain. Posterior instrumentation and bone graft material were utilized for stabilization and fusion. The surgical incision was closed meticulously, and the patient was transferred to the neurosurgical intensive care unit for comprehensive pain management and postoperative care.

9. Operative Note: Patient with Flatback Syndrome and unrelenting bone pain underwent a posterior spinal fusion with pedicle subtraction osteotomy. The posterior approach was utilized to access the spine. Pedicle subtraction osteotomy was performed to correct sagittal imbalance and alleviate the severe bone pain. Pedicle screws and rods were inserted for stabilization, and bone graft material was packed into the osteotomy sites. The surgical incision was closed, and the patient was transferred to the intensive care unit for aggressive pain management.

10. Operative Note: A patient diagnosed with Flatback Syndrome and agonizing bone pain underwent a vertebral column resection and anterior release procedure. The anterior approach was used to access the thoracolumbar spine. Vertebral column resection was performed to correct spinal alignment and address the severe bone pain. Anterior instrumentation and bone graft material were utilized for stabilization and fusion. The surgical incision was closed meticulously, and the patient was transferred to the post-anesthesia care unit for multimodal pain management and postoperative recovery.

1. Operative Note: Patient with Flatback Syndrome underwent a posterior spinal fusion with pedicle subtraction osteotomy. The surgical intervention was performed to correct sagittal imbalance and restore spinal alignment. Pedicle screws and rods were inserted for stabilization, and bone graft material was packed into the osteotomy sites. The procedure was completed successfully, and the patient was transferred to the post-anesthesia care unit for recovery and monitoring.

2. Operative Note: A patient diagnosed with Flatback Syndrome underwent a spinal osteotomy and anterior release procedure. The surgical intervention was performed to address spinal deformity and restore normal alignment. Anterior instrumentation and bone graft material were utilized for stabilization and fusion. The procedure was performed without complications, and the patient was transferred to the recovery area for further observation.

3. Operative Note: Patient with Flatback Syndrome underwent a posterior spinal fusion with vertebral column resection. The surgical intervention was performed to correct spinal deformity and improve sagittal balance. Pedicle screws and rods were inserted for stabilization, and bone graft material was used for fusion. The procedure was successfully completed, and the patient was transferred to the intensive care unit for postoperative management.

4. Operative Note: A patient diagnosed with Flatback Syndrome underwent a vertebral column resection and posterior release procedure. The surgical intervention was performed to correct spinal misalignment and alleviate symptoms. Posterior instrumentation and bone graft material were utilized to achieve stability and fusion. The procedure was uneventful, and the patient was transferred to the post-anesthesia care unit for recovery and pain management.

5. Operative Note: Patient with Flatback Syndrome underwent a posterior spinal fusion with pedicle subtraction osteotomy and vertebral column resection. The surgical intervention aimed to correct severe spinal deformity and restore proper alignment. Pedicle screws, rods, and bone graft material were utilized for stabilization and fusion. The procedure was performed successfully, and the patient was transferred to the intensive care unit for close monitoring and postoperative care.

6. Operative Note: A patient diagnosed with Flatback Syndrome underwent a spinal osteotomy and anterior column realignment procedure. The surgical intervention was performed to address spinal imbalance and restore normal alignment. Anterior instrumentation and bone graft material were utilized for stabilization and fusion. The procedure was completed without complications, and the patient was transferred to the post-anesthesia care unit for recovery and pain control.

7. Operative Note: Patient with Flatback Syndrome underwent a posterior spinal fusion with vertebral column resection and pedicle subtraction osteotomy. The surgical intervention aimed to correct spinal deformity and improve sagittal balance. Pedicle screws, rods, and bone graft material were utilized to achieve spinal stabilization and fusion. The procedure was successfully carried out, and the patient was transferred to the neurosurgical intensive care unit for postoperative management.

8. Operative Note: A patient diagnosed with Flatback Syndrome underwent a vertebral column resection and anterior release procedure. The surgical intervention was performed to address severe spinal misalignment and alleviate symptoms. Anterior instrumentation and bone graft material were used for stabilization and fusion. The procedure was uneventful, and the patient was transferred to the post-anesthesia care unit for recovery and close monitoring.

9. Operative Note: Patient with Flatback Syndrome underwent a posterior spinal fusion with pedicle subtraction osteotomy. The surgical intervention was performed to correct spinal deformity and restore proper alignment. Pedicle screws, rods, and bone graft material were used for stabilization and fusion. The procedure was successfully completed, and the patient was transferred to the intensive care unit for postoperative monitoring and pain management.

10. Operative Note: A patient diagnosed with Flatback Syndrome underwent a spinal osteotomy and posterior release procedure. The surgical intervention aimed to address spinal imbalance and restore normal alignment. Posterior instrumentation and bone graft material were utilized for stabilization and fusion. The procedure was completed without complications, and the patient was transferred to the recovery area for further observation and postoperative care.

1. Operative Note: Patient with Flatback Syndrome underwent a posterior spinal fusion with vertebral column resection and pedicle subtraction osteotomy. The surgical intervention aimed to correct severe spinal deformity and restore proper alignment. Pedicle screws, rods, and bone graft material were utilized for stabilization and fusion. The procedure was successfully completed, and the patient was transferred to the neurosurgical intensive care unit for close monitoring and postoperative care.

2. Operative Note: A patient diagnosed with Flatback Syndrome underwent a spinal osteotomy and anterior column realignment procedure. The surgical intervention was performed to address spinal imbalance and restore normal alignment. Anterior instrumentation and bone graft material were utilized for stabilization and fusion. The procedure was carried out without complications, and the patient was transferred to the post-anesthesia care unit for recovery and pain control.

3. Operative Note: Patient with Flatback Syndrome underwent a posterior spinal fusion with vertebral column resection. The surgical intervention aimed to correct spinal deformity and improve sagittal balance. Pedicle screws and rods were inserted for stabilization, and bone graft material was used for fusion. The procedure was successfully completed, and the patient was transferred to the intensive care unit for postoperative management and close monitoring.

4. Operative Note: A patient diagnosed with Flatback Syndrome underwent a vertebral column resection and posterior release procedure. The surgical intervention aimed to correct spinal misalignment and alleviate symptoms. Posterior instrumentation and bone graft material were utilized to achieve stability and fusion. The procedure was uneventful, and the patient was transferred to the post-anesthesia care unit for recovery and pain management.

5. Operative Note: Patient with Flatback Syndrome underwent a posterior spinal fusion with pedicle subtraction osteotomy and vertebral column resection. The surgical intervention aimed to correct severe spinal deformity and restore proper alignment. Pedicle screws, rods, and bone graft material were utilized for stabilization and fusion. The procedure was successfully completed, and the patient was transferred to the intensive care unit for close monitoring and postoperative care.

6. Operative Note: A patient diagnosed with Flatback Syndrome underwent a spinal osteotomy and anterior release procedure. The surgical intervention was performed to address spinal imbalance and restore normal alignment. Anterior instrumentation and bone graft material were utilized for stabilization and fusion. The procedure was completed without complications, and the patient was transferred to the post-anesthesia care unit for recovery and pain control.

7. Operative Note: Patient with Flatback Syndrome underwent a posterior spinal fusion with vertebral column resection and pedicle subtraction osteotomy. The surgical intervention aimed to correct spinal deformity and improve sagittal balance. Pedicle screws, rods, and bone graft material were utilized to achieve spinal stabilization and fusion. The procedure was successfully carried out, and the patient was transferred to the neurosurgical intensive care unit for postoperative management.

8. Operative Note: A patient diagnosed with Flatback Syndrome underwent a vertebral column resection and anterior release procedure. The surgical intervention was performed to address severe spinal misalignment and alleviate symptoms. Anterior instrumentation and bone graft material were used for stabilization and fusion. The procedure was uneventful, and the patient was transferred to the post-anesthesia care unit for recovery and close monitoring.

9. Operative Note: Patient with Flatback Syndrome underwent a posterior spinal fusion with pedicle subtraction osteotomy. The surgical intervention aimed to correct spinal deformity and restore proper alignment. Pedicle screws, rods, and bone graft material were used for stabilization and fusion. The procedure was successfully completed, and the patient was transferred to the intensive care unit for postoperative monitoring and pain management.

10. Operative Note: A patient diagnosed with Flatback Syndrome underwent a spinal osteotomy and posterior release procedure. The surgical intervention aimed to address spinal imbalance and restore normal alignment. Posterior instrumentation and bone graft material were utilized for stabilization and fusion. The procedure was completed without complications, and the patient was transferred to the recovery area for further observation and postoperative care.

1. Operative Note: Patient with Flatback Syndrome and a severe infection on the extreme moving joint underwent a surgical debridement and joint irrigation. The infected joint was accessed through an open incision, and thorough debridement was performed to remove infected tissues. The joint was then irrigated with antibiotic solution to control the infection. The wound was closed, and the patient was started on a course of intravenous antibiotics for further management.

2. Operative Note: A patient diagnosed with Flatback Syndrome and a severe infection on the extreme moving joint underwent an urgent surgical intervention. The infected joint was approached through a surgical incision, and meticulous debridement was performed to remove necrotic tissues and control the infection. The joint was irrigated with antibiotic solution, and a drain was placed for continuous drainage. The wound was closed, and the patient was initiated on a broad-spectrum antibiotic regimen.

3. Operative Note: Patient with Flatback Syndrome and a severe infection on the extreme moving joint required surgical intervention. The infected joint was accessed through an incision, and extensive debridement was performed to remove infected tissues and eliminate the source of infection. The joint was thoroughly irrigated with antibiotic solution, and a drain was inserted for proper drainage. The wound was closed, and the patient was started on intravenous antibiotics for postoperative infection control.

4. Operative Note: A patient diagnosed with Flatback Syndrome and a severe infection on the extreme moving joint underwent a surgical procedure for infection management. The infected joint was approached through an open incision, and aggressive debridement was performed to remove infected tissues. The joint was meticulously irrigated with antibiotic solution, and a drain was placed for continuous drainage of the infected fluid. The wound was closed, and the patient was initiated on intravenous antibiotics for infection eradication.

5. Operative Note: Patient with Flatback Syndrome and a severe infection on the extreme moving joint required urgent surgical intervention. The infected joint was accessed through a surgical incision, and thorough debridement was performed to remove infected tissues and reduce the bacterial load. The joint was extensively irrigated with antibiotic solution, and a drain was inserted for proper drainage. The wound was closed meticulously, and the patient was started on intravenous antibiotics for infection control.

6. Operative Note: A patient diagnosed with Flatback Syndrome and a severe infection on the extreme moving joint underwent a surgical debridement and joint irrigation. The infected joint was accessed through an open incision, and meticulous debridement was performed to remove infected tissues and purulent material. The joint was thoroughly irrigated with antibiotic solution, and a drain was placed for continuous drainage. The wound was closed, and the patient was initiated on intravenous antibiotics for infection eradication.

7. Operative Note: Patient with Flatback Syndrome and a severe infection on the extreme moving joint underwent a surgical procedure for infection control. The infected joint was accessed through an incision, and extensive debridement was performed to remove infected tissues and promote healing. The joint was irrigated with antibiotic solution, and a drain was inserted for proper drainage. The wound was closed carefully, and the patient was started on intravenous antibiotics for postoperative infection management.

8. Operative Note: A patient diagnosed with Flatback Syndrome and a severe infection on the extreme moving joint required urgent surgical intervention. The infected joint was approached through a surgical incision, and meticulous debridement was performed to remove infected tissues and reduce the bacterial load. The joint was thoroughly irrigated with antibiotic solution, and a drain was placed for continuous drainage. The wound was closed meticulously, and the patient was initiated on intravenous antibiotics for infection control and resolution.

9. Operative Note: Patient with Flatback Syndrome and a severe infection on the extreme moving joint underwent a surgical debridement and joint irrigation. The infected joint was accessed through an open incision, and extensive debridement was performed to remove infected tissues and necrotic material. The joint was irrigated with antibiotic solution, and a drain was inserted for proper drainage. The wound was closed, and the patient was started on intravenous antibiotics for infection eradication.

10. Operative Note: A patient diagnosed with Flatback Syndrome and a severe infection on the extreme moving joint required urgent surgical intervention. The infected joint was accessed through a surgical incision, and meticulous debridement was performed to remove infected tissues and control the spread of infection. The joint was thoroughly irrigated with antibiotic solution, and a drain was placed for continuous drainage. The wound was closed meticulously, and the patient was initiated on intravenous antibiotics for infection management and resolution.

1. Operative Note: Patient with Flatback Syndrome and severe joint inflammation underwent a surgical intervention for joint decompression. The inflamed joint was accessed through an open incision, and careful decompression was performed to alleviate pressure and reduce inflammation. The joint was irrigated with saline solution, and a drain was inserted for postoperative drainage. The wound was closed, and the patient was started on anti-inflammatory medications for inflammation control.

2. Operative Note: A patient diagnosed with Flatback Syndrome and significant joint inflammation underwent a surgical procedure for inflammation management. The inflamed joint was approached through a surgical incision, and thorough debridement was performed to remove inflamed tissues. The joint was irrigated with a sterile solution, and a drain was placed for continuous drainage. The wound was closed meticulously, and the patient was initiated on anti-inflammatory medications for postoperative inflammation control.

3. Operative Note: Patient with Flatback Syndrome and severe inflammation in the affected joint required surgical intervention. The inflamed joint was accessed through an incision, and meticulous debridement was performed to remove inflamed tissues and reduce inflammation. The joint was thoroughly irrigated with a sterile solution, and a drain was inserted for proper drainage. The wound was closed, and the patient was started on anti-inflammatory medications for inflammation management.

4. Operative Note: A patient diagnosed with Flatback Syndrome and intense joint inflammation underwent a surgical procedure for inflammation control. The inflamed joint was accessed through a surgical incision, and aggressive debridement was performed to remove inflamed tissues and alleviate inflammation. The joint was irrigated with a sterile solution, and a drain was placed for continuous drainage. The wound was closed meticulously, and the patient was initiated on anti-inflammatory medications for postoperative inflammation reduction.

5. Operative Note: Patient with Flatback Syndrome and severe inflammation in the affected joint required urgent surgical intervention. The inflamed joint was approached through a surgical incision, and meticulous debridement was performed to remove inflamed tissues and alleviate inflammation. The joint was thoroughly irrigated with a sterile solution, and a drain was inserted for proper drainage. The wound was closed carefully, and the patient was started on anti-inflammatory medications for inflammation control and reduction.

6. Operative Note: A patient diagnosed with Flatback Syndrome and significant joint inflammation underwent a surgical intervention for inflammation management. The inflamed joint was accessed through an open incision, and careful debridement was performed to remove inflamed tissues and control inflammation. The joint was irrigated with saline solution, and a drain was inserted for postoperative drainage. The wound was closed meticulously, and the patient was initiated on anti-inflammatory medications for inflammation control.

7. Operative Note: Patient with Flatback Syndrome and severe inflammation in the affected joint underwent a surgical intervention for inflammation control. The inflamed joint was approached through an incision, and extensive debridement was performed to remove inflamed tissues and reduce inflammation. The joint was thoroughly irrigated with a sterile solution, and a drain was placed for proper drainage. The wound was closed, and the patient was started on anti-inflammatory medications for inflammation management.

8. Operative Note: A patient diagnosed with Flatback Syndrome and intense joint inflammation underwent a surgical procedure for inflammation control. The inflamed joint was accessed through a surgical incision, and meticulous debridement was performed to remove inflamed tissues and alleviate inflammation. The joint was irrigated with a sterile solution, and a drain was inserted for continuous drainage. The wound was closed meticulously, and the patient was initiated on anti-inflammatory medications for postoperative inflammation reduction.

9. Operative Note: Patient with Flatback Syndrome and severe inflammation in the affected joint required urgent surgical intervention. The inflamed joint was approached through a surgical incision, and meticulous debridement was performed to remove inflamed tissues and control inflammation. The joint was thoroughly irrigated with a sterile solution, and a drain was inserted for proper drainage. The wound was closed carefully, and the patient was started on anti-inflammatory medications for inflammation control and reduction.

10. Operative Note: A patient diagnosed with Flatback Syndrome and significant joint inflammation underwent a surgical intervention for inflammation management. The inflamed joint was accessed through an open incision, and aggressive debridement was performed to remove inflamed tissues and reduce inflammation. The joint was irrigated with saline solution, and a drain was placed for postoperative drainage. The wound was closed meticulously, and the patient was initiated on anti-inflammatory medications for inflammation control.

1. Operative Note: Patient with severe Flatback Syndrome underwent a surgical intervention to address spinal deformity and restore proper alignment. Postoperatively, the patient's condition will be closely monitored with regular clinical evaluations, radiographic imaging, and physical therapy sessions. Further interventions, such as bracing or additional surgical procedures, may be considered based on the progress and severity of the patient's symptoms.

2. Operative Note: A patient diagnosed with moderate Flatback Syndrome underwent a surgical procedure to correct spinal imbalance. The postoperative plan includes regular follow-up visits to assess the patient's progress, monitor pain levels, and evaluate functional improvements. Physical therapy will be initiated to enhance spinal strength and flexibility. Additional interventions will be determined based on the severity of symptoms and the patient's response to treatment.

3. Operative Note: Patient with mild Flatback Syndrome underwent a surgical intervention to address spinal alignment issues. The postoperative follow-up plan includes periodic evaluations to assess the patient's symptoms, functional abilities, and radiographic findings. Non-operative management, including physical therapy and pain management, will be emphasized. If symptoms persist or worsen, further interventions may be recommended based on the severity of the patient's condition.

4. Operative Note: A patient diagnosed with severe Flatback Syndrome underwent a complex surgical procedure to correct spinal deformity. Postoperatively, the patient will be closely monitored with regular follow-up visits, imaging studies, and functional assessments. Pain management, physical therapy, and bracing may be employed based on the severity of symptoms and the patient's response to treatment. If necessary, additional surgical interventions will be considered in consultation with the patient.

5. Operative Note: Patient with moderate Flatback Syndrome underwent a surgical intervention to address spinal misalignment. The postoperative plan includes routine follow-up visits to evaluate the patient's progress, manage pain levels, and assess functional outcomes. Physical therapy will be initiated to improve spinal strength and range of motion. The need for additional interventions will be determined based on the severity of symptoms and the patient's response to treatment.

6. Operative Note: A patient diagnosed with mild Flatback Syndrome underwent a surgical procedure to correct spinal imbalance. The postoperative follow-up plan includes regular clinical assessments, radiographic evaluations, and physical therapy sessions. Non-operative management strategies, such as pain medications and bracing, will be employed based on the severity of symptoms and the patient's response to treatment.

7. Operative Note: Patient with severe Flatback Syndrome underwent a surgical intervention to address spinal deformity and improve sagittal balance. The postoperative follow-up will consist of frequent visits to monitor the patient's progress, assess pain levels, and track functional improvements. Further interventions, including physical therapy, pain management, or additional surgical procedures, will be recommended based on the severity of symptoms and the patient's response to treatment.

8. Operative Note: A patient diagnosed with moderate Flatback Syndrome underwent a surgical procedure to correct spinal alignment. The postoperative plan includes regular follow-up visits to evaluate the patient's condition, manage pain levels, and monitor functional outcomes. Non-operative management strategies, such as physical therapy and bracing, will be employed based on the severity of symptoms and the patient's response to treatment.

9. Operative Note: Patient with mild Flatback Syndrome underwent a surgical intervention to address spinal misalignment. The postoperative follow-up plan includes periodic assessments to monitor the patient's symptoms, functional abilities, and radiographic findings. Non-operative treatments, including physical therapy and pain management, will be emphasized. If symptoms persist or progress, further interventions will be considered based on the severity of the patient's condition.

10. Operative Note: A patient diagnosed with severe Flatback Syndrome underwent a complex surgical procedure to correct spinal deformity. Postoperatively, the patient will be closely monitored with frequent follow-up visits, radiographic evaluations, and functional assessments. Pain management, physical therapy, and bracing will be employed based on the severity of symptoms and the patient's response to treatment. Additional surgical interventions will be considered if necessary, in consultation with the patient and the multidisciplinary team.

## M40.4 Other lordosis

1. Operative Note: Patient underwent corrective surgery for other lordosis. A posterior approach was used, and the spinous processes were exposed. Appropriate levels were identified and fused using pedicle screws and rods. The surgical site was thoroughly irrigated, and wound closure was performed. Patient tolerated the procedure well, and postoperative X-rays confirmed successful correction of the other lordosis.

2. Operative Note: Surgical intervention was performed to address other lordosis. An anterior approach was employed, and the affected vertebral segments were exposed. After meticulous discectomy and decompression, an interbody fusion cage was inserted to restore spinal alignment. Additional fixation was achieved with anterior plating. The incision was closed in layers, and the patient was transferred to the recovery area without complications.

3. Operative Note: A minimally invasive procedure was carried out for other lordosis correction. Using fluoroscopic guidance, percutaneous pedicle screws were inserted at the affected levels. A connecting rod was placed, and compression was applied to correct the lordotic deformity. The incisions were closed, and the patient was discharged with postoperative instructions. Follow-up imaging revealed successful realignment and resolution of other lordosis.

4. Operative Note: Patient underwent a posterior spinal fusion for other lordosis. An incision was made along the midline, exposing the laminae and facet joints. Bilateral pedicle screws were meticulously placed, and fusion was achieved using bone graft and local autograft. The incision was closed, and the patient was transferred to the post-anesthesia care unit in stable condition. X-rays confirmed appropriate correction of other lordosis.

5. Operative Note: Surgical intervention was performed to address other lordosis. A lateral approach was chosen, allowing access to the affected spinal segments. Discectomy and decompression were carried out, followed by insertion of an expandable interbody cage for restoration of normal alignment. The surgical site was thoroughly irrigated, and wound closure was performed. The patient recovered well postoperatively, with resolution of other lordosis confirmed on follow-up imaging.

6. Operative Note: Patient underwent a posterior spinal osteotomy for correction of other lordosis. The appropriate levels were exposed, and a wedge resection was performed to realign the spine. Pedicle screws and rods were placed for stabilization. The osteotomy site was carefully reconstructed, and the incision was closed in layers. The patient was transferred to the recovery area and monitored closely without any complications.

7. Operative Note: A minimally invasive lateral approach was employed for surgical correction of other lordosis. After accessing the affected vertebral levels, an interbody fusion cage was inserted to restore alignment. Pedicle screws and rods were utilized for additional stability. The surgical site was irrigated, and the incision was closed. Postoperative recovery was uneventful, with subsequent imaging confirming successful correction of other lordosis.

8. Operative Note: Patient underwent a combined anterior and posterior spinal fusion procedure to address other lordosis. The anterior approach involved discectomy and placement of an interbody fusion cage. Subsequently, a posterior approach was used for pedicle screw insertion and rod placement. The surgical site was thoroughly irrigated, and wound closure was performed. The patient tolerated the procedure well, and postoperative imaging showed resolution of other lordosis.

9. Operative Note: Surgical intervention was performed to correct other lordosis. An oblique retroperitoneal approach was chosen to access the affected spinal levels. The intervertebral discs were removed, and an interbody fusion device was implanted to restore proper alignment. Posterior stabilization was achieved using pedicle screws and rods. The incisions were closed, and the patient recovered without complications, with subsequent imaging confirming successful correction of other lordosis.

10. Operative Note: A posterior vertebral column resection was performed to address other lordosis. The surgical levels were exposed, and a posterior osteotomy was executed to allow for spinal realignment. Pedicle screw fixation and rod placement provided stability. The osteotomy site was reconstructed, and the incision was closed meticulously. Postoperative recovery was uneventful, and follow-up imaging demonstrated successful correction of other lordosis.

1. Operative Note: Patient underwent a minimally invasive procedure for correction of other lordosis. Using a lateral transpsoas approach, access to the affected spinal levels was achieved. Discectomy and foraminal decompression were performed, followed by placement of an interbody fusion cage. Posterior stabilization was achieved with percutaneous pedicle screws. The incisions were closed, and the patient recovered well postoperatively, with resolution of other lordosis confirmed on follow-up imaging.

2. Operative Note: Surgical intervention was performed for correction of other lordosis. A posterior midline approach was employed, and the affected vertebrae were exposed. After meticulous release of the contracted soft tissues, posterior column osteotomies were performed for spinal realignment. Pedicle screws and rods were inserted for stabilization. The surgical site was irrigated, and wound closure was performed. Postoperative X-rays confirmed successful correction of other lordosis.

3. Operative Note: Patient underwent an anterior interbody fusion procedure to address other lordosis. The appropriate vertebral levels were accessed through a transabdominal approach. Discectomy and endplate preparation were carried out, followed by placement of an interbody fusion cage and anterior plate fixation. The surgical site was irrigated, and the incision was closed. The patient recovered well, and subsequent imaging revealed resolution of other lordosis.

4. Operative Note: Surgical correction of other lordosis was performed using a posterior vertebral column resection technique. The affected levels were exposed, and a posterior osteotomy was executed to enable spinal realignment. Pedicle screws and rods were inserted for stabilization. The osteotomy site was reconstructed, and the incisions were closed meticulously. The patient tolerated the procedure well, and follow-up imaging demonstrated successful correction of other lordosis.

5. Operative Note: Patient underwent a posterior correction surgery for other lordosis. A midline incision was made, exposing the spinous processes and laminae. Bilateral pedicle screws were meticulously placed, and posterior interbody fusion was achieved using bone graft material. The surgical site was irrigated, and wound closure was performed. Postoperative X-rays confirmed successful realignment and resolution of other lordosis.

6. Operative Note: A minimally invasive lateral transpsoas approach was utilized for surgical correction of other lordosis. The affected spinal levels were accessed, and a discectomy was performed. An interbody fusion cage was inserted to restore proper alignment. Posterior stabilization was achieved using percutaneous pedicle screws and rods. The incisions were closed, and the patient recovered without complications, with subsequent imaging confirming successful correction of other lordosis.

7. Operative Note: Surgical intervention was performed for other lordosis correction. An anterior approach was chosen, providing access to the affected vertebral segments. Discectomy and decompression were carried out, followed by insertion of an interbody fusion cage and anterior plate fixation. The incision was closed in layers, and the patient was transferred to the recovery area. Postoperative imaging revealed successful realignment and resolution of other lordosis.

8. Operative Note: Patient underwent a combined anterior and posterior spinal fusion procedure for correction of other lordosis. The anterior approach involved discectomy, endplate preparation, and placement of an interbody fusion cage. Posteriorly, pedicle screws and rods were inserted for stabilization. The surgical site was irrigated, and wound closure was performed. The patient tolerated the procedure well, and postoperative imaging confirmed successful correction of other lordosis.

9. Operative Note: Surgical correction of other lordosis was performed using a lateral approach. The affected spinal levels were exposed, and meticulous discectomy and decompression were performed. An interbody fusion cage was inserted, followed by percutaneous pedicle screw fixation for stabilization. The surgical site was irrigated, and the incisions were closed. The patient had an uneventful recovery, and subsequent imaging demonstrated resolution of other lordosis.

10. Operative Note: Patient underwent a posterior osteotomy and spinal fusion procedure for correction of other lordosis. The affected levels were exposed, and a posterior vertebral column resection was performed to enable spinal realignment. Pedicle screws and rods were inserted for stabilization. The osteotomy site was reconstructed, and the incisions were closed meticulously. The patient recovered well postoperatively, with successful correction of other lordosis confirmed on follow-up imaging.

1. Operative Note: Patient underwent corrective surgery for other lordosis under general anesthesia. A posterior approach was used, and the spinous processes were exposed. Appropriate levels were identified and fused using pedicle screws and rods. The surgical site was thoroughly irrigated, and wound closure was performed. The patient tolerated the procedure well with a standard anesthesia dosage, and postoperative X-rays confirmed successful correction of the other lordosis.

2. Operative Note: Surgical intervention was performed to address other lordosis with a modified anesthesia dosage. An anterior approach was employed, and the affected vertebral segments were exposed. After meticulous discectomy and decompression, an interbody fusion cage was inserted to restore spinal alignment. Additional fixation was achieved with anterior plating. The incision was closed in layers, and the patient was transferred to the recovery area without complications.

3. Operative Note: A minimally invasive procedure was carried out for other lordosis correction with a reduced anesthesia dosage. Using fluoroscopic guidance, percutaneous pedicle screws were inserted at the affected levels. A connecting rod was placed, and compression was applied to correct the lordotic deformity. The incisions were closed, and the patient was discharged with postoperative instructions. Follow-up imaging revealed successful realignment and resolution of other lordosis.

4. Operative Note: Patient underwent a posterior spinal fusion for other lordosis with an increased anesthesia dosage. An incision was made along the midline, exposing the laminae and facet joints. Bilateral pedicle screws were meticulously placed, and fusion was achieved using bone graft and local autograft. The incision was closed, and the patient was transferred to the post-anesthesia care unit in stable condition. X-rays confirmed appropriate correction of other lordosis.

5. Operative Note: Surgical intervention was performed to address other lordosis with a tailored anesthesia dosage. A lateral approach was chosen, allowing access to the affected spinal segments. Discectomy and decompression were carried out, followed by insertion of an expandable interbody cage for restoration of normal alignment. The surgical site was thoroughly irrigated, and wound closure was performed. The patient recovered well postoperatively, with resolution of other lordosis confirmed on follow-up imaging.

6. Operative Note: Patient underwent a posterior spinal osteotomy for correction of other lordosis with an adjusted anesthesia dosage. The appropriate levels were exposed, and a wedge resection was performed to realign the spine. Pedicle screws and rods were placed for stabilization. The osteotomy site was carefully reconstructed, and the incision was closed in layers. The patient was transferred to the recovery area and monitored closely without any complications.

7. Operative Note: A minimally invasive lateral approach was employed for surgical correction of other lordosis with a reduced anesthesia dosage. After accessing the affected vertebral levels, an interbody fusion cage was inserted to restore alignment. Pedicle screws and rods were utilized for additional stability. The surgical site was irrigated, and the incision was closed. Postoperative recovery was uneventful, with subsequent imaging confirming successful correction of other lordosis.

8. Operative Note: Patient underwent a combined anterior and posterior spinal fusion procedure to address other lordosis with a modified anesthesia dosage. The anterior approach involved discectomy and placement of an interbody fusion cage. Subsequently, a posterior approach was used for pedicle screw insertion and rod placement. The surgical site was thoroughly irrigated, and wound closure was performed. The patient tolerated the procedure well, and postoperative imaging showed resolution of other lordosis.

9. Operative Note: Surgical intervention was performed to correct other lordosis with an adjusted anesthesia dosage. An oblique retroperitoneal approach was chosen to access the affected spinal levels. The intervertebral discs were removed, and an interbody fusion device was implanted to restore proper alignment. Posterior stabilization was achieved using pedicle screws and rods. The incisions were closed, and the patient recovered without complications, with subsequent imaging confirming successful correction of other lordosis.

10. Operative Note: Patient underwent a posterior vertebral column resection for addressing other lordosis with a tailored anesthesia dosage. The surgical levels were exposed, and a posterior osteotomy was executed to allow for spinal realignment. Pedicle screws and rods were inserted for stabilization. The osteotomy site was reconstructed, and the incision was closed meticulously. The patient tolerated the procedure well with the adjusted anesthesia dosage, and follow-up imaging demonstrated successful correction of other lordosis.

1. Operative Note: Patient underwent corrective surgery for other lordosis with associated bone erosion under general anesthesia. A posterior approach was used to expose the affected vertebral segments. Bone erosion was observed at the affected levels, requiring meticulous debridement and removal of damaged bone. Fusion was achieved using pedicle screws, rods, and bone grafting to restore spinal alignment. The surgical site was irrigated, and wound closure was performed. Postoperative X-rays confirmed successful correction of other lordosis and addressed bone erosion.

2. Operative Note: Surgical intervention was performed to address other lordosis and bone erosion with a modified anesthesia dosage. An anterior approach was employed, providing access to the affected vertebral segments. Extensive debridement of eroded bone was performed, followed by reconstruction using interbody fusion cages and anterior plating. The incision was closed in layers, and the patient was transferred to the recovery area without complications.

3. Operative Note: A minimally invasive procedure was carried out for correction of other lordosis and bone erosion with reduced anesthesia dosage. Using fluoroscopic guidance, percutaneous pedicle screws were inserted, taking care to avoid the areas of bone erosion. Fusion was achieved using interbody fusion cages and additional bone grafting. The incisions were closed, and the patient was discharged with postoperative instructions. Follow-up imaging revealed successful realignment, resolution of other lordosis, and addressed bone erosion.

4. Operative Note: Patient underwent a posterior spinal fusion for other lordosis and bone erosion with an increased anesthesia dosage. Bone erosion was noted at the affected levels, requiring meticulous debridement and removal of eroded bone. Bilateral pedicle screws were placed, and fusion was achieved using bone graft and local autograft, carefully avoiding areas of bone erosion. The incision was closed, and the patient was transferred to the post-anesthesia care unit in stable condition. X-rays confirmed appropriate correction of other lordosis and addressed bone erosion.

5. Operative Note: Surgical intervention was performed to address other lordosis and bone erosion with tailored anesthesia dosage. A lateral approach was chosen, allowing access to the affected spinal segments. Debridement of eroded bone was performed, followed by insertion of interbody fusion cages to restore alignment. Care was taken to avoid areas of bone erosion during instrumentation. The surgical site was irrigated, and wound closure was performed. The patient recovered well postoperatively, with resolution of other lordosis and addressed bone erosion confirmed on follow-up imaging.

6. Operative Note: Patient underwent a posterior spinal osteotomy for correction of other lordosis and bone erosion with an adjusted anesthesia dosage. Bone erosion was carefully addressed during the procedure through meticulous debridement and removal of eroded bone. Pedicle screws and rods were placed for stabilization, avoiding areas of bone erosion. The osteotomy site was reconstructed, and the incision was closed in layers. The patient was transferred to the recovery area and monitored closely without any complications.

7. Operative Note: A minimally invasive lateral approach was employed for surgical correction of other lordosis and bone erosion with a reduced anesthesia dosage. After accessing the affected vertebral levels, debridement of eroded bone was performed, preserving as much healthy bone as possible. Interbody fusion cages were inserted, avoiding areas of bone erosion. Pedicle screws and rods were utilized for additional stability. The surgical site was irrigated, and the incision was closed. Postoperative recovery was uneventful, with subsequent imaging confirming successful correction of other lordosis and addressed bone erosion.

8. Operative Note: Patient underwent a combined anterior and posterior spinal fusion procedure to address other lordosis and bone erosion with a modified anesthesia dosage. The anterior approach involved debridement of eroded bone, placement of interbody fusion cages, and anterior plating. Subsequently, a posterior approach was used for pedicle screw insertion and rod placement, avoiding areas of bone erosion. The surgical site was thoroughly irrigated, and wound closure was performed. The patient tolerated the procedure well, and postoperative imaging showed resolution of other lordosis and addressed bone erosion.

9. Operative Note: Surgical intervention was performed to correct other lordosis and bone erosion with an adjusted anesthesia dosage. An oblique retroperitoneal approach was chosen to access the affected spinal levels. Extensive debridement of eroded bone was performed, followed by reconstruction using interbody fusion devices and additional bone grafting. The incisions were closed, and the patient recovered without complications, with subsequent imaging confirming successful correction of other lordosis and addressed bone erosion.

10. Operative Note: Patient underwent a posterior vertebral column resection for addressing other lordosis and bone erosion with a tailored anesthesia dosage. The surgical levels were exposed, and a posterior osteotomy was executed to allow for spinal realignment. Meticulous debridement of eroded bone was performed, preserving healthy bone for fusion. Pedicle screws and rods were inserted for stabilization, avoiding areas of bone erosion. The osteotomy site was reconstructed, and the incision was closed meticulously. The patient tolerated the procedure well with the adjusted anesthesia dosage, and follow-up imaging demonstrated successful correction of other lordosis and addressed bone erosion.

1. Operative Note: Patient underwent corrective surgery for other lordosis with severe bone pain under general anesthesia. A posterior approach was used, and the affected vertebral segments were exposed. Severe bone pain was noted, requiring meticulous debridement of the affected bone structures. Fusion was achieved using pedicle screws, rods, and bone grafting to restore spinal alignment. The surgical site was irrigated, and wound closure was performed. Postoperative X-rays confirmed successful correction of other lordosis and addressed severe bone pain.

2. Operative Note: Surgical intervention was performed to address other lordosis and severe bone pain with a modified anesthesia dosage. An anterior approach was employed, providing access to the affected vertebral segments. Extensive debridement of the bone structures causing severe pain was carried out. Interbody fusion cages and anterior plating were used for reconstruction. The incision was closed in layers, and the patient was transferred to the recovery area without complications.

3. Operative Note: A minimally invasive procedure was carried out for correction of other lordosis and severe bone pain with reduced anesthesia dosage. Using fluoroscopic guidance, percutaneous pedicle screws were inserted, taking care to alleviate the sources of severe bone pain. Fusion was achieved using interbody fusion cages and additional bone grafting. The incisions were closed, and the patient was discharged with postoperative instructions. Follow-up imaging revealed successful realignment, resolution of other lordosis, and alleviated severe bone pain.

4. Operative Note: Patient underwent a posterior spinal fusion for other lordosis and severe bone pain with an increased anesthesia dosage. Severe bone pain was localized and addressed through meticulous debridement and removal of the affected bone structures. Bilateral pedicle screws were placed, and fusion was achieved using bone graft and local autograft, effectively alleviating severe bone pain. The incision was closed, and the patient was transferred to the post-anesthesia care unit in stable condition. X-rays confirmed appropriate correction of other lordosis and resolved severe bone pain.

5. Operative Note: Surgical intervention was performed to address other lordosis and severe bone pain with tailored anesthesia dosage. A lateral approach was chosen, allowing access to the affected spinal segments. Debridement of the bone structures causing severe pain was performed, followed by insertion of interbody fusion cages to restore alignment. Care was taken to alleviate severe bone pain during instrumentation. The surgical site was irrigated, and wound closure was performed. The patient recovered well postoperatively, with resolution of other lordosis and alleviated severe bone pain confirmed on follow-up imaging.

6. Operative Note: Patient underwent a posterior spinal osteotomy for correction of other lordosis and severe bone pain with an adjusted anesthesia dosage. Severe bone pain was addressed during the procedure through meticulous debridement and removal of the affected bone structures. Pedicle screws and rods were placed for stabilization, effectively alleviating severe bone pain. The osteotomy site was reconstructed, and the incision was closed in layers. The patient was transferred to the recovery area and monitored closely without any complications.

7. Operative Note: A minimally invasive lateral approach was employed for surgical correction of other lordosis and severe bone pain with a reduced anesthesia dosage. After accessing the affected vertebral levels, debridement of the bone structures causing severe pain was performed, relieving the patient from discomfort. Interbody fusion cages were inserted, and pedicle screws and rods were utilized for additional stability. The surgical site was irrigated, and the incision was closed. Postoperative recovery was uneventful, with subsequent imaging confirming successful correction of other lordosis and alleviated severe bone pain.

8. Operative Note: Patient underwent a combined anterior and posterior spinal fusion procedure to address other lordosis and severe bone pain with a modified anesthesia dosage. The anterior approach involved debridement of the bone structures causing severe pain, placement of interbody fusion cages, and anterior plating. Subsequently, a posterior approach was used for pedicle screw insertion and rod placement, effectively alleviating severe bone pain. The surgical site was thoroughly irrigated, and wound closure was performed. The patient tolerated the procedure well, and postoperative imaging showed resolution of other lordosis and relieved severe bone pain.

9. Operative Note: Surgical intervention was performed to correct other lordosis and severe bone pain with an adjusted anesthesia dosage. An oblique retroperitoneal approach was chosen to access the affected spinal levels. Extensive debridement of the bone structures causing severe pain was performed, providing relief to the patient. Interbody fusion devices and additional bone grafting were used for reconstruction. The incisions were closed, and the patient recovered without complications, with subsequent imaging confirming successful correction of other lordosis and alleviated severe bone pain.

10. Operative Note: Patient underwent a posterior vertebral column resection for addressing other lordosis and severe bone pain with a tailored anesthesia dosage. The surgical levels were exposed, and a posterior osteotomy was executed to allow for spinal realignment. Meticulous debridement of the bone structures causing severe pain was performed, effectively relieving the patient. Pedicle screws and rods were inserted for stabilization, and the osteotomy site was reconstructed. The incision was closed meticulously. The patient tolerated the procedure well with the adjusted anesthesia dosage, and follow-up imaging demonstrated successful correction of other lordosis and alleviated severe bone pain.

1. Operative Note: Patient underwent surgical intervention for the management of other lordosis with severe bone pain. A posterior approach was utilized, exposing the affected vertebral segments. Extensive debridement of eroded bone and damaged structures was performed. Interbody fusion cages were inserted, followed by pedicle screw fixation and rod placement for stabilization. The surgical site was irrigated, and wound closure was performed. The patient's severe bone pain was significantly alleviated postoperatively, with subsequent imaging confirming successful correction of other lordosis.

2. Operative Note: Surgical intervention was performed to address other lordosis and severe bone pain using a modified anesthesia dosage. An anterior approach was employed, allowing access to the affected spinal levels. Discectomy, decompression, and extensive debridement of eroded bone were carried out. Interbody fusion cages were inserted to restore spinal alignment. Additional stabilization was achieved with anterior plating. The patient's severe bone pain was successfully managed, and the procedure resulted in correction of other lordosis.

3. Operative Note: A surgical intervention was performed to treat other lordosis and severe bone pain. Using a minimally invasive technique, percutaneous pedicle screws were inserted, followed by the placement of interbody fusion devices. The eroded bone was carefully debrided, and bone grafting was performed to facilitate fusion and alleviate severe bone pain. The surgical site was closed, and the patient experienced relief from severe bone pain following the procedure, with subsequent imaging confirming correction of other lordosis.

4. Operative Note: Patient underwent surgical intervention for the management of other lordosis with severe bone pain. A posterior vertebral column resection was performed, allowing for spinal realignment. Extensive debridement of eroded bone and damaged structures was carried out. Pedicle screws and rods were inserted to provide stabilization. Bone grafting was performed to promote fusion. The patient experienced significant relief from severe bone pain postoperatively, and subsequent imaging confirmed successful correction of other lordosis.

5. Operative Note: Surgical intervention was performed to address other lordosis and severe bone pain. An oblique retroperitoneal approach was employed, providing access to the affected spinal levels. Extensive debridement of eroded bone and damaged structures was performed, followed by the insertion of interbody fusion cages. Pedicle screw fixation and rod placement were carried out for stabilization. The patient's severe bone pain was effectively managed, and the procedure resulted in successful correction of other lordosis.

6. Operative Note: Patient underwent surgical intervention for the management of other lordosis with severe bone pain. A combined anterior and posterior approach was utilized. The anterior approach involved discectomy, extensive debridement of eroded bone, and placement of interbody fusion cages. The posterior approach included pedicle screw fixation and rod placement for stabilization. The patient's severe bone pain was significantly alleviated postoperatively, and subsequent imaging confirmed successful correction of other lordosis.

7. Operative Note: Surgical intervention was performed to address other lordosis and severe bone pain. A lateral approach was chosen, allowing access to the affected spinal levels. Discectomy, decompression, and meticulous debridement of eroded bone were performed. Interbody fusion cages were inserted, followed by pedicle screw fixation and rod placement for stabilization. The patient experienced relief from severe bone pain after the procedure, and subsequent imaging confirmed successful correction of other lordosis.

8. Operative Note: Patient underwent surgical intervention for the management of other lordosis with severe bone pain. A posterior spinal fusion was performed using a modified anesthesia dosage. Extensive debridement of eroded bone and damaged structures was carried out, followed by the insertion of interbody fusion cages. Pedicle screws and rods were placed for stabilization. The patient experienced significant relief from severe bone pain postoperatively, and subsequent imaging confirmed successful correction of other lordosis.

9. Operative Note: Surgical intervention was performed to address other lordosis and severe bone pain. An anterior lumbar interbody fusion (ALIF) approach was utilized, providing access to the affected spinal levels. Decompression and meticulous debridement of eroded bone were performed. Interbody fusion cages were inserted, and additional stabilization was achieved with posterior pedicle screw fixation and rod placement. The patient's severe bone pain was effectively managed, and the procedure resulted in successful correction of other lordosis.

10. Operative Note: Patient underwent surgical intervention for the management of other lordosis with severe bone pain. A posterior vertebral column resection was performed, allowing for spinal realignment and decompression. Extensive debridement of eroded bone and damaged structures was carried out. Interbody fusion cages were inserted, and posterior pedicle screw fixation with rod placement was performed for stabilization. The patient experienced significant relief from severe bone pain postoperatively, and subsequent imaging confirmed successful correction of other lordosis.

1. Operative Note: Surgical intervention was performed to address severe bone pain associated with other lordosis. A posterior approach was chosen, and extensive debridement of eroded bone and damaged structures was carried out. Interbody fusion cages were inserted to restore spinal alignment, followed by pedicle screw fixation and rod placement for stabilization. The surgical site was irrigated, and wound closure was performed. Postoperatively, the patient reported relief from severe bone pain, and imaging confirmed successful correction of other lordosis.

2. Operative Note: Patient underwent surgical intervention to manage severe bone pain secondary to other lordosis. An anterior approach was employed, allowing for the removal of eroded bone and damaged structures. Interbody fusion cages were inserted to restore disc height, and anterior plating was performed for additional stability. The patient experienced a significant reduction in severe bone pain postoperatively, and subsequent imaging revealed successful correction of other lordosis.

3. Operative Note: Surgical intervention was performed to address severe bone pain and correct other lordosis. A minimally invasive approach was chosen, involving percutaneous pedicle screw insertion and interbody fusion cage placement. Meticulous debridement of eroded bone was carried out, followed by bone grafting for fusion. The patient's severe bone pain was effectively managed, and the procedure resulted in successful correction of other lordosis.

4. Operative Note: Patient underwent surgical intervention for severe bone pain associated with other lordosis. A posterior vertebral column resection was performed to achieve spinal realignment and decompression. Extensive debridement of eroded bone and damaged structures was carried out, followed by the insertion of interbody fusion cages. Pedicle screw fixation and rod placement were performed for stabilization. The patient reported significant relief from severe bone pain postoperatively, and imaging confirmed successful correction of other lordosis.

5. Operative Note: Surgical intervention was performed to address severe bone pain secondary to other lordosis. An oblique retroperitoneal approach was used, allowing access to the affected spinal levels. Meticulous debridement of eroded bone and damaged structures was performed, followed by the insertion of interbody fusion cages. Pedicle screws and rods were placed for stabilization. The patient's severe bone pain was effectively managed, and subsequent imaging confirmed successful correction of other lordosis.

6. Operative Note: Patient underwent surgical intervention for severe bone pain associated with other lordosis. A combined anterior and posterior approach was utilized. The anterior approach involved discectomy, extensive debridement of eroded bone, and placement of interbody fusion cages. The posterior approach included pedicle screw fixation and rod placement for stabilization. The patient experienced significant relief from severe bone pain postoperatively, and subsequent imaging confirmed successful correction of other lordosis.

7. Operative Note: Surgical intervention was performed to address severe bone pain and correct other lordosis. A lateral approach was chosen, providing access to the affected spinal levels. Meticulous debridement of eroded bone and damaged structures was carried out, followed by the insertion of interbody fusion cages. Pedicle screw fixation and rod placement were performed for stabilization. The patient reported relief from severe bone pain following the procedure, and subsequent imaging confirmed successful correction of other lordosis.

8. Operative Note: Patient underwent surgical intervention for the management of severe bone pain associated with other lordosis. A posterior spinal fusion was performed, incorporating an adjusted anesthesia dosage. Extensive debridement of eroded bone and damaged structures was carried out, followed by the insertion of interbody fusion cages. Pedicle screws and rods were placed for stabilization. The patient experienced significant relief from severe bone pain postoperatively, and subsequent imaging confirmed successful correction of other lordosis.

9. Operative Note: Surgical intervention was performed to address severe bone pain and correct other lordosis. An anterior lumbar interbody fusion (ALIF) approach was utilized, providing access to the affected spinal levels. Decompression and meticulous debridement of eroded bone were performed. Interbody fusion cages were inserted, and additional stabilization was achieved with posterior pedicle screw fixation and rod placement. The patient's severe bone pain was effectively managed, and subsequent imaging confirmed successful correction of other lordosis.

10. Operative Note: Patient underwent surgical intervention for severe bone pain associated with other lordosis. A posterior vertebral column resection was performed to achieve spinal realignment and decompression. Extensive debridement of eroded bone and damaged structures was carried out, followed by the insertion of interbody fusion cages. Pedicle screws and rods were placed for stabilization. The patient reported significant relief from severe bone pain postoperatively, and subsequent imaging confirmed successful correction of other lordosis.

1. Operative Note: Surgical intervention was performed to address severe inflammation on the extreme moving joint associated with other lordosis. An arthroscopic approach was utilized, allowing visualization and debridement of the inflamed joint tissues. Synovectomy was performed to remove inflamed synovial lining. The joint was thoroughly irrigated with saline solution, and appropriate wound closure was performed. Postoperative anti-inflammatory medications were initiated, and the patient's severe joint inflammation was effectively managed.

2. Operative Note: Patient underwent surgical intervention for the management of severe inflammation on the extreme moving joint related to other lordosis. An open joint exploration was performed, revealing significant inflammation involving the joint and surrounding tissues. Debridement of the inflamed tissues, including eroded bone, was meticulously carried out. The joint was thoroughly irrigated with saline solution, and appropriate wound closure was performed. Postoperatively, the patient was initiated on a course of anti-inflammatory medications, and close monitoring was implemented to ensure resolution of the severe joint inflammation.

3. Operative Note: Surgical intervention was performed to address severe inflammation on the extreme moving joint associated with other lordosis. An arthrodesis procedure was performed to address the inflammation and provide stability. Inflamed tissues and eroded bone were meticulously debrided. Bone grafting and internal fixation were performed for joint fusion. The surgical site was thoroughly irrigated, and appropriate wound closure was performed. Postoperative anti-inflammatory medications were initiated, and the patient's severe joint inflammation was effectively managed.

4. Operative Note: Patient underwent surgical intervention for severe inflammation on the extreme moving joint due to other lordosis. An open arthrotomy was performed, allowing direct access to the inflamed joint. The inflamed joint capsule and surrounding tissues were meticulously debrided, and the eroded bone was excised. The joint was thoroughly irrigated with saline solution, and appropriate drainage was established. The wound was closed in layers, and postoperative anti-inflammatory medications were initiated to treat the severe joint inflammation.

5. Operative Note: Surgical intervention was performed to address severe inflammation on the extreme moving joint in the context of other lordosis. A joint lavage and debridement procedure were carried out, with meticulous attention to inflamed tissues and eroded bone. The joint was thoroughly irrigated with saline solution, and local anti-inflammatory agents were applied. The joint stability was ensured with appropriate fixation. The surgical site was closed, and the patient was initiated on a course of anti-inflammatory medications for the severe joint inflammation.

6. Operative Note: Patient underwent surgical intervention for severe inflammation on the extreme moving joint associated with other lordosis. A two-stage revision procedure was performed. The inflamed joint components were removed, and extensive debridement of eroded bone and inflamed tissues was carried out. A temporary spacer was placed to maintain joint space and facilitate healing. The patient was initiated on a course of anti-inflammatory medications, and a subsequent procedure was scheduled for spacer removal and joint reconstruction once the severe inflammation was resolved.

7. Operative Note: Surgical intervention was performed to address severe inflammation on the extreme moving joint related to other lordosis. An extensive joint debridement procedure was carried out, removing inflamed tissues and eroded bone. The joint was lavaged with saline solution, and thorough irrigation was performed. A drainage system was placed to facilitate healing. The wound was closed meticulously, and postoperative anti-inflammatory medications were initiated to treat the severe joint inflammation.

8. Operative Note: Patient underwent surgical intervention for the management of severe inflammation on the extreme moving joint associated with other lordosis. An arthroscopic synovectomy procedure was performed, targeting the inflamed synovial lining. The inflamed tissues were meticulously debrided, and the joint was thoroughly irrigated with saline solution. The surgical site was closed, and postoperative anti-inflammatory medications were prescribed to address the severe joint inflammation.

9. Operative Note: Surgical intervention was performed to address severe inflammation on the extreme moving joint in the context of other lordosis. A minimally invasive approach was chosen, involving the use of specialized instruments for joint debridement. Inflamed tissues and eroded bone were meticulously removed, and the joint was irrigated with saline solution. The patient was initiated on a course of anti-inflammatory medications postoperatively, and the severe joint inflammation was effectively managed.

10. Operative Note: Patient underwent surgical intervention for severe inflammation on the extreme moving joint associated with other lordosis. A joint arthroplasty procedure was performed, involving the removal of the inflamed joint components. The joint was thoroughly irrigated with saline solution, and a new prosthesis was implanted. The soft tissues were closed meticulously, and a drain was placed to facilitate wound healing. Postoperative anti-inflammatory medications and appropriate rehabilitation were initiated to address the severe joint inflammation.

1. Operative Note: Surgical intervention was performed to address the diagnosis of other lordosis, which was confirmed to be severe. The patient's postoperative follow-up will involve regular visits with the orthopedic surgeon to assess the progress of spinal alignment and monitor any potential complications. Additional imaging studies, such as X-rays or MRIs, may be scheduled to evaluate the success of the procedure. Physical therapy and rehabilitation sessions will also be recommended to optimize functional recovery and maintain the corrected spinal alignment.

2. Operative Note: Patient underwent surgical intervention for the management of other lordosis, classified as moderate in severity. The postoperative follow-up plan will include regular consultations with the orthopedic surgeon to assess the patient's progress and monitor any potential complications. Depending on the individual's response to treatment, physical therapy sessions may be initiated to improve core strength and posture. Imaging studies may be conducted to evaluate the stability of spinal correction and guide further management decisions.

3. Operative Note: Surgical intervention was performed to address the diagnosis of other lordosis, which was determined to be mild in severity. The patient's postoperative follow-up will involve periodic assessments with the orthopedic surgeon to monitor the stability of spinal alignment and evaluate the resolution of symptoms. Conservative measures, such as physical therapy and targeted exercises, may be recommended to improve posture and maintain spinal health. Further interventions will be considered based on the patient's response to treatment.

4. Operative Note: Patient underwent surgical intervention for the management of other lordosis, with a diagnosis of moderate to severe severity. The postoperative follow-up plan will entail regular evaluations with the orthopedic surgeon to assess the effectiveness of the procedure and monitor the patient's recovery. Imaging studies, such as X-rays or CT scans, will be scheduled to evaluate the stability of spinal correction and identify any potential complications. Physical therapy and rehabilitation sessions will be crucial to optimize functional outcomes and promote long-term spinal health.

5. Operative Note: Surgical intervention was performed to address the diagnosis of other lordosis, which was determined to be of mild severity. The patient's postoperative follow-up will involve periodic check-ups with the orthopedic surgeon to assess the progress of spinal alignment and monitor the resolution of symptoms. Depending on the individual's response to treatment, conservative measures such as posture correction exercises, lifestyle modifications, and ergonomic adjustments may be recommended to support spinal health and prevent recurrence.

6. Operative Note: Patient underwent surgical intervention for the management of other lordosis, classified as severe in severity. The postoperative follow-up plan will include frequent visits with the orthopedic surgeon to closely monitor the patient's recovery and assess the stability of spinal alignment. Imaging studies, such as X-rays or MRI scans, will be scheduled at regular intervals to evaluate the success of the procedure and detect any potential complications. Physical therapy and rehabilitation sessions will be integral to optimizing functional outcomes and promoting long-term spinal health.

7. Operative Note: Surgical intervention was performed to address the diagnosis of other lordosis, which was determined to be of moderate severity. The patient's postoperative follow-up will involve regular consultations with the orthopedic surgeon to evaluate the progress of spinal alignment and monitor the resolution of symptoms. Depending on the individual's response to treatment, a combination of physical therapy, postural education, and lifestyle modifications may be recommended to support spinal health and prevent further progression of the condition.

8. Operative Note: Patient underwent surgical intervention for the management of other lordosis, with a diagnosis of moderate to severe severity. The postoperative follow-up plan will entail frequent assessments with the orthopedic surgeon to monitor the patient's recovery and assess the stability of spinal correction. Imaging studies, such as X-rays or CT scans, will be conducted periodically to evaluate the success of the procedure and identify any potential complications. Physical therapy and rehabilitation sessions will be essential for restoring function and optimizing long-term spinal health.

9. Operative Note: Surgical intervention was performed to address the diagnosis of other lordosis, which was confirmed to be of mild severity. The patient's postoperative follow-up will involve regular visits with the orthopedic surgeon to assess the progress of spinal alignment and monitor the resolution of symptoms. Depending on the individual's response to treatment, conservative measures such as targeted exercises, postural education, and ergonomic modifications may be recommended to support spinal health and prevent recurrence.

10. Operative Note: Patient underwent surgical intervention for the management of other lordosis, classified as severe in severity. The postoperative follow-up plan will include frequent evaluations with the orthopedic surgeon to closely monitor the patient's recovery and assess the stability of spinal alignment. Imaging studies, such as X-rays or MRI scans, will be scheduled at regular intervals to evaluate the success of the procedure and detect any potential complications. Physical therapy and rehabilitation sessions will play a crucial role in optimizing functional outcomes and promoting long-term spinal health.

## M40.5 Lordosis, unspecified

1. Operative Note: Patient underwent posterior lumbar fusion for severe lordosis. Posterior approach was utilized, and pedicle screws were inserted from L3 to S1. Osteotomies were performed at L4 and L5 levels to correct the excessive curvature. Interbody fusion was achieved using cages at L4-L5 and L5-S1. Intraoperative monitoring showed no neurological deficits. Patient tolerated the procedure well and was transferred to the recovery unit in stable condition.

2. Operative Note: Patient with symptomatic lumbar lordosis underwent minimally invasive surgery. A lateral interbody fusion was performed at L4-L5 and L5-S1 levels. Pedicle screws were placed bilaterally from L3 to S1. The excessive curvature was corrected through ligamentotaxis technique. Intraoperative neurophysiological monitoring remained stable throughout the procedure. The patient had an uneventful recovery and was discharged with postoperative instructions.

3. Operative Note: Patient underwent an anterior lumbar interbody fusion (ALIF) for severe lordosis. A transperitoneal approach was used, and the L4-L5 and L5-S1 discs were accessed. The disc spaces were prepared, and interbody cages filled with bone graft were inserted. Anterior plating was performed to provide stability. Intraoperative fluoroscopy confirmed proper cage placement. The patient tolerated the procedure well and was transferred to the post-anesthesia care unit.

4. Operative Note: Patient underwent a posterior column osteotomy (PCO) for rigid thoracolumbar lordosis. A posterior approach was used, and pedicle screws were inserted from T10 to L4. A Ponte osteotomy was performed at T12-L1 and L1-L2 levels to achieve correction. Interbody fusion was performed using cages at L1-L2 and L2-L3 levels. Intraoperative neuromonitoring showed no changes. The patient recovered without complications and was discharged after appropriate postoperative care.

5. Operative Note: Patient underwent a pedicle subtraction osteotomy (PSO) for severe thoracic lordosis. A posterior approach was employed, and pedicle screws were inserted from T3 to T12. A PSO was performed at the apex of the deformity to achieve correction. Interbody fusion was achieved using cages at the adjacent levels. Intraoperative somatosensory evoked potentials remained stable. The patient recovered well postoperatively and was discharged with follow-up instructions.

6. Operative Note: Patient with lumbar hyperlordosis underwent a posterior decompression and fusion. The posterior approach was utilized, and pedicle screws were inserted from L1 to S1. Laminectomies were performed at L3-L5 levels to decompress the neural elements. Interbody fusion was achieved with cages at L4-L5 and L5-S1 levels. Intraoperative electromyography showed no significant changes. The patient had an uncomplicated postoperative course and was discharged after appropriate recovery.

7. Operative Note: Patient underwent a cervical osteotomy for cervical lordosis correction. Anterior approach was utilized, and discectomies were performed at C4-C7 levels. An anterior cervical fusion was achieved using bone graft and plating. A posterior column osteotomy was performed at C6-C7 to correct the excessive curvature. Intraoperative neuromonitoring showed no abnormalities. The patient tolerated the procedure well and was transferred to the intensive care unit for close monitoring.

8. Operative Note: Patient with thoracic hyperlordosis underwent a posterior spinal fusion. A posterior approach was employed, and pedicle screws were inserted from T5 to T12. A three-column osteotomy was performed at T9-T10 to correct the deformity. Interbody fusion was achieved with cages at the adjacent levels. Intraoperative monitoring demonstrated no neurological deficits. The patient had an uneventful recovery and was discharged with appropriate instructions.

9. Operative Note: Patient underwent a vertebral column resection (VCR) for severe lumbar lordosis. A posterior approach was employed, and pedicle screws were inserted from L2 to S1. The vertebral body at L4 was completely resected, and the gap was bridged with expandable cages. Interbody fusion was achieved at L3-L5 levels. Intraoperative neurophysiological monitoring remained stable. The patient's postoperative course was uncomplicated, and they were discharged with follow-up plans.

10. Operative Note: Patient with cervical hyperlordosis underwent a posterior-based osteotomy. Posterior approach was used, and pedicle screws were inserted from C3 to C7. A vertebral column resection was performed at C5-C6 to correct the excessive curvature. Interbody fusion was achieved using cages and bone graft. Intraoperative neurophysiological monitoring showed no changes. The patient recovered well postoperatively and was discharged with appropriate postoperative care instructions.

1. Operative Note: Patient underwent a sagittal osteotomy for thoracic hyperlordosis correction. A posterior approach was used, and pedicle screws were inserted from T4 to T12. The osteotomy was performed at T7-T8 to achieve realignment. Interbody fusion was performed using cages at the adjacent levels. Intraoperative neuromonitoring remained stable. The patient had an uncomplicated recovery and was discharged with postoperative rehabilitation instructions.

2. Operative Note: Patient underwent a posterior lumbar osteotomy for rigid lumbar lordosis. Posterior approach was employed, and pedicle screws were inserted from L1 to S1. The osteotomy was performed at L2-L3 and L3-L4 levels to achieve correction. Interbody fusion was achieved using cages and bone graft. Intraoperative somatosensory evoked potentials showed no significant changes. The patient recovered well and was discharged after appropriate postoperative care.

3. Operative Note: Patient underwent a posterior vertebral column resection (PVCR) for severe thoracic lordosis. A posterior approach was used, and pedicle screws were inserted from T5 to T12. The vertebral body at T8 was resected, and the defect was bridged using expandable cages. Interbody fusion was performed at T7-T9 levels. Intraoperative neurophysiological monitoring remained stable. The patient had an uneventful recovery and was discharged with follow-up plans.

4. Operative Note: Patient with lumbar hyperlordosis underwent a minimally invasive lateral lumbar interbody fusion (LLIF). Access was achieved through a lateral retroperitoneal approach at L4-L5 and L5-S1 levels. Disc space preparation was performed, and interbody cages filled with bone graft were inserted. Supplemental posterior instrumentation was placed for stability. Intraoperative fluoroscopy confirmed appropriate cage positioning. The patient tolerated the procedure well and was discharged with postoperative instructions.

5. Operative Note: Patient underwent an anterior column realignment (ACR) for cervical hyperlordosis correction. An anterior approach was used, and discectomies were performed at C3-C7 levels. The vertebral bodies were resected at C4-C5 and C5-C6, and the deformity was corrected through distraction and compression techniques. Anterior plating was performed for stability. Intraoperative neuromonitoring showed no significant changes. The patient had a smooth postoperative course and was discharged with appropriate care instructions.

6. Operative Note: Patient underwent a posterior-based osteotomy for thoracolumbar hyperlordosis correction. A posterior approach was utilized, and pedicle screws were inserted from T10 to L4. The osteotomy was performed at T11-T12 and L1-L2 levels to achieve realignment. Interbody fusion was achieved using cages and bone graft. Intraoperative somatosensory evoked potentials remained stable. The patient had an uncomplicated recovery and was discharged with follow-up plans.

7. Operative Note: Patient with lumbar hyperlordosis underwent a posterior lumbar interbody fusion (PLIF). A posterior approach was employed, and pedicle screws were inserted from L3 to S1. The disc spaces at L4-L5 and L5-S1 were accessed, and interbody cages filled with bone graft were inserted. Posterior instrumentation was used for additional stability. Intraoperative fluoroscopy confirmed proper cage placement. The patient had an uneventful postoperative course and was discharged with postoperative care instructions.

8. Operative Note: Patient underwent a posterior osteotomy for correction of thoracic hyperlordosis. A posterior approach was used, and pedicle screws were inserted from T3 to T12. The osteotomy was performed at T6-T7 and T7-T8 levels to achieve realignment. Interbody fusion was performed using cages at the adjacent levels. Intraoperative neurophysiological monitoring showed no changes. The patient had an uneventful recovery and was discharged after appropriate postoperative care.

9. Operative Note: Patient underwent a posterior lumbar fusion for symptomatic lumbar lordosis. A posterior approach was employed, and pedicle screws were inserted from L2 to S1. Laminectomies were performed at L3-L5 levels to decompress neural elements. Interbody fusion was achieved using cages at L4-L5 and L5-S1 levels. Intraoperative electromyography demonstrated no significant changes. The patient recovered well postoperatively and was discharged with appropriate follow-up plans.

10. Operative Note: Patient with thoracic hyperlordosis underwent a posterior vertebral column resection (PVCR). A posterior approach was used, and pedicle screws were inserted from T4 to T12. The vertebral body at T7 was resected, and the gap was bridged with expandable cages. Interbody fusion was performed at T6-T8 levels. Intraoperative neuromonitoring remained stable. The patient had a satisfactory recovery and was discharged with appropriate postoperative instructions.

1. Operative Note: Patient underwent posterior lumbar fusion for severe lordosis. General anesthesia was induced with propofol (100 mg) and maintained with sevoflurane (1.0 MAC). Analgesia was provided with fentanyl (100 mcg) and local infiltration of 0.25% bupivacaine (20 mL). Intraoperative monitoring remained stable. The patient tolerated the procedure well and was transferred to the recovery unit in stable condition.

2. Operative Note: Patient with symptomatic lumbar lordosis underwent minimally invasive surgery. General anesthesia was induced using propofol (150 mg) and maintained with desflurane (1.2 MAC). Analgesia was achieved with remifentanil infusion (0.1 mcg/kg/min). Intraoperative neurophysiological monitoring remained stable. The patient had an uneventful recovery and was discharged with postoperative instructions.

3. Operative Note: Patient underwent an anterior lumbar interbody fusion (ALIF) for severe lordosis. General anesthesia was induced with etomidate (20 mg) and maintained with isoflurane (1.2 MAC). Analgesia was provided with sufentanil (20 mcg) and epidural infusion of ropivacaine (0.2%, 5 mL/hr). Intraoperative fluoroscopy confirmed proper cage placement. The patient tolerated the procedure well and was transferred to the post-anesthesia care unit.

4. Operative Note: Patient underwent a posterior column osteotomy (PCO) for rigid thoracolumbar lordosis. General anesthesia was induced using sevoflurane (1.5 MAC) and maintained with intravenous propofol infusion (100 mcg/kg/min). Analgesia was achieved with a combination of fentanyl (150 mcg) and intrathecal morphine (0.2 mg). Intraoperative neuromonitoring showed no changes. The patient recovered without complications and was discharged after appropriate postoperative care.

5. Operative Note: Patient underwent a pedicle subtraction osteotomy (PSO) for severe thoracic lordosis. General anesthesia was induced using propofol (200 mg) and maintained with sevoflurane (1.3 MAC). Analgesia was provided with remifentanil infusion (0.2 mcg/kg/min). Intraoperative somatosensory evoked potentials remained stable throughout the procedure. The patient recovered well postoperatively and was discharged with follow-up instructions.

6. Operative Note: Patient with lumbar hyperlordosis underwent a posterior decompression and fusion. General anesthesia was induced with etomidate (15 mg) and maintained with desflurane (1.0 MAC). Analgesia was achieved with fentanyl (100 mcg) and epidural infusion of bupivacaine (0.1%, 8 mL/hr). Intraoperative electromyography showed no significant changes. The patient had an uncomplicated postoperative course and was discharged after appropriate recovery.

7. Operative Note: Patient underwent a cervical osteotomy for cervical lordosis correction. General anesthesia was induced using sevoflurane (1.2 MAC) and maintained with intravenous propofol infusion (75 mcg/kg/min). Analgesia was provided with remifentanil infusion (0.1 mcg/kg/min) and local infiltration of 0.5% bupivacaine (15 mL). Intraoperative neuromonitoring showed no abnormalities. The patient tolerated the procedure well and was transferred to the intensive care unit for close monitoring.

8. Operative Note: Patient with thoracic hyperlordosis underwent a posterior spinal fusion. General anesthesia was induced using propofol (100 mg) and maintained with desflurane (1.0 MAC). Analgesia was achieved with fentanyl (75 mcg) and thoracic epidural infusion of ropivacaine (0.15%, 6 mL/hr). Intraoperative fluoroscopy confirmed proper cage placement. The patient had an uneventful postoperative course and was discharged with postoperative care instructions.

9. Operative Note: Patient underwent a vertebral column resection (VCR) for severe lumbar lordosis. General anesthesia was induced with sevoflurane (1.3 MAC) and maintained with intravenous propofol infusion (100 mcg/kg/min). Analgesia was provided with remifentanil infusion (0.2 mcg/kg/min) and intrathecal morphine (0.3 mg). Intraoperative neurophysiological monitoring remained stable. The patient recovered well and was discharged with follow-up plans.

10. Operative Note: Patient with cervical hyperlordosis underwent a posterior-based osteotomy. General anesthesia was induced using propofol (150 mg) and maintained with desflurane (1.2 MAC). Analgesia was achieved with fentanyl (100 mcg) and epidural infusion of bupivacaine (0.1%, 8 mL/hr). Intraoperative somatosensory evoked potentials showed no changes. The patient recovered well postoperatively and was discharged with appropriate postoperative care.

1. Operative Note: Patient with lumbar hyperlordosis and severe bone pain underwent a posterior lumbar fusion. A posterior approach was employed, and pedicle screws were inserted from L3 to S1. Decortication and bone grafting were performed to address the eroded vertebrae. Interbody fusion was achieved with cages at L4-L5 and L5-S1 levels. Intraoperative monitoring remained stable. The patient had an uneventful recovery and reported significant relief from bone pain postoperatively.

2. Operative Note: Patient with thoracic hyperlordosis, vertebral bone erosion, and severe bone pain underwent a posterior osteotomy. A posterior approach was used, and pedicle screws were inserted from T4 to T12. The osteotomy was performed at T7-T8 and T8-T9 levels to correct the deformity and alleviate bone pain. Interbody fusion was achieved using cages and bone graft. Intraoperative neurophysiological monitoring showed no significant changes. The patient had a satisfactory recovery with notable improvement in bone pain.

3. Operative Note: Patient underwent an anterior lumbar interbody fusion (ALIF) for severe lordosis, extensive vertebral bone erosion, and debilitating bone pain. Anterior approach was utilized, and the L4-L5 and L5-S1 discs were accessed. The eroded vertebrae were carefully removed, and interbody cages filled with bone graft were inserted. Anterior plating was performed for stability. Intraoperative fluoroscopy confirmed appropriate cage placement. The patient experienced substantial relief from bone pain postoperatively and recovered well.

4. Operative Note: Patient with lumbar hyperlordosis, significant bone erosion, and severe bone pain underwent a posterior lumbar interbody fusion (PLIF). A posterior approach was employed, and pedicle screws were inserted from L3 to S1. Extensive debridement of the eroded bone was performed, and interbody fusion was achieved using cages packed with bone graft. Posterior instrumentation was used for additional stability. Intraoperative fluoroscopy confirmed proper cage positioning. The patient reported significant improvement in bone pain postoperatively.

5. Operative Note: Patient with thoracic hyperlordosis, vertebral bone erosion, and severe bone pain underwent a posterior spinal fusion. A posterior approach was employed, and pedicle screws were inserted from T4 to T12. Decortication and bone grafting were performed to address the eroded vertebrae and alleviate bone pain. Interbody fusion was achieved with cages at the adjacent levels. Intraoperative somatosensory evoked potentials remained stable throughout the procedure. The patient experienced substantial relief from bone pain and had an uneventful recovery.

6. Operative Note: Patient with lumbar hyperlordosis, extensive vertebral bone erosion, and severe bone pain underwent a posterior decompression and fusion. The posterior approach was utilized, and pedicle screws were inserted from L1 to S1. Laminectomies were performed at L3-L5 levels to decompress the neural elements. Extensive bone grafting was performed to address the erosion and alleviate bone pain. Interbody fusion was achieved with cages at L4-L5 and L5-S1 levels. The patient reported significant relief from bone pain postoperatively.

7. Operative Note: Patient with thoracic hyperlordosis, significant bone erosion, and severe bone pain underwent a posterior spinal fusion. A posterior approach was employed, and pedicle screws were inserted from T4 to T12. Decortication and bone grafting were performed to address the eroded vertebrae and alleviate bone pain. Interbody fusion was achieved with cages at the adjacent levels. Intraoperative electromyography showed no significant changes. The patient experienced notable improvement in bone pain and had a smooth recovery.

8. Operative Note: Patient with lumbar hyperlordosis, vertebral bone erosion, and severe bone pain underwent a posterior lumbar fusion. A posterior approach was used, and pedicle screws were inserted from L2 to S1. The eroded vertebrae were meticulously debrided, and bone grafting was performed to reconstruct the affected segments. Interbody fusion was achieved using cages at L4-L5 and L5-S1 levels. Intraoperative electromyography showed no significant changes. The patient reported significant relief from bone pain postoperatively and had an uneventful recovery.

9. Operative Note: Patient underwent a pedicle subtraction osteotomy (PSO) for severe thoracic lordosis, vertebral bone erosion, and severe bone pain. A posterior approach was utilized, and pedicle screws were inserted from T6 to T12. The osteotomy was performed at T7-T8 and T8-T9 levels to correct the deformity and alleviate bone pain. Extensive bone grafting was performed. Intraoperative neurophysiological monitoring showed no changes. The patient experienced notable improvement in bone pain and had a satisfactory recovery.

10. Operative Note: Patient with cervical hyperlordosis, vertebral bone erosion, and severe bone pain underwent a posterior-based osteotomy. A posterior approach was used, and pedicle screws were inserted from C3 to C7. The eroded vertebral bodies at C4-C5 and C5-C6 were carefully resected, and the deformity was corrected through osteotomy and realignment. Interbody fusion was achieved using cages and bone graft. Intraoperative neuromonitoring showed no significant changes. The patient reported significant relief from bone pain postoperatively and had a smooth recovery.

1. Operative Note: Patient with lumbar hyperlordosis and severe bone pain underwent a minimally invasive lateral lumbar interbody fusion (LLIF). A lateral approach was employed, and interbody cages were inserted at L4-L5 and L5-S1 levels. Pedicle screws were then placed for additional stability. The patient tolerated the procedure well and reported significant improvement in symptoms postoperatively.

2. Operative Note: Patient with thoracic hyperlordosis, vertebral bone erosion, and severe bone pain underwent a pedicle subtraction osteotomy (PSO). A posterior approach was utilized, and pedicle screws were inserted from T6 to T12. The osteotomy was performed at T7-T8 and T8-T9 levels to correct the deformity. The patient experienced significant relief from bone pain and had a satisfactory recovery.

3. Operative Note: Patient with lumbar hyperlordosis, extensive vertebral bone erosion, and severe bone pain underwent a posterior lumbar interbody fusion (PLIF) with expandable cages. A posterior approach was employed, and pedicle screws were inserted from L2 to S1. The eroded vertebrae were meticulously debrided, and expandable cages were inserted to achieve interbody fusion. The patient had an uneventful postoperative course and reported considerable improvement in bone pain.

4. Operative Note: Patient with thoracic hyperlordosis and severe bone pain underwent a vertebral column resection (VCR). A posterior approach was used, and pedicle screws were inserted from T4 to T12. The VCR was performed at T7-T8 and T8-T9 levels to correct the deformity and address the bone pathology. Intraoperative neurophysiological monitoring remained stable. The patient had a smooth recovery and reported significant relief from bone pain postoperatively.

5. Operative Note: Patient with lumbar hyperlordosis, significant bone erosion, and severe bone pain underwent a posterior lumbar fusion with bone morphogenetic protein (BMP) application. A posterior approach was employed, and pedicle screws were inserted from L3 to S1. Bone decortication and grafting were performed, and BMP was applied to enhance fusion. The patient tolerated the procedure well and experienced notable improvement in bone pain postoperatively.

6. Operative Note: Patient with thoracic hyperlordosis, vertebral bone erosion, and severe bone pain underwent an anterior vertebral column resection (AVCR). An anterior approach was utilized, and interbody cages were inserted at T7-T8 and T8-T9 levels. The eroded vertebral bodies were resected, and anterior instrumentation was performed. The patient had an uneventful recovery and reported significant relief from bone pain.

7. Operative Note: Patient with lumbar hyperlordosis, extensive vertebral bone erosion, and severe bone pain underwent a minimally invasive transforaminal lumbar interbody fusion (TLIF). A posterior approach was used, and pedicle screws were inserted from L4 to S1. The eroded vertebrae were debrided, and interbody fusion was achieved with cages. The patient had a satisfactory recovery and experienced considerable improvement in bone pain postoperatively.

8. Operative Note: Patient with thoracic hyperlordosis and severe bone pain underwent a posterior-based osteotomy with vertebral column resection (VCR). A posterior approach was employed, and pedicle screws were inserted from T4 to T12. The osteotomy and VCR were performed at T7-T8 and T8-T9 levels to correct the deformity and address the bone pathology. The patient reported significant relief from bone pain and had a smooth recovery.

9. Operative Note: Patient with lumbar hyperlordosis, significant bone erosion, and severe bone pain underwent an anterior lumbar corpectomy and fusion. An anterior approach was utilized, and the L4-L5 and L5-S1 vertebral bodies were removed. Interbody fusion was achieved using cages and bone graft. Anterior plating was performed for stability. The patient had an uneventful recovery and experienced significant improvement in bone pain postoperatively.

10. Operative Note: Patient with thoracic hyperlordosis, vertebral bone erosion, and severe bone pain underwent a posterior lumbar fusion with instrumentation extension to the thoracic spine. A posterior approach was employed, and pedicle screws were inserted from T10 to L5. The eroded vertebrae were debrided, and bone grafting was performed. The patient had a satisfactory recovery and reported considerable improvement in bone pain postoperatively.

1. Operative Note: Patient with lumbar hyperlordosis, vertebral bone erosion, and severe bone pain underwent a minimally invasive lateral lumbar interbody fusion (LLIF). The procedure involved a lateral approach, insertion of interbody cages at L4-L5 and L5-S1 levels, and pedicle screw fixation for stability. Intraoperative fluoroscopy confirmed proper cage positioning. The patient had an uneventful recovery with significant relief from bone pain.

2. Operative Note: Patient with thoracic hyperlordosis and severe bone pain underwent a pedicle subtraction osteotomy (PSO) combined with vertebral column resection (VCR). The posterior approach was used, and pedicle screws were inserted from T6 to T12. The PSO and VCR were performed at T7-T8 and T8-T9 levels to correct the deformity and address the bone erosion. The patient had a satisfactory postoperative course with notable improvement in bone pain.

3. Operative Note: Patient with lumbar hyperlordosis, extensive vertebral bone erosion, and severe bone pain underwent a posterior lumbar interbody fusion (PLIF) with titanium cages. A posterior approach was employed, and pedicle screws were inserted from L3 to S1. The eroded vertebrae were debrided, and interbody fusion was achieved using titanium cages filled with bone graft. Intraoperative monitoring remained stable, and the patient experienced significant relief from bone pain postoperatively.

4. Operative Note: Patient with thoracic hyperlordosis, vertebral bone erosion, and severe bone pain underwent an anterior vertebral column resection (AVCR) combined with a posterior spinal fusion. The AVCR was performed through an anterior approach with removal of the affected vertebrae. A posterior approach was then used, and pedicle screws were inserted from T4 to T12. The patient had a smooth recovery with significant improvement in bone pain.

5. Operative Note: Patient with lumbar hyperlordosis, significant bone erosion, and severe bone pain underwent a posterior lumbar fusion with the use of expandable interbody cages. A posterior approach was employed, and pedicle screws were inserted from L2 to S1. The eroded vertebrae were meticulously debrided, and expandable cages were inserted for interbody fusion. Intraoperative fluoroscopy confirmed proper cage expansion. The patient reported significant relief from bone pain postoperatively and had an uneventful recovery.

6. Operative Note: Patient with thoracic hyperlordosis, extensive vertebral bone erosion, and severe bone pain underwent a transforaminal lumbar interbody fusion (TLIF). The procedure involved a posterior approach with pedicle screw fixation from T10 to L5. The eroded vertebrae were debrided, and interbody fusion was achieved using cages and bone graft. The patient had a satisfactory postoperative course with notable improvement in bone pain.

7. Operative Note: Patient with lumbar hyperlordosis, vertebral bone erosion, and severe bone pain underwent a posterior lumbar interbody fusion (PLIF) with the use of a bone morphogenetic protein (BMP). A posterior approach was employed, and pedicle screws were inserted from L3 to S1. The eroded vertebrae were debrided, and interbody fusion was achieved using cages filled with BMP. The patient had a smooth recovery with significant relief from bone pain.

8. Operative Note: Patient with thoracic hyperlordosis, significant bone erosion, and severe bone pain underwent a vertebral column resection (VCR) combined with posterior instrumentation. The VCR was performed through a posterior approach, and pedicle screws were inserted from T4 to T12. The eroded vertebrae were removed, and the spine was reconstructed using bone graft and instrumentation. The patient had an uneventful recovery with notable improvement in bone pain.

9. Operative Note: Patient with lumbar hyperlordosis, extensive vertebral bone erosion, and severe bone pain underwent an anterior lumbar interbody fusion (ALIF) combined with posterior instrumentation. The ALIF was performed through an anterior approach, and interbody cages were inserted at L4-L5 and L5-S1 levels. The posterior approach involved pedicle screw fixation from L3 to S1. The patient had a satisfactory postoperative course with significant relief from bone pain.

10. Operative Note: Patient with thoracic hyperlordosis, vertebral bone erosion, and severe bone pain underwent a posterior osteotomy with pedicle subtraction. A posterior approach was utilized, and pedicle screws were inserted from T6 to T12. The osteotomy and pedicle subtraction were performed at T7-T8 and T8-T9 levels to correct the deformity and address the bone erosion. The patient had a smooth recovery with notable improvement in bone pain.

1. Operative Note: Patient with lumbar hyperlordosis, severe infection on the extreme moving joint, and associated bone erosion underwent a posterior lumbar fusion. A posterior approach was used, and pedicle screws were inserted from L3 to S1. Debridement of the infected joint was performed, followed by bone grafting and instrumentation. Intraoperative cultures were obtained, and appropriate antibiotic therapy was initiated. The patient had a satisfactory recovery with resolution of the infection.

2. Operative Note: Patient with thoracic hyperlordosis and severe infection on the extreme moving joint underwent a combined anterior and posterior spinal fusion. An anterior approach was employed to remove the infected joint and perform interbody fusion using cages and bone graft. This was followed by a posterior approach for pedicle screw fixation and additional bone grafting. Intraoperative irrigation with antibiotic solution was performed. The patient had an uneventful recovery with resolution of the infection.

3. Operative Note: Patient with lumbar hyperlordosis, extensive bone erosion, and severe infection on the extreme moving joint underwent a two-stage procedure. The first stage involved removal of the infected joint, debridement, and irrigation with antibiotic solution. The second stage involved a posterior lumbar interbody fusion (PLIF) with cages and posterior instrumentation. Intraoperative cultures were obtained, and appropriate antibiotics were administered. The patient had a satisfactory recovery with eradication of the infection.

4. Operative Note: Patient with thoracic hyperlordosis, severe infection on the extreme moving joint, and associated bone erosion underwent a posterior vertebral column resection (PVCR) combined with posterior spinal fusion. A posterior approach was utilized, and pedicle screws were inserted from T4 to T12. The infected joint was excised, and extensive debridement was performed. Additional bone grafting and instrumentation were done. The patient had a smooth recovery with resolution of the infection.

5. Operative Note: Patient with lumbar hyperlordosis, severe infection on the extreme moving joint, and bone erosion underwent a staged procedure. The first stage involved joint debridement and placement of an antibiotic-impregnated spacer. After eradication of the infection, a posterior lumbar fusion was performed using pedicle screws and interbody cages. The patient had a satisfactory recovery with resolution of the infection and improved alignment.

6. Operative Note: Patient with thoracic hyperlordosis, severe infection on the extreme moving joint, and associated bone erosion underwent a combined anterior and posterior spinal fusion with staged approach. The first stage involved removal of the infected joint, debridement, and placement of antibiotic-impregnated cement spacer. In the second stage, an anterior approach was used for interbody fusion, followed by posterior instrumentation and bone grafting. The patient had an uneventful recovery with resolution of the infection.

7. Operative Note: Patient with lumbar hyperlordosis, extensive bone erosion, and severe infection on the extreme moving joint underwent a posterior-based osteotomy and vertebral column resection (VCR). A posterior approach was employed, and pedicle screws were inserted from L3 to S1. The infected joint was removed, and the deformity was corrected through osteotomy and realignment. Intraoperative irrigation with antibiotic solution was performed. The patient had a satisfactory recovery with eradication of the infection.

8. Operative Note: Patient with thoracic hyperlordosis, severe infection on the extreme moving joint, and associated bone erosion underwent a posterior lumbar interbody fusion (PLIF) with antibiotic-impregnated graft material. A posterior approach was used, and pedicle screws were inserted from T10 to L5. The infected joint was debrided, and interbody fusion was achieved using graft material impregnated with antibiotics. The patient had a smooth recovery with resolution of the infection.

9. Operative Note: Patient with lumbar hyperlordosis, severe infection on the extreme moving joint, and bone erosion underwent a two-stage procedure. The first stage involved debridement of the infected joint, irrigation, and placement of an antibiotic-impregnated spacer. The second stage involved a posterior lumbar fusion using pedicle screws and interbody cages. Intraoperative cultures were obtained, and appropriate antibiotics were administered. The patient had a satisfactory recovery with eradication of the infection.

10. Operative Note: Patient with thoracic hyperlordosis, extensive bone erosion, and severe infection on the extreme moving joint underwent a posterior-based osteotomy and pedicle subtraction. A posterior approach was utilized, and pedicle screws were inserted from T6 to T12. The infected joint was excised, and the deformity was corrected through osteotomy and pedicle subtraction. Intraoperative irrigation with antibiotic solution was performed. The patient had a smooth recovery with resolution of the infection.

1. Operative Note: Patient with lumbar hyperlordosis, severe inflammation, and associated bone erosion underwent a posterior lumbar fusion. A posterior approach was used, and pedicle screws were inserted from L3 to S1. Intraoperative findings revealed extensive inflammatory changes, which were addressed through meticulous debridement and irrigation. Bone grafting and instrumentation were performed to promote fusion. The patient had an uneventful recovery with resolution of inflammation and improved alignment.

2. Operative Note: Patient with thoracic hyperlordosis and severe inflammation underwent a combined anterior and posterior spinal fusion. The anterior approach involved removal of the inflamed disc space and interbody fusion using cages and bone graft. The posterior approach involved pedicle screw fixation and additional bone grafting. Intraoperative findings showed marked inflammation, which was addressed through thorough debridement and irrigation. The patient had a satisfactory recovery with resolution of inflammation.

3. Operative Note: Patient with lumbar hyperlordosis, extensive bone erosion, and severe inflammation underwent a posterior lumbar interbody fusion (PLIF) with titanium cages. A posterior approach was employed, and pedicle screws were inserted from L3 to S1. Intraoperatively, significant inflammation was noted in the affected disc space, which was meticulously debrided and irrigated. Interbody fusion was achieved using titanium cages filled with bone graft. The patient had a smooth recovery with resolution of inflammation.

4. Operative Note: Patient with thoracic hyperlordosis, severe inflammation, and associated bone erosion underwent an anterior vertebral column resection (AVCR) combined with a posterior spinal fusion. The AVCR involved removing the inflamed vertebral body, while the posterior approach involved pedicle screw fixation and additional bone grafting. Intraoperative findings revealed marked inflammation, necessitating meticulous debridement and irrigation. The patient had a satisfactory recovery with resolution of inflammation and improved alignment.

5. Operative Note: Patient with lumbar hyperlordosis, significant bone erosion, and severe inflammation underwent a posterior lumbar fusion with the use of expandable interbody cages. A posterior approach was employed, and pedicle screws were inserted from L2 to S1. Intraoperative assessment revealed extensive inflammation in the affected disc space, which was meticulously debrided and irrigated. Expandable cages were inserted to achieve interbody fusion. The patient had a smooth recovery with resolution of inflammation.

6. Operative Note: Patient with thoracic hyperlordosis, severe inflammation, and associated bone erosion underwent a transforaminal lumbar interbody fusion (TLIF). The procedure involved a posterior approach with pedicle screw fixation from T10 to L5. Intraoperative findings showed significant inflammation in the affected disc space, which was addressed through meticulous debridement and irrigation. Interbody fusion was achieved using cages and bone graft. The patient had a satisfactory recovery with resolution of inflammation.

7. Operative Note: Patient with lumbar hyperlordosis, extensive bone erosion, and severe inflammation underwent a posterior lumbar interbody fusion (PLIF) with the use of a bone morphogenetic protein (BMP). A posterior approach was employed, and pedicle screws were inserted from L3 to S1. Intraoperative evaluation revealed marked inflammation, which was addressed through thorough debridement. Interbody fusion was achieved using BMP-infused cages. The patient had a smooth recovery with resolution of inflammation.

8. Operative Note: Patient with thoracic hyperlordosis, severe inflammation, and associated bone erosion underwent a vertebral column resection (VCR) combined with posterior instrumentation. The VCR was performed through a posterior approach, and pedicle screws were inserted from T4 to T12. Intraoperative findings revealed extensive inflammation, necessitating meticulous debridement and irrigation. The patient had a satisfactory recovery with resolution of inflammation and improved alignment.

9. Operative Note: Patient with lumbar hyperlordosis, extensive bone erosion, and severe inflammation underwent a posterior-based osteotomy and vertebral column resection (VCR). A posterior approach was employed, and pedicle screws were inserted from L3 to S1. Intraoperative evaluation revealed marked inflammation in the affected disc space, which was addressed through thorough debridement and irrigation. The patient had a smooth recovery with resolution of inflammation and improved alignment.

10. Operative Note: Patient with thoracic hyperlordosis, severe inflammation, and associated bone erosion underwent a posterior lumbar interbody fusion (PLIF) with antibiotic-impregnated graft material. A posterior approach was used, and pedicle screws were inserted from T10 to L5. Intraoperative findings showed significant inflammation, which was addressed through meticulous debridement and irrigation. Interbody fusion was achieved using graft material impregnated with antibiotics. The patient had a satisfactory recovery with resolution of inflammation.

1. Operative Note: Patient with lumbar hyperlordosis and mild-to-moderate vertebral bone erosion underwent a posterior lumbar fusion. A posterior approach was used, and pedicle screws were inserted from L3 to S1. The patient is scheduled for a follow-up appointment in six weeks to assess the progress of fusion and monitor any residual symptoms.

2. Operative Note: Patient with thoracic hyperlordosis, severe bone erosion, and associated neurological deficits underwent a posterior vertebral column resection (PVCR) combined with posterior instrumentation. A posterior approach was employed, and pedicle screws were inserted from T4 to T12. Due to the severity of the condition, the patient will require frequent follow-up appointments and imaging studies to monitor the fusion process and evaluate neurological recovery.

3. Operative Note: Patient with lumbar hyperlordosis, extensive bone erosion, and severe neurological deficits underwent a two-stage procedure. The first stage involved a decompressive laminectomy to relieve spinal cord compression. The second stage involved a posterior lumbar interbody fusion (PLIF) with pedicle screws and cages. The patient will require close monitoring and frequent follow-up visits to assess neurological improvement and fusion progression.

4. Operative Note: Patient with thoracic hyperlordosis, significant bone erosion, and severe spinal instability underwent a posterior-based osteotomy and vertebral column resection (VCR) with posterior spinal fusion. A posterior approach was utilized, and pedicle screws were inserted from T6 to T12. Given the complexity of the surgery, the patient will require regular follow-up visits to assess fusion, monitor for complications, and address any residual symptoms.

5. Operative Note: Patient with lumbar hyperlordosis, severe bone erosion, and associated radiculopathy underwent a minimally invasive lateral lumbar interbody fusion (LLIF) at L4-L5 level. The procedure involved a lateral approach with insertion of interbody cages and pedicle screw fixation. The patient will have a follow-up appointment in four weeks to evaluate pain relief, assess fusion progress, and consider further interventions if necessary.

6. Operative Note: Patient with thoracic hyperlordosis, extensive bone erosion, and severe radiculopathy underwent a posterior lumbar interbody fusion (PLIF) with bone graft and pedicle screw fixation. The patient will be closely monitored during the postoperative period and have follow-up visits at regular intervals to assess pain relief, neurological improvement, and fusion status.

7. Operative Note: Patient with lumbar hyperlordosis, significant bone erosion, and severe radiculopathy underwent an anterior lumbar interbody fusion (ALIF) with interbody cages and posterior instrumentation. The patient will require regular follow-up appointments to monitor pain relief, assess fusion progress, and manage any residual symptoms or complications.

8. Operative Note: Patient with thoracic hyperlordosis, severe bone erosion, and associated radiculopathy underwent a transforaminal lumbar interbody fusion (TLIF) with pedicle screw fixation. The patient will have a follow-up appointment in six weeks to evaluate pain relief, assess fusion progress, and address any postoperative concerns.

9. Operative Note: Patient with lumbar hyperlordosis, extensive bone erosion, and severe spinal instability underwent a posterior lumbar fusion with pedicle screw instrumentation. Given the complexity of the case, the patient will have regular follow-up visits for an extended period to assess fusion progress, manage pain, and monitor spinal stability.

10. Operative Note: Patient with thoracic hyperlordosis, severe bone erosion, and associated neurological deficits underwent an anterior vertebral column resection (AVCR) combined with posterior spinal fusion. The patient will require frequent follow-up appointments to monitor neurological recovery, assess fusion progress, and address any postoperative complications or residual symptoms.

## M41.0 Infantile idiopathic scoliosis

1. Operative Note: Patient underwent posterior spinal fusion for infantile idiopathic scoliosis. The procedure involved pedicle screw fixation and placement of interbody cages. Intraoperative neurophysiological monitoring was used. Hemostasis was achieved, and wound closure was performed without complications.

2. Operative Note: Infantile idiopathic scoliosis correction was achieved via anterior release and posterior spinal fusion. Pedicle screw instrumentation was utilized along with interbody graft placement. Intraoperative fluoroscopy confirmed proper alignment. Bleeding was minimal, and wound closure proceeded uneventfully.

3. Operative Note: Surgical correction of infantile idiopathic scoliosis was performed using posterior spinal fusion and pedicle screw fixation. Laminectomy and facetectomy were necessary for adequate exposure. The spinal curvature was successfully reduced, and interbody grafts were inserted. Hemostasis was achieved, and the incision was closed in layers.

4. Operative Note: Patient underwent anterior release and posterior spinal fusion to correct infantile idiopathic scoliosis. Anterior discectomy and interbody grafting were performed. Pedicle screws were meticulously placed, ensuring proper alignment. Intraoperative neuromonitoring showed no significant changes. Hemostasis was achieved, and the incision was closed without complications.

5. Operative Note: Surgical correction of infantile idiopathic scoliosis was achieved through posterior spinal fusion. Pedicle screws were inserted, and facet joints were decorticated. Intervertebral cages were placed, and bone grafting was performed. Intraoperative fluoroscopy confirmed satisfactory correction. Hemostasis was obtained, and the wound was meticulously closed.

6. Operative Note: Patient underwent posterior spinal fusion with pedicle screw fixation for infantile idiopathic scoliosis. Transverse process hooks were used for additional stabilization. Intraoperative neuromonitoring demonstrated stable signals. Hemostasis was attained, and wound closure proceeded without complications.

7. Operative Note: Infantile idiopathic scoliosis correction was achieved via posterior spinal fusion. Pedicle screws were inserted, and transverse process hooks were utilized for enhanced stability. Intraoperative neuromonitoring remained stable throughout the procedure. Hemostasis was achieved, and the incision was closed meticulously.

8. Operative Note: Surgical correction of infantile idiopathic scoliosis involved posterior spinal fusion with pedicle screw fixation. Segmental spinal instrumentation was performed, ensuring proper alignment. Intraoperative neuromonitoring showed no adverse changes. Hemostasis was obtained, and the wound was closed layer by layer.

9. Operative Note: Patient underwent anterior release and posterior spinal fusion for infantile idiopathic scoliosis. Anterior discectomy and fusion were performed with interbody grafts. Posterior instrumentation with pedicle screws was meticulously carried out. Intraoperative neuromonitoring remained stable. Hemostasis was achieved, and the incision was closed without complications.

10. Operative Note: Surgical correction of infantile idiopathic scoliosis was performed using posterior spinal fusion and pedicle screw fixation. Facetectomy and laminectomy were necessary for optimal exposure. Interbody cages were successfully placed, achieving satisfactory alignment. Hemostasis was achieved, and the wound was closed in layers.

1. Operative Note: Patient underwent minimally invasive posterior spinal fusion for infantile idiopathic scoliosis. Pedicle screws were inserted using image guidance. Intraoperative neurophysiological monitoring was utilized to ensure spinal cord safety. Hemostasis was achieved, and the incisions were closed with absorbable sutures.

2. Operative Note: Surgical correction of infantile idiopathic scoliosis was performed using a combination of posterior and anterior approaches. Posterior spinal fusion with pedicle screw fixation was carried out along with anterior release and fusion. Intraoperative fluoroscopy confirmed optimal alignment. Hemostasis was achieved, and the wounds were closed layer by layer.

3. Operative Note: Patient underwent video-assisted thoracoscopic surgery (VATS) for the correction of infantile idiopathic scoliosis. Anterior release and fusion were performed using interbody grafts. Posterior spinal fusion with pedicle screws was accomplished through small incisions. Intraoperative neuromonitoring showed no significant changes. Hemostasis was obtained, and the incisions were closed meticulously.

4. Operative Note: Surgical correction of infantile idiopathic scoliosis involved posterior spinal fusion and pedicle screw fixation. A vertebral body tethering technique was utilized to achieve gradual correction of the spinal curvature. Intraoperative fluoroscopy was used to monitor the progress. Hemostasis was achieved, and the incision was closed without complications.

5. Operative Note: Patient underwent posterior spinal fusion for infantile idiopathic scoliosis. The procedure was performed using a hybrid technique combining pedicle screw fixation and sublaminar bands. Intraoperative neurophysiological monitoring was utilized to ensure the safety of neural structures. Hemostasis was achieved, and the incision was closed meticulously.

6. Operative Note: Surgical correction of infantile idiopathic scoliosis was achieved through a posterior approach. Posterior spinal fusion with pedicle screw fixation and vertebral derotation was performed. Intraoperative neuromonitoring remained stable throughout the procedure. Hemostasis was obtained, and the wounds were closed layer by layer.

7. Operative Note: Patient underwent anterior release and posterior spinal fusion for infantile idiopathic scoliosis. Anterior discectomy and fusion were performed with the aid of a thoracoscope. Posterior instrumentation using pedicle screws was meticulously carried out. Intraoperative fluoroscopy confirmed satisfactory alignment. Hemostasis was achieved, and the incision was closed without complications.

8. Operative Note: Surgical correction of infantile idiopathic scoliosis involved posterior spinal fusion with pedicle screw fixation. Additional vertebral body stapling was performed for gradual correction. Intraoperative neuromonitoring showed no adverse changes. Hemostasis was achieved, and the wound was closed meticulously.

9. Operative Note: Patient underwent posterior spinal fusion for infantile idiopathic scoliosis. The procedure utilized a rod construct with pedicle screw fixation. Intraoperative fluoroscopy was used to confirm proper alignment. Hemostasis was achieved, and the incision was closed with sutures.

10. Operative Note: Surgical correction of infantile idiopathic scoliosis was performed using a dual-rod posterior spinal fusion technique. Pedicle screws were inserted bilaterally, and interbody grafts were placed. Intraoperative neuromonitoring remained stable. Hemostasis was obtained, and the incision was closed layer by layer.

1. Operative Note: Patient underwent posterior spinal fusion for infantile idiopathic scoliosis under general anesthesia. Anesthetic agents were administered as per standard protocol, maintaining adequate depth throughout the procedure. Hemostasis was achieved, and the incisions were closed with absorbable sutures.

2. Operative Note: Surgical correction of infantile idiopathic scoliosis was performed under monitored anesthesia care (MAC). Intravenous sedation and local anesthesia were administered to maintain patient comfort and cooperation during the procedure. Hemostasis was obtained, and the wounds were closed layer by layer.

3. Operative Note: Patient underwent anterior release and posterior spinal fusion for infantile idiopathic scoliosis. General anesthesia with balanced analgesia was provided to ensure complete muscle relaxation and pain control. Hemostasis was achieved, and the incisions were closed meticulously.

4. Operative Note: Surgical correction of infantile idiopathic scoliosis involved posterior spinal fusion and pedicle screw fixation under regional anesthesia. Spinal anesthesia was administered, providing effective intraoperative pain relief and muscle relaxation. Intraoperative neurophysiological monitoring was utilized. Hemostasis was achieved, and the incision was closed without complications.

5. Operative Note: Patient underwent posterior spinal fusion for infantile idiopathic scoliosis under local anesthesia with sedation. Tumescent local anesthesia technique was used to provide pain control and minimize bleeding. The patient remained comfortable and cooperative throughout the procedure. Hemostasis was obtained, and the wounds were closed meticulously.

6. Operative Note: Surgical correction of infantile idiopathic scoliosis was performed under general anesthesia with high-dose opioid analgesia. Anesthesia depth was maintained to ensure optimal muscle relaxation and pain management. Hemostasis was achieved, and the incision was closed with sutures.

7. Operative Note: Patient underwent anterior release and posterior spinal fusion for infantile idiopathic scoliosis under combined spinal-epidural anesthesia. The patient experienced effective intraoperative pain relief and muscle relaxation. Hemostasis was achieved, and the incision was closed without complications.

8. Operative Note: Surgical correction of infantile idiopathic scoliosis involved posterior spinal fusion with pedicle screw fixation under general anesthesia with a reduced dosage. The anesthesia plan was tailored to the patient's specific needs, considering factors such as age and weight. Hemostasis was achieved, and the wound was closed meticulously.

9. Operative Note: Patient underwent posterior spinal fusion for infantile idiopathic scoliosis under total intravenous anesthesia (TIVA). A balanced anesthesia approach was used to provide optimal muscle relaxation and pain control. Intraoperative neuromonitoring remained stable. Hemostasis was obtained, and the incision was closed layer by layer.

10. Operative Note: Surgical correction of infantile idiopathic scoliosis was performed under general anesthesia with the administration of a reduced dosage of volatile anesthetic agents. Anesthetic depth was adjusted to ensure patient safety and adequate pain control. Hemostasis was achieved, and the incision was closed with absorbable sutures.

1. Operative Note: Patient with infantile idiopathic scoliosis underwent posterior spinal fusion. Intraoperatively, bone erosion was noted at the apex of the scoliotic curve. Careful decortication and bone grafting were performed to promote fusion and restore stability. Pedicle screw fixation was used to enhance construct integrity. Hemostasis was achieved, and the incisions were closed meticulously.

2. Operative Note: Surgical correction of infantile idiopathic scoliosis involved posterior spinal fusion with pedicle screw fixation. Bone erosion was observed at multiple levels of the spinal column. Debridement of eroded bone was performed, followed by meticulous bone grafting. Intraoperative fluoroscopy confirmed proper alignment. Hemostasis was obtained, and the wounds were closed layer by layer.

3. Operative Note: Patient underwent anterior release and posterior spinal fusion for infantile idiopathic scoliosis. During the procedure, bone erosion was identified at the concave side of the spinal curvature. Thorough debridement and bone grafting were carried out to address the erosion. Pedicle screw fixation was performed for stabilization. Hemostasis was achieved, and the incisions were closed meticulously.

4. Operative Note: Surgical correction of infantile idiopathic scoliosis involved posterior spinal fusion with pedicle screw fixation. Intraoperatively, bone erosion was discovered at the vertebral bodies involved in the scoliotic curve. Eroded bone was meticulously removed, and bone grafting was performed. Intraoperative neuromonitoring remained stable. Hemostasis was achieved, and the wound was closed without complications.

5. Operative Note: Patient with infantile idiopathic scoliosis underwent posterior spinal fusion. Bone erosion was noted at the apical vertebrae. Eroded bone was carefully debrided, and a combination of autograft and allograft bone was used for grafting. Pedicle screw fixation was employed for stabilization. Hemostasis was obtained, and the incision was closed meticulously.

6. Operative Note: Surgical correction of infantile idiopathic scoliosis was performed using posterior spinal fusion and pedicle screw fixation. Bone erosion was encountered at the concave side of the scoliotic curve. Eroded bone was meticulously excised, and bone grafting was performed. Intraoperative fluoroscopy confirmed satisfactory alignment. Hemostasis was achieved, and the incision was closed with absorbable sutures.

7. Operative Note: Patient underwent anterior release and posterior spinal fusion for infantile idiopathic scoliosis. Bone erosion was identified at the vertebral bodies involved in the scoliotic deformity. Debridement of eroded bone was meticulously carried out, followed by extensive bone grafting. Hemostasis was achieved, and the incision was closed without complications.

8. Operative Note: Surgical correction of infantile idiopathic scoliosis involved posterior spinal fusion with pedicle screw fixation. Intraoperatively, bone erosion was observed at the concave side of the scoliotic curve. Thorough debridement and bone grafting were performed to address the erosion. Intraoperative neuromonitoring remained stable. Hemostasis was obtained, and the wound was closed meticulously.

9. Operative Note: Patient with infantile idiopathic scoliosis underwent posterior spinal fusion. Bone erosion was identified at the apical vertebrae, necessitating careful debridement. Bone grafting was performed to promote fusion and enhance stability. Pedicle screw fixation was utilized. Hemostasis was achieved, and the incisions were closed meticulously.

10. Operative Note: Surgical correction of infantile idiopathic scoliosis was performed using posterior spinal fusion and pedicle screw fixation. Bone erosion was encountered at multiple levels within the scoliotic curve. Thorough debridement of eroded bone was carried out, followed by meticulous bone grafting. Hemostasis was achieved, and the incision was closed with absorbable sutures.

1. Operative Note: Patient with infantile idiopathic scoliosis underwent posterior spinal fusion. Severe bone pain was reported preoperatively. Intraoperatively, bone erosion and inflammation were observed, contributing to the pain. Careful debridement of eroded bone was performed, and bone grafting was carried out. Pedicle screw fixation provided stability. Hemostasis was achieved, and the incisions were closed meticulously.

2. Operative Note: Surgical correction of infantile idiopathic scoliosis involved posterior spinal fusion with pedicle screw fixation. The patient experienced severe bone pain preoperatively. Intraoperatively, bone erosion and osteolytic lesions were noted, likely contributing to the pain. Eroded bone was meticulously debrided, and bone grafting was performed. Hemostasis was obtained, and the wounds were closed layer by layer.

3. Operative Note: Patient underwent anterior release and posterior spinal fusion for infantile idiopathic scoliosis. Severe bone pain was reported preoperatively. Intraoperatively, extensive bone erosion and inflammatory changes were identified. Careful debridement and bone grafting were carried out to address the pain. Hemostasis was achieved, and the incisions were closed meticulously.

4. Operative Note: Surgical correction of infantile idiopathic scoliosis involved posterior spinal fusion with pedicle screw fixation. The patient presented with severe bone pain. Intraoperatively, significant bone erosion and osteolytic lesions were observed, likely contributing to the pain. Thorough debridement and bone grafting were performed. Intraoperative neuromonitoring remained stable. Hemostasis was achieved, and the wound was closed without complications.

5. Operative Note: Patient with infantile idiopathic scoliosis underwent posterior spinal fusion. Severe bone pain was reported preoperatively and persisted during the procedure. Intraoperatively, bone erosion and intense inflammatory changes were noted. Meticulous debridement and bone grafting were performed to alleviate the pain. Hemostasis was obtained, and the incision was closed meticulously.

6. Operative Note: Surgical correction of infantile idiopathic scoliosis was performed using posterior spinal fusion and pedicle screw fixation. The patient experienced severe bone pain preoperatively. Intraoperatively, extensive bone erosion and inflammatory changes were observed. Thorough debridement and bone grafting were carried out to address the pain. Hemostasis was achieved, and the incision was closed with absorbable sutures.

7. Operative Note: Patient underwent anterior release and posterior spinal fusion for infantile idiopathic scoliosis. Severe bone pain was reported preoperatively, necessitating optimal pain management during the procedure. Intraoperatively, prominent bone erosion and associated inflammation were observed. Debridement of eroded bone and meticulous bone grafting were performed. Hemostasis was achieved, and the incision was closed without complications.

8. Operative Note: Surgical correction of infantile idiopathic scoliosis involved posterior spinal fusion with pedicle screw fixation. The patient presented with severe bone pain preoperatively. Intraoperatively, significant bone erosion and osteolytic lesions were identified, likely contributing to the pain. Thorough debridement and bone grafting were performed. Hemostasis was achieved, and the wounds were closed meticulously.

9. Operative Note: Patient with infantile idiopathic scoliosis underwent posterior spinal fusion. Severe bone pain was reported preoperatively, which persisted intraoperatively. Intraoperative examination revealed extensive bone erosion and inflammatory changes. Meticulous debridement of eroded bone and bone grafting were performed. Hemostasis was obtained, and the incisions were closed meticulously.

10. Operative Note: Surgical correction of infantile idiopathic scoliosis was performed using posterior spinal fusion and pedicle screw fixation. The patient experienced severe bone pain preoperatively, which persisted during the procedure. Intraoperatively, significant bone erosion and associated inflammation were observed. Thorough debridement and bone grafting were performed to address the pain. Hemostasis was achieved, and the incision was closed with absorbable sutures.

​​1. Operative Note: Patient with infantile idiopathic scoliosis underwent posterior spinal fusion with the additional surgical intervention of vertebral column resection (VCR). The VCR technique was employed to address severe spinal deformity. Pedicle screw fixation and bone grafting were performed to ensure stability and fusion. Hemostasis was achieved, and the incisions were closed meticulously.

2. Operative Note: Surgical correction of infantile idiopathic scoliosis involved posterior spinal fusion with the adjunctive surgical intervention of osteotomy. Multiple levels of osteotomy were performed to correct the severe spinal curvature. Pedicle screw fixation and bone grafting were carried out. Intraoperative neuromonitoring remained stable. Hemostasis was obtained, and the wounds were closed layer by layer.

3. Operative Note: Patient underwent anterior release and posterior spinal fusion for infantile idiopathic scoliosis with the surgical intervention of rib-based distraction. Rib distraction instrumentation was utilized to address severe thoracic deformity. Pedicle screw fixation and bone grafting were performed. Hemostasis was achieved, and the incisions were closed meticulously.

4. Operative Note: Surgical correction of infantile idiopathic scoliosis involved posterior spinal fusion with the additional surgical intervention of vertebral body stapling. Stapling was utilized to manage the severe spinal curvature and allow for gradual correction. Pedicle screw fixation and bone grafting were carried out. Hemostasis was achieved, and the incision was closed without complications.

5. Operative Note: Patient with infantile idiopathic scoliosis underwent posterior spinal fusion with the surgical intervention of intrathecal baclofen pump placement. The pump was implanted to manage spasticity associated with the spinal deformity. Pedicle screw fixation and bone grafting were performed. Hemostasis was obtained, and the incisions were closed meticulously.

6. Operative Note: Surgical correction of infantile idiopathic scoliosis involved posterior spinal fusion with the adjunctive surgical intervention of costoplasty. Costoplasty was performed to address rib deformities associated with the scoliotic curvature. Pedicle screw fixation and bone grafting were carried out. Hemostasis was achieved, and the incision was closed with absorbable sutures.

7. Operative Note: Patient underwent anterior release and posterior spinal fusion for infantile idiopathic scoliosis with the surgical intervention of thoracoscopic discectomy. The discectomy was performed to alleviate spinal compression and facilitate correction. Pedicle screw fixation and bone grafting were performed. Hemostasis was achieved, and the incision was closed meticulously.

8. Operative Note: Surgical correction of infantile idiopathic scoliosis involved posterior spinal fusion with the additional surgical intervention of growth-friendly implant placement. The implant was utilized to accommodate the patient's growth while maintaining spinal alignment. Pedicle screw fixation and bone grafting were carried out. Hemostasis was achieved, and the incision was closed without complications.

9. Operative Note: Patient with infantile idiopathic scoliosis underwent posterior spinal fusion with the surgical intervention of vertebral column decancellation. Decancellation was performed to address severe spinal deformity and restore proper alignment. Pedicle screw fixation and bone grafting were performed. Hemostasis was obtained, and the wounds were closed layer by layer.

10. Operative Note: Surgical correction of infantile idiopathic scoliosis involved posterior spinal fusion with the adjunctive surgical intervention of sacral dome osteotomy. The osteotomy was performed to correct pelvic tilt associated with the scoliotic curvature. Pedicle screw fixation and bone grafting were carried out. Hemostasis was achieved, and the incision was closed meticulously.

1. Operative Note: Patient with infantile idiopathic scoliosis underwent posterior spinal fusion with the surgical intervention of vertebral tethering. Tethering was performed to guide growth and gradually correct the spinal curvature. Pedicle screw fixation and bone grafting were carried out. Hemostasis was achieved, and the incisions were closed meticulously.

2. Operative Note: Surgical correction of infantile idiopathic scoliosis involved posterior spinal fusion with the additional surgical intervention of magnetically controlled growing rods placement. The growing rods were inserted to allow for spinal growth while maintaining stability. Pedicle screw fixation and bone grafting were performed. Hemostasis was obtained, and the incisions were closed layer by layer.

3. Operative Note: Patient underwent anterior release and posterior spinal fusion for infantile idiopathic scoliosis with the surgical intervention of vertebral body stapling. Stapling was utilized as a minimally invasive approach to manage the spinal curvature. Pedicle screw fixation and bone grafting were carried out. Hemostasis was achieved, and the incisions were closed meticulously.

4. Operative Note: Surgical correction of infantile idiopathic scoliosis involved posterior spinal fusion with the surgical intervention of vertebral body tethering. Tethering was performed to allow for controlled growth and correction of the spinal deformity. Pedicle screw fixation and bone grafting were performed. Hemostasis was achieved, and the incision was closed without complications.

5. Operative Note: Patient with infantile idiopathic scoliosis underwent posterior spinal fusion with the surgical intervention of vertebral body stapling combined with growth modulation. The stapling technique was employed to guide growth and correct the spinal curvature. Pedicle screw fixation and bone grafting were carried out. Hemostasis was obtained, and the incisions were closed meticulously.

6. Operative Note: Surgical correction of infantile idiopathic scoliosis involved posterior spinal fusion with the surgical intervention of intraspinal distraction implant placement. The implant was utilized to gradually distract and correct the spinal deformity. Pedicle screw fixation and bone grafting were performed. Hemostasis was achieved, and the incision was closed with absorbable sutures.

7. Operative Note: Patient underwent anterior release and posterior spinal fusion for infantile idiopathic scoliosis with the surgical intervention of vertebral column resection (VCR) combined with anterior vertebral tethering. VCR and tethering were performed to address severe spinal deformity. Pedicle screw fixation and bone grafting were carried out. Hemostasis was achieved, and the incision was closed meticulously.

8. Operative Note: Surgical correction of infantile idiopathic scoliosis involved posterior spinal fusion with the surgical intervention of posterior vertebral column resection (PVCR). PVCR was performed to address severe deformity and restore spinal alignment. Pedicle screw fixation and bone grafting were performed. Hemostasis was achieved, and the incision was closed without complications.

9. Operative Note: Patient with infantile idiopathic scoliosis underwent posterior spinal fusion with the surgical intervention of vertebral column decancellation combined with magnetically controlled growing rods placement. Decancellation and growing rods were utilized to correct the spinal curvature and allow for growth modulation. Pedicle screw fixation and bone grafting were carried out. Hemostasis was obtained, and the wounds were closed meticulously.

10. Operative Note: Surgical correction of infantile idiopathic scoliosis involved posterior spinal fusion with the surgical intervention of vertebral body stapling combined with anterior vertebral tethering. Stapling and tethering were performed to guide growth and correct the spinal curvature. Pedicle screw fixation and bone grafting were performed. Hemostasis was achieved, and the incision was closed meticulously.

1. Operative Note: Patient with infantile idiopathic scoliosis underwent posterior spinal fusion with the complication of a severe infection on the extreme moving joint. Intraoperatively, extensive debridement of infected tissues was performed. The affected joint was meticulously irrigated, and appropriate antibiotic treatment was administered. Pedicle screw fixation and bone grafting were carried out cautiously. Hemostasis was achieved, and the incisions were closed with the intention of preventing further contamination.

2. Operative Note: Surgical correction of infantile idiopathic scoliosis involved posterior spinal fusion with the added challenge of a severe infection on the extreme moving joint. Intraoperatively, meticulous debridement of the infected tissues was carried out. Thorough irrigation and drainage of the joint were performed. Pedicle screw fixation and bone grafting were cautiously executed. Hemostasis was achieved, and the incisions were closed with the aim of promoting healing and controlling the infection.

3. Operative Note: Patient underwent anterior release and posterior spinal fusion for infantile idiopathic scoliosis with the complication of a severe infection on the extreme moving joint. Intraoperatively, thorough debridement of the infected tissues was performed. The joint was irrigated extensively, and appropriate antibiotics were administered. Pedicle screw fixation and bone grafting were executed meticulously. Hemostasis was obtained, and the wounds were closed with the intention of preventing further spread of the infection.

4. Operative Note: Surgical correction of infantile idiopathic scoliosis involved posterior spinal fusion with the challenge of a severe infection on the extreme moving joint. Intraoperatively, extensive debridement of the infected joint was carried out. Adequate irrigation and antibiotic treatment were administered. Pedicle screw fixation and bone grafting were performed cautiously. Hemostasis was achieved, and the incisions were meticulously closed to minimize the risk of infection.

5. Operative Note: Patient with infantile idiopathic scoliosis underwent posterior spinal fusion with the complication of a severe infection on the extreme moving joint. Intraoperatively, thorough debridement of infected tissues was performed. The joint was irrigated meticulously, and appropriate antibiotic therapy was initiated. Pedicle screw fixation and bone grafting were executed with utmost care. Hemostasis was achieved, and the incisions were closed meticulously to prevent the spread of infection.

6. Operative Note: Surgical correction of infantile idiopathic scoliosis involved posterior spinal fusion with the additional challenge of a severe infection on the extreme moving joint. Intraoperatively, meticulous debridement of the infected joint was performed. The joint was thoroughly irrigated, and appropriate antibiotics were administered. Pedicle screw fixation and bone grafting were carried out cautiously. Hemostasis was obtained, and the incisions were closed meticulously to prevent further contamination.

7. Operative Note: Patient underwent anterior release and posterior spinal fusion for infantile idiopathic scoliosis with the complication of a severe infection on the extreme moving joint. Intraoperatively, extensive debridement of the infected tissues was performed. The joint was irrigated meticulously, and targeted antibiotic therapy was initiated. Pedicle screw fixation and bone grafting were executed with utmost care. Hemostasis was achieved, and the incisions were closed meticulously to prevent the spread of infection.

8. Operative Note: Surgical correction of infantile idiopathic scoliosis involved posterior spinal fusion with the challenge of a severe infection on the extreme moving joint. Intraoperatively, thorough debridement of the infected joint was carried out. Adequate irrigation and targeted antibiotic treatment were administered. Pedicle screw fixation and bone grafting were performed cautiously. Hemostasis was achieved, and the incisions were meticulously closed to minimize the risk of infection.

9. Operative Note: Patient with infantile idiopathic scoliosis underwent posterior spinal fusion with the complication of a severe infection on the extreme moving joint. Intraoperatively, meticulous debridement of the infected tissues was performed. The joint was irrigated extensively, and appropriate antibiotic therapy was initiated. Pedicle screw fixation and bone grafting were executed meticulously. Hemostasis was achieved, and the incisions were closed with the intention of preventing further spread of the infection.

10. Operative Note: Surgical correction of infantile idiopathic scoliosis involved posterior spinal fusion with the additional challenge of a severe infection on the extreme moving joint. Intraoperatively, thorough debridement of the infected joint was carried out. Adequate irrigation and antibiotic treatment were administered. Pedicle screw fixation and bone grafting were performed cautiously. Hemostasis was obtained, and the incisions were meticulously closed to prevent further contamination.

1. Operative Note: Patient with infantile idiopathic scoliosis underwent posterior spinal fusion with the complication of severe inflammation on the adjacent vertebral bodies. Intraoperatively, meticulous debridement of the inflamed tissues was performed. The affected area was thoroughly irrigated, and anti-inflammatory medications were administered. Pedicle screw fixation and bone grafting were carried out with caution. Hemostasis was achieved, and the incisions were closed meticulously to promote healing and reduce inflammation.

2. Operative Note: Surgical correction of infantile idiopathic scoliosis involved posterior spinal fusion with the additional challenge of marked inflammation on the adjacent vertebral bodies. Intraoperatively, extensive debridement of the inflamed tissues was performed. The affected area was irrigated meticulously, and anti-inflammatory agents were administered. Pedicle screw fixation and bone grafting were executed with care. Hemostasis was obtained, and the incisions were closed meticulously to minimize inflammation and promote recovery.

3. Operative Note: Patient underwent anterior release and posterior spinal fusion for infantile idiopathic scoliosis with the complication of severe inflammation on the adjacent vertebral bodies. Intraoperatively, thorough debridement of the inflamed tissues was performed. The affected area was irrigated meticulously, and appropriate anti-inflammatory therapy was initiated. Pedicle screw fixation and bone grafting were executed meticulously. Hemostasis was achieved, and the incisions were closed with the aim of reducing inflammation and facilitating healing.

4. Operative Note: Surgical correction of infantile idiopathic scoliosis involved posterior spinal fusion with the challenge of significant inflammation on the adjacent vertebral bodies. Intraoperatively, meticulous debridement of the inflamed tissues was carried out. The affected area was thoroughly irrigated, and anti-inflammatory medications were administered. Pedicle screw fixation and bone grafting were performed with caution. Hemostasis was achieved, and the incisions were closed meticulously to minimize inflammation and promote optimal recovery.

5. Operative Note: Patient with infantile idiopathic scoliosis underwent posterior spinal fusion with the complication of severe inflammation on the adjacent vertebral bodies. Intraoperatively, extensive debridement of the inflamed tissues was performed. The affected area was irrigated meticulously, and anti-inflammatory medications were administered. Pedicle screw fixation and bone grafting were carried out cautiously. Hemostasis was obtained, and the incisions were closed meticulously to minimize inflammation and support the healing process.

6. Operative Note: Surgical correction of infantile idiopathic scoliosis involved posterior spinal fusion with the additional challenge of marked inflammation on the adjacent vertebral bodies. Intraoperatively, thorough debridement of the inflamed tissues was performed. The affected area was meticulously irrigated, and anti-inflammatory agents were administered. Pedicle screw fixation and bone grafting were executed with care. Hemostasis was achieved, and the incisions were closed meticulously to minimize inflammation and facilitate optimal recovery.

7. Operative Note: Patient underwent anterior release and posterior spinal fusion for infantile idiopathic scoliosis with the complication of severe inflammation on the adjacent vertebral bodies. Intraoperatively, meticulous debridement of the inflamed tissues was performed. The affected area was irrigated meticulously, and appropriate anti-inflammatory therapy was initiated. Pedicle screw fixation and bone grafting were executed meticulously. Hemostasis was achieved, and the incisions were closed with the aim of reducing inflammation and supporting the healing process.

8. Operative Note: Surgical correction of infantile idiopathic scoliosis involved posterior spinal fusion with the challenge of significant inflammation on the adjacent vertebral bodies. Intraoperatively, thorough debridement of the inflamed tissues was carried out. The affected area was thoroughly irrigated, and anti-inflammatory medications were administered. Pedicle screw fixation and bone grafting were performed with caution. Hemostasis was achieved, and the incisions were closed meticulously to minimize inflammation and facilitate optimal recovery.

9. Operative Note: Patient with infantile idiopathic scoliosis underwent posterior spinal fusion with the complication of severe inflammation on the adjacent vertebral bodies. Intraoperatively, meticulous debridement of the inflamed tissues was performed. The affected area was irrigated extensively, and appropriate anti-inflammatory therapy was initiated. Pedicle screw fixation and bone grafting were executed meticulously. Hemostasis was obtained, and the incisions were closed meticulously to minimize inflammation and promote healing.

10. Operative Note: Surgical correction of infantile idiopathic scoliosis involved posterior spinal fusion with the additional challenge of marked inflammation on the adjacent vertebral bodies. Intraoperatively, thorough debridement of the inflamed tissues was performed. The affected area was meticulously irrigated, and anti-inflammatory agents were administered. Pedicle screw fixation and bone grafting were carried out with care. Hemostasis was achieved, and the incisions were closed meticulously to minimize inflammation and support the healing process.

1. Operative Note: Patient with infantile idiopathic scoliosis underwent posterior spinal fusion. Given the severity of the diagnosis, close postoperative follow-up is recommended to monitor spinal alignment and assess the progression of the condition. Regular clinical and radiological evaluations will be performed to determine the effectiveness of the surgical intervention and ensure optimal outcomes.

2. Operative Note: Surgical correction of infantile idiopathic scoliosis involved anterior release and posterior spinal fusion. Considering the severity of the diagnosis, a comprehensive postoperative care plan is advised. Follow-up visits will be scheduled to assess the patient's spinal alignment, monitor complications, and adjust treatment as necessary to achieve the best possible outcome.

3. Operative Note: Patient underwent posterior spinal fusion for infantile idiopathic scoliosis. Given the severity of the condition, a multidisciplinary approach to postoperative care is crucial. Regular follow-up appointments with the orthopedic surgeon, physical therapist, and pediatrician will be arranged to assess the patient's progress, manage pain, and optimize rehabilitation to enhance functional outcomes.

4. Operative Note: Surgical correction of infantile idiopathic scoliosis involved posterior spinal fusion and vertebral tethering. Due to the severity of the diagnosis, a structured postoperative monitoring plan is essential. Follow-up visits will be scheduled to assess spinal alignment, evaluate the effectiveness of the intervention, and address any potential complications or adverse events.

5. Operative Note: Patient with infantile idiopathic scoliosis underwent posterior spinal fusion with additional vertebral body stapling. Considering the severity of the diagnosis, a comprehensive postoperative management strategy will be implemented. Regular follow-up appointments will be scheduled to assess the patient's spinal alignment, monitor bone healing, and evaluate the need for further interventions based on the progression of the condition.

6. Operative Note: Surgical correction of infantile idiopathic scoliosis involved posterior spinal fusion and magnetically controlled growing rods placement. Given the severity of the diagnosis, a tailored postoperative follow-up plan is crucial. Regular clinic visits, along with periodic lengthening of the growing rods, will be conducted to monitor spinal growth, assess hardware integrity, and manage any potential complications.

7. Operative Note: Patient underwent posterior spinal fusion for infantile idiopathic scoliosis. Considering the severity of the condition, a comprehensive postoperative rehabilitation program will be initiated. Regular follow-up visits will be scheduled to monitor spinal alignment, assess pain levels, and provide targeted physical therapy to optimize functional recovery.

8. Operative Note: Surgical correction of infantile idiopathic scoliosis involved posterior spinal fusion and vertebral column resection (VCR). Given the severity of the diagnosis, postoperative care will be tailored to the specific needs of the patient. Frequent follow-up visits will be arranged to assess spinal alignment, evaluate the impact of the surgical intervention, and determine the potential need for additional interventions.

9. Operative Note: Patient with infantile idiopathic scoliosis underwent anterior release and posterior spinal fusion. Given the severity of the diagnosis, a comprehensive postoperative care plan is recommended. Follow-up appointments will be scheduled to monitor spinal alignment, assess wound healing, and address any concerns or complications that may arise during the recovery period.

10. Operative Note: Surgical correction of infantile idiopathic scoliosis involved posterior spinal fusion and vertebral column decancellation. Considering the severity of the diagnosis, a multidisciplinary team will be involved in postoperative management. Regular follow-up visits will be scheduled to evaluate spinal alignment, monitor bone healing, and determine the effectiveness of the surgical intervention in addressing the patient's condition.

## M41.1 Juvenile idiopathic scoliosis

1. Operative Note: Patient diagnosed with juvenile idiopathic scoliosis underwent posterior spinal fusion and instrumentation. Surgical correction achieved with pedicle screws and rods. Intraoperative neuromonitoring ensured spinal cord safety. Hemostasis achieved. Wound closed with absorbable sutures. Patient transferred to the post-anesthesia care unit in stable condition.

2. Operative Note: Minimally invasive surgery performed for juvenile idiopathic scoliosis. Anterior thoracoscopic approach used to insert thoracic spinal instrumentation. Intervertebral disc spaces preserved. Curve correction achieved and confirmed intraoperatively. Hemostasis secured. Incisions closed using absorbable sutures. Patient transferred to recovery with stable vital signs.

3. Operative Note: Juvenile idiopathic scoliosis patient underwent vertebral body tethering surgery. Thoracic incision made to access the spine. Polyaxial screws inserted into vertebral bodies. Tether tensioned to correct spinal curvature. Intraoperative imaging confirmed satisfactory correction. Wound closed with layered sutures. Patient transported to the postoperative unit in stable condition.

4. Operative Note: Patient with juvenile idiopathic scoliosis underwent anterior spinal release and posterior spinal fusion. Anterior approach allowed for vertebral disc excision and release. Pedicle screws and rods inserted posteriorly for stabilization. Intraoperative fluoroscopy used to confirm alignment. Hemostasis achieved. Wounds closed meticulously. Patient transferred to the recovery room with stable vital signs.

5. Operative Note: Surgical correction performed on a patient with juvenile idiopathic scoliosis. Posterior spinal fusion and instrumentation accomplished using pedicle screws and rods. Intraoperative neurophysiological monitoring employed for spinal cord safety. Curve correction assessed with imaging. Hemostasis secured. Incisions closed meticulously. Patient transported to the post-anesthesia care unit hemodynamically stable.

6. Operative Note: Juvenile idiopathic scoliosis patient underwent thoracoscopic anterior spinal fusion. Disc spaces preserved during vertebral body preparation. Spinal instrumentation placed using a minimally invasive approach. Intraoperative imaging confirmed satisfactory correction. Hemostasis ensured. Incisions closed meticulously. Patient transferred to the recovery area in stable condition.

7. Operative Note: Patient diagnosed with juvenile idiopathic scoliosis underwent posterior spinal fusion and instrumentation. Pedicle screws and rods utilized for correction. Intraoperative neuromonitoring employed to monitor spinal cord integrity. Curve correction assessed and confirmed. Hemostasis achieved. Incisions closed meticulously. Patient transported to the postoperative recovery area with stable vital signs.

8. Operative Note: Minimally invasive surgery performed on a juvenile idiopathic scoliosis patient. Anterior thoracoscopic approach used for vertebral body tethering. Tether applied to correct spinal curvature. Intraoperative imaging confirmed satisfactory alignment. Hemostasis achieved. Wounds closed meticulously. Patient transferred to the post-anesthesia care unit in stable condition.

9. Operative Note: Juvenile idiopathic scoliosis patient underwent vertebral body tethering surgery. Thoracic incision made to access the spine. Polyaxial screws inserted into vertebral bodies. Tether tensioned to achieve curve correction. Intraoperative imaging confirmed satisfactory alignment. Hemostasis ensured. Wounds closed with meticulous attention. Patient transported to recovery hemodynamically stable.

10. Operative Note: Surgical correction performed on a patient with juvenile idiopathic scoliosis. Anterior spinal release and posterior spinal fusion accomplished. Anterior approach utilized for vertebral disc excision and release. Pedicle screws and rods inserted posteriorly for stabilization. Intraoperative fluoroscopy employed to confirm alignment. Hemostasis achieved. Wounds closed meticulously. Patient transferred to the postoperative unit in stable condition.

1. Operative Note: Juvenile idiopathic scoliosis patient underwent posterior spinal fusion and instrumentation. Pedicle screws and rods used for correction. Intraoperative neuromonitoring ensured spinal cord safety. Curve correction confirmed with intraoperative imaging. Hemostasis achieved. Wounds meticulously closed. Patient transferred to the post-anesthesia care unit with stable vital signs.

2. Operative Note: Minimally invasive surgery performed on a patient with juvenile idiopathic scoliosis. Thoracoscopic approach utilized for anterior spinal fusion. Vertebral body preparation carried out while preserving disc spaces. Spinal instrumentation placed with precision. Intraoperative imaging confirmed satisfactory correction. Hemostasis secured. Incisions closed meticulously. Patient transported to recovery in stable condition.

3. Operative Note: Juvenile idiopathic scoliosis patient underwent vertebral body tethering. Thoracic incision made for access. Polyaxial screws inserted into vertebral bodies. Tether tensioned to achieve desired spinal alignment. Intraoperative imaging verified satisfactory correction. Hemostasis ensured. Incisions meticulously closed. Patient transferred to recovery with stable vital signs.

4. Operative Note: Surgical correction performed on a patient with juvenile idiopathic scoliosis. Posterior spinal fusion and instrumentation carried out using pedicle screws and rods. Intraoperative neurophysiological monitoring employed for spinal cord safety. Curve correction assessed with imaging. Hemostasis achieved. Wounds closed meticulously. Patient transported to the postoperative unit with stable vital signs.

5. Operative Note: Juvenile idiopathic scoliosis patient underwent anterior spinal release and posterior spinal fusion. Anterior approach allowed for disc excision and release. Pedicle screws and rods inserted posteriorly for stabilization. Intraoperative fluoroscopy used to confirm alignment. Hemostasis achieved. Incisions closed meticulously. Patient transferred to recovery in stable condition.

6. Operative Note: Surgical correction performed on a patient with juvenile idiopathic scoliosis. Anterior spinal fusion and posterior spinal fusion accomplished. Anterior approach employed for disc excision and release. Pedicle screws and rods inserted posteriorly for stabilization. Intraoperative fluoroscopy utilized to confirm alignment. Hemostasis achieved. Wounds closed meticulously. Patient transferred to the postoperative unit with stable vital signs.

7. Operative Note: Juvenile idiopathic scoliosis patient underwent thoracoscopic anterior spinal fusion. Preservation of intervertebral disc spaces ensured during vertebral body preparation. Spinal instrumentation placed using a minimally invasive technique. Intraoperative imaging confirmed satisfactory correction. Hemostasis secured. Incisions closed meticulously. Patient transported to recovery with stable vital signs.

8. Operative Note: Patient diagnosed with juvenile idiopathic scoliosis underwent posterior spinal fusion and instrumentation. Pedicle screws and rods employed for correction. Intraoperative neuromonitoring utilized for spinal cord safety. Curve correction assessed and confirmed. Hemostasis achieved. Wounds closed meticulously. Patient transferred to the post-anesthesia care unit with stable vital signs.

9. Operative Note: Minimally invasive surgery performed on a juvenile idiopathic scoliosis patient. Anterior thoracoscopic approach utilized for vertebral body tethering. Tether applied to correct spinal curvature. Intraoperative imaging confirmed satisfactory alignment. Hemostasis achieved. Wounds closed meticulously. Patient transported to recovery in stable condition.

10. Operative Note: Juvenile idiopathic scoliosis patient underwent vertebral body tethering surgery. Thoracic incision made to access the spine. Polyaxial screws inserted into vertebral bodies. Tether tensioned to achieve curve correction. Intraoperative imaging confirmed satisfactory alignment. Hemostasis ensured. Wounds closed with meticulous attention. Patient transferred to the postoperative recovery area with stable vital signs.

1. Operative Note: Juvenile idiopathic scoliosis patient underwent posterior spinal fusion and instrumentation. Pedicle screws and rods used for correction. Intraoperative neuromonitoring ensured spinal cord safety. Anesthesia administered as per weight-based dosage. Curve correction confirmed with intraoperative imaging. Hemostasis achieved. Wounds meticulously closed. Patient transferred to the post-anesthesia care unit with stable vital signs.

2. Operative Note: Minimally invasive surgery performed on a patient with juvenile idiopathic scoliosis. Thoracoscopic approach utilized for anterior spinal fusion. Vertebral body preparation carried out while preserving disc spaces. Spinal instrumentation placed with precision. Anesthetic dosage adjusted based on patient's age and weight. Intraoperative imaging confirmed satisfactory correction. Hemostasis secured. Incisions closed meticulously. Patient transported to recovery in stable condition.

3. Operative Note: Juvenile idiopathic scoliosis patient underwent vertebral body tethering. Thoracic incision made for access. Polyaxial screws inserted into vertebral bodies. Tether tensioned to achieve desired spinal alignment. Anesthetic dosage tailored to patient's age and condition. Intraoperative imaging verified satisfactory correction. Hemostasis ensured. Incisions meticulously closed. Patient transferred to recovery with stable vital signs.

4. Operative Note: Surgical correction performed on a patient with juvenile idiopathic scoliosis. Posterior spinal fusion and instrumentation carried out using pedicle screws and rods. Intraoperative neurophysiological monitoring employed for spinal cord safety. Anesthesia adjusted based on patient's weight and medical history. Curve correction assessed with imaging. Hemostasis achieved. Wounds closed meticulously. Patient transported to the postoperative unit with stable vital signs.

5. Operative Note: Juvenile idiopathic scoliosis patient underwent anterior spinal release and posterior spinal fusion. Anterior approach allowed for disc excision and release. Pedicle screws and rods inserted posteriorly for stabilization. Anesthetic dosage carefully titrated to patient's age and body mass index. Intraoperative fluoroscopy used to confirm alignment. Hemostasis achieved. Incisions closed meticulously. Patient transferred to recovery in stable condition.

6. Operative Note: Surgical correction performed on a patient with juvenile idiopathic scoliosis. Anterior spinal fusion and posterior spinal fusion accomplished. Anterior approach employed for disc excision and release. Pedicle screws and rods inserted posteriorly for stabilization. Anesthetic dosage adjusted based on patient's weight and medical condition. Intraoperative fluoroscopy utilized to confirm alignment. Hemostasis achieved. Wounds closed meticulously. Patient transferred to the postoperative unit with stable vital signs.

7. Operative Note: Juvenile idiopathic scoliosis patient underwent thoracoscopic anterior spinal fusion. Preservation of intervertebral disc spaces ensured during vertebral body preparation. Spinal instrumentation placed using a minimally invasive technique. Anesthesia dosage calculated based on patient's age, weight, and comorbidities. Intraoperative imaging confirmed satisfactory correction. Hemostasis secured. Incisions closed meticulously. Patient transported to recovery with stable vital signs.

8. Operative Note: Patient diagnosed with juvenile idiopathic scoliosis underwent posterior spinal fusion and instrumentation. Pedicle screws and rods employed for correction. Intraoperative neuromonitoring utilized for spinal cord safety. Anesthetic dosage adjusted to patient's age, weight, and medical history. Curve correction assessed and confirmed. Hemostasis achieved. Wounds closed meticulously. Patient transferred to the post-anesthesia care unit with stable vital signs.

9. Operative Note: Minimally invasive surgery performed on a juvenile idiopathic scoliosis patient. Anterior thoracoscopic approach utilized for vertebral body tethering. Tether applied to correct spinal curvature. Anesthesia dosage customized based on patient's age, weight, and tolerance. Intraoperative imaging confirmed satisfactory alignment. Hemostasis achieved. Wounds closed meticulously. Patient transported to recovery in stable condition.

10. Operative Note: Juvenile idiopathic scoliosis patient underwent vertebral body tethering surgery. Thoracic incision made to access the spine. Polyaxial screws inserted into vertebral bodies. Tether tensioned to achieve curve correction. Anesthetic dosage tailored to patient's age, weight, and underlying health conditions. Intraoperative imaging confirmed satisfactory alignment. Hemostasis ensured. Wounds closed with meticulous attention. Patient transferred to the postoperative recovery area with stable vital signs.

1. Operative Note: Juvenile idiopathic scoliosis patient with significant bone erosion underwent posterior spinal fusion and instrumentation. Pedicle screws and rods used for stabilization. Intraoperative neuromonitoring ensured spinal cord safety. Bone graft harvested from iliac crest to address erosion. Curve correction assessed with intraoperative imaging. Hemostasis achieved. Wounds meticulously closed. Patient transferred to the post-anesthesia care unit with stable vital signs.

2. Operative Note: Minimally invasive surgery performed on a patient with juvenile idiopathic scoliosis and bone erosion. Anterior thoracoscopic approach utilized for vertebral body tethering. Bone graft applied to address erosion and promote fusion. Intraoperative imaging confirmed satisfactory alignment. Hemostasis secured. Wounds closed meticulously. Patient transported to recovery in stable condition.

3. Operative Note: Juvenile idiopathic scoliosis patient with bone erosion underwent vertebral body tethering surgery. Thoracic incision made to access the spine. Polyaxial screws inserted into vertebral bodies. Bone graft utilized to address erosion and enhance stability. Intraoperative imaging confirmed satisfactory alignment. Hemostasis ensured. Wounds closed with meticulous attention. Patient transferred to recovery with stable vital signs.

4. Operative Note: Surgical correction performed on a patient with juvenile idiopathic scoliosis and bone erosion. Posterior spinal fusion and instrumentation carried out using pedicle screws and rods. Intraoperative neurophysiological monitoring employed for spinal cord safety. Bone graft harvested from local autograft site to address erosion. Curve correction assessed with imaging. Hemostasis achieved. Wounds closed meticulously. Patient transferred to the postoperative unit with stable vital signs.

5. Operative Note: Juvenile idiopathic scoliosis patient with bone erosion underwent anterior spinal release and posterior spinal fusion. Anterior approach allowed for disc excision and release. Pedicle screws and rods inserted posteriorly for stabilization. Bone graft utilized to address erosion and enhance fusion. Intraoperative fluoroscopy used to confirm alignment. Hemostasis achieved. Incisions closed meticulously. Patient transferred to recovery in stable condition.

6. Operative Note: Surgical correction performed on a patient with juvenile idiopathic scoliosis and bone erosion. Anterior spinal fusion and posterior spinal fusion accomplished. Anterior approach employed for disc excision and release. Pedicle screws and rods inserted posteriorly for stabilization. Bone graft utilized to address erosion and promote fusion. Intraoperative fluoroscopy utilized to confirm alignment. Hemostasis achieved. Wounds closed meticulously. Patient transferred to the postoperative unit with stable vital signs.

7. Operative Note: Juvenile idiopathic scoliosis patient with bone erosion underwent thoracoscopic anterior spinal fusion. Preservation of intervertebral disc spaces ensured during vertebral body preparation. Spinal instrumentation placed using a minimally invasive technique. Bone graft used to address erosion and enhance stability. Intraoperative imaging confirmed satisfactory correction. Hemostasis secured. Incisions closed meticulously. Patient transported to recovery with stable vital signs.

8. Operative Note: Patient diagnosed with juvenile idiopathic scoliosis and bone erosion underwent posterior spinal fusion and instrumentation. Pedicle screws and rods employed for correction. Intraoperative neuromonitoring utilized for spinal cord safety. Bone graft utilized to address erosion and promote fusion. Curve correction assessed and confirmed. Hemostasis achieved. Wounds closed meticulously. Patient transferred to the post-anesthesia care unit with stable vital signs.

9. Operative Note: Minimally invasive surgery performed on a juvenile idiopathic scoliosis patient with bone erosion. Anterior thoracoscopic approach utilized for vertebral body tethering. Tether applied to correct spinal curvature. Bone graft utilized to address erosion and enhance fusion. Intraoperative imaging confirmed satisfactory alignment. Hemostasis achieved. Wounds closed meticulously. Patient transported to recovery in stable condition.

10. Operative Note: Juvenile idiopathic scoliosis patient with bone erosion underwent vertebral body tethering surgery. Thoracic incision made to access the spine. Polyaxial screws inserted into vertebral bodies. Tether tensioned to achieve curve correction. Bone graft utilized to address erosion and promote fusion. Intraoperative imaging confirmed satisfactory alignment. Hemostasis ensured. Wounds closed with meticulous attention. Patient transferred to the postoperative recovery area with stable vital signs.

1. Operative Note: Juvenile idiopathic scoliosis patient with severe bone pain and bone erosion underwent posterior spinal fusion and instrumentation. Pedicle screws and rods used for stabilization. Intraoperative neuromonitoring ensured spinal cord safety. Bone graft harvested from iliac crest to address erosion and alleviate pain. Curve correction assessed with intraoperative imaging. Hemostasis achieved. Wounds meticulously closed. Patient transferred to the post-anesthesia care unit with stable vital signs.

2. Operative Note: Minimally invasive surgery performed on a patient with juvenile idiopathic scoliosis, severe bone pain, and bone erosion. Anterior thoracoscopic approach utilized for vertebral body tethering. Bone graft applied to address erosion and relieve pain. Intraoperative imaging confirmed satisfactory alignment. Hemostasis secured. Wounds closed meticulously. Patient transported to recovery in stable condition.

3. Operative Note: Juvenile idiopathic scoliosis patient with severe bone pain and bone erosion underwent vertebral body tethering surgery. Thoracic incision made to access the spine. Polyaxial screws inserted into vertebral bodies. Bone graft utilized to address erosion and alleviate pain. Intraoperative imaging confirmed satisfactory alignment. Hemostasis ensured. Wounds closed with meticulous attention. Patient transferred to recovery with stable vital signs.

4. Operative Note: Surgical correction performed on a patient with juvenile idiopathic scoliosis, severe bone pain, and bone erosion. Posterior spinal fusion and instrumentation carried out using pedicle screws and rods. Intraoperative neurophysiological monitoring employed for spinal cord safety. Bone graft harvested from local autograft site to address erosion and alleviate pain. Curve correction assessed with imaging. Hemostasis achieved. Wounds closed meticulously. Patient transferred to the postoperative unit with stable vital signs.

5. Operative Note: Juvenile idiopathic scoliosis patient with severe bone pain and bone erosion underwent anterior spinal release and posterior spinal fusion. Anterior approach allowed for disc excision and release. Pedicle screws and rods inserted posteriorly for stabilization. Bone graft utilized to address erosion and relieve pain. Intraoperative fluoroscopy used to confirm alignment. Hemostasis achieved. Incisions closed meticulously. Patient transferred to recovery in stable condition.

6. Operative Note: Surgical correction performed on a patient with juvenile idiopathic scoliosis, severe bone pain, and bone erosion. Anterior spinal fusion and posterior spinal fusion accomplished. Anterior approach employed for disc excision and release. Pedicle screws and rods inserted posteriorly for stabilization. Bone graft utilized to address erosion and alleviate severe bone pain. Intraoperative fluoroscopy utilized to confirm alignment. Hemostasis achieved. Wounds closed meticulously. Patient transferred to the postoperative unit with stable vital signs.

7. Operative Note: Juvenile idiopathic scoliosis patient with severe bone pain and bone erosion underwent thoracoscopic anterior spinal fusion. Preservation of intervertebral disc spaces ensured during vertebral body preparation. Spinal instrumentation placed using a minimally invasive technique. Bone graft used to address erosion and relieve severe bone pain. Intraoperative imaging confirmed satisfactory correction. Hemostasis secured. Incisions closed meticulously. Patient transported to recovery with stable vital signs.

8. Operative Note: Patient diagnosed with juvenile idiopathic scoliosis, severe bone pain, and bone erosion underwent posterior spinal fusion and instrumentation. Pedicle screws and rods employed for correction. Intraoperative neuromonitoring utilized for spinal cord safety. Bone graft utilized to address erosion and alleviate severe bone pain. Curve correction assessed and confirmed. Hemostasis achieved. Wounds closed meticulously. Patient transferred to the post-anesthesia care unit with stable vital signs.

9. Operative Note: Minimally invasive surgery performed on a juvenile idiopathic scoliosis patient with severe bone pain and bone erosion. Anterior thoracoscopic approach utilized for vertebral body tethering. Tether applied to correct spinal curvature. Bone graft utilized to address erosion and relieve severe bone pain. Intraoperative imaging confirmed satisfactory alignment. Hemostasis achieved. Wounds closed meticulously. Patient transported to recovery in stable condition.

10. Operative Note: Juvenile idiopathic scoliosis patient with severe bone pain and bone erosion underwent vertebral body tethering surgery. Thoracic incision made to access the spine. Polyaxial screws inserted into vertebral bodies. Tether tensioned to achieve curve correction. Bone graft utilized to address erosion and alleviate severe bone pain. Intraoperative imaging confirmed satisfactory alignment. Hemostasis ensured. Wounds closed with meticulous attention. Patient transferred to the postoperative recovery area with stable vital signs.

1. Operative Note: Juvenile idiopathic scoliosis patient with severe bone pain and bone erosion underwent spinal osteotomy for correction. Posterior approach utilized for the procedure. Pedicle screws and rods employed for stabilization. Intraoperative neuromonitoring ensured spinal cord safety. Bone graft harvested to address erosion and facilitate fusion. Curve correction assessed with intraoperative imaging. Hemostasis achieved. Wounds meticulously closed. Patient transferred to the post-anesthesia care unit with stable vital signs.

2. Operative Note: Surgical intervention performed on a patient with juvenile idiopathic scoliosis, severe bone pain, and bone erosion. Anterior release and fusion procedure executed to address the condition. Disc excision and vertebral body preparation carried out. Pedicle screws and rods inserted posteriorly for stabilization. Bone graft utilized to address erosion and alleviate pain. Intraoperative fluoroscopy used to confirm alignment. Hemostasis achieved. Incisions closed meticulously. Patient transferred to recovery in stable condition.

3. Operative Note: Juvenile idiopathic scoliosis patient with severe bone pain and bone erosion underwent vertebral column resection for correction. Thoracic incision made to access the spine. Vertebral body removal performed. Pedicle screws and rods inserted to restore alignment. Bone graft utilized to address erosion and promote fusion. Intraoperative imaging confirmed satisfactory correction. Hemostasis ensured. Wounds closed with meticulous attention. Patient transferred to recovery with stable vital signs.

4. Operative Note: Surgical intervention performed on a patient with severe bone pain and bone erosion due to juvenile idiopathic scoliosis. Posterior spinal fusion and instrumentation carried out to address the condition. Pedicle screws and rods utilized for stabilization. Intraoperative neurophysiological monitoring employed for spinal cord safety. Bone graft harvested to address erosion and facilitate fusion. Curve correction assessed with imaging. Hemostasis achieved. Wounds closed meticulously. Patient transferred to the postoperative unit with stable vital signs.

5. Operative Note: Juvenile idiopathic scoliosis patient with severe bone pain and bone erosion underwent anterior spinal release followed by posterior spinal fusion and instrumentation. Anterior approach allowed for disc excision and release. Pedicle screws and rods inserted posteriorly for stabilization. Bone graft utilized to address erosion and alleviate pain. Intraoperative fluoroscopy used to confirm alignment. Hemostasis achieved. Incisions closed meticulously. Patient transferred to recovery in stable condition.

6. Operative Note: Surgical intervention performed on a patient with severe bone pain and bone erosion associated with juvenile idiopathic scoliosis. Anterior spinal fusion and posterior spinal fusion accomplished to address the condition. Anterior approach employed for disc excision and release. Pedicle screws and rods inserted posteriorly for stabilization. Bone graft utilized to address erosion and promote fusion. Intraoperative fluoroscopy utilized to confirm alignment. Hemostasis achieved. Wounds closed meticulously. Patient transferred to the postoperative unit with stable vital signs.

7. Operative Note: Juvenile idiopathic scoliosis patient with severe bone pain and bone erosion underwent thoracoscopic anterior spinal fusion with instrumentation. Preservation of intervertebral disc spaces ensured during vertebral body preparation. Spinal instrumentation placed using a minimally invasive technique. Bone graft used to address erosion and relieve pain. Intraoperative imaging confirmed satisfactory correction. Hemostasis secured. Incisions closed meticulously. Patient transported to recovery with stable vital signs.

8. Operative Note: Surgical intervention performed on a patient with severe bone pain and bone erosion due to juvenile idiopathic scoliosis. Posterior spinal fusion and instrumentation carried out to address the condition. Pedicle screws and rods employed for correction. Intraoperative neuromonitoring utilized for spinal cord safety. Bone graft utilized to address erosion and alleviate pain. Curve correction assessed and confirmed. Hemostasis achieved. Wounds closed meticulously. Patient transferred to the post-anesthesia care unit with stable vital signs.

9. Operative Note: Minimally invasive surgical intervention performed on a patient with severe bone pain, bone erosion, and juvenile idiopathic scoliosis. Anterior thoracoscopic approach utilized for vertebral body tethering. Tether applied to correct spinal curvature. Bone graft utilized to address erosion and relieve pain. Intraoperative imaging confirmed satisfactory alignment. Hemostasis achieved. Wounds closed meticulously. Patient transported to recovery in stable condition.

10. Operative Note: Juvenile idiopathic scoliosis patient with severe bone pain and bone erosion underwent vertebral body tethering surgery as a surgical intervention. Thoracic incision made to access the spine. Polyaxial screws inserted into vertebral bodies. Tether tensioned to achieve curve correction. Bone graft utilized to address erosion and alleviate pain. Intraoperative imaging confirmed satisfactory alignment. Hemostasis ensured. Wounds closed with meticulous attention. Patient transferred to the postoperative recovery area with stable vital signs.

1. Operative Note: Juvenile idiopathic scoliosis patient with severe bone pain and extensive bone erosion underwent posterior spinal fusion combined with vertebral column resection. A posterior approach was used to access the spine. Pedicle screws and rods were inserted for stabilization. Vertebral body removal performed to address erosion. Bone graft harvested to promote fusion and alleviate pain. Intraoperative imaging confirmed satisfactory correction. Hemostasis achieved. Wounds meticulously closed. Patient transferred to the post-anesthesia care unit with stable vital signs.

2. Operative Note: Surgical intervention performed on a patient with severe bone pain, significant bone erosion, and juvenile idiopathic scoliosis. Anterior spinal release and posterior spinal fusion carried out to address the condition. Disc excision and vertebral body preparation performed. Pedicle screws and rods inserted for stabilization. Bone graft utilized to address erosion and alleviate pain. Intraoperative fluoroscopy used to confirm alignment. Hemostasis achieved. Incisions closed meticulously. Patient transferred to recovery in stable condition.

3. Operative Note: Juvenile idiopathic scoliosis patient with severe bone pain and extensive bone erosion underwent vertebral column resection combined with posterior spinal fusion. Thoracic incision made to access the spine. Vertebral body removal performed to address erosion. Pedicle screws and rods inserted for stabilization. Bone graft utilized to promote fusion and alleviate pain. Intraoperative imaging confirmed satisfactory correction. Hemostasis ensured. Wounds closed with meticulous attention. Patient transferred to recovery with stable vital signs.

4. Operative Note: Surgical intervention performed on a patient with severe bone pain, significant bone erosion, and juvenile idiopathic scoliosis. Posterior spinal fusion and instrumentation carried out to address the condition. Pedicle screws and rods employed for correction. Intraoperative neurophysiological monitoring utilized for spinal cord safety. Bone graft harvested to address erosion and promote fusion. Curve correction assessed with imaging. Hemostasis achieved. Wounds closed meticulously. Patient transferred to the postoperative unit with stable vital signs.

5. Operative Note: Juvenile idiopathic scoliosis patient with severe bone pain and extensive bone erosion underwent anterior spinal release followed by posterior spinal fusion and instrumentation. Anterior approach allowed for disc excision and release. Pedicle screws and rods inserted posteriorly for stabilization. Bone graft utilized to address erosion and alleviate pain. Intraoperative fluoroscopy used to confirm alignment. Hemostasis achieved. Incisions closed meticulously. Patient transferred to recovery in stable condition.

6. Operative Note: Surgical intervention performed on a patient with severe bone pain, significant bone erosion, and juvenile idiopathic scoliosis. Anterior spinal fusion and posterior spinal fusion accomplished to address the condition. Anterior approach employed for disc excision and release. Pedicle screws and rods inserted posteriorly for stabilization. Bone graft utilized to address erosion and relieve pain. Intraoperative fluoroscopy utilized to confirm alignment. Hemostasis achieved. Wounds closed meticulously. Patient transferred to the postoperative unit with stable vital signs.

7. Operative Note: Juvenile idiopathic scoliosis patient with severe bone pain and extensive bone erosion underwent thoracoscopic anterior spinal fusion with instrumentation. Preservation of intervertebral disc spaces ensured during vertebral body preparation. Spinal instrumentation placed using a minimally invasive technique. Bone graft used to address erosion and alleviate pain. Intraoperative imaging confirmed satisfactory correction. Hemostasis secured. Incisions closed meticulously. Patient transported to recovery with stable vital signs.

8. Operative Note: Surgical intervention performed on a patient with severe bone pain, significant bone erosion, and juvenile idiopathic scoliosis. Posterior spinal fusion and instrumentation carried out to address the condition. Pedicle screws and rods employed for correction. Intraoperative neuromonitoring utilized for spinal cord safety. Bone graft utilized to address erosion and alleviate pain. Curve correction assessed and confirmed. Hemostasis achieved. Wounds closed meticulously. Patient transferred to the post-anesthesia care unit with stable vital signs.

9. Operative Note: Minimally invasive surgical intervention performed on a patient with severe bone pain, extensive bone erosion, and juvenile idiopathic scoliosis. Anterior thoracoscopic approach utilized for vertebral body tethering. Tether applied to correct spinal curvature. Bone graft utilized to address erosion and relieve pain. Intraoperative imaging confirmed satisfactory alignment. Hemostasis achieved. Wounds closed meticulously. Patient transported to recovery in stable condition.

10. Operative Note: Juvenile idiopathic scoliosis patient with severe bone pain and extensive bone erosion underwent vertebral body tethering surgery combined with vertebral column resection. Thoracic incision made to access the spine. Polyaxial screws inserted into vertebral bodies. Tether tensioned to achieve curve correction. Bone graft utilized to address erosion and alleviate pain. Intraoperative imaging confirmed satisfactory alignment. Hemostasis ensured. Wounds closed with meticulous attention. Patient transferred to the postoperative recovery area with stable vital signs.

1. Operative Note: Juvenile idiopathic scoliosis patient with severe bone pain, bone erosion, and a severe infection on the extreme moving joint underwent urgent surgical intervention. Posterior spinal fusion and instrumentation were performed to address the scoliosis. Aggressive debridement and irrigation of the infected joint were carried out. Antibiotic-loaded bone cement was utilized for stabilization and infection control. Intraoperative imaging confirmed satisfactory correction. Hemostasis achieved. Wounds closed meticulously. Patient transferred to the intensive care unit for further monitoring and treatment.

2. Operative Note: Surgical intervention performed on a patient with severe bone pain, extensive bone erosion, and a severe infection involving the extreme moving joint due to juvenile idiopathic scoliosis. Anterior release and fusion procedure executed to address the scoliosis. Simultaneous joint debridement and irrigation performed to control the infection. Pedicle screws and rods inserted posteriorly for stabilization. Antibiotic beads placed to provide localized antibiotic therapy. Bone graft utilized to address erosion and promote fusion. Intraoperative fluoroscopy used to confirm alignment. Hemostasis achieved. Incisions closed meticulously. Patient transferred to the postoperative unit with plans for targeted antibiotic therapy.

3. Operative Note: Juvenile idiopathic scoliosis patient with severe bone pain, bone erosion, and a severe infection involving the extreme moving joint underwent vertebral column resection combined with joint debridement and irrigation. Thoracic incision made to access the spine and joint. Vertebral body removal performed to address erosion. Aggressive debridement and irrigation of the infected joint were carried out. Pedicle screws and rods inserted for stabilization. Antibiotic-loaded bone graft utilized to promote fusion and infection control. Intraoperative imaging confirmed satisfactory correction. Hemostasis ensured. Wounds closed with meticulous attention. Patient transferred to recovery with plans for targeted antibiotic therapy.

4. Operative Note: Surgical intervention performed on a patient with severe bone pain, extensive bone erosion, and a severe infection on the extreme moving joint associated with juvenile idiopathic scoliosis. Posterior spinal fusion and instrumentation carried out to address the scoliosis. Simultaneous joint debridement and irrigation performed to control the infection. Pedicle screws and rods employed for correction and stabilization. Antibiotic beads placed to provide localized antibiotic therapy. Bone graft harvested to address erosion and promote fusion. Curve correction assessed with imaging. Hemostasis achieved. Wounds closed meticulously. Patient transferred to the postoperative unit with plans for targeted antibiotic therapy.

5. Operative Note: Juvenile idiopathic scoliosis patient with severe bone pain, bone erosion, and a severe infection on the extreme moving joint underwent anterior spinal release followed by posterior spinal fusion and instrumentation. Anterior approach allowed for disc excision and release. Simultaneous joint debridement and irrigation performed to control the infection. Pedicle screws and rods inserted posteriorly for stabilization. Antibiotic beads placed to provide localized antibiotic therapy. Bone graft utilized to address erosion and alleviate pain. Intraoperative fluoroscopy used to confirm alignment. Hemostasis achieved. Incisions closed meticulously. Patient transferred to recovery with plans for targeted antibiotic therapy.

6. Operative Note: Surgical intervention performed on a patient with severe bone pain, extensive bone erosion, and a severe infection involving the extreme moving joint due to juvenile idiopathic scoliosis. Anterior spinal fusion and posterior spinal fusion accomplished to address the scoliosis. Simultaneous joint debridement and irrigation performed to control the infection. Anterior approach employed for disc excision and release. Pedicle screws and rods inserted posteriorly for stabilization. Antibiotic beads placed to provide localized antibiotic therapy. Bone graft utilized to address erosion and relieve pain. Intraoperative fluoroscopy utilized to confirm alignment. Hemostasis achieved. Wounds closed meticulously. Patient transferred to the postoperative unit with plans for targeted antibiotic therapy.

7. Operative Note: Juvenile idiopathic scoliosis patient with severe bone pain, bone erosion, and a severe infection on the extreme moving joint underwent thoracoscopic anterior spinal fusion with instrumentation. Preservation of intervertebral disc spaces ensured during vertebral body preparation. Simultaneous joint debridement and irrigation performed to control the infection. Spinal instrumentation placed using a minimally invasive technique. Antibiotic beads placed to provide localized antibiotic therapy. Bone graft used to address erosion and alleviate pain. Intraoperative imaging confirmed satisfactory correction. Hemostasis secured. Incisions closed meticulously. Patient transported to recovery with plans for targeted antibiotic therapy.

8. Operative Note: Surgical intervention performed on a patient with severe bone pain, extensive bone erosion, and a severe infection involving the extreme moving joint associated with juvenile idiopathic scoliosis. Posterior spinal fusion and instrumentation carried out to address the scoliosis. Simultaneous joint debridement and irrigation performed to control the infection. Pedicle screws and rods employed for correction and stabilization. Antibiotic beads placed to provide localized antibiotic therapy. Bone graft utilized to address erosion and relieve pain. Curve correction assessed and confirmed. Hemostasis achieved. Wounds closed meticulously. Patient transferred to the post-anesthesia care unit with plans for targeted antibiotic therapy.

9. Operative Note: Minimally invasive surgical intervention performed on a patient with severe bone pain, extensive bone erosion, and a severe infection on the extreme moving joint associated with juvenile idiopathic scoliosis. Anterior thoracoscopic approach utilized for vertebral body tethering. Simultaneous joint debridement and irrigation performed to control the infection. Tether applied to correct spinal curvature. Antibiotic beads placed to provide localized antibiotic therapy. Bone graft utilized to address erosion and relieve pain. Intraoperative imaging confirmed satisfactory alignment. Hemostasis achieved. Wounds closed meticulously. Patient transported to recovery with plans for targeted antibiotic therapy.

10. Operative Note: Juvenile idiopathic scoliosis patient with severe bone pain, bone erosion, and a severe infection involving the extreme moving joint underwent vertebral body tethering surgery combined with joint debridement and irrigation. Thoracic incision made to access the spine and joint. Polyaxial screws inserted into vertebral bodies. Tether tensioned to achieve curve correction. Aggressive debridement and irrigation of the infected joint were carried out. Antibiotic-loaded bone graft utilized to promote fusion and infection control. Intraoperative imaging confirmed satisfactory alignment. Hemostasis ensured. Wounds closed with meticulous attention. Patient transferred to the postoperative recovery area with plans for targeted antibiotic therapy.

1. Operative Note: Juvenile idiopathic scoliosis patient with severe bone pain, bone erosion, and significant inflammation underwent surgical intervention. Posterior spinal fusion and instrumentation performed to address the scoliosis. Intraoperative assessment revealed marked inflammation around the affected vertebrae. Aggressive debridement and irrigation carried out to reduce inflammation. Pedicle screws and rods inserted for stabilization. Bone graft utilized to address erosion and alleviate pain. Hemostasis achieved. Wounds closed meticulously. Patient transferred to the post-anesthesia care unit with plans for anti-inflammatory therapy.

2. Operative Note: Surgical intervention performed on a patient with severe bone pain, extensive bone erosion, and pronounced inflammation associated with juvenile idiopathic scoliosis. Anterior spinal release and posterior spinal fusion executed to address the scoliosis. Intraoperative evaluation revealed significant inflammation in the affected vertebral segments. Intensive debridement and irrigation performed to mitigate inflammation. Pedicle screws and rods inserted for stabilization. Bone graft utilized to address erosion and relieve pain. Hemostasis achieved. Incisions closed meticulously. Patient transferred to recovery with plans for anti-inflammatory treatment.

3. Operative Note: Juvenile idiopathic scoliosis patient with severe bone pain, bone erosion, and marked inflammation underwent vertebral column resection combined with inflammation management. Thoracic incision made to access the spine. Vertebral body removal performed to address erosion. Intraoperative assessment revealed significant inflammation in the surrounding tissues. Aggressive debridement and irrigation conducted to reduce inflammation. Pedicle screws and rods inserted for stabilization. Bone graft utilized to promote fusion and alleviate pain. Hemostasis ensured. Wounds closed meticulously. Patient transferred to recovery with plans for anti-inflammatory therapy.

4. Operative Note: Surgical intervention performed on a patient with severe bone pain, extensive bone erosion, and notable inflammation associated with juvenile idiopathic scoliosis. Posterior spinal fusion and instrumentation carried out to address the scoliosis. Intraoperative assessment revealed significant inflammation around the affected vertebrae. Aggressive debridement and irrigation performed to reduce inflammation. Pedicle screws and rods employed for correction and stabilization. Bone graft utilized to address erosion and alleviate pain. Hemostasis achieved. Wounds closed meticulously. Patient transferred to the postoperative unit with plans for anti-inflammatory treatment.

5. Operative Note: Juvenile idiopathic scoliosis patient with severe bone pain, bone erosion, and significant inflammation underwent anterior spinal release followed by posterior spinal fusion and instrumentation. Anterior approach allowed for disc excision and release. Intraoperative evaluation revealed pronounced inflammation around the affected vertebrae. Intensive debridement and irrigation carried out to mitigate inflammation. Pedicle screws and rods inserted posteriorly for stabilization. Bone graft utilized to address erosion and relieve pain. Hemostasis achieved. Incisions closed meticulously. Patient transferred to recovery with plans for anti-inflammatory therapy.

6. Operative Note: Surgical intervention performed on a patient with severe bone pain, extensive bone erosion, and marked inflammation associated with juvenile idiopathic scoliosis. Anterior spinal fusion and posterior spinal fusion accomplished to address the scoliosis. Intraoperative assessment revealed significant inflammation in the affected vertebral segments. Aggressive debridement and irrigation performed to reduce inflammation. Anterior approach employed for disc excision and release. Pedicle screws and rods inserted posteriorly for stabilization. Bone graft utilized to address erosion and alleviate pain. Hemostasis achieved. Wounds closed meticulously. Patient transferred to the postoperative unit with plans for anti-inflammatory treatment.

7. Operative Note: Juvenile idiopathic scoliosis patient with severe bone pain, bone erosion, and inflammation underwent thoracoscopic anterior spinal fusion with instrumentation. Preservation of intervertebral disc spaces ensured during vertebral body preparation. Intraoperative assessment revealed significant inflammation in the affected vertebral segments. Aggressive debridement and irrigation performed to mitigate inflammation. Spinal instrumentation placed using a minimally invasive technique. Bone graft used to address erosion and alleviate pain. Hemostasis achieved. Wounds closed meticulously. Patient transported to recovery with plans for anti-inflammatory therapy.

8. Operative Note: Surgical intervention performed on a patient with severe bone pain, extensive bone erosion, and notable inflammation associated with juvenile idiopathic scoliosis. Posterior spinal fusion and instrumentation carried out to address the scoliosis. Intraoperative assessment revealed significant inflammation around the affected vertebrae. Aggressive debridement and irrigation performed to reduce inflammation. Pedicle screws and rods employed for correction and stabilization. Bone graft utilized to address erosion and relieve pain. Curve correction assessed and confirmed. Hemostasis achieved. Wounds closed meticulously. Patient transferred to the post-anesthesia care unit with plans for anti-inflammatory treatment.

9. Operative Note: Minimally invasive surgical intervention performed on a patient with severe bone pain, extensive bone erosion, and pronounced inflammation associated with juvenile idiopathic scoliosis. Anterior thoracoscopic approach utilized for vertebral body tethering. Intraoperative assessment revealed significant inflammation in the affected vertebral segments. Aggressive debridement and irrigation performed to mitigate inflammation. Tether applied to correct spinal curvature. Bone graft utilized to address erosion and alleviate pain. Hemostasis achieved. Wounds closed meticulously. Patient transported to recovery with plans for anti-inflammatory therapy.

10. Operative Note: Juvenile idiopathic scoliosis patient with severe bone pain, bone erosion, and marked inflammation underwent vertebral body tethering surgery combined with inflammation management. Thoracic incision made to access the spine. Polyaxial screws inserted into vertebral bodies. Tether tensioned to achieve curve correction. Intraoperative assessment revealed significant inflammation in the surrounding tissues. Aggressive debridement and irrigation conducted to reduce inflammation. Bone graft utilized to address erosion and promote fusion. Hemostasis ensured. Wounds closed with meticulous attention. Patient transferred to the postoperative recovery area with plans for anti-inflammatory therapy.

1. Operative Note: Surgical intervention performed on a patient diagnosed with severe juvenile idiopathic scoliosis. Posterior spinal fusion and instrumentation carried out to address the condition. Intraoperative assessment confirmed the severity of the curvature, requiring extensive correction. Pedicle screws and rods inserted for stabilization. Bone graft utilized to promote fusion. Hemostasis achieved. Patient scheduled for frequent follow-up visits to monitor the progression and ensure optimal healing.

2. Operative Note: Juvenile idiopathic scoliosis patient with a moderate degree of spinal curvature underwent anterior release and posterior spinal fusion surgery. Intraoperative assessment revealed satisfactory correction of the curvature. Pedicle screws and rods inserted to stabilize the spine. Bone graft used to promote fusion. Hemostasis achieved. Patient advised regular follow-up visits to assess the outcome of the procedure and monitor for any potential complications.

3. Operative Note: Surgical intervention performed on a patient diagnosed with mild juvenile idiopathic scoliosis. Anterior spinal release and posterior spinal fusion carried out to address the condition. Intraoperative assessment demonstrated successful correction of the curvature. Pedicle screws and rods inserted for stabilization. Bone graft utilized to promote fusion. Hemostasis achieved. Patient instructed to schedule follow-up appointments as per the surgeon's recommendations to monitor the progress and ensure favorable outcomes.

4. Operative Note: Juvenile idiopathic scoliosis patient with a severe spinal curvature underwent extensive surgical intervention, including vertebral column resection. Intraoperative assessment confirmed the severity of the condition and the need for aggressive correction. Pedicle screws and rods inserted to stabilize the spine. Bone graft utilized to promote fusion. Hemostasis achieved. Patient instructed to adhere to a strict follow-up schedule to monitor the healing process, manage pain, and address any potential complications.

5. Operative Note: Surgical intervention performed on a patient diagnosed with moderate juvenile idiopathic scoliosis. Posterior spinal fusion and instrumentation carried out to correct the curvature. Intraoperative assessment demonstrated satisfactory correction. Pedicle screws and rods inserted for stabilization. Bone graft utilized to promote fusion. Hemostasis achieved. Patient advised to follow up with the surgeon at regular intervals to evaluate the progress, ensure successful fusion, and address any concerns.

6. Operative Note: Juvenile idiopathic scoliosis patient with a mild degree of spinal curvature underwent minimally invasive surgical intervention. Anterior thoracoscopic approach utilized for vertebral body tethering. Intraoperative assessment confirmed successful correction. Tether applied to stabilize the spine. Bone graft utilized to promote fusion. Hemostasis achieved. Patient scheduled for periodic follow-up appointments to monitor the response to treatment, assess fusion progress, and provide necessary postoperative care.

7. Operative Note: Surgical intervention performed on a patient diagnosed with severe juvenile idiopathic scoliosis. Posterior spinal fusion and instrumentation carried out to address the condition. Intraoperative assessment revealed a complex curvature, requiring extensive correction and meticulous placement of pedicle screws and rods. Bone graft utilized to promote fusion. Hemostasis achieved. Patient instructed to schedule regular follow-up visits for close monitoring of the surgical outcome and rehabilitation progress.

8. Operative Note: Juvenile idiopathic scoliosis patient with a moderate degree of spinal curvature underwent anterior release and posterior spinal fusion surgery. Intraoperative assessment demonstrated successful correction of the curvature and proper placement of pedicle screws and rods. Bone graft used to promote fusion. Hemostasis achieved. Patient advised to attend routine follow-up appointments to evaluate the effectiveness of the procedure, manage postoperative pain, and assess the progression of fusion.

9. Operative Note: Surgical intervention performed on a patient diagnosed with mild juvenile idiopathic scoliosis. Anterior spinal release and posterior spinal fusion carried out to address the condition. Intraoperative assessment confirmed satisfactory correction of the curvature. Pedicle screws and rods inserted for stabilization. Bone graft utilized to promote fusion. Hemostasis achieved. Patient advised to follow up with the surgeon as per the recommended schedule for monitoring the healing process and assessing the success of fusion.

10. Operative Note: Juvenile idiopathic scoliosis patient with a severe spinal curvature underwent extensive surgical intervention, including vertebral column resection. Intraoperative assessment revealed the severity of the condition, necessitating meticulous correction and stabilization with pedicle screws and rods. Bone graft utilized to promote fusion. Hemostasis achieved. Patient instructed to adhere to a comprehensive follow-up plan to closely monitor the progress, manage postoperative pain, and address any potential complications.

## M41.2 Other idiopathic scoliosis

1. Patient underwent posterior spinal fusion for severe other idiopathic scoliosis. Surgical correction involved placement of pedicle screws from T2 to L4 with interbody fusion. Intraoperative neurophysiological monitoring was utilized to ensure spinal cord integrity. Estimated blood loss was 600ml, and the patient tolerated the procedure well. Postoperative radiographs revealed satisfactory correction.

2. Operative intervention for other idiopathic scoliosis included anterior release and fusion. An anterior approach was used to access the thoracic and lumbar spine. Vertebral bodies from T4 to L3 were decorticated, and a bone graft was placed. The patient remained stable throughout the procedure, and postoperative imaging demonstrated appropriate alignment.

3. Patient underwent minimally invasive surgery for other idiopathic scoliosis. Bilateral percutaneous pedicle screw fixation was performed from T3 to L4, followed by percutaneous interbody fusion. The procedure was successful, and the patient experienced minimal blood loss. Immediate postoperative imaging confirmed satisfactory alignment.

4. Surgical correction of other idiopathic scoliosis involved posterior spinal fusion using a combination of pedicle screws and hooks. The fusion extended from T1 to L5, with segmental instrumentation. Intraoperative neuromonitoring was employed to ensure spinal cord safety. The patient tolerated the procedure well, and postoperative imaging demonstrated adequate alignment.

5. Minimally invasive lateral interbody fusion was performed to address other idiopathic scoliosis. Through a lateral approach, the disc spaces from T12 to L4 were accessed and prepared. Cage placement and interbody fusion were achieved using fluoroscopic guidance. The patient had an uneventful intraoperative course, and postoperative imaging showed improved spinal alignment.

6. Patient underwent posterior spinal fusion for other idiopathic scoliosis. Pedicle screws and rods were used for instrumentation from T2 to L5, achieving adequate correction. Intraoperative neuromonitoring was utilized to safeguard spinal cord integrity. Estimated blood loss was minimal, and the patient had a smooth recovery. Follow-up imaging demonstrated satisfactory alignment and fusion.

7. Surgical intervention for other idiopathic scoliosis involved vertebral body tethering. The tether was placed between T5 and L4 to correct the spinal deformity. Intraoperative imaging was used to confirm appropriate tensioning of the tether. The patient tolerated the procedure well, and immediate postoperative imaging showed improved alignment.

8. Patient underwent posterior spinal fusion for severe other idiopathic scoliosis. Pedicle screws and hooks were used for instrumentation from T3 to L5, followed by interbody fusion. Intraoperative neuromonitoring ensured spinal cord safety. The patient had minimal blood loss and an uneventful recovery. Postoperative imaging revealed satisfactory alignment and fusion.

9. Minimally invasive thoracoscopic surgery was performed to address other idiopathic scoliosis. Through small incisions, thoracic and lumbar curves were corrected using a combination of screws and rods. Intraoperative fluoroscopy confirmed appropriate alignment. The patient had an uncomplicated intraoperative course, and postoperative imaging showed improved spinal alignment.

10. Surgical correction of other idiopathic scoliosis involved posterior spinal fusion using pedicle screws and rods from T4 to L4. Intraoperative neuromonitoring ensured spinal cord safety. The patient tolerated the procedure well, and postoperative imaging demonstrated satisfactory alignment and fusion.

1. Patient underwent anterior vertebral body tethering to address other idiopathic scoliosis. The tether was placed between T4 and L4, providing corrective tension. Intraoperative imaging confirmed optimal tether placement. The patient had a smooth intraoperative course, and postoperative imaging revealed improved spinal alignment.

2. Surgical intervention for other idiopathic scoliosis involved posterior spinal fusion using pedicle screws and hooks from T2 to L5. Intraoperative neuromonitoring ensured spinal cord safety. The patient experienced minimal blood loss and tolerated the procedure well. Postoperative imaging demonstrated satisfactory alignment and fusion.

3. Minimally invasive lateral lumbar interbody fusion was performed to correct other idiopathic scoliosis. The procedure involved accessing the disc spaces from L1 to L5 through a lateral approach. Cage placement and interbody fusion were achieved using fluoroscopic guidance. The patient had an uneventful intraoperative course, and postoperative imaging confirmed improved spinal alignment.

4. Patient underwent posterior spinal fusion with hybrid instrumentation for other idiopathic scoliosis. Pedicle screws were placed from T3 to L4, and hooks were utilized at the apex of the curve. Intraoperative neurophysiological monitoring ensured spinal cord integrity. The patient tolerated the procedure well, and postoperative imaging showed satisfactory correction.

5. Operative intervention for other idiopathic scoliosis included vertebral column resection (VCR). The procedure involved removing the vertebral body at the apex of the curve and fusing the remaining segments. Intraoperative imaging confirmed optimal resection and alignment. The patient had an uneventful intraoperative course, and postoperative imaging demonstrated improved spinal alignment.

6. Minimally invasive posterior spinal fusion was performed for other idiopathic scoliosis. Pedicle screws and rods were used for instrumentation from T4 to L4. Intraoperative neuromonitoring ensured spinal cord safety. The patient experienced minimal blood loss and tolerated the procedure well. Follow-up imaging revealed satisfactory alignment and fusion.

7. Surgical correction of other idiopathic scoliosis involved anterior and posterior spinal fusion. Anterior release and fusion were performed first, followed by posterior instrumentation from T2 to L5. Intraoperative imaging confirmed adequate correction. The patient had a smooth intraoperative course, and postoperative imaging showed improved spinal alignment.

8. Patient underwent posterior spinal fusion with segmental pedicle screw fixation for other idiopathic scoliosis. The fusion extended from T3 to L4. Intraoperative neuromonitoring was employed to ensure spinal cord integrity. The patient had minimal blood loss and tolerated the procedure well. Postoperative imaging demonstrated satisfactory alignment and fusion.

9. Minimally invasive surgical correction of other idiopathic scoliosis involved percutaneous vertebral body stapling. Staples were placed at the apex of the curvature to halt its progression. The patient had an uneventful intraoperative course, and immediate postoperative imaging showed improved spinal alignment.

10. Operative intervention for other idiopathic scoliosis included posterior spinal fusion using pedicle screws and rods from T4 to L4. Intraoperative neuromonitoring ensured spinal cord safety. The patient tolerated the procedure well, and postoperative imaging revealed satisfactory alignment and fusion.

1. Patient underwent posterior spinal fusion for other idiopathic scoliosis under general anesthesia. Anesthetic agents were titrated to maintain a balanced depth of anesthesia. Intraoperative neuromonitoring was utilized to ensure spinal cord integrity. The patient tolerated the procedure well, and postoperative imaging demonstrated satisfactory alignment and fusion.

2. Surgical correction of other idiopathic scoliosis involved posterior spinal fusion under monitored anesthesia care. Local anesthesia was administered at the surgical site, supplemented with intravenous sedation. Intraoperative neuromonitoring ensured spinal cord safety. The patient had minimal discomfort and postoperative imaging revealed adequate alignment.

3. Minimally invasive lateral interbody fusion was performed for other idiopathic scoliosis under general anesthesia. Anesthetic agents were adjusted to maintain optimal depth of anesthesia. Intraoperative fluoroscopy guided the procedure, and the patient remained stable throughout. Postoperative imaging showed improved spinal alignment.

4. Patient underwent posterior spinal fusion with pedicle screws and hooks for other idiopathic scoliosis under spinal anesthesia. The anesthesia was supplemented with light sedation to ensure patient comfort. Intraoperative neuromonitoring was utilized to ensure spinal cord safety. The patient had a smooth intraoperative course, and postoperative imaging confirmed satisfactory alignment.

5. Surgical intervention for other idiopathic scoliosis involved anterior vertebral body tethering under general anesthesia. The anesthetic agents were adjusted to maintain hemodynamic stability. Intraoperative imaging confirmed optimal tether placement. The patient had an uneventful intraoperative course, and postoperative imaging revealed improved spinal alignment.

6. Patient underwent minimally invasive thoracoscopic surgery for other idiopathic scoliosis under combined epidural and general anesthesia. Epidural analgesia provided postoperative pain control. Intraoperative fluoroscopy guided the procedure, and the patient tolerated the anesthesia well. Follow-up imaging demonstrated improved spinal alignment.

7. Operative intervention for other idiopathic scoliosis included posterior spinal fusion using pedicle screws and rods under general anesthesia with total intravenous anesthesia (TIVA). TIVA allowed precise control of anesthesia depth and minimized side effects. Intraoperative neuromonitoring ensured spinal cord safety. The patient had a smooth intraoperative course, and postoperative imaging showed satisfactory alignment and fusion.

8. Minimally invasive lateral lumbar interbody fusion was performed for other idiopathic scoliosis under monitored anesthesia care. Intravenous sedation and analgesia provided patient comfort. Intraoperative fluoroscopy guided the procedure, and the patient remained stable throughout. Postoperative imaging confirmed improved spinal alignment.

9. Surgical correction of other idiopathic scoliosis involved posterior spinal fusion using pedicle screws and hooks under general anesthesia with regional anesthesia supplementation. A thoracic epidural catheter provided postoperative pain control. Intraoperative neuromonitoring ensured spinal cord safety. The patient tolerated the anesthesia well, and postoperative imaging revealed satisfactory alignment and fusion.

10. Patient underwent anterior release and fusion for other idiopathic scoliosis under general anesthesia with inhalational agents. Intraoperative neuromonitoring ensured spinal cord integrity. The patient had a smooth intraoperative course, and postoperative imaging demonstrated improved spinal alignment.

1. Surgical intervention for other idiopathic scoliosis with associated bone erosion involved posterior spinal fusion. Pedicle screws and rods were utilized to stabilize the spine from T2 to L4, addressing the erosion site. Intraoperative neuromonitoring ensured spinal cord safety. The patient tolerated the procedure well, and postoperative imaging confirmed successful alignment and stabilization.

2. Patient underwent anterior vertebral body tethering for other idiopathic scoliosis with concurrent bone erosion. The tether was placed between T3 and L3, addressing both the spinal deformity and erosion. Intraoperative imaging confirmed optimal tether positioning. The patient had an uneventful intraoperative course, and postoperative imaging revealed improved spinal alignment and stabilization of the eroded segment.

3. Surgical correction of other idiopathic scoliosis with bone erosion involved posterior spinal fusion using pedicle screws and hooks from T4 to L5. Additional bone grafting was performed at the erosion site to facilitate healing and stabilization. Intraoperative neuromonitoring ensured spinal cord integrity. The patient tolerated the procedure well, and postoperative imaging demonstrated satisfactory correction and bone fusion.

4. Minimally invasive lateral lumbar interbody fusion was performed for other idiopathic scoliosis complicated by bone erosion. The procedure involved accessing the disc spaces from L1 to L5, addressing both the scoliotic curve and erosion. Cage placement and interbody fusion were achieved, promoting stability and fusion. The patient had a smooth intraoperative course, and postoperative imaging confirmed improved spinal alignment and stabilization of the eroded area.

5. Patient underwent posterior spinal fusion for other idiopathic scoliosis with associated bone erosion using pedicle screws and rods. Intraoperatively, bone grafting was performed at the erosion site to promote healing and stabilization. Intraoperative neuromonitoring ensured spinal cord safety. The patient tolerated the procedure well, and postoperative imaging revealed satisfactory alignment and fusion, addressing both the scoliosis and bone erosion.

6. Surgical intervention for other idiopathic scoliosis with concurrent bone erosion involved anterior release and fusion. The procedure addressed the spinal deformity and erosion site. Bone grafting was performed to stabilize the eroded segment. The patient had an uneventful intraoperative course, and postoperative imaging showed improved spinal alignment and successful stabilization of the eroded area.

7. Minimally invasive lateral interbody fusion was performed for other idiopathic scoliosis complicated by bone erosion. The procedure aimed to correct the scoliotic curvature and stabilize the eroded area. Cage placement and interbody fusion were achieved, promoting stability and fusion. The patient had a smooth intraoperative course, and postoperative imaging confirmed improved spinal alignment and successful stabilization of the eroded segment.

8. Patient underwent posterior spinal fusion for other idiopathic scoliosis with associated bone erosion. Pedicle screws and hooks were used for instrumentation from T3 to L5, addressing both the scoliotic curve and bone erosion. Intraoperative neuromonitoring ensured spinal cord safety. The patient tolerated the procedure well, and postoperative imaging demonstrated satisfactory alignment and successful stabilization of the eroded site.

9. Surgical correction of other idiopathic scoliosis complicated by bone erosion involved posterior spinal fusion using pedicle screws and rods. The fusion extended from T4 to L4, with additional bone grafting at the erosion site. Intraoperative neuromonitoring ensured spinal cord integrity. The patient had a smooth intraoperative course, and postoperative imaging revealed improved spinal alignment and successful stabilization of the eroded segment.

10. Minimally invasive thoracoscopic surgery was performed for other idiopathic scoliosis with concurrent bone erosion. The procedure aimed to correct the scoliotic curvature and stabilize the eroded area. Intraoperative fluoroscopy guided the procedure, and additional bone grafting was performed. The patient had an uncomplicated intraoperative course, and postoperative imaging confirmed improved spinal alignment and successful stabilization of the eroded site.

1. Surgical intervention for other idiopathic scoliosis with severe bone pain involved posterior spinal fusion using pedicle screws and rods. The fusion extended from T2 to L4, addressing both the scoliotic curve and the source of pain. Intraoperative neuromonitoring ensured spinal cord safety. The patient tolerated the procedure well, and postoperative imaging demonstrated improved spinal alignment and relief of severe bone pain.

2. Patient underwent anterior release and fusion for other idiopathic scoliosis with severe bone pain. The procedure aimed to correct the spinal deformity and alleviate the pain. Bone grafting was performed to promote stability and fusion. The patient had an uneventful intraoperative course, and postoperative imaging revealed improved spinal alignment and significant reduction in severe bone pain.

3. Surgical correction of other idiopathic scoliosis with severe bone pain involved posterior spinal fusion using pedicle screws and hooks from T4 to L5. Intraoperative neuromonitoring ensured spinal cord integrity. The patient experienced minimal discomfort during the procedure, and postoperative imaging confirmed satisfactory alignment and substantial relief of severe bone pain.

4. Minimally invasive lateral lumbar interbody fusion was performed for other idiopathic scoliosis with severe bone pain. The procedure addressed both the scoliotic curvature and the source of pain. Cage placement and interbody fusion were achieved, providing stability and pain relief. The patient had a smooth intraoperative course, and postoperative imaging demonstrated improved spinal alignment and significant reduction in severe bone pain.

5. Patient underwent posterior spinal fusion for severe other idiopathic scoliosis with associated bone pain. Pedicle screws and rods were used for instrumentation from T3 to L4, addressing both the scoliotic curve and the source of pain. Intraoperative neuromonitoring ensured spinal cord safety. The patient tolerated the procedure well, and postoperative imaging revealed satisfactory alignment and substantial relief of severe bone pain.

6. Surgical intervention for other idiopathic scoliosis with severe bone pain involved anterior vertebral body tethering. The tether was placed between T4 and L4, correcting the spinal deformity and alleviating the pain. Intraoperative imaging confirmed optimal tether positioning. The patient had an uneventful intraoperative course, and postoperative imaging revealed improved spinal alignment and significant reduction in severe bone pain.

7. Minimally invasive lateral interbody fusion was performed for other idiopathic scoliosis with severe bone pain. The procedure aimed to correct the scoliotic curvature and provide relief from severe bone pain. Cage placement and interbody fusion were achieved, promoting stability and pain reduction. The patient had a smooth intraoperative course, and postoperative imaging confirmed improved spinal alignment and significant alleviation of severe bone pain.

8. Patient underwent posterior spinal fusion with hybrid instrumentation for severe other idiopathic scoliosis with associated bone pain. Pedicle screws were placed from T3 to L4, and hooks were utilized to address the pain site. Intraoperative neuromonitoring ensured spinal cord safety. The patient tolerated the procedure well, and postoperative imaging showed satisfactory correction and substantial relief of severe bone pain.

9. Surgical correction of other idiopathic scoliosis with severe bone pain involved posterior spinal fusion using pedicle screws and rods from T4 to L5. Additional bone grafting was performed to promote fusion and alleviate the pain. Intraoperative neuromonitoring ensured spinal cord integrity. The patient had a smooth intraoperative course, and postoperative imaging demonstrated improved spinal alignment and significant reduction in severe bone pain.

10. Minimally invasive lateral lumbar interbody fusion was performed for other idiopathic scoliosis with severe bone pain. The procedure aimed to correct the scoliotic curvature and relieve the intense bone pain. Cage placement and interbody fusion were achieved, providing stability and significant pain relief. The patient had an uncomplicated intraoperative course, and postoperative imaging confirmed improved spinal alignment and substantial alleviation of severe bone pain.

1. Patient underwent vertebral column resection (VCR) as a surgical intervention for other idiopathic scoliosis. The procedure involved removing the vertebral body at the apex of the curve and fusing the remaining segments. Intraoperative neuromonitoring ensured spinal cord safety. The patient had a smooth intraoperative course, and postoperative imaging showed improved spinal alignment and stabilization.

2. Surgical correction of other idiopathic scoliosis involved posterior spinal fusion with segmental pedicle screw fixation. The fusion extended from T3 to L4, addressing the scoliotic curve. Intraoperative neuromonitoring ensured spinal cord integrity. The patient tolerated the procedure well, and postoperative imaging demonstrated satisfactory alignment and fusion.

3. Minimally invasive surgical intervention for other idiopathic scoliosis included percutaneous vertebral body stapling. The staples were placed at the apex of the curvature to halt its progression. The patient had an uneventful intraoperative course, and immediate postoperative imaging showed improved spinal alignment and stabilization.

4. Patient underwent posterior spinal fusion with hybrid instrumentation as a surgical intervention for other idiopathic scoliosis. Pedicle screws were placed from T4 to L4, and hooks were utilized at the apex of the curve. Intraoperative neurophysiological monitoring ensured spinal cord integrity. The patient tolerated the procedure well, and postoperative imaging demonstrated satisfactory correction and stabilization.

5. Surgical intervention for other idiopathic scoliosis involved anterior and posterior spinal fusion. Anterior release and fusion were performed first, followed by posterior instrumentation from T2 to L5. Intraoperative imaging confirmed adequate correction. The patient had a smooth intraoperative course, and postoperative imaging showed improved spinal alignment and stabilization.

6. Patient underwent posterior spinal fusion with vertebral body tethering as a surgical intervention for other idiopathic scoliosis. The tether was placed between T4 and L4, providing corrective tension. Intraoperative imaging confirmed optimal tether placement. The patient had an uneventful intraoperative course, and postoperative imaging revealed improved spinal alignment and stabilization.

7. Minimally invasive surgical intervention for other idiopathic scoliosis involved lateral lumbar interbody fusion. The procedure accessed the disc spaces from L1 to L5 through a lateral approach. Cage placement and interbody fusion were achieved using fluoroscopic guidance. The patient had a smooth intraoperative course, and postoperative imaging confirmed improved spinal alignment and stabilization.

8. Surgical correction of other idiopathic scoliosis involved posterior spinal fusion with pedicle screws and rods. The fusion extended from T2 to L5, addressing the scoliotic curve. Intraoperative neuromonitoring ensured spinal cord safety. The patient tolerated the procedure well, and postoperative imaging demonstrated satisfactory alignment and stabilization.

9. Patient underwent anterior release and fusion as a surgical intervention for other idiopathic scoliosis. The procedure involved removing the intervertebral discs and placing bone grafts to promote fusion. Intraoperative imaging confirmed adequate correction. The patient had a smooth intraoperative course, and postoperative imaging showed improved spinal alignment and stabilization.

10. Minimally invasive surgical intervention for other idiopathic scoliosis included posterior spinal fusion using pedicle screws and rods. The fusion extended from T3 to L4, addressing the scoliotic curvature. Intraoperative neuromonitoring ensured spinal cord integrity. The patient tolerated the procedure well, and postoperative imaging revealed satisfactory alignment and stabilization.

1. Surgical intervention for other idiopathic scoliosis involved posterior vertebral column resection (PVCR). The procedure aimed to correct the severe spinal deformity by removing the entire vertebral body at the apex of the curve and fusing the adjacent segments. Intraoperative neuromonitoring ensured spinal cord safety. The patient had an uneventful intraoperative course, and postoperative imaging demonstrated significant improvement in spinal alignment and stabilization.

2. Patient underwent anterior vertebral body tethering as a surgical intervention for other idiopathic scoliosis. The procedure involved placing a dynamic tether between the vertebrae at the apex of the curve to correct the deformity and provide flexibility. Intraoperative imaging confirmed optimal tether positioning. The patient had a smooth intraoperative course, and postoperative imaging revealed improved spinal alignment and stabilization.

3. Surgical correction of other idiopathic scoliosis involved posterior spinal fusion with instrumentation using pedicle screws and hooks. The fusion extended from T4 to L4, addressing the scoliotic curve. Intraoperative neuromonitoring ensured spinal cord integrity. The patient tolerated the procedure well, and postoperative imaging demonstrated satisfactory correction and stabilization of the spine.

4. Minimally invasive surgical intervention for other idiopathic scoliosis included posterior vertebral body tethering. The procedure aimed to correct the spinal deformity by placing tethers between the vertebrae at the apex of the curve. Intraoperative imaging confirmed optimal tether placement. The patient had a smooth intraoperative course, and postoperative imaging revealed improved spinal alignment and stabilization.

5. Patient underwent posterior spinal fusion with hybrid instrumentation as a surgical intervention for other idiopathic scoliosis. Pedicle screws were placed from T3 to L5, and hooks were utilized to address the deformity. Intraoperative neuromonitoring ensured spinal cord safety. The patient had an uneventful intraoperative course, and postoperative imaging demonstrated satisfactory correction and stabilization.

6. Surgical intervention for other idiopathic scoliosis involved anterior vertebral body reconstruction and fusion. The procedure aimed to correct the severe spinal deformity by removing the affected vertebrae and replacing them with bone grafts. Intraoperative imaging confirmed adequate correction and fusion. The patient had a smooth intraoperative course, and postoperative imaging showed improved spinal alignment and stabilization.

7. Patient underwent posterior spinal fusion with segmental pedicle screw fixation as a surgical intervention for other idiopathic scoliosis. The fusion extended from T4 to L4, addressing the scoliotic curvature. Intraoperative neuromonitoring ensured spinal cord integrity. The patient tolerated the procedure well, and postoperative imaging demonstrated satisfactory alignment and fusion.

8. Surgical correction of other idiopathic scoliosis involved posterior vertebral column resection (PVCR) with pedicle screw instrumentation. The procedure aimed to correct the severe spinal deformity by removing the affected vertebral body and fusing the spine. Intraoperative neuromonitoring ensured spinal cord safety. The patient had an uneventful intraoperative course, and postoperative imaging revealed significant improvement in spinal alignment and stabilization.

9. Minimally invasive surgical intervention for other idiopathic scoliosis included lateral lumbar interbody fusion (LLIF). The procedure accessed the disc spaces from L1 to L5 through a lateral approach, allowing for fusion and correction of the scoliotic curvature. Intraoperative imaging guided the procedure, and the patient had a smooth intraoperative course. Postoperative imaging confirmed improved spinal alignment and stabilization.

10. Patient underwent anterior release and fusion with instrumentation as a surgical intervention for other idiopathic scoliosis. The procedure aimed to correct the spinal deformity and stabilize the spine using bone grafts and implants. Intraoperative imaging confirmed optimal correction and fusion. The patient had an uneventful intraoperative course, and postoperative imaging revealed improved spinal alignment and significant stabilization.

1. Surgical intervention was performed for other idiopathic scoliosis with a severe infection affecting the extreme moving joint. The procedure involved extensive debridement of the infected joint followed by spinal fusion from T2 to L4. Intraoperative irrigation with antimicrobial solutions was performed to minimize the infection. The patient tolerated the procedure well, and postoperative imaging demonstrated improved spinal alignment and successful eradication of the severe joint infection.

2. Patient underwent surgical correction of other idiopathic scoliosis with a severe infection at the extreme moving joint. The procedure involved removal of infected tissues and debridement followed by posterior spinal fusion from T3 to L5. Intraoperative measures, including wound irrigation with antimicrobial agents, were implemented to address the infection. The patient had a smooth intraoperative course, and postoperative imaging showed improved spinal alignment and resolution of the severe joint infection.

3. Surgical intervention for other idiopathic scoliosis with a severe infection at the extreme moving joint included extensive debridement and spinal fusion. The infected joint was thoroughly cleaned, and instrumentation with pedicle screws and rods was performed from T4 to L4. Intraoperative measures were taken to control the infection. The patient tolerated the procedure well, and postoperative imaging demonstrated improved spinal alignment and successful eradication of the severe joint infection.

4. Patient underwent surgical correction of other idiopathic scoliosis with a severe infection affecting the extreme moving joint. The procedure involved debridement of infected tissues, followed by anterior and posterior spinal fusion from T2 to L5. Intraoperative irrigation with antimicrobial solutions was performed to address the infection. The patient had an uneventful intraoperative course, and postoperative imaging revealed improved spinal alignment and resolution of the severe joint infection.

5. Surgical intervention for other idiopathic scoliosis with a severe infection at the extreme moving joint involved extensive debridement and posterior spinal fusion. The infected joint was meticulously cleaned, and instrumentation with pedicle screws and hooks was performed from T3 to L4. Intraoperative measures were taken to eradicate the infection. The patient tolerated the procedure well, and postoperative imaging showed improved spinal alignment and successful resolution of the severe joint infection.

6. Patient underwent surgical correction of other idiopathic scoliosis with a severe infection affecting the extreme moving joint. The procedure involved debridement of the infected joint followed by posterior spinal fusion from T4 to L5. Intraoperative irrigation with antimicrobial agents was performed to control the infection. The patient had a smooth intraoperative course, and postoperative imaging demonstrated improved spinal alignment and eradication of the severe joint infection.

7. Surgical intervention for other idiopathic scoliosis with a severe infection at the extreme moving joint included thorough debridement and spinal fusion. The infected joint was extensively cleaned, and pedicle screw fixation was performed from T2 to L4. Intraoperative measures were taken to address the infection. The patient tolerated the procedure well, and postoperative imaging revealed improved spinal alignment and successful eradication of the severe joint infection.

8. Patient underwent surgical correction of other idiopathic scoliosis with a severe infection affecting the extreme moving joint. The procedure involved debridement of infected tissues and posterior spinal fusion from T3 to L5. Intraoperative irrigation with antimicrobial solutions was performed to control the infection. The patient had an uneventful intraoperative course, and postoperative imaging showed improved spinal alignment and resolution of the severe joint infection.

9. Surgical intervention for other idiopathic scoliosis with a severe infection at the extreme moving joint involved extensive debridement and posterior spinal fusion. The infected joint was thoroughly cleaned, and instrumentation with pedicle screws and rods was performed from T4 to L4. Intraoperative measures were taken to eradicate the infection. The patient tolerated the procedure well, and postoperative imaging demonstrated improved spinal alignment and successful eradication of the severe joint infection.

10. Patient underwent surgical correction of other idiopathic scoliosis with a severe infection affecting the extreme moving joint. The procedure involved debridement of the infected joint followed by anterior and posterior spinal fusion from T2 to L5. Intraoperative irrigation with antimicrobial agents was performed to address the infection. The patient had a smooth intraoperative course, and postoperative imaging revealed improved spinal alignment and resolution of the severe joint infection.

1. Surgical intervention was performed for other idiopathic scoliosis with severe inflammation at the site of the curvature. The procedure involved extensive debridement of the inflamed tissues followed by posterior spinal fusion from T2 to L4. Intraoperative measures were taken to reduce inflammation. The patient tolerated the procedure well, and postoperative imaging demonstrated improved spinal alignment and reduction in inflammation.

2. Patient underwent surgical correction of other idiopathic scoliosis with significant inflammation at the site of the curvature. The procedure involved removal of inflamed tissues and debridement followed by posterior spinal fusion from T3 to L5. Intraoperative measures were implemented to address the inflammation. The patient had a smooth intraoperative course, and postoperative imaging showed improved spinal alignment and decreased inflammation.

3. Surgical intervention for other idiopathic scoliosis with inflammation at the site of the curvature included extensive debridement and spinal fusion. The inflamed tissues were thoroughly cleaned, and instrumentation with pedicle screws and rods was performed from T4 to L4. Intraoperative measures were taken to control the inflammation. The patient tolerated the procedure well, and postoperative imaging demonstrated improved spinal alignment and reduction in inflammation.

4. Patient underwent surgical correction of other idiopathic scoliosis with notable inflammation at the site of the curvature. The procedure involved debridement of inflamed tissues, followed by anterior and posterior spinal fusion from T2 to L5. Intraoperative measures were implemented to address the inflammation. The patient had an uneventful intraoperative course, and postoperative imaging revealed improved spinal alignment and decreased inflammation.

5. Surgical intervention for other idiopathic scoliosis with inflammation at the site of the curvature involved extensive debridement and posterior spinal fusion. The inflamed tissues were meticulously cleaned, and instrumentation with pedicle screws and hooks was performed from T3 to L4. Intraoperative measures were taken to reduce the inflammation. The patient tolerated the procedure well, and postoperative imaging showed improved spinal alignment and decreased inflammation.

6. Patient underwent surgical correction of other idiopathic scoliosis with inflammation at the site of the curvature. The procedure involved debridement of the inflamed tissues followed by posterior spinal fusion from T4 to L5. Intraoperative measures were taken to address the inflammation. The patient had a smooth intraoperative course, and postoperative imaging demonstrated improved spinal alignment and reduction in inflammation.

7. Surgical intervention for other idiopathic scoliosis with inflammation at the site of the curvature included thorough debridement and spinal fusion. The inflamed tissues were extensively cleaned, and pedicle screw fixation was performed from T2 to L4. Intraoperative measures were taken to control the inflammation. The patient tolerated the procedure well, and postoperative imaging revealed improved spinal alignment and decreased inflammation.

8. Patient underwent surgical correction of other idiopathic scoliosis with significant inflammation at the site of the curvature. The procedure involved debridement of inflamed tissues and posterior spinal fusion from T3 to L5. Intraoperative measures were implemented to address the inflammation. The patient had an uneventful intraoperative course, and postoperative imaging showed improved spinal alignment and reduction in inflammation.

9. Surgical intervention for other idiopathic scoliosis with inflammation at the site of the curvature involved extensive debridement and posterior spinal fusion. The inflamed tissues were thoroughly cleaned, and instrumentation with pedicle screws and rods was performed from T4 to L4. Intraoperative measures were taken to reduce the inflammation. The patient tolerated the procedure well, and postoperative imaging demonstrated improved spinal alignment and decreased inflammation.

10. Patient underwent surgical correction of other idiopathic scoliosis with notable inflammation at the site of the curvature. The procedure involved debridement of inflamed tissues followed by anterior and posterior spinal fusion from T2 to L5. Intraoperative measures were implemented to address the inflammation. The patient had a smooth intraoperative course, and postoperative imaging revealed improved spinal alignment and reduction in inflammation.

1. Follow-up for a severe diagnosis of other idiopathic scoliosis involved frequent clinical evaluations every two weeks for the first three months, followed by monthly check-ups thereafter. X-ray imaging was performed at six months and one year to assess the progress of spinal alignment. If significant improvement was observed, follow-up appointments were scheduled every six months. However, if the condition persisted or worsened, more frequent monitoring and intervention were recommended.

2. Based on the severity of the diagnosis of other idiopathic scoliosis, the patient required close follow-up with a spine specialist. Weekly check-ups were conducted for the first month to closely monitor the progression of the condition. If the scoliotic curve showed improvement, follow-up appointments were scheduled every three months. However, if there was no improvement or worsening of the curve, more frequent visits were recommended to explore additional treatment options.

3. Follow-up care for a moderate diagnosis of other idiopathic scoliosis involved regular check-ups every three months to assess the stability of the spinal curvature. X-ray imaging was performed at six months and one year to evaluate the progression of the condition. If the curve remained stable, follow-up appointments were scheduled every six months to monitor any changes. In case of significant progression, more frequent visits and potential treatment interventions were advised.

4. In the case of a mild diagnosis of other idiopathic scoliosis, follow-up visits were scheduled every six months for the first two years. These appointments involved physical examinations and monitoring of the scoliotic curve through X-ray imaging. If the condition remained stable, follow-up appointments were extended to once a year. However, if there was any indication of progression, closer monitoring and potential treatment options were discussed.

5. Following a severe diagnosis of other idiopathic scoliosis, the patient required regular follow-up visits every month for the first six months. These visits included clinical evaluations, X-ray imaging, and discussions about potential treatment interventions. Depending on the response to treatment, follow-up appointments were adjusted accordingly, with the possibility of transitioning to less frequent visits if the condition stabilized or more frequent visits if further intervention was required.

6. For a moderate diagnosis of other idiopathic scoliosis, follow-up appointments were scheduled every three to four months. During these visits, the patient underwent physical examinations, spinal measurements, and discussions about potential treatment options. If the scoliotic curve showed improvement or remained stable, follow-up visits were extended to every six months. However, if there was any progression, closer monitoring and potential intervention were recommended.

7. Follow-up care for a mild diagnosis of other idiopathic scoliosis involved regular check-ups every six months to assess the stability of the spinal curvature. Physical examinations and periodic X-ray imaging were performed to monitor any changes. If the condition remained mild and did not progress, follow-up appointments were extended to once a year. However, if there were any indications of worsening, closer monitoring and potential treatment interventions were considered.

8. Based on the severity of the diagnosis of other idiopathic scoliosis, the patient required follow-up appointments every three months for the first year. These visits included physical examinations, spinal measurements, and discussions about potential treatment options. If the scoliotic curve showed improvement or remained stable, follow-up visits were extended to every six months. However, if there was any progression, more frequent monitoring and potential intervention were recommended.

9. Follow-up care for a severe diagnosis of other idiopathic scoliosis involved frequent visits every three to four weeks initially, to closely monitor the progression of the condition. Physical examinations, spinal measurements, and periodic X-ray imaging were performed during these appointments. Depending on the response to treatment, follow-up visits were adjusted accordingly, with the possibility of transitioning to less frequent visits if the condition stabilized or more frequent visits if further intervention was required.

10. In the case of a moderate diagnosis of other idiopathic scoliosis, follow-up appointments were scheduled every four to six months. These visits involved physical examinations, spinal measurements, and discussions about potential treatment options. If the scoliotic curve showed improvement or remained stable, follow-up visits were extended to once a year. However, if there was any progression, closer monitoring and potential intervention were recommended.

## M41.3 Thoracogenic scoliosis

1. Operative Note: Thoracogenic scoliosis correction was performed via posterior spinal fusion with instrumentation. The thoracic spine was exposed, and pedicle screws were placed from T1 to T12. Deformity correction was achieved by derotation and translation maneuvers. Autogenous bone graft was placed bilaterally. Hemostasis was achieved, and wound closure was performed. The patient tolerated the procedure well.

2. Operative Note: Intraoperative neurophysiological monitoring was utilized during the correction of thoracogenic scoliosis. The patient underwent posterior spinal fusion with pedicle screw instrumentation from T2 to L4. Intraoperative monitoring showed stable signals throughout the procedure. The thoracic spine was successfully corrected, and the incision was closed in layers. The patient remained hemodynamically stable during the operation.

3. Operative Note: Thoracogenic scoliosis correction was performed using a minimally invasive approach. Bilateral thoracic pedicle screws were inserted under fluoroscopic guidance from T4 to T12. The scoliotic curve was corrected through sequential rod derotation and translation. The fusion was augmented with bone graft and local autograft. Hemostasis was obtained, and the incisions were closed without complications.

4. Operative Note: Thoracogenic scoliosis correction was achieved through an anterior approach. A left thoracotomy was performed, and the ribs were resected. The thoracic vertebrae were exposed, and a release of the anterior longitudinal ligament was performed. The deformity was corrected using distraction and compression techniques. A structural bone graft was placed, and the incision was closed layer by layer. The patient tolerated the procedure well.

5. Operative Note: Thoracogenic scoliosis correction was performed using a combined anterior-posterior approach. The patient underwent a thoracoscopic release of the anterior longitudinal ligament, followed by a posterior spinal fusion with pedicle screw instrumentation. The scoliotic curve was successfully corrected, and interbody grafts were placed anteriorly. The patient remained stable throughout the procedure, and the wounds were closed without any issues.

6. Operative Note: Intraoperative navigation was used during the correction of thoracogenic scoliosis. A posterior spinal fusion was performed with pedicle screw instrumentation from T3 to L5. Real-time navigation guidance aided in accurate screw placement. The deformity was corrected using rod derotation and translation techniques. Autograft and allograft were used for fusion. Hemostasis was achieved, and the incisions were closed meticulously.

7. Operative Note: Thoracogenic scoliosis correction was achieved through a video-assisted thoracoscopic surgery (VATS) approach. The patient underwent a release of the anterior longitudinal ligament and thoracic spinal fusion using pedicle screws from T5 to T12. The scoliosis was corrected using rod derotation and compression. The fusion was augmented with bone graft and synthetic bone substitute. The procedure was uneventful, and the patient recovered well postoperatively.

8. Operative Note: Thoracogenic scoliosis correction was performed via a posterior vertebral column resection (PVCR) technique. The patient underwent a T4-L4 posterior fusion with pedicle screw instrumentation. The vertebral column was resected at the apex of the scoliosis, and a temporary rod was placed for stability. The deformity was corrected by closing the gap with rods and connectors. The final construct was secured, and wound closure was performed without complications.

9. Operative Note: Thoracogenic scoliosis correction was achieved using a magnetically controlled growing rod (MCGR) system. The patient underwent a posterior spinal fusion with pedicle screw instrumentation from T2 to L4. The MCGR was implanted to allow for gradual correction and growth. The rod length was adjusted under fluoroscopy guidance. Hemostasis was achieved, and the incisions were closed in layers. The patient's postoperative course was uneventful.

10. Operative Note: Thoracogenic scoliosis correction was performed using a hybrid technique. The patient underwent an anterior release of the anterior longitudinal ligament and vertebral column osteotomies, followed by a posterior spinal fusion with pedicle screw instrumentation from T3 to L4. The deformity was successfully corrected using rod derotation and compression. Autograft and allograft were used for fusion. The wounds were closed meticulously, and the patient recovered well postoperatively.

1. Operative Note: Thoracogenic scoliosis correction was performed using a thoracoscopic-assisted anterior release technique. The anterior longitudinal ligament was released, and thoracic discs were removed. Anterior interbody grafts were placed, followed by a posterior spinal fusion from T4 to L4 using pedicle screw instrumentation. The scoliosis deformity was adequately corrected. Hemostasis was achieved, and wound closure was performed without complications.

2. Operative Note: Thoracogenic scoliosis correction was achieved through a vertebral column resection (VCR) procedure. The patient underwent a T3-L3 posterior spinal fusion with pedicle screw instrumentation. Vertebral column resection was performed at the apex of the deformity, and the remaining vertebrae were fused using rods and connectors. Hemostasis was obtained, and the incisions were closed layer by layer. The patient tolerated the procedure well.

3. Operative Note: Thoracogenic scoliosis correction was performed using a posterior-only approach. A posterior spinal fusion with pedicle screw instrumentation was done from T5 to L4. Deformity correction was achieved using rod derotation and compression techniques. The fusion was augmented with bone graft and synthetic bone substitute. Hemostasis was achieved, and the incisions were closed meticulously. The patient had an uneventful intraoperative course.

4. Operative Note: Thoracogenic scoliosis correction was achieved through a minimally invasive lateral approach. The patient underwent lateral interbody fusion at the thoracic levels using expandable cages and posterior pedicle screw instrumentation from T4 to T12. The scoliotic curve was adequately corrected, and fusion was achieved with bone graft and bone morphogenetic protein. Hemostasis was obtained, and the incisions were closed without complications.

5. Operative Note: Thoracogenic scoliosis correction was performed using a growing rod technique. The patient underwent a posterior spinal fusion with pedicle screw instrumentation from T2 to L4. Dual growing rods were implanted to allow for gradual correction and lengthening. The rods were adjusted under fluoroscopic guidance. Hemostasis was achieved, and the wounds were closed meticulously. The patient tolerated the procedure well.

6. Operative Note: Thoracogenic scoliosis correction was achieved through a hybrid technique. The patient underwent an anterior release of the anterior longitudinal ligament and thoracic disc removal. This was followed by posterior spinal fusion with pedicle screw instrumentation from T3 to L3. The deformity was corrected using rod derotation and compression techniques. Bone graft and synthetic bone substitute were used for fusion. The incisions were closed in layers without complications.

7. Operative Note: Thoracogenic scoliosis correction was performed using a rib-based technique. The patient underwent rib osteotomies at the apex of the deformity. Posterior spinal fusion with pedicle screw instrumentation was done from T3 to L3. The rib segments were used as structural grafts for fusion. Hemostasis was achieved, and the wounds were closed meticulously. The patient had an uneventful intraoperative course.

8. Operative Note: Thoracogenic scoliosis correction was achieved through a posterior vertebral column resection (PVCR) and staged anterior release. The patient underwent a PVCR at T5-L2, followed by a second-stage anterior release of the remaining thoracic levels. Posterior spinal fusion with pedicle screw instrumentation from T4 to L4 was performed. The deformity was successfully corrected, and bone grafts were placed. Hemostasis was obtained, and wound closure was performed without complications.

9. Operative Note: Thoracogenic scoliosis correction was performed using a posterior spinal fusion with hybrid instrumentation. Pedicle screws were placed from T2 to L5, and sublaminar wires were used for additional stability. The deformity was corrected using rod derotation and translation techniques. Bone graft and synthetic bone substitute were utilized for fusion. Hemostasis was achieved, and the incisions were closed meticulously. The patient tolerated the procedure well.

10. Operative Note: Thoracogenic scoliosis correction was achieved through a posterior vertebral column resection (PVCR) technique combined with anterior release. The patient underwent a PVCR at T6-L3, followed by an anterior release of the remaining thoracic levels. Posterior spinal fusion with pedicle screw instrumentation from T4 to L4 was performed. The deformity was adequately corrected, and bone grafts were placed. Hemostasis was achieved, and wound closure was performed without complications.

1. Operative Note: Thoracogenic scoliosis correction was performed under general anesthesia with endotracheal intubation. Anesthesia induction was achieved with propofol (2 mg/kg) and fentanyl (1 mcg/kg). Maintenance was provided using sevoflurane and remifentanil infusion (0.1-0.3 mcg/kg/min). Intraoperative monitoring showed stable vital signs. The posterior spinal fusion with pedicle screw instrumentation was successfully performed from T4 to L4. The patient recovered smoothly from anesthesia without complications.

2. Operative Note: Thoracogenic scoliosis correction was performed under general anesthesia with a balanced technique. Anesthesia induction was achieved using propofol (1.5-2 mg/kg) and remifentanil (0.5-1 mcg/kg). Anesthesia maintenance was provided with sevoflurane and remifentanil infusion (0.05-0.2 mcg/kg/min). The posterior spinal fusion with pedicle screw instrumentation from T3 to L4 was performed successfully. The patient's vital signs remained stable throughout the procedure, and anesthesia was smoothly reversed.

3. Operative Note: Thoracogenic scoliosis correction was performed under general anesthesia with a total intravenous anesthesia (TIVA) technique. Anesthesia induction was achieved using propofol (2-3 mg/kg) and fentanyl (1 mcg/kg). Anesthesia was maintained with propofol infusion (100-200 mcg/kg/min) and remifentanil infusion (0.1-0.3 mcg/kg/min). The posterior spinal fusion with pedicle screw instrumentation from T5 to L4 was completed without complications. The patient recovered well from anesthesia.

4. Operative Note: Thoracogenic scoliosis correction was performed under general anesthesia with a high-dose opioid technique. Anesthesia induction was achieved using fentanyl (3-5 mcg/kg) and propofol (1.5-2 mg/kg). Anesthesia maintenance was provided with sevoflurane and continuous infusion of high-dose remifentanil (0.5-1 mcg/kg/min). The posterior spinal fusion with pedicle screw instrumentation from T2 to L3 was successfully performed. The patient's vital signs were stable throughout the procedure, and anesthesia was smoothly reversed.

5. Operative Note: Thoracogenic scoliosis correction was performed under general anesthesia with a low-dose opioid technique. Anesthesia induction was achieved using fentanyl (0.5-1 mcg/kg) and propofol (1.5-2 mg/kg). Anesthesia maintenance was provided with sevoflurane and intermittent boluses of fentanyl (25-50 mcg). The posterior spinal fusion with pedicle screw instrumentation from T4 to L5 was completed without complications. The patient recovered smoothly from anesthesia with minimal postoperative sedation.

6. Operative Note: Thoracogenic scoliosis correction was performed under general anesthesia with a balanced technique. Anesthesia induction was achieved using propofol (1-2 mg/kg) and sufentanil (0.2-0.4 mcg/kg). Anesthesia maintenance was provided with desflurane and a continuous infusion of remifentanil (0.05-0.15 mcg/kg/min). The posterior spinal fusion with pedicle screw instrumentation from T3 to L4 was successfully performed. The patient's vital signs remained stable, and anesthesia was smoothly reversed.

7. Operative Note: Thoracogenic scoliosis correction was performed under general anesthesia with a total intravenous anesthesia (TIVA) technique. Anesthesia induction was achieved using etomidate (0.2-0.3 mg/kg) and remifentanil (0.5-1 mcg/kg). Anesthesia maintenance was provided with a propofol infusion (75-150 mcg/kg/min) and remifentanil infusion (0.05-0.1 mcg/kg/min). The posterior spinal fusion with pedicle screw instrumentation from T5 to L4 was completed without complications. The patient recovered smoothly from anesthesia.

8. Operative Note: Thoracogenic scoliosis correction was performed under general anesthesia with a high-dose opioid technique. Anesthesia induction was achieved using sufentanil (0.5-1 mcg/kg) and propofol (1.5-2.5 mg/kg). Anesthesia maintenance was provided with sevoflurane and continuous infusion of high-dose remifentanil (1-2 mcg/kg/min). The posterior spinal fusion with pedicle screw instrumentation from T4 to L3 was successfully performed. The patient's vital signs were stable throughout the procedure, and anesthesia was smoothly reversed.

9. Operative Note: Thoracogenic scoliosis correction was performed under general anesthesia with a low-dose opioid technique. Anesthesia induction was achieved using remifentanil (0.1-0.2 mcg/kg) and propofol (1-2 mg/kg). Anesthesia maintenance was provided with sevoflurane and intermittent boluses of fentanyl (10-25 mcg). The posterior spinal fusion with pedicle screw instrumentation from T2 to L4 was completed without complications. The patient recovered smoothly from anesthesia with minimal postoperative sedation.

10. Operative Note: Thoracogenic scoliosis correction was performed under general anesthesia with a balanced technique. Anesthesia induction was achieved using propofol (1.5-2.5 mg/kg) and sufentanil (0.2-0.3 mcg/kg). Anesthesia maintenance was provided with desflurane and a continuous infusion of remifentanil (0.1-0.2 mcg/kg/min). The posterior spinal fusion with pedicle screw instrumentation from T3 to L5 was successfully performed. The patient's vital signs remained stable, and anesthesia was smoothly reversed.

1. Operative Note: Thoracogenic scoliosis correction was performed due to progressive spinal deformity and associated bone erosion. The patient underwent posterior spinal fusion with pedicle screw instrumentation from T4 to L4. The bone erosion was carefully addressed during the procedure by meticulous decortication and removal of the eroded bony fragments. Autograft and allograft were used to facilitate fusion. The incisions were closed layer by layer, and the patient tolerated the surgery well.

2. Operative Note: Thoracogenic scoliosis correction was performed in the setting of severe spinal deformity and extensive bone erosion. The patient underwent anterior release of the anterior longitudinal ligament and disc removal followed by posterior spinal fusion from T3 to L3 using pedicle screw instrumentation. The eroded bone fragments were carefully excised and replaced with bone graft and synthetic bone substitute to promote fusion. The wounds were closed meticulously, and the patient recovered well postoperatively.

3. Operative Note: Thoracogenic scoliosis correction was performed in a patient with significant bone erosion at the thoracic levels. The patient underwent a combined anterior and posterior approach. The anterior release involved removal of eroded discs and meticulous debridement of the affected bone. Subsequently, posterior spinal fusion with pedicle screw instrumentation from T5 to L4 was performed. Bone graft and synthetic bone substitute were used to address the bone erosion. The patient had an uneventful intraoperative course.

4. Operative Note: Thoracogenic scoliosis correction was performed in a patient with severe bone erosion requiring extensive reconstruction. The patient underwent a posterior vertebral column resection (PVCR) technique. The eroded vertebral segments were carefully removed, and remaining vertebrae were fused using rods and connectors. Additional bone graft and synthetic bone substitute were utilized to address the bone erosion. The patient's intraoperative course was uneventful, and the wounds were closed meticulously.

5. Operative Note: Thoracogenic scoliosis correction was performed in a patient with advanced bone erosion affecting the thoracic spine. The patient underwent a staged procedure. The first stage involved anterior release of the eroded segments with meticulous removal of affected discs. The second stage involved posterior spinal fusion with pedicle screw instrumentation from T2 to L3. Autograft and allograft were used to address the bone erosion. The patient tolerated the surgery well.

6. Operative Note: Thoracogenic scoliosis correction was performed in a patient with severe bone erosion necessitating extensive reconstruction. The patient underwent anterior release followed by posterior spinal fusion with pedicle screw instrumentation from T4 to L4. The eroded bone segments were carefully excised, and autogenous bone grafts were placed to address the bone erosion. Synthetic bone substitute was used as an adjunct for fusion. The incisions were closed meticulously, and the patient recovered well postoperatively.

7. Operative Note: Thoracogenic scoliosis correction was performed in a patient with significant bone erosion affecting multiple thoracic vertebrae. The patient underwent a combined approach, including anterior release and posterior spinal fusion with pedicle screw instrumentation from T3 to L3. The eroded bone was meticulously debrided, and bone graft with synthetic bone substitute was used to address the erosion and facilitate fusion. The patient's intraoperative course was uneventful, and the wounds were closed in layers.

8. Operative Note: Thoracogenic scoliosis correction was performed in a patient with extensive bone erosion at the thoracic levels. The patient underwent a posterior spinal fusion with pedicle screw instrumentation from T2 to L5. The eroded bone fragments were carefully excised, and autograft with synthetic bone substitute was used to address the bone erosion. The fusion was achieved successfully, and the patient recovered well postoperatively without complications.

9. Operative Note: Thoracogenic scoliosis correction was performed in a patient with severe bone erosion requiring meticulous reconstruction. The patient underwent posterior spinal fusion with pedicle screw instrumentation from T4 to L4. The eroded bone was meticulously excised, and bone graft with synthetic bone substitute was used to address the bone erosion. The fusion was achieved successfully, and the patient's postoperative course was uneventful.

10. Operative Note: Thoracogenic scoliosis correction was performed in a patient with significant bone erosion at the thoracic levels. The patient underwent a hybrid technique, combining anterior release and posterior spinal fusion with pedicle screw instrumentation from T3 to L3. The eroded bone fragments were meticulously removed, and bone graft along with synthetic bone substitute was used to address the erosion and promote fusion. The patient tolerated the procedure well, and the wounds were closed meticulously.

1. Operative Note: Thoracogenic scoliosis correction was performed in a patient with severe bone pain due to progressive spinal deformity. The patient underwent posterior spinal fusion with pedicle screw instrumentation from T4 to L4. Meticulous attention was given to addressing the eroded bone and relieving the pressure on the affected nerves. The procedure provided significant relief from the patient's severe bone pain. The wounds were closed meticulously, and the patient tolerated the surgery well.

2. Operative Note: Thoracogenic scoliosis correction was performed in a patient with debilitating bone pain caused by the spinal deformity. The patient underwent a combined approach with anterior release followed by posterior spinal fusion from T3 to L3. Meticulous removal of the eroded discs and bony fragments was carried out to alleviate the severe bone pain. The patient experienced immediate relief postoperatively, and the wounds were closed meticulously.

3. Operative Note: Thoracogenic scoliosis correction was performed in a patient with severe bone pain refractory to conservative measures. The patient underwent a posterior vertebral column resection (PVCR) technique to address the spinal deformity and alleviate the intense bone pain. Meticulous attention was given to removing the eroded bone segments causing the pain. Postoperatively, the patient experienced a significant reduction in severe bone pain and had an uneventful recovery.

4. Operative Note: Thoracogenic scoliosis correction was performed in a patient with debilitating bone pain affecting the thoracic spine. The patient underwent a posterior spinal fusion with pedicle screw instrumentation from T4 to L4. Special attention was given to decompressing the affected nerve roots and relieving the severe bone pain. The procedure resulted in significant pain relief, and the patient's postoperative course was uneventful.

5. Operative Note: Thoracogenic scoliosis correction was performed in a patient with severe bone pain impairing daily activities. The patient underwent anterior release followed by posterior spinal fusion with pedicle screw instrumentation from T2 to L3. Meticulous attention was given to decompressing the affected nerve roots and addressing the eroded bone causing the severe bone pain. Postoperatively, the patient reported remarkable improvement in pain symptoms, and the wounds were closed meticulously.

6. Operative Note: Thoracogenic scoliosis correction was performed in a patient with incapacitating bone pain affecting the thoracic spine. The patient underwent a combined approach, including anterior release and posterior spinal fusion with pedicle screw instrumentation from T3 to L3. Meticulous decompression of the nerve roots and removal of eroded bone fragments were performed to alleviate the severe bone pain. The patient experienced immediate postoperative relief and had an uneventful recovery.

7. Operative Note: Thoracogenic scoliosis correction was performed in a patient with severe bone pain refractory to conservative measures. The patient underwent posterior spinal fusion with pedicle screw instrumentation from T2 to L5. Meticulous attention was given to decompressing the affected nerve roots and addressing the eroded bone causing the severe bone pain. Postoperatively, the patient reported a significant reduction in pain and had a smooth recovery.

8. Operative Note: Thoracogenic scoliosis correction was performed in a patient with excruciating bone pain affecting the thoracic spine. The patient underwent a posterior vertebral column resection (PVCR) technique to address the severe spinal deformity and alleviate the debilitating bone pain. Meticulous removal of the eroded bone segments causing the pain was carried out. The patient experienced immediate relief from severe bone pain postoperatively, and the wounds were closed meticulously.

9. Operative Note: Thoracogenic scoliosis correction was performed in a patient with severe bone pain significantly impacting quality of life. The patient underwent a combined anterior and posterior approach, with anterior release followed by posterior spinal fusion from T4 to L4. Special attention was given to decompressing the nerve roots and relieving the intense bone pain. The patient reported substantial improvement in pain symptoms postoperatively, and the wounds were closed meticulously.

10. Operative Note: Thoracogenic scoliosis correction was performed in a patient with intractable bone pain due to progressive spinal deformity. The patient underwent posterior spinal fusion with pedicle screw instrumentation from T3 to L3. Meticulous attention was given to addressing the eroded bone and decompressing the affected nerves causing the severe bone pain. Postoperatively, the patient experienced significant relief from bone pain and had an uneventful recovery.

! Here are 10 additional synthetic operative notes pertaining to "Thoracogenic scoliosis" with mention of a surgical intervention:

1. Operative Note: Thoracogenic scoliosis correction was performed utilizing a posterior spinal fusion with pedicle screw instrumentation from T4 to L4. A surgical intervention was required to address the progressive spinal deformity and stabilize the spine. The procedure was successful, and the patient's spinal alignment was significantly improved. The wounds were closed meticulously, and the patient tolerated the surgery well.

2. Operative Note: Thoracogenic scoliosis correction was performed using a surgical intervention known as posterior vertebral column resection (PVCR). The eroded vertebrae were carefully removed, and the spine was reconstructed using pedicle screw instrumentation from T3 to L3. The PVCR technique allowed for correction of the spinal deformity and provided stability. The patient's intraoperative course was uneventful, and the wounds were closed meticulously.

3. Operative Note: Thoracogenic scoliosis correction was performed utilizing a combined surgical approach. An anterior release was first performed, followed by a posterior spinal fusion with pedicle screw instrumentation from T2 to L3. The surgical intervention was necessary to correct the spinal deformity and restore alignment. The procedure was successful, and the patient's postoperative course was uneventful.

4. Operative Note: Thoracogenic scoliosis correction was performed using a surgical intervention called vertebral column resection (VCR). The eroded vertebral segments were meticulously removed, and the spine was stabilized with pedicle screw instrumentation from T4 to L4. The VCR technique allowed for significant correction of the spinal deformity. The patient's intraoperative course was uneventful, and the wounds were closed meticulously.

5. Operative Note: Thoracogenic scoliosis correction was performed utilizing a surgical intervention known as posterior spinal fusion with instrumentation. Pedicle screws were inserted from T3 to L3 to stabilize the spine and correct the deformity. The surgical intervention successfully addressed the patient's spinal pathology, and the patient had an uneventful recovery postoperatively.

6. Operative Note: Thoracogenic scoliosis correction was performed using a surgical intervention called selective thoracic fusion. The procedure involved posterior spinal fusion with pedicle screw instrumentation from T3 to L3. Selective fusion was performed to stabilize the affected thoracic spine and correct the scoliotic curvature. The surgical intervention resulted in improved spinal alignment, and the patient's postoperative course was uneventful.

7. Operative Note: Thoracogenic scoliosis correction was performed utilizing a surgical intervention known as growing rod technique. Dual growing rods were implanted along the concave side of the scoliotic curve from T4 to L4. The surgical intervention aimed to provide gradual correction and allow for future lengthening procedures. The patient tolerated the surgery well, and the wounds were closed meticulously.

8. Operative Note: Thoracogenic scoliosis correction was performed using a surgical intervention called posterior-based Ponte osteotomies. Multiple Ponte osteotomies were performed to release the tension on the concave side of the scoliotic curve. Subsequently, posterior spinal fusion with pedicle screw instrumentation from T5 to L5 was carried out. The surgical intervention allowed for correction of the spinal deformity, and the patient's postoperative course was uneventful.

9. Operative Note: Thoracogenic scoliosis correction was performed utilizing a surgical intervention called vertebral body tethering (VBT). The procedure involved the placement of a flexible tether along the concave side of the scoliotic curve from T4 to L4. The VBT technique aimed to correct the deformity while preserving spinal flexibility. The surgical intervention was successful, and the patient's postoperative recovery was uneventful.

10. Operative Note: Thoracogenic scoliosis correction was performed using a surgical intervention called pedicle subtraction osteotomy (PSO). The eroded vertebrae were carefully removed, and a posterior spinal fusion with pedicle screw instrumentation from T3 to L3 was carried out. The PSO technique allowed for significant correction of the spinal deformity and restoration of spinal alignment. The patient tolerated the surgery well, and the wounds were closed meticulously.

1. Operative Note: Thoracogenic scoliosis correction was performed in a patient with severe infection at the extreme moving joint. The patient underwent posterior spinal fusion with pedicle screw instrumentation from T4 to L4. Meticulous debridement of the infected tissue was performed, and appropriate antibiotics were administered. The procedure successfully addressed the scoliotic deformity and controlled the infection. The wounds were closed meticulously, and the patient's postoperative course was closely monitored.

2. Operative Note: Thoracogenic scoliosis correction was performed in a patient with a severe infection at the extreme moving joint requiring urgent intervention. The patient underwent a combined approach with anterior release followed by posterior spinal fusion from T3 to L3. Extensive debridement of the infected tissue was performed, and antibiotic-impregnated bone graft was used to promote healing. The surgical intervention successfully corrected the deformity and controlled the infection. The patient's postoperative recovery was carefully managed.

3. Operative Note: Thoracogenic scoliosis correction was performed in a patient with a severe infection involving the extreme moving joint. The patient underwent posterior spinal fusion with pedicle screw instrumentation from T4 to L4. Intraoperative irrigation with antimicrobial solutions was performed to eradicate the infection. Meticulous debridement of the infected tissue was carried out, and appropriate antibiotic therapy was initiated. The surgical intervention successfully corrected the scoliosis and addressed the infection.

4. Operative Note: Thoracogenic scoliosis correction was performed in a patient with severe infection at the extreme moving joint requiring immediate surgical intervention. The patient underwent posterior spinal fusion with pedicle screw instrumentation from T3 to L3. Aggressive debridement of the infected joint was performed, and a course of intravenous antibiotics was initiated. The surgical intervention successfully corrected the spinal deformity and controlled the infection. The patient's postoperative course was closely monitored.

5. Operative Note: Thoracogenic scoliosis correction was performed in a patient with a severe infection at the extreme moving joint necessitating prompt surgical intervention. The patient underwent a combined approach, including anterior release and posterior spinal fusion with pedicle screw instrumentation from T2 to L3. Thorough debridement of the infected joint was performed, and intravenous antibiotics were administered. The surgical intervention successfully addressed the scoliotic deformity and controlled the infection.

6. Operative Note: Thoracogenic scoliosis correction was performed in a patient with severe infection at the extreme moving joint. The patient underwent a two-stage surgical approach, starting with debridement and irrigation of the infected joint, followed by posterior spinal fusion with pedicle screw instrumentation from T4 to L4. The infected tissues were meticulously excised, and appropriate antibiotics were administered. The surgical intervention successfully corrected the scoliosis and managed the infection.

7. Operative Note: Thoracogenic scoliosis correction was performed in a patient with a severe infection involving the extreme moving joint. The patient underwent posterior spinal fusion with pedicle screw instrumentation from T3 to L3. Extensive debridement of the infected joint was performed, and a course of intravenous antibiotics was initiated. The surgical intervention successfully corrected the spinal deformity and controlled the infection. Postoperatively, the patient's wound was monitored closely for signs of recurrence.

8. Operative Note: Thoracogenic scoliosis correction was performed in a patient with severe infection at the extreme moving joint requiring urgent intervention. The patient underwent posterior spinal fusion with pedicle screw instrumentation from T4 to L4. Thorough debridement of the infected joint was performed, and antibiotic-impregnated bone graft was used to promote healing. The surgical intervention successfully corrected the scoliotic deformity and addressed the infection. The patient's postoperative recovery was closely monitored.

9. Operative Note: Thoracogenic scoliosis correction was performed in a patient with a severe infection involving the extreme moving joint necessitating immediate surgical intervention. The patient underwent a combined approach, including anterior release and posterior spinal fusion with pedicle screw instrumentation from T3 to L3. Extensive debridement of the infected joint was carried out, and systemic antibiotic therapy was administered. The surgical intervention successfully corrected the spinal deformity and managed the infection.

10. Operative Note: Thoracogenic scoliosis correction was performed in a patient with severe infection at the extreme moving joint requiring prompt surgical intervention. The patient underwent posterior spinal fusion with pedicle screw instrumentation from T4 to L4. Aggressive debridement of the infected tissues was performed, and intravenous antibiotics were administered perioperatively. The surgical intervention successfully corrected the scoliosis and controlled the infection. The patient's postoperative course was carefully managed, and wound healing was closely monitored.

1. Operative Note: Thoracogenic scoliosis correction was performed in a patient with severe inflammation associated with the spinal deformity. The patient underwent a posterior spinal fusion with pedicle screw instrumentation from T4 to L4. Meticulous attention was given to addressing the inflamed tissues and minimizing surgical trauma. Postoperatively, the patient's inflammation was closely monitored, and appropriate anti-inflammatory medications were administered to manage the condition.

2. Operative Note: Thoracogenic scoliosis correction was performed in a patient with moderate inflammation of the spinal structures. The surgical intervention involved posterior spinal fusion with pedicle screw instrumentation from T3 to L3. Special care was taken to minimize intraoperative inflammation by gentle tissue handling and meticulous hemostasis. Postoperatively, the patient received anti-inflammatory medications to control the residual inflammation and promote healing.

3. Operative Note: Thoracogenic scoliosis correction was performed in a patient with mild inflammation associated with the spinal deformity. The patient underwent posterior spinal fusion with pedicle screw instrumentation from T4 to L4. Intraoperatively, steps were taken to minimize tissue trauma and subsequent inflammation. The patient's postoperative course was uneventful, with mild residual inflammation managed conservatively through the use of anti-inflammatory medications.

4. Operative Note: Thoracogenic scoliosis correction was performed in a patient with severe inflammation affecting the spinal structures. The patient underwent a combined approach, including anterior release and posterior spinal fusion with pedicle screw instrumentation from T2 to L3. Intraoperatively, extensive irrigation was performed to reduce inflammation, and anti-inflammatory medications were administered perioperatively. Postoperatively, the patient's inflammation was closely monitored, and appropriate interventions were undertaken to manage the condition.

5. Operative Note: Thoracogenic scoliosis correction was performed in a patient with moderate inflammation associated with the spinal deformity. The surgical intervention involved posterior spinal fusion with pedicle screw instrumentation from T3 to L3. Preoperatively, the patient received a short course of anti-inflammatory medications to reduce the inflammation. Intraoperatively, care was taken to minimize tissue trauma and subsequent inflammation. The patient's postoperative course was uneventful, with conservative management of the residual inflammation.

6. Operative Note: Thoracogenic scoliosis correction was performed in a patient with mild inflammation affecting the spinal structures. The patient underwent posterior spinal fusion with pedicle screw instrumentation from T4 to L4. Intraoperatively, measures were taken to minimize tissue trauma and subsequent inflammation. Postoperatively, the patient's mild inflammation was managed conservatively through the use of anti-inflammatory medications, and close follow-up was planned to monitor the resolution of inflammation.

7. Operative Note: Thoracogenic scoliosis correction was performed in a patient with severe inflammation associated with the spinal deformity. The patient underwent posterior spinal fusion with pedicle screw instrumentation from T4 to L4. Intraoperatively, meticulous care was taken to address the inflamed tissues and minimize tissue trauma. Postoperatively, the patient's inflammation was closely monitored, and appropriate anti-inflammatory medications were administered to manage the condition and promote healing.

8. Operative Note: Thoracogenic scoliosis correction was performed in a patient with moderate inflammation of the spinal structures. The surgical intervention involved posterior spinal fusion with pedicle screw instrumentation from T3 to L3. Intraoperatively, steps were taken to minimize tissue trauma and subsequent inflammation. The patient's postoperative course was uneventful, with conservative management of the residual inflammation through the use of anti-inflammatory medications and close monitoring.

9. Operative Note: Thoracogenic scoliosis correction was performed in a patient with mild inflammation associated with the spinal deformity. The patient underwent posterior spinal fusion with pedicle screw instrumentation from T4 to L4. Intraoperatively, measures were taken to minimize tissue trauma and subsequent inflammation. The patient's mild inflammation was managed conservatively postoperatively through the use of anti-inflammatory medications and appropriate postoperative care.

10. Operative Note: Thoracogenic scoliosis correction was performed in a patient with severe inflammation affecting the spinal structures. The patient underwent a combined approach, including anterior release and posterior spinal fusion with pedicle screw instrumentation from T2 to L3. Intraoperatively, special attention was given to addressing the inflamed tissues and minimizing tissue trauma. Postoperatively, the patient's inflammation was closely monitored, and appropriate interventions were undertaken to manage the condition effectively.

1. Operative Note: Thoracogenic scoliosis correction was performed in a patient with severe thoracic spinal curvature. The patient will require frequent follow-up visits every three months for the first year postoperatively to monitor the progression of the spinal correction, assess the healing of the surgical incision, and evaluate the overall spinal alignment. Subsequent follow-ups will be scheduled based on the patient's progress and the severity of the scoliosis.

2. Operative Note: Thoracogenic scoliosis correction was performed in a patient with moderate thoracic spinal curvature. The patient's postoperative follow-up schedule will include visits at six weeks, three months, and six months to monitor the healing process, assess spinal alignment, and evaluate any potential complications. Further follow-up appointments will be determined based on the patient's response to treatment and the severity of the scoliosis.

3. Operative Note: Thoracogenic scoliosis correction was performed in a patient with mild thoracic spinal curvature. The patient's postoperative follow-up plan will consist of visits at three months and six months to assess the progress of spinal correction, evaluate the healing of the surgical incision, and monitor any potential complications. Subsequent follow-ups will be scheduled as needed, considering the patient's response to treatment and the severity of the scoliosis.

4. Operative Note: Thoracogenic scoliosis correction was performed in a patient with severe thoracic spinal curvature. Given the complexity of the case and the severity of the scoliosis, the patient will require frequent follow-up appointments every four weeks for the first six months postoperatively. These visits will involve monitoring spinal alignment, assessing healing, and conducting necessary imaging studies. Subsequent follow-ups will be scheduled based on the patient's progress and the severity of the scoliosis.

5. Operative Note: Thoracogenic scoliosis correction was performed in a patient with moderate thoracic spinal curvature. The patient's postoperative follow-up plan will include visits at six weeks, three months, and nine months to assess the progression of spinal correction, monitor the healing process, and evaluate any potential complications. The frequency of follow-up appointments beyond the first year will be determined based on the patient's response to treatment and the severity of the scoliosis.

6. Operative Note: Thoracogenic scoliosis correction was performed in a patient with mild thoracic spinal curvature. The patient's postoperative follow-up schedule will include visits at three months and nine months to assess spinal alignment, evaluate the healing of the surgical incision, and monitor the patient's overall progress. Further follow-up appointments will be determined based on the patient's response to treatment and the severity of the scoliosis.

7. Operative Note: Thoracogenic scoliosis correction was performed in a patient with severe thoracic spinal curvature. Postoperative follow-up visits will be scheduled at six weeks, three months, and one year to monitor spinal alignment, assess the healing process, and evaluate any potential complications. The frequency of follow-ups beyond the first year will depend on the patient's response to treatment, the severity of the scoliosis, and the need for continued monitoring.

8. Operative Note: Thoracogenic scoliosis correction was performed in a patient with moderate thoracic spinal curvature. The patient's postoperative follow-up plan will consist of visits at six weeks, four months, and one year to evaluate the progression of spinal correction, assess healing, and address any concerns. Subsequent follow-ups will be scheduled based on the patient's response to treatment and the severity of the scoliosis.

9. Operative Note: Thoracogenic scoliosis correction was performed in a patient with mild thoracic spinal curvature. The patient's postoperative follow-up visits will occur at three months and one year to assess spinal alignment, monitor the healing process, and evaluate the patient's overall recovery. Additional follow-ups will be scheduled as necessary, considering the patient's response to treatment and the severity of the scoliosis.

10. Operative Note: Thoracogenic scoliosis correction was performed in a patient with severe thoracic spinal curvature. Postoperative follow-up appointments will be scheduled at six weeks, three months, and 18 months to assess spinal alignment, evaluate the healing process, and monitor any potential complications. The frequency of follow-ups beyond 18 months will be determined based on the patient's response to treatment, the severity of the scoliosis, and the need for continued monitoring.

## M41.4 Neuromuscular scoliosis

1. Patient underwent posterior spinal fusion surgery for neuromuscular scoliosis. A midline incision was made, and pedicle screws were inserted. Fusion was achieved using autogenous bone graft and bone morphogenetic protein. Intraoperative neuromonitoring was utilized to assess spinal cord integrity.

2. Operative intervention involved the correction of severe neuromuscular scoliosis through posterior spinal fusion. Bilateral laminectomies were performed, followed by pedicle screw placement and rod insertion. The deformity was successfully reduced, and fusion was achieved using allograft and bone morphogenetic protein.

3. Minimally invasive posterior spinal fusion was performed to correct neuromuscular scoliosis. Through a small incision, pedicle screws were inserted, and deformity was corrected using a rod system. The procedure was aided by intraoperative navigation and neuromonitoring to ensure optimal placement and spinal cord safety.

4. A comprehensive spinal fusion was conducted to address the progressive neuromuscular scoliosis. Pedicle screws were inserted, and posterior instrumentation was utilized to correct the deformity. Autologous iliac crest bone graft and bone morphogenetic protein were employed for fusion. Intraoperative neuromonitoring demonstrated intact spinal cord function throughout the procedure.

5. Surgical intervention involved the correction of neuromuscular scoliosis using posterior spinal fusion. Pedicle screws were placed, and the deformity was corrected with rod insertion. Intraoperative neuromonitoring was employed to assess spinal cord integrity, ensuring the safety of the procedure. Allograft and bone morphogenetic protein were used to achieve successful fusion.

6. Posterior spinal fusion was performed to address neuromuscular scoliosis. Pedicle screws were inserted, followed by rod placement to correct the deformity. Intraoperative neuromonitoring confirmed spinal cord integrity. Autologous bone graft and bone morphogenetic protein were used to achieve fusion.

7. Minimally invasive posterior spinal fusion was carried out to correct neuromuscular scoliosis. Pedicle screws were inserted bilaterally, and the deformity was corrected using a rod system. Intraoperative neuromonitoring ensured the safety of the procedure. Fusion was achieved using allograft and bone morphogenetic protein.

8. A posterior spinal fusion procedure was performed for neuromuscular scoliosis. Pedicle screws were inserted to anchor the spinal instrumentation, and rod insertion allowed for deformity correction. Intraoperative neuromonitoring was utilized to monitor spinal cord function. Fusion was achieved using autogenous bone graft and bone morphogenetic protein.

9. Surgical intervention involved posterior spinal fusion for neuromuscular scoliosis. Pedicle screws were inserted to provide stability, and rod placement allowed for deformity correction. Intraoperative neuromonitoring was employed to ensure spinal cord safety. Autologous bone graft and bone morphogenetic protein were used for successful fusion.

10. Minimally invasive posterior spinal fusion was performed to correct neuromuscular scoliosis. Pedicle screws were inserted bilaterally, followed by rod insertion to achieve deformity correction. Intraoperative neuromonitoring confirmed spinal cord integrity. Allograft and bone morphogenetic protein were utilized for successful fusion.

1. The patient underwent a complex posterior spinal fusion procedure to address severe neuromuscular scoliosis. Pedicle screws were meticulously placed to provide stability, and a multi-level osteotomy was performed to correct the deformity. Intraoperative neuromonitoring ensured the safety of the spinal cord throughout the procedure. Autologous bone graft and bone morphogenetic protein were utilized to achieve successful fusion.

2. Surgical intervention involved a posterior spinal fusion for progressive neuromuscular scoliosis. Pedicle screws were meticulously inserted, and the deformity was corrected using a rod system. Intraoperative neuromonitoring was employed to assess spinal cord function. Successful fusion was achieved using a combination of autograft and bone morphogenetic protein.

3. A comprehensive posterior spinal fusion procedure was performed to address neuromuscular scoliosis. Pedicle screws were precisely placed, and a three-column osteotomy was performed to correct the deformity. Intraoperative neuromonitoring was utilized to ensure spinal cord safety. Fusion was achieved using a combination of allograft and bone morphogenetic protein.

4. Minimally invasive posterior spinal fusion was carried out to correct neuromuscular scoliosis. Pedicle screws were meticulously inserted, and a rod system was used for deformity correction. Intraoperative neuromonitoring played a crucial role in ensuring the safety of the spinal cord. Autologous bone graft and bone morphogenetic protein were used for successful fusion.

5. The patient underwent posterior spinal fusion surgery to address severe neuromuscular scoliosis. Pedicle screws were accurately placed, and a multi-level osteotomy was performed to correct the deformity. Intraoperative neuromonitoring was employed to safeguard spinal cord integrity. Autogenous bone graft and bone morphogenetic protein were utilized for successful fusion.

6. Surgical intervention involved a posterior spinal fusion for progressive neuromuscular scoliosis. Pedicle screws were meticulously inserted, and the deformity was corrected using a rod system. Intraoperative neuromonitoring played a crucial role in ensuring spinal cord safety. Successful fusion was achieved using allograft and bone morphogenetic protein.

7. A comprehensive posterior spinal fusion procedure was performed to correct severe neuromuscular scoliosis. Pedicle screws were accurately placed, and a three-column osteotomy was conducted for deformity correction. Intraoperative neuromonitoring was utilized to assess spinal cord function. Successful fusion was achieved using a combination of autograft and bone morphogenetic protein.

8. Minimally invasive posterior spinal fusion was carried out to address neuromuscular scoliosis. Precise placement of pedicle screws provided stability, and a rod system was used to correct the deformity. Intraoperative neuromonitoring ensured the safety of the spinal cord. Fusion was successfully achieved using autologous bone graft and bone morphogenetic protein.

9. The patient underwent posterior spinal fusion surgery to correct progressive neuromuscular scoliosis. Pedicle screws were meticulously inserted, and deformity correction was achieved through rod insertion. Intraoperative neuromonitoring was employed to safeguard spinal cord integrity. Successful fusion was achieved using a combination of allograft and bone morphogenetic protein.

10. Surgical intervention involved a posterior spinal fusion for severe neuromuscular scoliosis. Accurate placement of pedicle screws provided stability, and a rod system was utilized for deformity correction. Intraoperative neuromonitoring played a vital role in ensuring spinal cord safety. Successful fusion was achieved using autogenous bone graft and bone morphogenetic protein.

1. The patient underwent posterior spinal fusion surgery for neuromuscular scoliosis under general anesthesia with endotracheal intubation. Intraoperative neuromonitoring and somatosensory-evoked potentials were monitored throughout the procedure. A balanced anesthesia technique was employed using sevoflurane and remifentanil infusion.

2. Surgical intervention involved posterior spinal fusion for neuromuscular scoliosis under monitored anesthesia care (MAC). The patient received a combination of intravenous sedation with propofol and local anesthesia infiltration. Intraoperative neuromonitoring ensured spinal cord safety throughout the procedure.

3. A comprehensive posterior spinal fusion procedure was performed for neuromuscular scoliosis under combined spinal-epidural anesthesia. The patient received intrathecal administration of local anesthetic and opioids for surgical anesthesia, supplemented with epidural analgesia for postoperative pain management. Intraoperative neuromonitoring confirmed spinal cord integrity.

4. Minimally invasive posterior spinal fusion was carried out for neuromuscular scoliosis under general anesthesia with a laryngeal mask airway. The patient received a balanced anesthesia technique using propofol, remifentanil, and rocuronium. Intraoperative neuromonitoring was employed to ensure the safety of the spinal cord.

5. The patient underwent posterior spinal fusion surgery for neuromuscular scoliosis under regional anesthesia with a thoracic epidural. Anesthesia was maintained with a continuous infusion of local anesthetic and opioids. Intraoperative neuromonitoring and motor-evoked potentials were monitored throughout the procedure.

6. Surgical intervention involved posterior spinal fusion for neuromuscular scoliosis under general anesthesia with endotracheal intubation. Anesthesia was induced using intravenous propofol and maintained with a combination of sevoflurane and remifentanil infusion. Intraoperative neuromonitoring ensured spinal cord safety during the procedure.

7. A comprehensive posterior spinal fusion procedure was performed for neuromuscular scoliosis under monitored anesthesia care (MAC). The patient received intravenous sedation with propofol and a continuous infusion of remifentanil for anesthesia. Intraoperative neuromonitoring and somatosensory-evoked potentials were monitored throughout the surgery.

8. Minimally invasive posterior spinal fusion was carried out for neuromuscular scoliosis under general anesthesia with endotracheal intubation. Anesthesia was induced using intravenous propofol and maintained with sevoflurane and remifentanil. Intraoperative neuromonitoring and motor-evoked potentials were monitored to ensure spinal cord safety.

9. The patient underwent posterior spinal fusion surgery for neuromuscular scoliosis under regional anesthesia with a thoracic epidural. Anesthesia was maintained with a continuous infusion of local anesthetic and opioids. Intraoperative neuromonitoring and somatosensory-evoked potentials were monitored throughout the procedure.

10. Surgical intervention involved posterior spinal fusion for neuromuscular scoliosis under general anesthesia with a laryngeal mask airway. Anesthesia was induced using intravenous propofol and maintained with sevoflurane and remifentanil infusion. Intraoperative neuromonitoring and motor-evoked potentials were monitored to ensure spinal cord safety.

1. The patient presented with severe neuromuscular scoliosis and significant bone erosion at the vertebral levels. Surgical intervention involved posterior spinal fusion with meticulous debridement of the eroded bone. Pedicle screws were inserted above and below the affected segments to provide stability. Allograft and bone morphogenetic protein were used to achieve fusion and restore spinal alignment.

2. A complex posterior spinal fusion was performed for neuromuscular scoliosis, complicated by extensive bone erosion at multiple vertebral levels. Intraoperative exploration revealed the need for bone grafting to restore vertebral stability. Pedicle screws were meticulously placed, and a combination of autograft and allograft was used to promote fusion and address the erosion.

3. The patient underwent posterior spinal fusion surgery for neuromuscular scoliosis with significant bone erosion. Extensive debridement of the eroded bone was performed, followed by the insertion of pedicle screws and rods to correct the deformity. Autograft and bone morphogenetic protein were utilized to promote fusion and reconstruct the affected vertebrae.

4. Surgical intervention involved a posterior spinal fusion procedure for neuromuscular scoliosis complicated by bone erosion. Intraoperative exploration revealed extensive erosion at the affected levels, necessitating meticulous debridement and augmentation with allograft and bone morphogenetic protein. Pedicle screws and rods were inserted to restore stability and correct the deformity.

5. The patient presented with neuromuscular scoliosis and significant bone erosion at the vertebral levels. A comprehensive posterior spinal fusion was performed, involving thorough debridement of the eroded bone. Pedicle screws were precisely inserted, and fusion was achieved using autologous bone graft and bone morphogenetic protein to address the erosion and stabilize the spine.

6. Surgical intervention was performed for neuromuscular scoliosis with extensive bone erosion. Meticulous debridement of the eroded bone was carried out, followed by the placement of pedicle screws and rods to correct the deformity. A combination of autograft and allograft was used for fusion to address the bone erosion and restore spinal stability.

7. The patient underwent posterior spinal fusion surgery for neuromuscular scoliosis complicated by bone erosion. Intraoperative assessment revealed the extent of erosion, leading to meticulous debridement of the affected bone. Pedicle screws were accurately inserted, and fusion was achieved using autologous bone graft and bone morphogenetic protein, targeting the eroded areas for restoration.

8. Surgical intervention involved a posterior spinal fusion procedure for neuromuscular scoliosis with extensive bone erosion. Thorough debridement of the eroded bone was performed, followed by the placement of pedicle screws and rods. Allograft and bone morphogenetic protein were used to achieve fusion and address the erosion, promoting spinal stability.

9. The patient presented with neuromuscular scoliosis and significant bone erosion at the vertebral levels. Surgical intervention involved posterior spinal fusion, with meticulous debridement of the eroded bone to promote optimal healing. Pedicle screws and rods were inserted, and fusion was achieved using a combination of autograft and allograft to address the bone erosion.

10. Surgical intervention was performed for neuromuscular scoliosis with extensive bone erosion. Thorough debridement of the eroded bone was carried out, followed by the placement of pedicle screws and rods to correct the deformity. Autograft and bone morphogenetic protein were used to achieve fusion and address the erosion, restoring spinal stability.

1. The patient presented with severe neuromuscular scoliosis accompanied by debilitating bone pain. Surgical intervention involved posterior spinal fusion to correct the deformity and alleviate the pain. Pedicle screws were meticulously placed, and fusion was achieved using autologous bone graft and bone morphogenetic protein, aiming to restore spinal stability and provide long-term relief from the severe bone pain.

2. Surgical intervention was performed for neuromuscular scoliosis with severe bone pain. Extensive debridement of the eroded bone was carried out to alleviate the pain, followed by posterior spinal fusion. Pedicle screws and rods were precisely inserted, and fusion was achieved using allograft and bone morphogenetic protein, targeting the source of the severe bone pain for relief.

3. The patient underwent posterior spinal fusion surgery for severe neuromuscular scoliosis and excruciating bone pain. Meticulous debridement of the affected bone was performed to alleviate the pain, followed by the placement of pedicle screws and rods. Autograft and bone morphogenetic protein were used to achieve fusion and provide relief from the severe bone pain.

4. Surgical intervention involved a comprehensive posterior spinal fusion procedure for severe neuromuscular scoliosis accompanied by severe bone pain. Extensive debridement of the eroded bone was performed to alleviate the pain, followed by the insertion of pedicle screws and rods. Fusion was achieved using a combination of autograft and allograft, targeting the source of the severe bone pain.

5. The patient presented with severe neuromuscular scoliosis and debilitating bone pain. Surgical intervention involved posterior spinal fusion to correct the deformity and relieve the pain. Meticulous debridement of the eroded bone was performed, followed by the placement of pedicle screws and rods. Autologous bone graft and bone morphogenetic protein were used to achieve fusion and alleviate the severe bone pain.

6. Surgical intervention was performed for severe neuromuscular scoliosis with excruciating bone pain. Thorough debridement of the eroded bone was carried out to relieve the pain, followed by posterior spinal fusion. Precise placement of pedicle screws and rods was done, and fusion was achieved using allograft and bone morphogenetic protein, targeting the source of the severe bone pain.

7. The patient presented with severe neuromuscular scoliosis accompanied by debilitating bone pain. Surgical intervention involved posterior spinal fusion to correct the deformity and provide relief from the pain. Meticulous debridement of the eroded bone was performed, followed by the placement of pedicle screws and rods. Autologous bone graft and bone morphogenetic protein were utilized to achieve fusion and alleviate the severe bone pain.

8. Surgical intervention was performed for severe neuromuscular scoliosis with excruciating bone pain. Thorough debridement of the eroded bone was carried out to alleviate the pain, followed by posterior spinal fusion. Pedicle screws and rods were precisely inserted, and fusion was achieved using autograft and allograft, targeting the source of the severe bone pain for relief.

9. The patient underwent posterior spinal fusion surgery for severe neuromuscular scoliosis and severe bone pain. Extensive debridement of the affected bone was performed to alleviate the pain, followed by the placement of pedicle screws and rods. Autologous bone graft and bone morphogenetic protein were utilized to achieve fusion and provide relief from the severe bone pain.

10. Surgical intervention involved a comprehensive posterior spinal fusion procedure for severe neuromuscular scoliosis accompanied by debilitating bone pain. Thorough debridement of the eroded bone was performed to alleviate the pain, followed by the insertion of pedicle screws and rods.

1. The patient with severe neuromuscular scoliosis and persistent bone pain underwent a surgical intervention known as vertebral column resection. This complex procedure involved removing the affected vertebral segments and replacing them with bone grafts. Pedicle screws and rods were meticulously placed to restore spinal alignment and stability. The surgery successfully addressed the severe bone pain and improved the patient's quality of life.

2. Surgical intervention in the form of a spinal osteotomy was performed for severe neuromuscular scoliosis with accompanying debilitating bone pain. The procedure involved the deliberate resection and realignment of vertebral segments to correct the deformity and alleviate the pain. Pedicle screws and rods were meticulously inserted to maintain stability, and autograft or allograft was used for fusion, resulting in significant relief from the severe bone pain.

3. The patient underwent a surgical intervention called a spinal decompression and fusion procedure to address severe neuromuscular scoliosis and alleviate the debilitating bone pain. The procedure involved decompressing nerve roots and stabilizing the spine through the placement of pedicle screws, rods, and bone grafts. Successful fusion achieved through the surgery alleviated the severe bone pain and improved the patient's overall condition.

4. Surgical intervention in the form of a posterior spinal fusion was performed for severe neuromuscular scoliosis with persistent bone pain. Pedicle screws and rods were meticulously inserted to correct the deformity and provide stability. Autograft or allograft was used to achieve fusion and alleviate the severe bone pain. The surgery successfully improved the patient's spinal alignment and relieved their debilitating bone pain.

5. The patient underwent a surgical intervention known as a vertebral column resection for severe neuromuscular scoliosis and excruciating bone pain. This intricate procedure involved removing the affected vertebral segments and replacing them with bone grafts. Pedicle screws and rods were meticulously placed to restore spinal stability. The surgery effectively addressed the severe bone pain and improved the patient's quality of life.

6. Surgical intervention in the form of a spinal osteotomy was performed for severe neuromuscular scoliosis accompanied by persistent bone pain. The procedure involved the intentional removal and realignment of vertebral segments to correct the deformity and alleviate the pain. Pedicle screws and rods were meticulously inserted to ensure stability, and autograft or allograft was used for fusion, providing relief from the severe bone pain.

7. The patient underwent a surgical intervention called a spinal decompression and fusion procedure to address severe neuromuscular scoliosis and alleviate the severe bone pain. The procedure involved decompressing nerve roots and stabilizing the spine through the placement of pedicle screws, rods, and bone grafts. Successful fusion achieved through the surgery relieved the severe bone pain and improved the patient's overall condition.

8. Surgical intervention in the form of a posterior spinal fusion was performed for severe neuromuscular scoliosis with debilitating bone pain. Precise placement of pedicle screws and rods was carried out to correct the deformity and provide stability. Autograft or allograft was used for fusion, resulting in significant relief from the severe bone pain. The surgery successfully improved the patient's spinal alignment and relieved their debilitating bone pain.

9. The patient underwent a surgical intervention known as a vertebral column resection to address severe neuromuscular scoliosis and persistent bone pain. This complex procedure involved the removal of affected vertebral segments and their replacement with bone grafts. Meticulous placement of pedicle screws and rods restored spinal stability. The surgery effectively addressed the severe bone pain and significantly improved the patient's quality of life.

10. Surgical intervention in the form of a spinal osteotomy was performed for severe neuromuscular scoliosis with chronic bone pain. The procedure involved the deliberate resection and realignment of vertebral segments to correct the deformity and alleviate the pain. Meticulous placement of pedicle screws and rods ensured stability, and autograft or allograft was used for fusion, providing relief from the severe bone pain.

1. The patient underwent surgical intervention in the form of a posterior spinal fusion for severe neuromuscular scoliosis accompanied by debilitating bone pain. The procedure involved the placement of pedicle screws and rods to correct the spinal deformity and restore stability. Autograft or allograft was used for fusion, effectively alleviating the severe bone pain and improving the patient's overall condition.

2. Surgical intervention in the form of a vertebral column resection was performed for severe neuromuscular scoliosis with persistent bone pain. This intricate procedure involved the removal of affected vertebral segments and their replacement with bone grafts. Meticulous placement of pedicle screws and rods restored spinal alignment and stability, resulting in significant relief from the severe bone pain.

3. The patient underwent a surgical intervention called a spinal decompression and fusion procedure to address severe neuromuscular scoliosis and alleviate debilitating bone pain. The procedure involved decompressing nerve roots and stabilizing the spine with pedicle screws, rods, and bone grafts. Successful fusion achieved through the surgery effectively relieved the severe bone pain and improved the patient's quality of life.

4. Surgical intervention in the form of a posterior spinal fusion was performed for severe neuromuscular scoliosis accompanied by excruciating bone pain. Precise placement of pedicle screws and rods was carried out to correct the deformity and restore spinal stability. Autograft or allograft was used for fusion, resulting in significant relief from the severe bone pain and improved functionality.

5. The patient underwent surgical intervention in the form of a vertebral column resection to address severe neuromuscular scoliosis and debilitating bone pain. This complex procedure involved the removal of affected vertebral segments and the use of bone grafts to reconstruct the spine. The meticulous placement of pedicle screws and rods restored stability and relieved the severe bone pain.

6. Surgical intervention was performed for severe neuromuscular scoliosis with persistent bone pain. A comprehensive posterior spinal fusion was conducted, involving the placement of pedicle screws and rods to correct the spinal deformity and provide stability. Autologous bone graft or bone morphogenetic protein was used for fusion, effectively alleviating the severe bone pain and improving the patient's quality of life.

7. The patient underwent a surgical intervention known as a spinal osteotomy to address severe neuromuscular scoliosis and chronic bone pain. This procedure involved the deliberate resection and realignment of vertebral segments to correct the deformity and relieve the pain. Meticulous placement of pedicle screws and rods restored stability, resulting in significant relief from the severe bone pain.

8. Surgical intervention in the form of a posterior spinal fusion was performed for severe neuromuscular scoliosis accompanied by debilitating bone pain. Precise placement of pedicle screws and rods was carried out to correct the deformity and restore spinal stability. Autograft or allograft was used for fusion, effectively alleviating the severe bone pain and improving the patient's overall condition.

9. The patient underwent a surgical intervention called a spinal decompression and fusion procedure to address severe neuromuscular scoliosis and persistent bone pain. The procedure involved decompressing nerve roots and stabilizing the spine through the placement of pedicle screws, rods, and bone grafts. Successful fusion achieved through the surgery alleviated the severe bone pain and improved the patient's overall quality of life.

10. Surgical intervention in the form of a posterior spinal fusion was performed for severe neuromuscular scoliosis with chronic bone pain. Meticulous placement of pedicle screws and rods was carried out to correct the deformity and provide stability. Autograft or allograft was used for fusion, resulting in significant relief from the severe bone pain and improved functionality.

1. The patient presented with severe neuromuscular scoliosis and a concurrent infection in the extreme moving joint of the spine. Surgical intervention involved a thorough debridement of the infected joint, followed by posterior spinal fusion to correct the deformity and stabilize the spine. Intravenous antibiotics were administered to combat the infection, ensuring a successful outcome in treating both the scoliosis and the severe joint infection.

2. Surgical intervention was performed for neuromuscular scoliosis with a severe infection in the extreme moving joint. The procedure involved debridement of the infected joint, followed by posterior spinal fusion to correct the spinal deformity and provide stability. Aggressive antibiotic therapy was administered to eliminate the infection, resulting in the successful treatment of both the scoliosis and the severe joint infection.

3. The patient underwent surgical intervention for severe neuromuscular scoliosis complicated by a severe infection in the extreme moving joint. Extensive debridement of the infected joint was performed, followed by posterior spinal fusion to correct the deformity and restore stability. Aggressive antibiotic treatment was administered to combat the infection, leading to the resolution of both the scoliosis and the severe joint infection.

4. Surgical intervention was undertaken for severe neuromuscular scoliosis with an accompanying severe infection in the extreme moving joint. The procedure involved meticulous debridement of the infected joint, followed by posterior spinal fusion to address the scoliosis and provide stability. Aggressive antibiotic therapy was administered to eradicate the infection, resulting in successful treatment of both conditions.

5. The patient with severe neuromuscular scoliosis and a severe infection in the extreme moving joint underwent surgical intervention. Extensive debridement of the infected joint was performed, followed by posterior spinal fusion to correct the spinal deformity and restore stability. Intensive antibiotic treatment was initiated to resolve the infection, leading to the successful management of both the scoliosis and the severe joint infection.

6. Surgical intervention was performed for severe neuromuscular scoliosis accompanied by a severe infection in the extreme moving joint. Thorough debridement of the infected joint was carried out, followed by posterior spinal fusion to correct the spinal deformity and provide stability. Aggressive antibiotic therapy was administered to eliminate the infection, resulting in the successful treatment of both the scoliosis and the severe joint infection.

7. The patient underwent surgical intervention for severe neuromuscular scoliosis complicated by a severe infection in the extreme moving joint. Meticulous debridement of the infected joint was performed, followed by posterior spinal fusion to correct the deformity and restore stability. A comprehensive antibiotic regimen was administered to combat the infection, leading to the resolution of both the scoliosis and the severe joint infection.

8. Surgical intervention was undertaken for severe neuromuscular scoliosis with a concurrent severe infection in the extreme moving joint. The procedure involved extensive debridement of the infected joint, followed by posterior spinal fusion to address the scoliosis and provide stability. Intensive antibiotic therapy was initiated to eradicate the infection, resulting in successful treatment of both conditions.

9. The patient with severe neuromuscular scoliosis and a severe infection in the extreme moving joint underwent surgical intervention. Thorough debridement of the infected joint was performed, followed by posterior spinal fusion to correct the spinal deformity and restore stability. Aggressive antibiotic treatment was administered to eliminate the infection, leading to the successful management of both the scoliosis and the severe joint infection.

10. Surgical intervention was performed for severe neuromuscular scoliosis accompanied by a severe infection in the extreme moving joint. Meticulous debridement of the infected joint was carried out, followed by posterior spinal fusion to correct the spinal deformity and provide stability. Intensive antibiotic therapy was administered to combat the infection, resulting in the successful treatment of both the scoliosis and the severe joint infection.

1. Surgical intervention was performed for severe neuromuscular scoliosis complicated by significant inflammation in the affected region. The procedure involved thorough debridement of the inflamed tissues, followed by posterior spinal fusion to correct the deformity and restore stability. Anti-inflammatory medications were administered to address the inflammation, leading to successful management of both the scoliosis and the severe inflammation.

2. The patient presented with severe neuromuscular scoliosis and concurrent inflammation in the affected area. Surgical intervention included debridement of the inflamed tissues, followed by posterior spinal fusion to correct the spinal deformity and provide stability. Anti-inflammatory drugs were administered to reduce inflammation, resulting in successful treatment of both the scoliosis and the severe inflammation.

3. Surgical intervention was undertaken for severe neuromuscular scoliosis accompanied by significant inflammation in the affected region. Thorough debridement of the inflamed tissues was performed, followed by posterior spinal fusion to correct the deformity and restore stability. Anti-inflammatory medication was administered to address the inflammation, resulting in successful management of both the scoliosis and the severe inflammation.

4. The patient underwent surgical intervention for severe neuromuscular scoliosis complicated by substantial inflammation in the affected area. The procedure involved meticulous debridement of the inflamed tissues, followed by posterior spinal fusion to correct the spinal deformity and provide stability. Anti-inflammatory therapy was initiated to alleviate the inflammation, leading to successful treatment of both the scoliosis and the severe inflammation.

5. Surgical intervention was performed for severe neuromuscular scoliosis accompanied by notable inflammation in the affected region. Thorough debridement of the inflamed tissues was conducted, followed by posterior spinal fusion to correct the deformity and restore stability. Anti-inflammatory medications were administered to address the inflammation, resulting in successful management of both the scoliosis and the severe inflammation.

6. The patient presented with severe neuromuscular scoliosis and concurrent inflammation in the affected area, requiring surgical intervention. The procedure involved extensive debridement of the inflamed tissues, followed by posterior spinal fusion to correct the spinal deformity and provide stability. Anti-inflammatory drugs were administered to mitigate the inflammation, resulting in successful treatment of both the scoliosis and the severe inflammation.

7. Surgical intervention was undertaken for severe neuromuscular scoliosis accompanied by significant inflammation in the affected region. Meticulous debridement of the inflamed tissues was performed, followed by posterior spinal fusion to correct the deformity and restore stability. Anti-inflammatory medication was administered to address the inflammation, leading to successful management of both the scoliosis and the severe inflammation.

8. The patient underwent surgical intervention for severe neuromuscular scoliosis complicated by notable inflammation in the affected area. Thorough debridement of the inflamed tissues was conducted, followed by posterior spinal fusion to correct the spinal deformity and provide stability. Anti-inflammatory therapy was initiated to alleviate the inflammation, resulting in successful treatment of both the scoliosis and the severe inflammation.

9. Surgical intervention was performed for severe neuromuscular scoliosis accompanied by significant inflammation in the affected region. Extensive debridement of the inflamed tissues was carried out, followed by posterior spinal fusion to correct the deformity and restore stability. Anti-inflammatory medications were administered to address the inflammation, resulting in successful management of both the scoliosis and the severe inflammation.

10. The patient presented with severe neuromuscular scoliosis and concurrent inflammation in the affected area, necessitating surgical intervention. Meticulous debridement of the inflamed tissues was performed, followed by posterior spinal fusion to correct the spinal deformity and provide stability. Anti-inflammatory drugs were administered to mitigate the inflammation, leading to successful treatment of both the scoliosis and the severe inflammation.

1. The patient's postoperative follow-up will be tailored based on the severity of the diagnosed neuromuscular scoliosis. For mild cases, regular monitoring of the spinal curvature and periodic assessments of the patient's symptoms will be conducted. In moderate cases, additional imaging studies may be required to evaluate the progression of the scoliosis. Severe cases will necessitate frequent visits to assess spinal stability, functional outcomes, and potential complications, with the involvement of a multidisciplinary team for comprehensive management.

2. The severity of the diagnosed neuromuscular scoliosis will determine the postoperative follow-up plan. In cases of mild scoliosis, regular clinical evaluations and conservative management may suffice. Moderate cases will require periodic imaging studies to monitor spinal curvature and assess treatment effectiveness. Severe cases will necessitate more frequent follow-ups, including clinical examinations, imaging, and functional assessments, to closely monitor spinal stability, manage pain, and address potential complications.

3. Depending on the severity of the diagnosed neuromuscular scoliosis, the patient's postoperative follow-up will be customized accordingly. Mild cases may require occasional check-ups to monitor symptoms and evaluate treatment effectiveness. Moderate cases will necessitate regular visits, including clinical assessments, imaging studies, and physiotherapy sessions to manage scoliosis progression and functional limitations. Severe cases will require frequent follow-ups, involving comprehensive evaluations, multidisciplinary care, and potential interventions to address spinal instability, pain, and associated complications.

4. The postoperative follow-up plan for the diagnosed neuromuscular scoliosis will be determined based on its severity. Mild cases may require periodic check-ups to assess symptom progression and potential non-surgical interventions. Moderate cases will necessitate regular visits, including clinical evaluations, imaging studies, and physical therapy sessions to manage scoliosis progression and optimize functional outcomes. Severe cases will entail frequent and comprehensive follow-ups, involving multidisciplinary assessments, potential surgical interventions, and long-term management strategies.

5. The severity of the diagnosed neuromuscular scoliosis will guide the postoperative follow-up approach. For mild cases, periodic evaluations will be conducted to monitor symptoms and assess the need for conservative treatments. Moderate cases will require regular follow-ups, including clinical examinations, imaging studies, and physical therapy interventions to manage scoliosis progression and improve functional capacity. Severe cases will demand frequent and comprehensive assessments, involving a multidisciplinary team, surgical considerations, and ongoing monitoring of spinal stability and potential complications.

6. The postoperative follow-up plan for the diagnosed neuromuscular scoliosis will be individualized based on the severity of the condition. Mild cases may involve intermittent clinical assessments and lifestyle modifications. Moderate cases will require regular evaluations, including radiographic imaging, physiotherapy sessions, and pain management strategies. Severe cases will necessitate frequent and comprehensive follow-ups, involving close monitoring of spinal alignment, functional outcomes, potential infections, and the need for additional interventions.

7. Depending on the severity of the diagnosed neuromuscular scoliosis, the postoperative follow-up strategy will be tailored accordingly. Mild cases may require periodic clinical evaluations and lifestyle modifications to manage symptoms. Moderate cases will necessitate regular visits, including radiographic assessments, physiotherapy sessions, and bracing if applicable. Severe cases will demand frequent and comprehensive follow-ups, involving close monitoring of spinal stability, potential complications, and the need for surgical interventions or other advanced treatments.

8. The postoperative follow-up plan for the diagnosed neuromuscular scoliosis will be determined based on the severity of the condition. Mild cases may require periodic check-ups to monitor symptoms and recommend conservative measures. Moderate cases will necessitate regular visits, including clinical assessments, radiographic evaluations, and therapeutic interventions to manage scoliosis progression and functional limitations. Severe cases will demand frequent follow-ups, involving multidisciplinary evaluations, potential surgical considerations, and long-term management strategies.

9. Depending on the severity of the diagnosed neuromuscular scoliosis, the patient's postoperative follow-up will be customized. For mild cases, intermittent clinical assessments and non-surgical interventions may be sufficient. Moderate cases will require regular visits, including radiographic assessments, physiotherapy sessions, and possible bracing. Severe cases will necessitate frequent and comprehensive follow-ups, involving close monitoring of spinal stability, potential complications, and the need for surgical interventions or other advanced treatment options.

10. The postoperative follow-up plan for the diagnosed neuromuscular scoliosis will be individualized based on its severity. Mild cases may involve periodic evaluations to assess symptoms and the effectiveness of conservative measures. Moderate cases will require regular visits, including clinical assessments, radiographic imaging, and physiotherapy interventions to manage scoliosis progression and optimize functional outcomes. Severe cases will require frequent and comprehensive follow-ups, involving multidisciplinary evaluations, potential surgical considerations, and long-term management strategies tailored to the patient's needs.

## M41.5 Other secondary scoliosis

1. Operative Note: Patient underwent posterior spinal fusion for other secondary scoliosis. Surgical approach involved a midline incision. Pedicle screws were inserted bilaterally, followed by osteotomy and spinal realignment. Fusion was achieved using autograft and allograft. Intraoperative neuromonitoring was utilized to ensure spinal cord integrity. Hemostasis was achieved, and wound was closed in layers.

2. Operative Note: Surgery performed for other secondary scoliosis included anterior release and posterior spinal fusion. A transverse incision was made, allowing access to the anterior spine. Discectomy and vertebral body resection were performed to release the deformity. Posteriorly, pedicle screws were placed, followed by spinal fusion using autograft and allograft. Closure was performed in a routine manner.

3. Operative Note: Patient underwent thoracoscopic spinal fusion for other secondary scoliosis. Three small incisions were made for the thoracoscopic ports. Rib resection was performed to access the spine. Pedicle screws were inserted, and spinal fusion was achieved using bone graft. The procedure was completed endoscopically, and the incisions were closed with sutures.

4. Operative Note: Surgery performed for other secondary scoliosis included a vertebral column resection. A posterior midline incision was made, allowing access to the spine. Osteotomy was performed at the apex of the deformity, followed by removal of the affected vertebral segment. Spinal realignment was achieved, and fusion was performed using autograft and allograft. Hemostasis was ensured, and the wound was closed layer by layer.

5. Operative Note: Patient underwent minimally invasive lateral interbody fusion for other secondary scoliosis. The procedure was performed through a small retroperitoneal incision. Access to the intervertebral disc space was achieved, and a fusion cage was inserted. Supplemental posterior instrumentation was applied using percutaneous pedicle screws. The incision was closed using sutures, and postoperative imaging confirmed appropriate cage placement.

6. Operative Note: Surgery performed for other secondary scoliosis involved posterior vertebral column resection. A midline incision was made, and laminectomy was performed to expose the spine. Osteotomy was performed above and below the deformity, followed by removal of the affected vertebral segment. Spinal alignment was corrected, and fusion was achieved using bone graft. Hemostasis was ensured, and the wound was closed in layers.

7. Operative Note: Patient underwent corrective surgery for other secondary scoliosis using a hybrid technique. Anteriorly, an incision was made for anterior release and interbody fusion. Pedicle screws were placed posteriorly, followed by posterior spinal fusion. Autograft and allograft were used for fusion. The incisions were closed in a routine manner, and postoperative imaging showed satisfactory correction.

8. Operative Note: Surgery performed for other secondary scoliosis involved anterior spinal release and fusion. An incision was made along the thoracic spine, allowing access to the anterior column. Discectomy and vertebral body resection were performed to release the deformity. Fusion was achieved using a combination of bone graft and anterior interbody cage. Closure was performed layer by layer.

9. Operative Note: Patient underwent posterior spinal fusion with segmental instrumentation for other secondary scoliosis. A midline incision was made, exposing the spine. Pedicle screws were inserted, and the deformity was corrected using rod constructs. Fusion was achieved using autograft and allograft. Hemostasis was ensured, and the incision was closed in layers. Intraoperative neuromonitoring confirmed spinal cord integrity throughout the procedure.

10. Operative Note: Surgery performed for other secondary scoliosis involved a posterior spinal fusion with the use of growing rods. A midline incision was made, allowing access to the spine. Pedicle screws were inserted, and the growing rods were connected. Fusion was achieved using autograft and allograft. The incision was closed, and postoperative imaging confirmed proper rod placement and alignment.

1. Operative Note: Patient underwent vertebral body tethering for other secondary scoliosis. A small incision was made, and access to the spine was obtained. The tether was secured to the vertebral bodies, providing dynamic correction. Intraoperative imaging confirmed appropriate placement. The incision was closed in a routine manner, and postoperative assessment showed satisfactory alignment.

2. Operative Note: Surgery performed for other secondary scoliosis included posterior spinal fusion with hybrid instrumentation. Pedicle screws were inserted, and a combination of hooks and wires were used for additional stabilization. Spinal alignment was corrected, and fusion was achieved using bone graft. The incision was closed layer by layer, and postoperative imaging confirmed satisfactory correction.

3. Operative Note: Patient underwent anterior release and posterior spinal fusion for other secondary scoliosis. An incision was made along the thoracic spine, allowing access to the anterior column. Discectomy and vertebral body resection were performed, followed by placement of interbody cages. Posteriorly, pedicle screws were inserted, and fusion was achieved using bone graft. Closure was performed in a routine manner.

4. Operative Note: Surgery performed for other secondary scoliosis involved posterior vertebral column resection and anterior interbody fusion. A midline incision was made, and osteotomy was performed to remove the affected vertebral segment. Anteriorly, an incision was made, allowing for discectomy and placement of interbody cages. Spinal realignment was achieved, and fusion was performed using autograft and allograft. The wounds were closed layer by layer.

5. Operative Note: Patient underwent minimally invasive posterior spinal fusion for other secondary scoliosis. Small incisions were made for the placement of percutaneous pedicle screws. Rod constructs were inserted, and spinal alignment was corrected. Fusion was achieved using autograft and allograft. The incisions were closed with sutures, and postoperative imaging confirmed satisfactory rod placement and alignment.

6. Operative Note: Surgery performed for other secondary scoliosis involved posterior vertebral column resection and posterior spinal fusion. A midline incision was made, exposing the spine. Osteotomy was performed above and below the deformity, followed by removal of the affected vertebral segment. Pedicle screws were inserted, and spinal alignment was corrected using rod constructs. Fusion was achieved using bone graft. Hemostasis was ensured, and the incision was closed layer by layer.

7. Operative Note: Patient underwent anterior release and posterior spinal fusion with pedicle subtraction osteotomy for other secondary scoliosis. An anterior incision was made, allowing for discectomy and vertebral body resection. Pedicle screws were inserted posteriorly, and a pedicle subtraction osteotomy was performed. Spinal alignment was corrected, and fusion was achieved using autograft and allograft. The incisions were closed in a routine manner, and postoperative imaging showed satisfactory correction.

8. Operative Note: Surgery performed for other secondary scoliosis involved posterior vertebral column resection with anterior and posterior spinal fusion. A midline incision was made, exposing the spine. Osteotomy was performed above and below the deformity, followed by removal of the affected vertebral segment. Anteriorly, an incision was made for discectomy and placement of interbody cages. Spinal alignment was corrected, and fusion was achieved using bone graft. The incisions were closed layer by layer.

9. Operative Note: Patient underwent posterior spinal fusion with pelvic fixation for other secondary scoliosis. A midline incision was made, allowing access to the spine. Pedicle screws were inserted, and sacral-iliac screws were placed for pelvic fixation. Spinal alignment was corrected using rod constructs. Fusion was achieved using autograft and allograft. The incision was closed in layers, and postoperative imaging confirmed satisfactory alignment and fixation.

10. Operative Note: Surgery performed for other secondary scoliosis included posterior vertebral column resection and posterior spinal fusion with vertebral body reconstruction. A midline incision was made, exposing the spine. Osteotomy was performed above and below the deformity, followed by removal of the affected vertebral segment. Reconstruction was performed using a synthetic vertebral body implant. Spinal alignment was corrected, and fusion was achieved using autograft and allograft. The incision was closed layer by layer.

1. Operative Note: Patient underwent posterior spinal fusion for other secondary scoliosis under general anesthesia. Anesthesia was induced with 150 mg of propofol and maintained with a sevoflurane concentration of 1-2%. Analgesia was provided using a continuous infusion of 1 mcg/kg/hour of fentanyl. The procedure was performed without complications, and the patient tolerated the anesthesia well.

2. Operative Note: Surgery performed for other secondary scoliosis included anterior release and posterior spinal fusion under general anesthesia. Anesthesia was induced with 200 mg of propofol and maintained with a desflurane concentration of 4-6%. Analgesia was achieved using a combination of 1 mcg/kg of remifentanil and a thoracic epidural infusion of 0.1% bupivacaine. The patient remained stable throughout the procedure.

3. Operative Note: Patient underwent thoracoscopic spinal fusion for other secondary scoliosis under general anesthesia. Anesthesia was induced with 2 mg/kg of propofol and maintained with a sevoflurane concentration of 1-2%. A total intravenous anesthesia (TIVA) technique was used, with a remifentanil infusion rate of 0.1-0.3 mcg/kg/minute. The patient had stable vital signs throughout the procedure, and adequate pain control was achieved.

4. Operative Note: Surgery performed for other secondary scoliosis involved posterior vertebral column resection under general anesthesia. Anesthesia was induced with 100 mcg of fentanyl and 150 mg of propofol. Maintenance was achieved using a desflurane concentration of 4-6% and an infusion of remifentanil at a rate of 0.05-0.1 mcg/kg/minute. The patient tolerated the anesthesia well, and postoperative pain was managed effectively.

5. Operative Note: Patient underwent minimally invasive lateral interbody fusion for other secondary scoliosis under general anesthesia. Anesthesia was induced with 2 mg/kg of propofol and 100 mcg of fentanyl. Maintenance was achieved using a sevoflurane concentration of 1-2% and a remifentanil infusion rate of 0.05-0.1 mcg/kg/minute. The patient remained hemodynamically stable, and postoperative pain was adequately controlled.

6. Operative Note: Surgery performed for other secondary scoliosis involved posterior spinal fusion with segmental instrumentation under general anesthesia. Anesthesia was induced with 200 mg of propofol and 100 mcg of fentanyl. Maintenance was achieved using a desflurane concentration of 4-6% and an infusion of remifentanil at a rate of 0.05-0.1 mcg/kg/minute. The patient's vital signs were stable throughout the procedure, and postoperative pain was well-managed.

7. Operative Note: Patient underwent corrective surgery for other secondary scoliosis using a hybrid technique under general anesthesia. Anesthesia was induced with 2 mg/kg of propofol and 100 mcg of fentanyl. Maintenance was achieved using a sevoflurane concentration of 1-2% and a remifentanil infusion rate of 0.1-0.2 mcg/kg/minute. The patient tolerated the anesthesia well, and postoperative pain was effectively controlled.

8. Operative Note: Surgery performed for other secondary scoliosis involved anterior spinal release and fusion under general anesthesia. Anesthesia was induced with 150 mcg of fentanyl and 2 mg/kg of propofol. Maintenance was achieved using a desflurane concentration of 4-6% and an infusion of remifentanil at a rate of 0.05-0.1 mcg/kg/minute. The patient remained stable throughout the procedure, and adequate analgesia was provided.

9. Operative Note: Patient underwent posterior spinal fusion with pelvic fixation for other secondary scoliosis under general anesthesia. Anesthesia was induced with 2 mg/kg of propofol and 100 mcg of fentanyl. Maintenance was achieved using a sevoflurane concentration of 1-2% and an infusion of remifentanil at a rate of 0.05-0.1 mcg/kg/minute. The patient had stable vital signs throughout the procedure, and effective pain control was maintained.

10. Operative Note: Surgery performed for other secondary scoliosis involved posterior vertebral column resection with anterior and posterior spinal fusion under general anesthesia. Anesthesia was induced with 150 mcg of fentanyl and 2 mg/kg of propofol. Maintenance was achieved using a desflurane concentration of 4-6% and an infusion of remifentanil at a rate of 0.05-0.1 mcg/kg/minute. The patient tolerated the anesthesia well, and postoperative pain was appropriately managed.

1. Operative Note: Patient with severe bone pain due to other secondary scoliosis underwent posterior spinal fusion under general anesthesia. Anesthesia was induced with 200 mcg of fentanyl and 2 mg/kg of propofol. Maintenance was achieved using a sevoflurane concentration of 1-2% and an infusion of remifentanil at a rate of 0.1-0.2 mcg/kg/minute. The patient's severe bone pain was closely monitored and managed throughout the procedure, resulting in adequate pain relief.

2. Operative Note: Surgery performed for other secondary scoliosis in a patient with severe bone pain included anterior release and posterior spinal fusion under general anesthesia. Anesthesia was induced with 150 mcg of fentanyl and 2 mg/kg of propofol. Maintenance was achieved using a desflurane concentration of 4-6% and an infusion of remifentanil at a rate of 0.1-0.2 mcg/kg/minute. The patient's severe bone pain was effectively controlled during the procedure.

3. Operative Note: Patient with severe bone pain secondary to other secondary scoliosis underwent thoracoscopic spinal fusion under general anesthesia. Anesthesia was induced with 2 mg/kg of propofol and 100 mcg of fentanyl. Maintenance was achieved using a sevoflurane concentration of 1-2% and a remifentanil infusion rate of 0.05-0.1 mcg/kg/minute. Close attention was given to managing the patient's severe bone pain throughout the procedure, ensuring adequate analgesia.

4. Operative Note: Surgery performed for other secondary scoliosis in a patient experiencing severe bone pain included posterior vertebral column resection under general anesthesia. Anesthesia was induced with 150 mcg of fentanyl and 2 mg/kg of propofol. Maintenance was achieved using a desflurane concentration of 4-6% and an infusion of remifentanil at a rate of 0.05-0.1 mcg/kg/minute. The patient's severe bone pain was diligently addressed, resulting in effective pain relief during the procedure.

5. Operative Note: Patient with severe bone pain due to other secondary scoliosis underwent minimally invasive lateral interbody fusion under general anesthesia. Anesthesia was induced with 200 mcg of fentanyl and 2 mg/kg of propofol. Maintenance was achieved using a sevoflurane concentration of 1-2% and an infusion of remifentanil at a rate of 0.1-0.2 mcg/kg/minute. Special attention was given to managing the patient's severe bone pain, ensuring optimal pain control during the procedure.

6. Operative Note: Surgery performed for other secondary scoliosis in a patient with severe bone pain involved posterior vertebral column resection and posterior spinal fusion under general anesthesia. Anesthesia was induced with 150 mcg of fentanyl and 2 mg/kg of propofol. Maintenance was achieved using a desflurane concentration of 4-6% and an infusion of remifentanil at a rate of 0.05-0.1 mcg/kg/minute. The patient's severe bone pain was meticulously managed, resulting in significant pain reduction throughout the procedure.

7. Operative Note: Patient with severe bone pain secondary to other secondary scoliosis underwent corrective surgery using a hybrid technique under general anesthesia. Anesthesia was induced with 200 mcg of fentanyl and 2 mg/kg of propofol. Maintenance was achieved using a sevoflurane concentration of 1-2% and an infusion of remifentanil at a rate of 0.1-0.2 mcg/kg/minute. The patient's severe bone pain was closely monitored and effectively addressed during the procedure.

8. Operative Note: Surgery performed for other secondary scoliosis in a patient experiencing severe bone pain included anterior spinal release and fusion under general anesthesia. Anesthesia was induced with 150 mcg of fentanyl and 2 mg/kg of propofol. Maintenance was achieved using a desflurane concentration of 4-6% and an infusion of remifentanil at a rate of 0.05-0.1 mcg/kg/minute. The patient's severe bone pain was actively managed throughout the procedure, resulting in significant pain relief.

9. Operative Note: Patient with severe bone pain due to other secondary scoliosis underwent posterior spinal fusion with pelvic fixation under general anesthesia. Anesthesia was induced with 200 mcg of fentanyl and 2 mg/kg of propofol. Maintenance was achieved using a sevoflurane concentration of 1-2% and an infusion of remifentanil at a rate of 0.05-0.1 mcg/kg/minute. The patient's severe bone pain was carefully addressed, providing effective pain control during the procedure.

10. Operative Note: Surgery performed for other secondary scoliosis in a patient with severe bone pain involved posterior vertebral column resection with anterior and posterior spinal fusion under general anesthesia. Anesthesia was induced with 150 mcg of fentanyl and 2 mg/kg of propofol. Maintenance was achieved using a desflurane concentration of 4-6% and an infusion of remifentanil at a rate of 0.05-0.1 mcg/kg/minute. The patient's severe bone pain was given utmost attention, ensuring optimal pain management throughout the procedure.

1. Operative Note: Surgical intervention for other secondary scoliosis included posterior spinal fusion with instrumentation. A midline incision was made, exposing the spine. Pedicle screws were inserted, and a rod construct was used for correction of spinal alignment. Fusion was achieved using a combination of autograft and allograft. The surgical site was thoroughly irrigated, and the incision was closed in layers. The patient tolerated the procedure well.

2. Operative Note: Surgical intervention for other secondary scoliosis involved anterior release and posterior spinal fusion. An anterior approach was used to release the spinal segments, followed by posterior instrumentation and fusion. The spinal alignment was corrected, and fusion was achieved using a combination of bone grafts. The surgical site was irrigated and closed meticulously. The patient's vital signs remained stable throughout the procedure.

3. Operative Note: Surgical intervention for other secondary scoliosis included posterior vertebral column resection (PVCR) and posterior spinal fusion. PVCR was performed to remove the affected vertebral segments, followed by correction of spinal alignment using rod constructs. Fusion was achieved using autograft and allograft. The surgical site was irrigated, and meticulous closure was performed. The patient tolerated the procedure well without any complications.

4. Operative Note: Surgical intervention for other secondary scoliosis involved minimally invasive lateral interbody fusion (MIS-LIF) and posterior spinal fusion. MIS-LIF was performed to restore disc height and correct the scoliotic curve. Posterior instrumentation and fusion were carried out to stabilize the spine. The surgical site was irrigated, and the incisions were closed meticulously. The patient's postoperative recovery was uneventful.

5. Operative Note: Surgical intervention for other secondary scoliosis included posterior spinal fusion with pelvic fixation. A midline incision was made, exposing the spine and pelvis. Pedicle screws and sacral-iliac screws were inserted for spinal and pelvic stabilization. Fusion was achieved using bone grafts. The surgical site was thoroughly irrigated, and the incisions were closed in layers. The patient's intraoperative course was unremarkable.

6. Operative Note: Surgical intervention for other secondary scoliosis involved posterior vertebral column resection (PVCR) with vertebral body reconstruction. PVCR was performed above and below the deformity, followed by removal of the affected vertebral segment. Reconstruction was carried out using a synthetic vertebral body implant. Spinal alignment was corrected, and fusion was achieved using autograft and allograft. The surgical site was irrigated and closed meticulously.

7. Operative Note: Surgical intervention for other secondary scoliosis included anterior spinal release and fusion with posterior instrumentation. An anterior approach was used for spinal release, followed by placement of anterior interbody cages. Posterior instrumentation and fusion were performed for spinal stabilization. The surgical site was irrigated, and the incisions were closed meticulously. The patient tolerated the procedure well.

8. Operative Note: Surgical intervention for other secondary scoliosis involved posterior spinal fusion with segmental instrumentation and fusion. Pedicle screws and rods were used for spinal alignment correction and stabilization. Fusion was achieved using autograft and allograft. The surgical site was irrigated, and meticulous closure was performed. The patient's postoperative course was uneventful.

9. Operative Note: Surgical intervention for other secondary scoliosis included posterior spinal fusion with osteotomy. An osteotomy was performed above and below the deformity to achieve spinal realignment. Pedicle screws and rods were used for instrumentation and stabilization. Fusion was achieved using bone grafts. The surgical site was irrigated, and the incisions were closed meticulously. The patient's intraoperative course was smooth.

10. Operative Note: Surgical intervention for other secondary scoliosis involved corrective osteotomy with posterior spinal fusion. An osteotomy was performed to correct the spinal curvature, followed by placement of pedicle screws and rods for stabilization. Fusion was achieved using autograft and allograft. The surgical site was irrigated, and meticulous closure was performed. The patient tolerated the procedure well without any complications.

1. Operative Note: Surgical intervention for other secondary scoliosis included posterior spinal fusion with the use of expandable cages. A midline incision was made, and pedicle screws were inserted for instrumentation. Expandable cages were placed to restore disc height and achieve spinal alignment. Fusion was achieved using bone grafts. The surgical site was thoroughly irrigated, and the incision was closed in layers. The patient's intraoperative course was unremarkable.

2. Operative Note: Surgical intervention for other secondary scoliosis involved anterior and posterior spinal fusion with vertebral body reconstruction. An anterior approach was used to remove the affected vertebral segments and reconstruct the vertebral bodies with synthetic cages. Posterior instrumentation and fusion were performed for spinal stabilization. The surgical site was irrigated, and meticulous closure was carried out. The patient tolerated the procedure well.

3. Operative Note: Surgical intervention for other secondary scoliosis included posterior vertebral column resection (PVCR) and posterior spinal fusion with vertebral body augmentation. PVCR was performed to remove the deformed vertebral segments. Vertebral body augmentation was achieved using synthetic bone cement. Posterior instrumentation and fusion were carried out for spinal stabilization. The surgical site was irrigated, and the incisions were closed meticulously. The patient's intraoperative course was smooth.

4. Operative Note: Surgical intervention for other secondary scoliosis involved minimally invasive lateral interbody fusion (MIS-LIF) and posterior spinal fusion with the use of expandable cages. MIS-LIF was performed to restore disc height and correct the scoliotic curve. Posterior instrumentation and fusion were carried out for spinal stabilization. Expandable cages were utilized to optimize the fusion process. The surgical site was irrigated, and meticulous closure was performed. The patient's postoperative recovery was uneventful.

5. Operative Note: Surgical intervention for other secondary scoliosis included posterior spinal fusion with the placement of vertebral body replacement devices. A midline incision was made, and pedicle screws were inserted for spinal instrumentation. Synthetic vertebral body replacement devices were used to restore disc height and promote spinal alignment. Fusion was achieved using bone grafts. The surgical site was thoroughly irrigated, and the incision was closed in layers. The patient's intraoperative course was unremarkable.

6. Operative Note: Surgical intervention for other secondary scoliosis involved posterior vertebral column resection (PVCR) and posterior spinal fusion with the use of interbody cages. PVCR was performed to remove the deformed vertebral segments. Interbody cages were inserted to restore disc height and facilitate fusion. Posterior instrumentation and fusion were carried out for spinal stabilization. The surgical site was irrigated, and meticulous closure was performed. The patient's intraoperative course was smooth.

7. Operative Note: Surgical intervention for other secondary scoliosis included anterior spinal release and fusion with posterior spinal fusion using synthetic bone graft substitutes. An anterior approach was used for spinal release and placement of synthetic bone graft substitutes. Posterior instrumentation and fusion were performed for spinal stabilization. The surgical site was irrigated, and the incisions were closed meticulously. The patient tolerated the procedure well.

8. Operative Note: Surgical intervention for other secondary scoliosis involved posterior spinal fusion with the use of expandable titanium cages. Pedicle screws and rods were inserted for spinal instrumentation, and expandable titanium cages were placed to restore disc height and promote fusion. The surgical site was irrigated, and meticulous closure was performed. The patient's postoperative course was uneventful.

9. Operative Note: Surgical intervention for other secondary scoliosis included posterior vertebral column resection (PVCR) and posterior spinal fusion with the use of synthetic bone graft extenders. PVCR was performed to remove the deformed vertebral segments. Synthetic bone graft extenders were used to augment fusion. Posterior instrumentation and fusion were carried out for spinal stabilization. The surgical site was irrigated, and the incisions were closed meticulously. The patient tolerated the procedure well.

10. Operative Note: Surgical intervention for other secondary scoliosis involved anterior and posterior spinal fusion with the use of 3D-printed interbody cages. An anterior approach was used for discectomy and placement of 3D-printed interbody cages. Posterior instrumentation and fusion were performed for spinal stabilization. The surgical site was irrigated, and meticulous closure was carried out. The patient's intraoperative course was unremarkable.

1. Operative Note: Surgical intervention for other secondary scoliosis with a severe infection on the extreme moving joint involved extensive debridement and posterior spinal fusion. The infected joint was thoroughly irrigated and debrided. Pedicle screws and rods were placed for spinal stabilization, and fusion was achieved using antibiotic-impregnated bone grafts. The surgical site was irrigated with antibiotic solution, and a closed suction drain was placed. The patient's postoperative antibiotics were adjusted according to the culture sensitivity report.

2. Operative Note: Surgical intervention for other secondary scoliosis with a severe infection on the extreme moving joint included anterior release, debridement, and posterior spinal fusion. The infected joint was meticulously debrided, followed by placement of anterior interbody cages. Pedicle screws and rods were inserted for spinal stabilization, and fusion was achieved using a combination of antibiotic-impregnated bone grafts and allograft. The surgical site was thoroughly irrigated with antibiotic solution, and the incisions were closed in layers.

3. Operative Note: Surgical intervention for other secondary scoliosis with a severe infection on the extreme moving joint involved posterior vertebral column resection (PVCR), debridement, and posterior spinal fusion. PVCR was performed above and below the infected joint, and the affected joint was debrided meticulously. Pedicle screws and rods were placed for spinal alignment correction, and fusion was achieved using antibiotic-impregnated bone grafts. The surgical site was irrigated with antibiotic solution, and a drain was placed for postoperative wound care.

4. Operative Note: Surgical intervention for other secondary scoliosis with a severe infection on the extreme moving joint included minimally invasive lateral interbody fusion (MIS-LIF) with debridement and posterior spinal fusion. MIS-LIF was performed to restore disc height, followed by meticulous debridement of the infected joint. Pedicle screws and rods were inserted for spinal stabilization, and fusion was achieved using antibiotic-impregnated bone grafts. The surgical site was irrigated with antibiotic solution, and the incisions were closed meticulously.

5. Operative Note: Surgical intervention for other secondary scoliosis with a severe infection on the extreme moving joint involved posterior spinal fusion with extensive debridement and irrigation. The infected joint was thoroughly debrided, and all necrotic tissue was removed. Pedicle screws and rods were placed for spinal stabilization, and fusion was achieved using a combination of antibiotic-impregnated bone grafts and autograft. The surgical site was irrigated with antibiotic solution, and negative pressure wound therapy was initiated for optimal wound healing.

6. Operative Note: Surgical intervention for other secondary scoliosis with a severe infection on the extreme moving joint included posterior vertebral column resection (PVCR) with debridement and posterior spinal fusion. PVCR was performed above and below the infected joint, and meticulous debridement was carried out. Pedicle screws and rods were inserted for spinal alignment correction, and fusion was achieved using antibiotic-impregnated bone grafts. The surgical site was irrigated with antibiotic solution, and a wound vacuum was applied for postoperative wound care.

7. Operative Note: Surgical intervention for other secondary scoliosis with a severe infection on the extreme moving joint involved anterior release, extensive debridement, and posterior spinal fusion. The infected joint was meticulously debrided, and anterior interbody cages were placed for restoration of disc height. Pedicle screws and rods were inserted for spinal stabilization, and fusion was achieved using antibiotic-impregnated bone grafts. The surgical site was thoroughly irrigated with antibiotic solution, and meticulous closure was performed.

8. Operative Note: Surgical intervention for other secondary scoliosis with a severe infection on the extreme moving joint included posterior spinal fusion with aggressive debridement and irrigation. The infected joint was extensively debrided, removing all infected tissue. Pedicle screws and rods were placed for spinal stabilization, and fusion was achieved using antibiotic-impregnated bone grafts. The surgical site was irrigated with antibiotic solution, and a closed suction drain was placed. The patient's postoperative antibiotic regimen was tailored to the specific infecting organism.

9. Operative Note: Surgical intervention for other secondary scoliosis with a severe infection on the extreme moving joint involved posterior vertebral column resection (PVCR), debridement, and posterior spinal fusion. PVCR was performed above and below the infected joint, and meticulous debridement was carried out to eliminate all infected tissue. Pedicle screws and rods were inserted for spinal alignment correction, and fusion was achieved using antibiotic-impregnated bone grafts. The surgical site was irrigated with antibiotic solution, and negative pressure wound therapy was initiated for wound healing optimization.

10. Operative Note: Surgical intervention for other secondary scoliosis with a severe infection on the extreme moving joint included anterior and posterior spinal fusion with extensive debridement and irrigation. The infected joint was meticulously debrided, and anterior interbody cages were placed for disc height restoration. Pedicle screws and rods were inserted for spinal stabilization, and fusion was achieved using antibiotic-impregnated bone grafts. The surgical site was thoroughly irrigated with antibiotic solution, and meticulous closure of the incisions was performed.

1. Operative Note: Surgical intervention for other secondary scoliosis with severe inflammation involved posterior spinal fusion with extensive soft tissue debridement. The inflamed tissues were meticulously excised, and pedicle screws and rods were placed for spinal stabilization. Fusion was achieved using bone grafts. The surgical site was irrigated with saline solution, and a closed suction drain was inserted. The patient's postoperative anti-inflammatory regimen was adjusted to manage the inflammation.

2. Operative Note: Surgical intervention for other secondary scoliosis with acute inflammation involved anterior release, debridement, and posterior spinal fusion. The inflamed tissues were carefully excised, and anterior interbody cages were placed. Posterior instrumentation and fusion were performed for spinal stabilization. The surgical site was irrigated with an anti-inflammatory solution, and meticulous closure was performed. The patient's postoperative anti-inflammatory medication was modified based on the degree of inflammation observed.

3. Operative Note: Surgical intervention for other secondary scoliosis with chronic inflammation involved posterior vertebral column resection (PVCR) and posterior spinal fusion. PVCR was performed to remove the affected vertebral segments, and meticulous debridement was carried out. Pedicle screws and rods were inserted for spinal alignment correction and stabilization. Fusion was achieved using bone grafts. The surgical site was irrigated with an anti-inflammatory solution, and the incisions were closed meticulously.

4. Operative Note: Surgical intervention for other secondary scoliosis with moderate inflammation involved minimally invasive lateral interbody fusion (MIS-LIF) and posterior spinal fusion. MIS-LIF was performed to restore disc height, while the inflamed tissues were carefully managed. Posterior instrumentation and fusion were carried out for spinal stabilization. The surgical site was irrigated with a solution containing anti-inflammatory agents, and meticulous closure was performed. The patient's postoperative anti-inflammatory medication was adjusted based on the level of inflammation observed.

5. Operative Note: Surgical intervention for other secondary scoliosis with severe inflammation involved posterior spinal fusion with the use of anti-inflammatory bone graft substitutes. The inflamed tissues were meticulously addressed, and pedicle screws and rods were placed for spinal stabilization. Fusion was achieved using bone graft substitutes with anti-inflammatory properties. The surgical site was irrigated with an anti-inflammatory solution, and meticulous closure was performed. The patient's postoperative anti-inflammatory regimen was tailored to control the inflammation.

6. Operative Note: Surgical intervention for other secondary scoliosis with acute inflammation involved posterior vertebral column resection (PVCR) with extensive soft tissue debridement. The inflamed tissues were meticulously excised, and PVCR was performed to correct the spinal deformity. Pedicle screws and rods were inserted for spinal alignment correction and stabilization. Fusion was achieved using bone grafts. The surgical site was irrigated with a solution containing anti-inflammatory agents, and meticulous closure was performed.

7. Operative Note: Surgical intervention for other secondary scoliosis with chronic inflammation involved anterior release, debridement, and posterior spinal fusion with the use of anti-inflammatory bone graft substitutes. The inflamed tissues were carefully managed, and anterior interbody cages were placed. Posterior instrumentation and fusion were performed for spinal stabilization using bone graft substitutes with anti-inflammatory properties. The surgical site was irrigated with an anti-inflammatory solution, and meticulous closure was performed.

8. Operative Note: Surgical intervention for other secondary scoliosis with moderate inflammation involved posterior spinal fusion with the application of anti-inflammatory agents. The inflamed tissues were addressed, and pedicle screws and rods were placed for spinal stabilization. Fusion was achieved using bone grafts supplemented with anti-inflammatory agents. The surgical site was irrigated with an anti-inflammatory solution, and meticulous closure was performed. The patient's postoperative anti-inflammatory regimen was adjusted based on the degree of inflammation observed.

9. Operative Note: Surgical intervention for other secondary scoliosis with severe inflammation involved posterior vertebral column resection (PVCR) and posterior spinal fusion with anti-inflammatory bone graft substitutes. The inflamed tissues were meticulously debrided, and PVCR was performed to correct the spinal deformity. Pedicle screws and rods were inserted for spinal alignment correction and stabilization. Fusion was achieved using bone graft substitutes with anti-inflammatory properties. The surgical site was irrigated with an anti-inflammatory solution, and meticulous closure was performed.

10. Operative Note: Surgical intervention for other secondary scoliosis with acute inflammation involved anterior and posterior spinal fusion with anti-inflammatory bone graft substitutes. The inflamed tissues were carefully managed, and anterior interbody cages were placed. Posterior instrumentation and fusion were performed for spinal stabilization using bone graft substitutes with anti-inflammatory properties. The surgical site was irrigated with an anti-inflammatory solution, and meticulous closure was performed. The patient's postoperative anti-inflammatory medication was modified to control the inflammation effectively.

1. Operative Note: Surgical intervention for other secondary scoliosis was performed based on the severity of the diagnosis. In mild cases, posterior spinal fusion was carried out without complications. The patient will undergo routine follow-up visits at 6 weeks, 3 months, and 6 months postoperatively for monitoring of spinal alignment and fusion progression.

2. Operative Note: Surgical intervention for other secondary scoliosis was tailored to the severity of the diagnosis. In moderate cases, anterior and posterior spinal fusion with interbody cages and pedicle screws were performed. The patient will have follow-up appointments at 4 weeks, 3 months, and 6 months postoperatively to assess spinal fusion and monitor for any signs of implant failure or complications.

3. Operative Note: Surgical intervention for other secondary scoliosis was necessary due to the severity of the diagnosis. Posterior vertebral column resection (PVCR) and posterior spinal fusion were performed to correct the deformity. The patient will require close follow-up visits at 2 weeks, 6 weeks, and 3 months postoperatively to evaluate spinal alignment, fusion progress, and to manage any potential complications.

4. Operative Note: Surgical intervention for other secondary scoliosis was indicated due to the severity of the diagnosis. Minimally invasive lateral interbody fusion (MIS-LIF) and posterior spinal fusion were performed to address the condition. The patient will have follow-up appointments at 6 weeks, 3 months, and 1 year postoperatively to assess spinal fusion, monitor for any complications, and evaluate the effectiveness of the procedure.

5. Operative Note: Surgical intervention for other secondary scoliosis was performed based on the severity of the diagnosis. In moderate to severe cases, extensive debridement, posterior spinal fusion, and placement of synthetic bone graft extenders were carried out. The patient will require frequent follow-up visits at 2 weeks, 4 weeks, and 3 months postoperatively to assess fusion progress, manage pain, and monitor for any signs of infection or complications.

6. Operative Note: Surgical intervention for other secondary scoliosis was necessary due to the severity of the diagnosis. Anterior release, debridement, and posterior spinal fusion with extensive instrumentation were performed. The patient will have regular follow-up appointments at 2 weeks, 6 weeks, and 6 months postoperatively to evaluate spinal alignment, monitor fusion progress, and assess functional outcomes.

7. Operative Note: Surgical intervention for other secondary scoliosis was tailored to the severity of the diagnosis. In severe cases, posterior vertebral column resection (PVCR), debridement, and posterior spinal fusion were performed. The patient will require frequent follow-up visits at 2 weeks, 4 weeks, and 3 months postoperatively to assess spinal alignment, monitor for signs of infection, and manage any complications that may arise.

8. Operative Note: Surgical intervention for other secondary scoliosis was indicated based on the severity of the diagnosis. Posterior spinal fusion with the use of expandable titanium cages was performed. The patient will have follow-up appointments at 6 weeks, 3 months, and 1 year postoperatively to assess fusion progress, evaluate spinal alignment, and monitor for any complications or implant-related issues.

9. Operative Note: Surgical intervention for other secondary scoliosis was performed based on the severity of the diagnosis. In moderate cases, posterior spinal fusion with the placement of vertebral body replacement devices was carried out. The patient will require regular follow-up visits at 4 weeks, 3 months, and 6 months postoperatively to assess fusion progress, manage pain, and monitor for any signs of complications or implant failure.

10. Operative Note: Surgical intervention for other secondary scoliosis was necessary due to the severity of the diagnosis. Posterior spinal fusion with the use of 3D-printed interbody cages and pedicle screws was performed. The patient will have frequent follow-up appointments at 2 weeks, 4 weeks, and 3 months postoperatively to evaluate fusion progress, assess spinal alignment, and monitor for any complications or adverse reactions to the implants.

## M41.8 Other forms of scoliosis

1. Operative Note: Patient underwent corrective surgery for congenital scoliosis, involving spinal fusion and instrumentation with pedicle screws. Intraoperative monitoring showed no significant neurological changes. Adequate correction of the spinal deformity was achieved, and the patient tolerated the procedure well. Hemostasis was secured, and the wound was closed in layers. Postoperative X-rays confirmed satisfactory alignment.

2. Operative Note: Surgical intervention was performed on the patient with neuromuscular scoliosis. A posterior spinal fusion was carried out, incorporating segmental instrumentation and bone grafting. No intraoperative complications were encountered, and the patient's neuromuscular function remained stable. The surgical site was closed meticulously, and postoperative imaging confirmed satisfactory correction of the scoliotic curve.

3. Operative Note: The patient underwent a minimally invasive surgical procedure for idiopathic scoliosis. Utilizing a video-assisted thoracoscopic approach, a selective fusion of the affected thoracic vertebrae was accomplished. The procedure was uneventful, and no significant intraoperative complications were observed. The patient's vital signs remained stable throughout the surgery, and postoperative imaging demonstrated adequate correction of the scoliotic curvature.

4. Operative Note: Surgical correction was performed on a patient with syndromic scoliosis. A combined anterior and posterior approach was employed to achieve spinal fusion and stabilization. Intraoperative neuromonitoring indicated no detrimental changes, and the patient's condition remained stable. Closure of the surgical incision was performed meticulously, and postoperative assessment revealed satisfactory realignment of the scoliotic spine.

5. Operative Note: The patient with degenerative scoliosis underwent a decompression and fusion procedure. Laminectomy and discectomy were performed to relieve neural compression, followed by posterior spinal fusion with pedicle screws and rods. The procedure was uneventful, and the patient tolerated it well. Intraoperative imaging confirmed appropriate decompression and alignment of the spinal column.

6. Operative Note: A corrective surgical intervention was carried out on a patient with thoracogenic scoliosis. The procedure involved posterior spinal fusion with instrumentation using hybrid constructs. Intraoperative monitoring demonstrated no significant neurological changes, and the patient remained hemodynamically stable. The surgical wound was meticulously closed, and postoperative X-rays confirmed satisfactory correction of the scoliotic deformity.

7. Operative Note: The patient with idiopathic adult scoliosis underwent a posterior spinal fusion procedure. Pedicle screws and rods were utilized for instrumentation and stabilization. No intraoperative complications were encountered, and the patient's vital signs remained stable. Closure of the surgical incision was performed in layers, and postoperative imaging confirmed adequate correction of the scoliotic curvature.

8. Operative Note: Surgical intervention was performed on a patient with kyphoscoliosis. A combined anterior and posterior approach was utilized for spinal fusion and stabilization. Intraoperative neuromonitoring showed no significant changes, and the patient tolerated the procedure well. Meticulous closure of the surgical site was carried out, and postoperative assessment revealed satisfactory correction of the kyphoscoliotic deformity.

9. Operative Note: The patient underwent corrective surgery for iatrogenic scoliosis. A posterior spinal fusion was performed, incorporating segmental instrumentation and bone grafting. No intraoperative complications occurred, and the patient's condition remained stable throughout the procedure. The surgical incision was closed meticulously, and postoperative imaging demonstrated satisfactory realignment of the scoliotic spine.

10. Operative Note: Surgical correction was carried out on a patient with idiopathic adolescent scoliosis. A posterior approach was employed, involving spinal fusion with pedicle screws and rods. Intraoperative monitoring indicated no significant neurological changes, and the patient tolerated the procedure well. Closure of the surgical wound was performed meticulously, and postoperative X-rays confirmed satisfactory alignment and correction of the scoliotic curvature.

1. Operative Note: The patient with osteopathic scoliosis underwent a posterior spinal fusion procedure with instrumentation using pedicle screws and rods. Intraoperative monitoring showed stable neurological function, and the patient's vital signs remained within normal limits. The surgical incision was closed in layers, and postoperative imaging confirmed successful correction of the scoliotic deformity.

2. Operative Note: Surgical intervention was performed on a patient with idiopathic juvenile scoliosis. A dual approach involving anterior release and posterior spinal fusion was carried out. Intraoperative neuromonitoring demonstrated no adverse changes, and the patient's condition remained stable. The surgical site was meticulously closed, and postoperative imaging confirmed satisfactory realignment of the scoliotic spine.

3. Operative Note: The patient with neurofibromatosis-associated scoliosis underwent a posterior spinal fusion procedure. Pedicle screws and rods were utilized for instrumentation and stabilization. Intraoperative monitoring indicated no significant neurological alterations, and the patient tolerated the procedure well. The surgical incision was closed meticulously, and postoperative imaging demonstrated adequate correction of the scoliotic curvature.

4. Operative Note: Surgical correction was performed on a patient with idiopathic infantile scoliosis. A growing rod technique was employed to address the spinal deformity. No intraoperative complications were encountered, and the patient's vital signs remained stable. The surgical wound was closed meticulously, and postoperative assessment revealed satisfactory correction of the scoliotic curve.

5. Operative Note: The patient underwent a revision surgery for recurrent scoliosis following a previous spinal fusion. Posterior revision with extension of the fusion construct was carried out, incorporating additional pedicle screws and rods. Intraoperative monitoring showed no significant neurological changes, and the patient tolerated the procedure well. Closure of the surgical incision was performed meticulously, and postoperative imaging confirmed improved alignment.

6. Operative Note: Surgical intervention was performed on a patient with idiopathic late-onset scoliosis. A minimally invasive approach was utilized, involving the placement of interspinous spacers and percutaneous pedicle screws for stabilization. No intraoperative complications were encountered, and the patient's vital signs remained stable. Closure of the surgical site was performed meticulously, and postoperative imaging confirmed satisfactory correction of the scoliotic curvature.

7. Operative Note: The patient with congenital kyphoscoliosis underwent a combined anterior and posterior spinal fusion procedure. Anterior release and interbody fusion were performed initially, followed by posterior instrumentation and fusion. Intraoperative neuromonitoring demonstrated no significant changes, and the patient tolerated the procedure well. The surgical wound was closed meticulously, and postoperative assessment revealed satisfactory correction of the kyphoscoliotic deformity.

8. Operative Note: Surgical correction was carried out on a patient with idiopathic hyperkyphosis. A posterior spinal fusion with pedicle screws and rods was performed. Intraoperative monitoring indicated no significant neurological changes, and the patient's condition remained stable throughout the procedure. The surgical incision was closed meticulously, and postoperative imaging confirmed adequate realignment of the hyperkyphotic spine.

9. Operative Note: The patient with postural scoliosis underwent a selective nerve root block procedure. Under fluoroscopic guidance, local anesthetic and corticosteroid were injected into the affected nerve root to alleviate pain and improve postural alignment. The procedure was well-tolerated, and the patient reported immediate relief. No postoperative complications were observed, and the patient was discharged with instructions for follow-up care.

10. Operative Note: Surgical intervention was performed on a patient with idiopathic scoliosis and associated spinal stenosis. A combined decompression and fusion procedure was carried out, incorporating laminectomy and posterior spinal fusion.

1. Operative Note: The patient with idiopathic scoliosis underwent a posterior spinal fusion procedure under general anesthesia with standard dosage. Intraoperative neuromonitoring indicated no significant changes, and the patient tolerated the procedure well. The surgical incision was closed meticulously, and postoperative imaging confirmed satisfactory correction of the scoliotic curvature.

2. Operative Note: Surgical intervention was performed on a patient with neuromuscular scoliosis using moderate sedation. A posterior spinal fusion was carried out, incorporating segmental instrumentation and bone grafting. No intraoperative complications were encountered, and the patient's vital signs remained stable. Closure of the surgical site was performed meticulously, and postoperative imaging demonstrated adequate correction of the scoliotic deformity.

3. Operative Note: The patient with degenerative scoliosis underwent a decompression and fusion procedure under local anesthesia with conscious sedation. Laminectomy and discectomy were performed to relieve neural compression, followed by posterior spinal fusion with pedicle screws and rods. The procedure was uneventful, and the patient tolerated it well. Intraoperative imaging confirmed appropriate decompression and alignment of the spinal column.

4. Operative Note: Surgical correction was performed on a patient with syndromic scoliosis under general anesthesia with reduced dosage. A combined anterior and posterior approach was employed to achieve spinal fusion and stabilization. Intraoperative neuromonitoring indicated no detrimental changes, and the patient's condition remained stable. Closure of the surgical incision was performed meticulously, and postoperative assessment revealed satisfactory realignment of the scoliotic spine.

5. Operative Note: The patient with idiopathic adolescent scoliosis underwent a posterior spinal fusion procedure under general anesthesia with increased dosage. Pedicle screws and rods were utilized for instrumentation and stabilization. No intraoperative complications were encountered, and the patient's vital signs remained stable. Closure of the surgical incision was performed in layers, and postoperative imaging confirmed adequate correction of the scoliotic curvature.

6. Operative Note: Surgical intervention was performed on a patient with thoracogenic scoliosis under regional anesthesia with intravenous sedation. The procedure involved posterior spinal fusion with instrumentation using hybrid constructs. Intraoperative monitoring demonstrated no significant neurological changes, and the patient remained hemodynamically stable. The surgical wound was meticulously closed, and postoperative X-rays confirmed satisfactory correction of the scoliotic deformity.

7. Operative Note: The patient with idiopathic adult scoliosis underwent a posterior spinal fusion procedure under general anesthesia with standard dosage. Pedicle screws and rods were utilized for instrumentation and stabilization. No intraoperative complications were encountered, and the patient's vital signs remained stable. Closure of the surgical incision was performed meticulously, and postoperative imaging confirmed adequate correction of the scoliotic curvature.

8. Operative Note: Surgical correction was carried out on a patient with kyphoscoliosis under general anesthesia with reduced dosage. A combined anterior and posterior approach was utilized for spinal fusion and stabilization. Intraoperative neuromonitoring showed no significant changes, and the patient tolerated the procedure well. Meticulous closure of the surgical site was carried out, and postoperative assessment revealed satisfactory correction of the kyphoscoliotic deformity.

9. Operative Note: The patient underwent corrective surgery for iatrogenic scoliosis under local anesthesia with conscious sedation. A posterior spinal fusion was performed, incorporating segmental instrumentation and bone grafting. No intraoperative complications occurred, and the patient's condition remained stable throughout the procedure. The surgical incision was closed meticulously, and postoperative imaging demonstrated satisfactory realignment of the scoliotic spine.

10. Operative Note: Surgical correction was carried out on a patient with idiopathic juvenile scoliosis under general anesthesia with increased dosage. A posterior approach involving spinal fusion with pedicle screws and rods was performed. Intraoperative monitoring indicated no significant neurological changes, and the patient tolerated the procedure well. Closure of the surgical wound was performed meticulously, and postoperative imaging confirmed successful correction of the scoliotic deformity.

1. Operative Note: The patient with scoliosis and associated bone erosion underwent a posterior spinal fusion procedure with extensive bone grafting. Preoperative imaging revealed significant erosion of the vertebral bodies. Intraoperatively, meticulous decortication and graft placement were performed to address the bone loss. Pedicle screws and rods were used for stabilization. The surgical incision was closed in layers, and postoperative imaging confirmed successful fusion and stabilization.

2. Operative Note: Surgical intervention was performed on a patient with scoliosis and adjacent vertebral erosion. A combined anterior and posterior approach was utilized to address the deformity and bone erosion. Intraoperative exploration revealed erosion of the adjacent vertebral bodies, requiring meticulous debridement and placement of structural allografts. Posterior spinal fusion with instrumentation was performed for stabilization. The surgical site was closed meticulously, and postoperative imaging confirmed adequate correction and stabilization.

3. Operative Note: The patient with scoliosis and severe vertebral erosion underwent a complex revision surgery. The procedure involved removal of previous instrumentation and extensive debridement of eroded bone. Structural allografts were meticulously placed to restore vertebral height and stability. Posterior spinal fusion with pedicle screws and rods was performed. The surgical incision was closed meticulously, and postoperative imaging confirmed improved alignment and stabilization.

4. Operative Note: Surgical correction was performed on a patient with scoliosis and erosive changes in the lumbar spine. The procedure involved anterior column reconstruction using expandable cages and bone grafts to address the erosion. Posterior spinal fusion with pedicle screws and rods was performed for stabilization. Intraoperative imaging confirmed adequate placement of implants and realignment of the spine. The surgical site was closed meticulously, and postoperative imaging demonstrated improved vertebral integrity.

5. Operative Note: The patient with scoliosis and significant bone erosion at the thoracic level underwent a posterior spinal fusion procedure. Intraoperative exploration revealed erosive changes in the vertebral bodies necessitating meticulous debridement and graft placement. Additional structural support with pedicle screws and rods was employed. The surgical incision was closed in layers, and postoperative imaging confirmed satisfactory correction and stabilization of the scoliotic curve.

6. Operative Note: Surgical intervention was performed on a patient with scoliosis and extensive erosion of the sacrum. The procedure involved sacral debridement, bone grafting, and posterior instrumentation for stabilization. Intraoperative findings revealed significant bone loss requiring meticulous preparation of the graft bed. The surgical site was closed meticulously, and postoperative imaging confirmed successful fusion and stabilization despite the erosive changes.

7. Operative Note: The patient with scoliosis and erosive changes in the cervical spine underwent a combined anterior and posterior corrective surgery. Anterior decompression and fusion were performed to address the erosion and restore vertebral height. Posterior spinal fusion with pedicle screws and rods was carried out for stabilization. Intraoperative imaging confirmed appropriate graft placement and alignment. The surgical incision was closed meticulously, and postoperative imaging demonstrated improved cervical alignment.

8. Operative Note: Surgical correction was performed on a patient with scoliosis and erosive changes in the lumbar and thoracic spine. A comprehensive procedure was undertaken, involving anterior column reconstruction, posterior spinal fusion with pedicle screws and rods, and extensive bone grafting. Intraoperative exploration revealed significant erosion requiring meticulous debridement. The surgical incision was closed meticulously, and postoperative imaging confirmed successful restoration of vertebral height and stabilization.

9. Operative Note: The patient with scoliosis and erosive changes at the thoracolumbar junction underwent a posterior spinal fusion procedure. Intraoperative findings revealed erosive bone loss necessitating meticulous debridement and bone graft placement. Pedicle screws and rods were used for stabilization. The surgical incision was closed in layers, and postoperative imaging confirmed successful fusion and stabilization despite the erosive changes.

10. Operative Note: Surgical intervention was performed on a patient with scoliosis and erosive changes in the lumbar spine. The procedure involved extensive debridement of the eroded vertebral bodies and meticulous bone grafting. Posterior spinal fusion with pedicle screws and rods was performed for stabilization. Intraoperative imaging confirmed appropriate graft placement and alignment. The surgical site was closed meticulously, and postoperative imaging demonstrated improved vertebral integrity and alignment.

1. Operative Note: The patient with severe scoliosis and debilitating bone pain underwent a posterior spinal fusion procedure with the aim of relieving pain and correcting the deformity. Intraoperative findings revealed significant degenerative changes in the vertebral bodies. Meticulous debridement, decompression, and bone grafting were performed. Pedicle screws and rods were used for stabilization. The surgical incision was closed meticulously, and postoperative imaging confirmed improved alignment and reduction in bone pain.

2. Operative Note: Surgical intervention was performed on a patient with scoliosis and severe bone pain refractory to conservative measures. A comprehensive procedure involving anterior release, decompression, and posterior spinal fusion was carried out. Intraoperative exploration revealed degenerative changes and osteophyte formation in the affected vertebrae. Meticulous debridement and bone grafting were performed to address the pathology. The surgical site was closed meticulously, and postoperative imaging confirmed improved alignment and alleviation of bone pain.

3. Operative Note: The patient with severe idiopathic scoliosis and intractable bone pain underwent a posterior spinal fusion procedure. Intraoperative findings revealed degenerative changes and severe facet joint arthropathy. Meticulous decompression, facetectomy, and fusion were performed to alleviate the bone pain and stabilize the spine. Pedicle screws and rods were utilized for fixation. The surgical incision was closed meticulously, and postoperative imaging confirmed improved alignment and relief of bone pain.

4. Operative Note: Surgical correction was performed on a patient with severe scoliosis and excruciating bone pain. Intraoperative exploration revealed osteolytic lesions within the vertebral bodies. Meticulous curettage, bone grafting, and posterior spinal fusion were performed. Pedicle screws and rods were used for stabilization. The surgical incision was closed meticulously, and postoperative imaging confirmed improved alignment and substantial reduction in bone pain.

5. Operative Note: The patient with severe degenerative scoliosis and intractable bone pain underwent a combined anterior and posterior approach for spinal fusion. Intraoperative findings revealed severe disc degeneration and bone spurs contributing to the pain. Meticulous discectomy, decompression, and fusion were performed. The surgical incision was closed meticulously, and postoperative imaging confirmed improved alignment and significant reduction in bone pain.

6. Operative Note: Surgical intervention was performed on a patient with severe scoliosis and incapacitating bone pain. Intraoperative exploration revealed vertebral compression fractures and extensive osteoporosis. Meticulous vertebroplasty, posterior spinal fusion, and stabilization were performed. Pedicle screws and rods were used to augment stability. The surgical site was closed meticulously, and postoperative imaging confirmed improved alignment and remarkable alleviation of bone pain.

7. Operative Note: The patient with severe neurogenic scoliosis and excruciating bone pain underwent a posterior spinal fusion procedure. Intraoperative findings revealed significant foraminal stenosis and nerve root impingement contributing to the pain. Meticulous decompression, foraminotomy, and fusion were performed. Pedicle screws and rods were utilized for stabilization. The surgical incision was closed meticulously, and postoperative imaging confirmed improved alignment and substantial reduction in bone pain.

8. Operative Note: Surgical correction was performed on a patient with severe scoliosis and severe bone pain refractory to conservative measures. Intraoperative exploration revealed extensive vertebral osteophytes and facet joint hypertrophy. Meticulous decompression, facetectomy, and fusion were carried out to alleviate the bone pain and stabilize the spine. The surgical incision was closed meticulously, and postoperative imaging confirmed improved alignment and relief of bone pain.

9. Operative Note: The patient with severe idiopathic adolescent scoliosis and debilitating bone pain underwent a posterior spinal fusion procedure. Intraoperative findings revealed degenerative disc disease and severe osteophyte formation. Meticulous discectomy, decompression, and fusion were performed. Pedicle screws and rods were used for stabilization. The surgical incision was closed meticulously, and postoperative imaging confirmed improved alignment and significant reduction in bone pain.

10. Operative Note: Surgical intervention was performed on a patient with severe scoliosis and severe bone pain resistant to conservative management. Intraoperative exploration revealed osteolytic lesions and severe degeneration of the vertebral bodies. Meticulous curettage, bone grafting, and posterior spinal fusion were carried out. Pedicle screws and rods were utilized for stabilization. The surgical incision was closed meticulously, and postoperative imaging confirmed improved alignment and substantial reduction in bone pain.

1. Operative Note: The patient with severe scoliosis and persistent pain underwent a surgical intervention for spinal correction. A posterior spinal fusion procedure was performed, incorporating pedicle screws and rods for stabilization. Intraoperative findings revealed vertebral rotation and facet joint degeneration contributing to the pain. Meticulous decompression, fusion, and alignment were achieved. The surgical incision was closed meticulously, and postoperative imaging confirmed improved spinal alignment and significant reduction in pain.

2. Operative Note: Surgical correction was undertaken on a patient with severe idiopathic scoliosis. A comprehensive procedure involving a combined anterior and posterior approach was performed. Anterior release, interbody fusion, and posterior spinal fusion with pedicle screws and rods were carried out. Intraoperative assessment revealed significant vertebral rotation and kyphosis. The surgical incision was closed meticulously, and postoperative imaging confirmed improved alignment and relief of pain.

3. Operative Note: The patient with severe degenerative scoliosis and incapacitating pain underwent a surgical intervention. A posterior spinal fusion procedure was performed, incorporating extensive decompression, facet joint fusion, and stabilization using pedicle screws and rods. Intraoperative findings revealed severe disc degeneration and foraminal stenosis contributing to the pain. The surgical incision was closed meticulously, and postoperative imaging confirmed improved spinal alignment and substantial reduction in pain.

4. Operative Note: Surgical correction was performed on a patient with severe scoliosis and persistent pain refractory to conservative measures. A comprehensive procedure involving osteotomy, extensive fusion, and stabilization was carried out. Intraoperative assessment revealed significant spinal deformity and rotation. Meticulous realignment, decompression, and fusion were achieved. The surgical incision was closed meticulously, and postoperative imaging confirmed improved spinal alignment and remarkable reduction in pain.

5. Operative Note: The patient with severe congenital scoliosis and severe pain underwent a surgical intervention. A posterior spinal fusion procedure was performed, incorporating meticulous correction of the deformity using osteotomy, fusion, and pedicle screws and rods for stabilization. Intraoperative findings revealed vertebral anomalies and significant curvature. The surgical incision was closed meticulously, and postoperative imaging confirmed improved alignment and substantial relief of pain.

6. Operative Note: Surgical intervention was undertaken on a patient with severe scoliosis and debilitating pain. A combined anterior and posterior approach was utilized, involving vertebral column resection, fusion, and stabilization. Intraoperative assessment revealed severe vertebral rotation and compression of neural structures. Meticulous realignment and fusion were achieved. The surgical incision was closed meticulously, and postoperative imaging confirmed improved spinal alignment and significant reduction in pain.

7. Operative Note: The patient with severe neuromuscular scoliosis and intractable pain underwent a surgical intervention. A posterior spinal fusion procedure was performed, incorporating meticulous correction of the deformity using osteotomy, fusion, and pedicle screws and rods for stabilization. Intraoperative findings revealed vertebral anomalies and significant curvature. The surgical incision was closed meticulously, and postoperative imaging confirmed improved alignment and substantial relief of pain.

8. Operative Note: Surgical correction was carried out on a patient with severe scoliosis and persistent pain. A comprehensive procedure involving anterior release, extensive fusion, and posterior spinal fusion with pedicle screws and rods was performed. Intraoperative assessment revealed severe vertebral rotation and disc degeneration. Meticulous realignment, decompression, and fusion were achieved. The surgical incision was closed meticulously, and postoperative imaging confirmed improved spinal alignment and remarkable reduction in pain.

9. Operative Note: The patient with severe adolescent idiopathic scoliosis and severe pain underwent a surgical intervention. A posterior spinal fusion procedure was performed, incorporating meticulous correction of the deformity using osteotomy, fusion, and pedicle screws and rods for stabilization. Intraoperative findings revealed severe vertebral rotation and disc degeneration. The surgical incision was closed meticulously, and postoperative imaging confirmed improved alignment and substantial relief of pain.

10. Operative Note: Surgical correction was undertaken on a patient with severe scoliosis and incapacitating pain. A comprehensive procedure involving anterior release, extensive fusion, and posterior spinal fusion with pedicle screws and rods was carried out. Intraoperative assessment revealed severe vertebral rotation and facet joint degeneration. Meticulous realignment, decompression, and fusion were achieved. The surgical incision was closed meticulously, and postoperative imaging confirmed improved spinal alignment and remarkable reduction in pain.

1. Operative Note: The patient with severe scoliosis and debilitating pain underwent a surgical intervention for spinal correction. A posterior spinal fusion procedure was performed, incorporating pedicle screws and rods for stabilization. Intraoperative findings revealed vertebral rotation and facet joint degeneration contributing to the pain. Meticulous decompression, fusion, and alignment were achieved. The surgical incision was closed meticulously, and postoperative imaging confirmed improved spinal alignment and significant reduction in pain.

2. Operative Note: Surgical correction was undertaken on a patient with severe idiopathic scoliosis. A comprehensive procedure involving a combined anterior and posterior approach was performed. Anterior release, interbody fusion, and posterior spinal fusion with pedicle screws and rods were carried out. Intraoperative assessment revealed significant vertebral rotation and kyphosis. The surgical incision was closed meticulously, and postoperative imaging confirmed improved alignment and relief of pain.

3. Operative Note: The patient with severe degenerative scoliosis and incapacitating pain underwent a surgical intervention. A posterior spinal fusion procedure was performed, incorporating extensive decompression, facet joint fusion, and stabilization using pedicle screws and rods. Intraoperative findings revealed severe disc degeneration and foraminal stenosis contributing to the pain. The surgical incision was closed meticulously, and postoperative imaging confirmed improved spinal alignment and substantial reduction in pain.

4. Operative Note: Surgical correction was performed on a patient with severe scoliosis and persistent pain refractory to conservative measures. A comprehensive procedure involving osteotomy, extensive fusion, and stabilization was carried out. Intraoperative assessment revealed significant spinal deformity and rotation. Meticulous realignment, decompression, and fusion were achieved. The surgical incision was closed meticulously, and postoperative imaging confirmed improved spinal alignment and remarkable reduction in pain.

5. Operative Note: The patient with severe congenital scoliosis and severe pain underwent a surgical intervention. A posterior spinal fusion procedure was performed, incorporating meticulous correction of the deformity using osteotomy, fusion, and pedicle screws and rods for stabilization. Intraoperative findings revealed vertebral anomalies and significant curvature. The surgical incision was closed meticulously, and postoperative imaging confirmed improved alignment and substantial relief of pain.

6. Operative Note: Surgical intervention was undertaken on a patient with severe scoliosis and debilitating pain. A combined anterior and posterior approach was utilized, involving vertebral column resection, fusion, and stabilization. Intraoperative assessment revealed severe vertebral rotation and compression of neural structures. Meticulous realignment and fusion were achieved. The surgical incision was closed meticulously, and postoperative imaging confirmed improved spinal alignment and significant reduction in pain.

7. Operative Note: The patient with severe neuromuscular scoliosis and intractable pain underwent a surgical intervention. A posterior spinal fusion procedure was performed, incorporating meticulous correction of the deformity using osteotomy, fusion, and pedicle screws and rods for stabilization. Intraoperative findings revealed vertebral anomalies and significant curvature. The surgical incision was closed meticulously, and postoperative imaging confirmed improved alignment and substantial relief of pain.

8. Operative Note: Surgical correction was carried out on a patient with severe scoliosis and persistent pain. A comprehensive procedure involving anterior release, extensive fusion, and posterior spinal fusion with pedicle screws and rods was performed. Intraoperative assessment revealed severe vertebral rotation and disc degeneration. Meticulous realignment, decompression, and fusion were achieved. The surgical incision was closed meticulously, and postoperative imaging confirmed improved spinal alignment and remarkable reduction in pain.

9. Operative Note: The patient with severe adolescent idiopathic scoliosis and severe pain underwent a surgical intervention. A posterior spinal fusion procedure was performed, incorporating meticulous correction of the deformity using osteotomy, fusion, and pedicle screws and rods for stabilization. Intraoperative findings revealed severe vertebral rotation and disc degeneration. The surgical incision was closed meticulously, and postoperative imaging confirmed improved alignment and substantial relief of pain.

10. Operative Note: Surgical correction was undertaken on a patient with severe scoliosis and incapacitating pain. A comprehensive procedure involving anterior release, extensive fusion, and posterior spinal fusion with pedicle screws and rods was carried out. Intraoperative assessment revealed severe vertebral rotation and facet joint degeneration. Meticulous realignment, decompression, and fusion were achieved. The surgical incision was closed meticulously, and postoperative imaging confirmed improved spinal alignment and remarkable reduction in pain.

1. Operative Note: The patient with severe scoliosis and a severe infection in the extreme moving joint underwent a surgical intervention for spinal correction. A posterior spinal fusion procedure was performed, incorporating meticulous debridement of the infected joint and surrounding tissues. Intraoperative findings revealed extensive inflammation and purulent drainage. Meticulous debridement, irrigation, and fusion were achieved. The surgical incision was closed meticulously, and appropriate antibiotic therapy was initiated postoperatively.

2. Operative Note: Surgical correction was undertaken on a patient with severe scoliosis and a severe infection affecting the extreme moving joint. A comprehensive procedure involving anterior release, extensive debridement, and posterior spinal fusion with pedicle screws and rods was performed. Intraoperative assessment revealed purulent fluid accumulation and joint destruction. Meticulous debridement, irrigation, and fusion were achieved. The surgical incision was closed meticulously, and postoperative antibiotic therapy was initiated.

3. Operative Note: The patient with severe degenerative scoliosis and a severe infection in the extreme moving joint underwent a surgical intervention. A posterior spinal fusion procedure was performed, incorporating meticulous debridement, removal of infected hardware, and extensive irrigation. Intraoperative findings revealed extensive joint erosion and pus formation. Meticulous debridement, fusion, and stabilization were achieved. The surgical incision was closed meticulously, and appropriate intravenous antibiotics were initiated postoperatively.

4. Operative Note: Surgical correction was performed on a patient with severe scoliosis and a severe infection involving the extreme moving joint. A comprehensive procedure involving anterior release, debridement, and posterior spinal fusion was carried out. Intraoperative exploration revealed purulent fluid collection and joint space destruction. Meticulous debridement, irrigation, and fusion were performed. The surgical incision was closed meticulously, and appropriate antibiotic therapy was administered postoperatively.

5. Operative Note: The patient with severe idiopathic scoliosis and a severe infection in the extreme moving joint underwent a surgical intervention. A posterior spinal fusion procedure was performed, incorporating meticulous debridement, removal of infected tissue, and fusion. Intraoperative findings revealed extensive joint erosion and purulent discharge. Meticulous debridement, irrigation, and fusion were achieved. The surgical incision was closed meticulously, and intravenous antibiotics were initiated postoperatively.

6. Operative Note: Surgical correction was undertaken on a patient with severe scoliosis and a severe infection affecting the extreme moving joint. A comprehensive procedure involving anterior release, debridement, and posterior spinal fusion with pedicle screws and rods was performed. Intraoperative assessment revealed joint destruction and purulent drainage. Meticulous debridement, irrigation, and fusion were achieved. The surgical incision was closed meticulously, and appropriate antibiotic therapy was initiated postoperatively.

7. Operative Note: The patient with severe neurogenic scoliosis and a severe infection in the extreme moving joint underwent a surgical intervention. A posterior spinal fusion procedure was performed, incorporating meticulous debridement, irrigation, and fusion. Intraoperative findings revealed extensive joint erosion and purulent fluid accumulation. Meticulous debridement, fusion, and stabilization were achieved. The surgical incision was closed meticulously, and appropriate intravenous antibiotics were initiated postoperatively.

8. Operative Note: Surgical correction was carried out on a patient with severe scoliosis and a severe infection involving the extreme moving joint. A comprehensive procedure involving anterior release, debridement, and posterior spinal fusion was performed. Intraoperative exploration revealed purulent drainage and joint destruction. Meticulous debridement, irrigation, and fusion were performed. The surgical incision was closed meticulously, and appropriate antibiotic therapy was administered postoperatively.

9. Operative Note: The patient with severe adolescent idiopathic scoliosis and a severe infection in the extreme moving joint underwent a surgical intervention. A posterior spinal fusion procedure was performed, incorporating meticulous debridement, removal of infected hardware, and extensive irrigation. Intraoperative findings revealed extensive joint erosion and purulent fluid collection. Meticulous debridement, fusion, and stabilization were achieved. The surgical incision was closed meticulously, and appropriate intravenous antibiotics were initiated postoperatively.

10. Operative Note: Surgical correction was undertaken on a patient with severe scoliosis and a severe infection affecting the extreme moving joint. A comprehensive procedure involving anterior release, debridement, and posterior spinal fusion with pedicle screws and rods was performed. Intraoperative assessment revealed joint destruction and purulent discharge. Meticulous debridement, irrigation, and fusion were achieved. The surgical incision was closed meticulously, and appropriate antibiotic therapy was initiated postoperatively.

1. Operative Note: The patient with severe scoliosis and a highly inflamed extreme moving joint underwent a surgical intervention for spinal correction. A posterior spinal fusion procedure was performed, incorporating meticulous debridement of the inflamed tissues and joint space. Intraoperative findings revealed significant inflammation, redness, and swelling. Meticulous debridement, irrigation, and fusion were achieved. The surgical incision was closed meticulously, and appropriate anti-inflammatory medications were administered postoperatively.

2. Operative Note: Surgical correction was undertaken on a patient with severe scoliosis and a severely inflamed extreme moving joint. A comprehensive procedure involving anterior release, extensive debridement, and posterior spinal fusion with pedicle screws and rods was performed. Intraoperative assessment revealed pronounced joint inflammation, heat, and tenderness. Meticulous debridement, irrigation, and fusion were achieved. The surgical incision was closed meticulously, and postoperative anti-inflammatory treatment was initiated.

3. Operative Note: The patient with severe degenerative scoliosis and a highly inflamed extreme moving joint underwent a surgical intervention. A posterior spinal fusion procedure was performed, incorporating meticulous debridement, removal of inflamed tissues, and extensive irrigation. Intraoperative findings revealed extensive joint inflammation, edema, and erythema. Meticulous debridement, fusion, and stabilization were achieved. The surgical incision was closed meticulously, and appropriate anti-inflammatory medication was administered postoperatively.

4. Operative Note: Surgical correction was performed on a patient with severe scoliosis and a severely inflamed joint affecting the extreme moving joint. A comprehensive procedure involving anterior release, debridement, and posterior spinal fusion was carried out. Intraoperative exploration revealed significant joint inflammation, swelling, and pain. Meticulous debridement, irrigation, and fusion were performed. The surgical incision was closed meticulously, and postoperative anti-inflammatory therapy was administered.

5. Operative Note: The patient with severe idiopathic scoliosis and a highly inflamed extreme moving joint underwent a surgical intervention. A posterior spinal fusion procedure was performed, incorporating meticulous debridement, removal of inflamed tissue, and fusion. Intraoperative findings revealed pronounced joint inflammation, warmth, and limited range of motion. Meticulous debridement, irrigation, and fusion were achieved. The surgical incision was closed meticulously, and anti-inflammatory medication was initiated postoperatively.

6. Operative Note: Surgical correction was undertaken on a patient with severe scoliosis and a severely inflamed joint affecting the extreme moving joint. A comprehensive procedure involving anterior release, debridement, and posterior spinal fusion with pedicle screws and rods was performed. Intraoperative assessment revealed joint inflammation, erythema, and increased temperature. Meticulous debridement, irrigation, and fusion were achieved. The surgical incision was closed meticulously, and postoperative anti-inflammatory treatment was initiated.

7. Operative Note: The patient with severe neurogenic scoliosis and a highly inflamed extreme moving joint underwent a surgical intervention. A posterior spinal fusion procedure was performed, incorporating meticulous debridement, irrigation, and fusion. Intraoperative findings revealed significant joint inflammation, redness, and swelling. Meticulous debridement, fusion, and stabilization were achieved. The surgical incision was closed meticulously, and appropriate anti-inflammatory medication was administered postoperatively.

8. Operative Note: Surgical correction was carried out on a patient with severe scoliosis and a severely inflamed joint involving the extreme moving joint. A comprehensive procedure involving anterior release, debridement, and posterior spinal fusion was performed. Intraoperative exploration revealed pronounced joint inflammation, heat, and pain. Meticulous debridement, irrigation, and fusion were performed. The surgical incision was closed meticulously, and appropriate anti-inflammatory therapy was administered postoperatively.

9. Operative Note: The patient with severe adolescent idiopathic scoliosis and a highly inflamed extreme moving joint underwent a surgical intervention. A posterior spinal fusion procedure was performed, incorporating meticulous debridement, removal of inflamed tissue, and extensive irrigation. Intraoperative findings revealed significant joint inflammation, tenderness, and swelling. Meticulous debridement, fusion, and stabilization were achieved. The surgical incision was closed meticulously, and appropriate anti-inflammatory medication was initiated postoperatively.

10. Operative Note: Surgical correction was undertaken on a patient with severe scoliosis and a highly inflamed joint affecting the extreme moving joint. A comprehensive procedure involving anterior release, debridement, and posterior spinal fusion with pedicle screws and rods was performed. Intraoperative assessment revealed joint inflammation, edema, and increased pain. Meticulous debridement, irrigation, and fusion were achieved. The surgical incision was closed meticulously, and postoperative anti-inflammatory treatment was initiated.

1. Operative Note: The patient with severe scoliosis and a diagnosis of advanced spinal degeneration underwent a surgical intervention for spinal correction. A posterior spinal fusion procedure was performed, incorporating extensive decompression, interbody fusion, and stabilization using pedicle screws and rods. Intraoperative findings revealed severe disc degeneration, spinal stenosis, and nerve root compression. The surgical incision was closed meticulously, and postoperative follow-up appointments were scheduled based on the severity of the diagnosis and the patient's recovery progress.

2. Operative Note: Surgical correction was undertaken on a patient with severe idiopathic scoliosis and a diagnosis of congenital vertebral anomalies. A comprehensive procedure involving osteotomy, fusion, and pedicle screws and rods was performed. Intraoperative assessment revealed significant vertebral malformation and spinal curvature. The surgical incision was closed meticulously, and postoperative follow-up appointments were scheduled to monitor the patient's progress, assess fusion healing, and address any potential complications.

3. Operative Note: The patient with severe degenerative scoliosis and a diagnosis of spinal instability underwent a surgical intervention. A posterior spinal fusion procedure was performed, incorporating extensive decompression, facet joint fusion, and stabilization using pedicle screws and rods. Intraoperative findings revealed severe facet joint arthrosis, ligamentous laxity, and vertebral slippage. The surgical incision was closed meticulously, and postoperative follow-up appointments were planned to evaluate the patient's fusion progress, manage pain, and monitor spinal stability.

4. Operative Note: Surgical correction was performed on a patient with severe scoliosis and a diagnosis of spinal infection. A comprehensive procedure involving extensive debridement, irrigation, and posterior spinal fusion was carried out. Intraoperative exploration revealed severe inflammation, abscess formation, and bone erosion. The surgical incision was closed meticulously, and postoperative follow-up appointments were scheduled to monitor infection control, assess wound healing, and evaluate the effectiveness of antibiotic therapy.

5. Operative Note: The patient with severe idiopathic scoliosis and a diagnosis of spinal cord compression underwent a surgical intervention. A posterior spinal fusion procedure was performed, incorporating decompression of the spinal cord, fusion, and stabilization with pedicle screws and rods. Intraoperative assessment revealed significant spinal cord compression, myelopathy, and neurological deficits. The surgical incision was closed meticulously, and postoperative follow-up appointments were planned to monitor neurological recovery, assess fusion healing, and address any residual symptoms.

6. Operative Note: Surgical correction was undertaken on a patient with severe scoliosis and a diagnosis of spinal tumor. A comprehensive procedure involving tumor resection, spinal reconstruction, and stabilization was performed. Intraoperative findings revealed a large tumor mass, vertebral destruction, and spinal instability. The surgical incision was closed meticulously, and postoperative follow-up appointments were scheduled to monitor tumor recurrence, evaluate fusion progress, and manage any residual neurological symptoms.

7. Operative Note: The patient with severe degenerative scoliosis and a diagnosis of spinal canal stenosis underwent a surgical intervention. A posterior spinal fusion procedure was performed, incorporating decompression of the spinal canal, interbody fusion, and stabilization using pedicle screws and rods. Intraoperative findings revealed severe spinal cord compression, foraminal narrowing, and radiculopathy. The surgical incision was closed meticulously, and postoperative follow-up appointments were planned to assess neurological recovery, monitor fusion healing, and address any persistent symptoms.

8. Operative Note: Surgical correction was carried out on a patient with severe scoliosis and a diagnosis of vertebral fracture. A comprehensive procedure involving vertebral augmentation, fusion, and stabilization was performed. Intraoperative assessment revealed a collapsed vertebra, spinal instability, and severe pain. The surgical incision was closed meticulously, and postoperative follow-up appointments were scheduled to monitor pain management, evaluate vertebral height restoration, and assess fusion progress.

9. Operative Note: The patient with severe idiopathic scoliosis and a diagnosis of spinal instability underwent a surgical intervention. A comprehensive procedure involving extensive ligamentous reconstruction, fusion, and stabilization with pedicle screws and rods was performed. Intraoperative assessment revealed severe ligament laxity, vertebral subluxation, and abnormal spinal curvature. The surgical incision was closed meticulously, and postoperative follow-up appointments were planned to monitor spinal stability, evaluate fusion progress, and address any residual symptoms.

10. Operative Note: Surgical correction was undertaken on a patient with severe scoliosis and a diagnosis of spinal deformity. A comprehensive procedure involving osteotomy, fusion, and pedicle screws and rods was performed. Intraoperative exploration revealed severe vertebral rotation, asymmetry, and abnormal spinal alignment. The surgical incision was closed meticulously, and postoperative follow-up appointments were scheduled to assess spinal alignment correction, monitor fusion healing, and address any postoperative complications.

## M41.9 Scoliosis, unspecified

1. Procedure: Posterior Spinal Fusion. Patient presented with severe scoliosis. The procedure involved posterior approach with pedicle screw instrumentation and fusion from T2 to L4. Surgical correction achieved optimal alignment, and autograft bone was used for fusion. No intraoperative complications were noted. Patient was transferred to the recovery room in stable condition.

2. Procedure: Anterior Scoliosis Correction. Patient diagnosed with thoracic scoliosis. Anterior approach was used to access the spine. Intervertebral disc resection and placement of interbody cages were performed to correct the curvature. Fusion was achieved with the assistance of anterior instrumentation. Patient tolerated the procedure well and was transferred to the ward for postoperative care.

3. Procedure: Growing Rods Implantation. An adolescent patient with progressive scoliosis underwent bilateral growing rods implantation. The rods were attached to the spine using hooks and submuscular technique. Lengthening mechanism was incorporated for future adjustments. The procedure was successful, and the patient was sent for regular follow-up visits to monitor the growth and make necessary adjustments.

4. Procedure: Minimally Invasive Scoliosis Correction. Patient with moderate scoliosis underwent minimally invasive procedure. The surgeon used a combination of percutaneous screws and rods to correct the spinal curvature. Limited soft tissue dissection was performed, resulting in smaller incisions and reduced blood loss. Patient's postoperative recovery was uneventful, and significant improvement in spinal alignment was observed.

5. Procedure: Vertebral Body Tethering. A teenager with idiopathic scoliosis underwent vertebral body tethering. Anchors were placed on the concave side of the curve, and a flexible cord was tensioned to gradually correct the curvature. Intraoperative fluoroscopy was used to guide the placement. The procedure was successful, and the patient was advised to avoid strenuous activities during the recovery period.

6. Procedure: Halo Gravity Traction. Patient presented with severe scoliosis and underwent halo gravity traction. A halo vest was attached to the skull, and traction was applied gradually to reduce the spinal deformity. The patient remained in traction for a specified period. Regular radiographs were obtained to monitor the progress. Following the traction period, further treatment options were discussed with the patient.

7. Procedure: Spinal Orthosis Fitting. A patient with mild scoliosis was fitted with a custom spinal orthosis. Measurements were taken, and a personalized brace was fabricated. The brace was designed to support the spine and limit further progression of the curvature. The patient was instructed on proper brace usage and follow-up appointments were scheduled for monitoring and adjustments.

8. Procedure: Thoracoplasty. A patient with severe thoracic scoliosis underwent thoracoplasty to improve cosmetic appearance and reduce rib prominence. Multiple segments of the ribs were resected and contoured to achieve a more symmetrical appearance. The patient experienced relief from associated discomfort and achieved improved body image postoperatively.

9. Procedure: Selective Thoracic Fusion. Patient presented with a double major curve scoliosis, with the thoracic curve requiring surgical intervention. Selective thoracic fusion was performed, utilizing pedicle screw instrumentation and bone grafting. The procedure successfully addressed the primary curve, resulting in improved alignment. The patient was placed in a thoracolumbosacral orthosis for postoperative support.

10. Procedure: Revision Surgery for Scoliosis. A patient with a previous spinal fusion for scoliosis presented with instrumentation failure and recurrent curvature. Revision surgery was performed to remove the failed hardware, extend the fusion to additional levels, and achieve improved correction. Intraoperative findings included pseudarthrosis at the previous fusion site. The revision procedure was successful, and the patient was placed in a brace for continued support.

1. Procedure: Kyphoplasty for Scheuermann's Kyphosis. Patient with Scheuermann's kyphosis underwent kyphoplasty to correct the excessive thoracic curvature. Balloon kyphoplasty was performed to restore vertebral body height and stabilize the spine. Bone cement was injected into the affected vertebrae to provide structural support. The procedure was successful in reducing the kyphotic deformity, and the patient experienced relief from associated symptoms.

2. Procedure: Rib-based Distraction for Congenital Scoliosis. Infant diagnosed with congenital scoliosis underwent rib-based distraction surgery. The deformed ribs were osteotomized and a custom-made device was placed to gradually distract the ribs, allowing for correction of the spinal curvature. Regular follow-up appointments were scheduled to monitor the progress of the distraction and adjust the device as needed.

3. Procedure: Spinal Osteotomy for Severe Scoliosis. Patient with severe scoliosis underwent spinal osteotomy to correct the abnormal spinal curvature. Multiple vertebral segments were resected and realigned to achieve proper spinal alignment. The procedure involved posterior approach with pedicle screw fixation and fusion. The patient tolerated the surgery well and showed significant improvement in spinal alignment postoperatively.

4. Procedure: Scoliosis Screening and Observation. An adolescent patient presented with mild scoliosis. A thorough screening and observation process was initiated, including regular monitoring of the spinal curvature through physical examinations and radiographic assessments. The patient was advised on posture correction and exercises to maintain spine health. Follow-up appointments were scheduled to evaluate any progression of the condition.

5. Procedure: Spinal Traction for Scoliosis. Patient with moderate scoliosis underwent spinal traction to reduce the spinal curvature. Traction was applied using a system of pulleys and weights, gradually stretching the spine to improve alignment. Regular monitoring of the traction progress and spinal curvature was performed through radiographic evaluations. The patient showed noticeable improvement in spinal alignment after the traction period.

6. Procedure: Magnetic Expansion Control (MAGEC) Rods Placement. An adolescent with early-onset scoliosis received MAGEC rods placement. The rods were surgically implanted and adjusted non-invasively using an external magnet to gradually correct the spinal curvature as the patient grows. The procedure allowed for regular lengthening without the need for repeated surgeries. The patient was scheduled for periodic rod adjustments based on growth patterns.

7. Procedure: Bracing for Adolescent Idiopathic Scoliosis. An adolescent with moderate idiopathic scoliosis was prescribed a custom spinal brace. The brace was designed to be worn for a specific number of hours each day to halt the progression of the spinal curvature. The patient received instructions on proper brace usage, skin care, and follow-up visits for brace adjustments and monitoring the effectiveness of treatment.

8. Procedure: Vertebral Column Resection. Patient with severe scoliosis and vertebral column rotation underwent vertebral column resection. The affected vertebrae were removed, and the spine was reconstructed using a combination of pedicle screw fixation, interbody fusion, and bone grafting. The procedure successfully corrected the spinal deformity and improved the patient's overall spinal alignment.

9. Procedure: Schroth Method Rehabilitation for Scoliosis. A patient with mild scoliosis underwent Schroth Method rehabilitation. This non-surgical approach involves a customized exercise program aimed at improving posture, muscle balance, and spinal alignment. The patient received individualized instruction from a certified therapist and was advised to continue home exercises regularly to maintain the benefits achieved during rehabilitation.

10. Procedure: Mehta Casting for Infantile Scoliosis. Infant diagnosed with infantile scoliosis received Mehta casting. The patient's torso was gently molded and immobilized using specialized casts to guide the growth of the spine in a corrected alignment. Regular cast adjustments were made to accommodate the infant's growth. The casting treatment aimed to minimize progression of the scoliosis and provide early intervention for optimal spinal development.

1. Procedure: Posterior Spinal Fusion. Patient presented with severe scoliosis. The procedure involved posterior approach with pedicle screw instrumentation and fusion from T2 to L4. General anesthesia was administered with a total dosage of 600 mg of propofol. Surgical correction achieved optimal alignment, and autograft bone was used for fusion. No intraoperative complications were noted. Patient was transferred to the recovery room in stable condition.

2. Procedure: Anterior Scoliosis Correction Patient diagnosed with thoracic scoliosis. Anterior approach was used to access the spine. Intervertebral disc resection and placement of interbody cages were performed to correct the curvature. Fusion was achieved with the assistance of anterior instrumentation. General anesthesia was administered with a total dosage of 1,200 mg of propofol. Patient tolerated the procedure well and was transferred to the ward for postoperative care.

3. Procedure: Growing Rods Implantation. An adolescent patient with progressive scoliosis underwent bilateral growing rods implantation. The rods were attached to the spine using hooks and submuscular technique. General anesthesia was administered with a total dosage of 800 mg of propofol. Lengthening mechanism was incorporated for future adjustments. The procedure was successful, and the patient was sent for regular follow-up visits to monitor the growth and make necessary adjustments.

4. Procedure: Minimally Invasive Scoliosis Correction. Patient with moderate scoliosis underwent minimally invasive procedure. The surgeon used a combination of percutaneous screws and rods to correct the spinal curvature. Limited soft tissue dissection was performed, resulting in smaller incisions and reduced blood loss. General anesthesia was administered with a total dosage of 500 mg of propofol. Patient's postoperative recovery was uneventful, and significant improvement in spinal alignment was observed.

5. Procedure: Vertebral Body Tethering. A teenager with idiopathic scoliosis underwent vertebral body tethering. Anchors were placed on the concave side of the curve, and a flexible cord was tensioned to gradually correct the curvature. Intraoperative fluoroscopy was used to guide the placement. General anesthesia was administered with a total dosage of 700 mg of propofol. The procedure was successful, and the patient was advised to avoid strenuous activities during the recovery period.

6. Procedure: Halo Gravity Traction. Patient presented with severe scoliosis and underwent halo gravity traction. A halo vest was attached to the skull, and traction was applied gradually to reduce the spinal deformity. The patient remained in traction for a specified period. General anesthesia was administered with a total dosage of 550 mg of propofol. Regular radiographs were obtained to monitor the progress. Following the traction period, further treatment options were discussed with the patient.

7. Procedure: Spinal Orthosis Fitting. A patient with mild scoliosis was fitted with a custom spinal orthosis. Measurements were taken, and a personalized brace was fabricated. The brace was designed to support the spine and limit further progression of the curvature. Local anesthesia with sedation was administered using a combination of lidocaine and midazolam. The patient was instructed on proper brace usage, and follow-up appointments were scheduled for monitoring and adjustments.

8. Procedure: Thoracoplasty. A patient with severe thoracic scoliosis underwent thoracoplasty to improve cosmetic appearance and reduce rib prominence. Multiple segments of the ribs were resected and contoured to achieve a more symmetrical appearance. General anesthesia was administered with a total dosage of 900 mg of propofol. The patient experienced relief from associated discomfort and achieved improved body image postoperatively.

9. Procedure: Selective Thoracic Fusion. Patient presented with a double major curve scoliosis, with the thoracic curve requiring surgical intervention. Selective thoracic fusion was performed, utilizing pedicle screw instrumentation and bone grafting. General anesthesia was administered with a total dosage of 1,000 mg of propofol. The procedure successfully addressed the primary curve, resulting in improved alignment. The patient was placed in a thoracolumbosacral orthosis for postoperative support.

10. Procedure: Revision Surgery for Scoliosis. A patient with a previous spinal fusion for scoliosis presented with instrumentation failure and recurrent curvature. Revision surgery was performed to remove the failed hardware, extend the fusion to additional levels, and achieve improved correction. General anesthesia was administered with a total dosage of 750 mg of propofol. Intraoperative findings included pseudarthrosis at the previous fusion site. The revision procedure was successful, and the patient was placed in a brace for continued support.

1. Procedure: Posterior Spinal Fusion with Bone Grafting. Patient presented with scoliosis and significant bone erosion at the affected vertebrae. The procedure involved posterior approach with pedicle screw instrumentation and fusion. Extensive bone grafting was performed to address the erosion and promote spinal fusion. General anesthesia was administered with a total dosage of 600 mg of propofol. The surgical correction achieved improved alignment, and the patient was closely monitored for any signs of graft failure or complications.

2. Procedure: Anterior Scoliosis Correction with Structural Allograft. Patient diagnosed with scoliosis and severe bone erosion underwent anterior approach for correction. Structural allografts were used to reconstruct the eroded vertebral bodies and restore stability. General anesthesia was administered with a total dosage of 1,200 mg of propofol. The surgical procedure successfully addressed the erosion and achieved realignment. Postoperative monitoring included assessing graft integration and the patient's overall spinal stability.

3. Procedure: Vertebral Column Resection with Augmented Bone Grafting. Patient with scoliosis and extensive bone erosion underwent vertebral column resection. The eroded vertebrae were excised, and augmented bone grafting was performed to promote spinal fusion. General anesthesia was administered with a total dosage of 800 mg of propofol. The procedure successfully corrected the curvature and addressed the erosion. The patient was closely monitored for graft incorporation and fusion progression.

4. Procedure: Scoliosis Decompression Surgery with Bone Cement Augmentation.Patient presented with scoliosis and vertebral bone erosion causing spinal compression. Decompression surgery was performed, and bone cement augmentation was utilized to stabilize the affected vertebrae. General anesthesia was administered with a total dosage of 500 mg of propofol. The procedure successfully relieved spinal compression and addressed the erosion. Postoperative monitoring involved assessing the stability of the cemented vertebrae and the patient's neurological status.

5. Procedure: Revision Surgery for Scoliosis with Bone Graft RevisionPatient with recurrent scoliosis and bone erosion at the previous fusion site underwent revision surgery. The eroded bone graft was removed, and a revision bone grafting procedure was performed to promote fusion and stability. General anesthesia was administered with a total dosage of 700 mg of propofol. The revision surgery successfully addressed the erosion and achieved improved spinal alignment. The patient was closely monitored for graft incorporation and fusion progression.

6. Procedure: Minimally Invasive Scoliosis Correction with Synthetic Bone SubstitutePatient with scoliosis and localized bone erosion underwent minimally invasive correction using synthetic bone substitute. The eroded area was filled with the bone substitute material to restore stability and promote fusion. General anesthesia was administered with a total dosage of 550 mg of propofol. The minimally invasive procedure successfully addressed the erosion and achieved spinal realignment. Postoperative monitoring included assessing the integration of the synthetic bone substitute.

7. Procedure: Halo Gravity Traction with Bone Grafting. Patient presented with severe scoliosis and extensive bone erosion requiring halo gravity traction. The traction was applied to gradually correct the deformity, and bone grafting was performed to address the erosion and promote stability. General anesthesia was administered with a total dosage of 900 mg of propofol. The procedure successfully reduced the curvature and stabilized the affected vertebrae. Postoperative monitoring included assessing graft integration and the patient's response to traction.

8. Procedure: Spinal Osteotomy with Autologous Bone Graft. Patient with scoliosis and localized bone erosion underwent spinal osteotomy. The eroded vertebrae were resected, and autologous bone grafting was performed to restore stability and achieve realignment. General anesthesia was administered with a total dosage of 750 mg of propofol. The procedure successfully corrected the curvature and addressed the bone erosion. Postoperative monitoring included assessing graft incorporation and the patient's overall spinal alignment.

9. Procedure: Growing Rods Implantation with Bone Augmentation An adolescent with progressive scoliosis and bone erosion received growing rods implantation. The eroded vertebrae were augmented with bone grafting to enhance stability and fusion. General anesthesia was administered with a total dosage of 600 mg of propofol. The growing rods allowed for gradual correction and spinal growth. Postoperative monitoring included assessing graft integration, rod adjustment, and monitoring for any signs of implant-related complications.

10. Procedure: Spinal Fusion with Bone Morphogenetic Protein Patient presented with scoliosis and extensive bone erosion. Spinal fusion was performed using bone morphogenetic protein (BMP) to promote fusion and stability. General anesthesia was administered with a total dosage of 800 mg of propofol. The procedure successfully addressed the erosion and achieved spinal alignment. Postoperative monitoring involved assessing fusion progression and the patient's response to the BMP treatment.

1. Procedure: Radiofrequency Ablation for Severe Scoliosis-Related Bone Pain Patient presented with severe scoliosis-associated bone pain. Radiofrequency ablation was performed to alleviate pain by using heat to disrupt nerve signals in the affected area. The procedure targeted the specific pain-generating nerves along the spine. Local anesthesia with sedation was administered using a combination of lidocaine and midazolam. The patient reported significant pain relief following the procedure and was advised on postoperative care and pain management strategies.

2. Procedure: Percutaneous Vertebroplasty for Severe Scoliosis-Related Bone Pain Patient with severe bone pain associated with scoliosis underwent percutaneous vertebroplasty. The procedure involved the injection of bone cement into the fractured and painful vertebral bodies to stabilize them. Local anesthesia with sedation was administered using a combination of lidocaine and midazolam. The patient experienced immediate pain relief and was monitored for any complications or adverse reactions to the cement.

3. Procedure: Spinal Cord Stimulation for Severe Scoliosis-Related Bone Pain Patient with severe scoliosis-related bone pain underwent spinal cord stimulation. A specialized device was implanted near the spinal cord, delivering electrical impulses to disrupt pain signals. The procedure was performed under general anesthesia with a total dosage of 700 mg of propofol. The patient reported significant reduction in pain intensity and improved quality of life following the stimulation therapy.

4. Procedure: Epidural Steroid Injection for Severe Scoliosis-Related Bone Pain Patient presented with severe bone pain associated with scoliosis. Epidural steroid injection was performed to reduce inflammation and alleviate pain. Local anesthesia with sedation was administered using a combination of lidocaine and midazolam. The patient experienced temporary pain relief and was advised on the potential need for repeat injections or alternative pain management strategies.

5. Procedure: Sacroiliac Joint Fusion for Severe Scoliosis-Related Bone Pain Patient with severe scoliosis-related bone pain underwent sacroiliac joint fusion. The procedure aimed to stabilize the painful joint and alleviate pain. General anesthesia was administered with a total dosage of 600 mg of propofol. The patient reported reduced pain levels and improved functional mobility following the fusion surgery.

6. Procedure: Dorsal Root Ganglion Stimulation for Severe Scoliosis-Related Bone Pain Patient presented with severe scoliosis-related bone pain. Dorsal root ganglion stimulation was performed to target the specific nerves transmitting pain signals. The procedure involved the placement of stimulating electrodes near the affected ganglia. General anesthesia was administered with a total dosage of 800 mg of propofol. The patient experienced significant pain reduction and improvement in daily activities post-stimulation.

7. Procedure: Neurolysis for Severe Scoliosis-Related Bone Pain Patient with severe bone pain associated with scoliosis underwent neurolysis. The procedure involved the chemical or thermal ablation of pain-generating nerves in the affected area. Local anesthesia with sedation was administered using a combination of lidocaine and midazolam. The patient reported decreased pain intensity and improved quality of life after the neurolysis procedure.

8. Procedure: Transcutaneous Electrical Nerve Stimulation for Severe Scoliosis-Related Bone Pain Patient with severe scoliosis-related bone pain received transcutaneous electrical nerve stimulation (TENS). TENS involved the application of electrical impulses to the affected area, disrupting pain signals. The patient underwent TENS therapy under the supervision of a pain management specialist and reported significant pain relief during and after the sessions.

9. Procedure: Spinal Decompression for Severe Scoliosis-Related Bone Pain Patient with severe scoliosis-related bone pain underwent spinal decompression surgery. The procedure aimed to relieve pressure on the affected nerves and reduce pain. General anesthesia was administered with a total dosage of 750 mg of propofol. The patient experienced decreased pain intensity and improved functional ability following the surgery.

10. Procedure: Sympathetic Ganglion Block for Severe Scoliosis-Related Bone Pain Patient with severe scoliosis-related bone pain received a sympathetic ganglion block. The procedure involved the injection of local anesthetic and anti-inflammatory medication near the sympathetic ganglia to interrupt pain signals. The patient reported immediate pain relief and improved daily functioning following the sympathetic ganglion block.

1. Procedure: Scoliosis Correction with Spinal Osteotomy Patient with severe scoliosis underwent spinal osteotomy to correct the spinal curvature. The procedure involved the surgical resection and realignment of the affected vertebrae. General anesthesia was administered with a total dosage of 800 mg of propofol. The osteotomy successfully improved the spinal alignment, and postoperative monitoring was initiated to ensure proper healing and stabilization.

2. Procedure: Scoliosis Fusion with Dual Rod Instrumentation Patient presented with progressive scoliosis and underwent scoliosis fusion surgery with dual rod instrumentation. The procedure involved the placement of pedicle screws and rods to stabilize the spine. General anesthesia was administered with a total dosage of 700 mg of propofol. The surgery successfully corrected the curvature and achieved spinal stability. Postoperative care included monitoring for any signs of implant-related complications.

3. Procedure: Scoliosis Correction with Vertebral Body Tethering An adolescent patient with scoliosis underwent vertebral body tethering to correct the spinal curvature. The surgical procedure involved the placement of a flexible cord to gradually realign the spine. General anesthesia was administered with a total dosage of 900 mg of propofol. The vertebral body tethering procedure successfully achieved spinal correction while preserving spinal flexibility.

4. Procedure: Scoliosis Fusion with Bone Grafting Patient with severe scoliosis underwent scoliosis fusion surgery with bone grafting. The procedure involved the placement of pedicle screws and rods along with the application of bone grafts to promote spinal fusion. General anesthesia was administered with a total dosage of 600 mg of propofol. The surgery successfully achieved spinal stabilization and initiated the fusion process.

5. Procedure: Scoliosis Correction with Anterior Approach Patient with thoracic scoliosis underwent scoliosis correction surgery using an anterior approach. The procedure involved accessing the spine from the front and performing interbody fusion and instrumentation. General anesthesia was administered with a total dosage of 750 mg of propofol. The anterior approach surgery successfully corrected the curvature and achieved spinal stability.

6. Procedure: Scoliosis Fusion with Pedicle Screw Instrumentation Patient with progressive scoliosis underwent scoliosis fusion surgery with pedicle screw instrumentation. The procedure involved the placement of pedicle screws and rods to stabilize the spine and achieve correction. General anesthesia was administered with a total dosage of 550 mg of propofol. The fusion surgery successfully corrected the curvature and provided spinal stability.

7. Procedure: Scoliosis Correction with Posterior Spinal Fusion Patient with scoliosis underwent posterior spinal fusion surgery to correct the spinal curvature. The procedure involved the placement of pedicle screws, rods, and bone grafts. General anesthesia was administered with a total dosage of 800 mg of propofol. The posterior spinal fusion surgery successfully achieved spinal alignment and stability.

8. Procedure: Scoliosis Correction with Growing Rods Implantation A young patient with progressive scoliosis underwent growing rods implantation surgery. The procedure involved the placement of adjustable rods to support spinal growth and correction. General anesthesia was administered with a total dosage of 650 mg of propofol. The growing rods implantation successfully provided spinal support and allowed for future adjustments as the patient grows.

9. Procedure: Revision Surgery for Recurrent Scoliosis Patient with recurrent scoliosis underwent revision surgery to address the progression of the spinal curvature. The procedure involved the removal of previous implants and the placement of new instrumentation and bone grafts. General anesthesia was administered with a total dosage of 750 mg of propofol. The revision surgery successfully corrected the curvature and achieved spinal stabilization.

10. Procedure: Scoliosis Correction with Vertebral Column Resection Patient with severe scoliosis underwent vertebral column resection surgery. The procedure involved the removal of one or more vertebrae to achieve correction and realignment. General anesthesia was administered with a total dosage of 700 mg of propofol. The vertebral column resection successfully corrected the curvature and provided spinal stability. Postoperative monitoring was initiated to ensure proper healing and fusion.

1. Procedure: Scoliosis Correction with Posterior Spinal Fusion and Segmental Instrumentation Patient with scoliosis underwent posterior spinal fusion surgery with segmental instrumentation to correct the spinal curvature. The procedure involved the placement of pedicle screws, rods, and cross-links to stabilize the spine. General anesthesia was administered with a total dosage of 800 mg of propofol. The surgery successfully achieved spinal alignment and provided long-term stability.

2. Procedure: Scoliosis Correction with Vertebral Body Tethering and Thoracic Fusion An adolescent patient with scoliosis underwent vertebral body tethering along with thoracic fusion to correct the spinal curvature. The surgical procedure involved the placement of a flexible cord and fusion of the thoracic vertebrae. General anesthesia was administered with a total dosage of 900 mg of propofol. The combined treatment successfully achieved spinal correction and maintained flexibility.

3. Procedure: Scoliosis Correction with Anterior Release and Posterior Instrumentation Patient with severe scoliosis underwent scoliosis correction surgery involving an anterior release and posterior instrumentation. The procedure began with an anterior approach to release the spinal discs, followed by posterior placement of pedicle screws and rods. General anesthesia was administered with a total dosage of 750 mg of propofol. The combined surgical intervention successfully corrected the curvature and achieved spinal stabilization.

4. Procedure: Scoliosis Correction with Minimally Invasive Thoracoscopic Surgery Patient with scoliosis underwent minimally invasive thoracoscopic surgery for scoliosis correction. The procedure involved the insertion of small instruments and a camera through tiny incisions to perform spinal fusion and instrumentation. General anesthesia was administered with a total dosage of 600 mg of propofol. The minimally invasive approach successfully corrected the curvature while minimizing surgical trauma and promoting faster recovery.

5. Procedure: Scoliosis Revision Surgery with Explantation of Failed Implants Patient with recurrent scoliosis underwent revision surgery for the removal of failed implants. The procedure involved the explantation of previous instrumentation and fusion extension to address progression. General anesthesia was administered with a total dosage of 700 mg of propofol. The revision surgery successfully addressed the failed implants, corrected the curvature, and achieved spinal stability.

6. Procedure: Scoliosis Correction with Hybrid Technique (Anterior and Posterior Approach) Patient with severe scoliosis underwent scoliosis correction surgery utilizing a hybrid technique involving both anterior and posterior approaches. The procedure included anterior release, placement of anterior interbody cages, and posterior instrumentation. General anesthesia was administered with a total dosage of 550 mg of propofol. The hybrid approach successfully corrected the curvature and provided comprehensive spinal stabilization.

7. Procedure: Scoliosis Correction with Vertebral Body Tethering and Posterior Fusion An adolescent patient with scoliosis underwent vertebral body tethering along with posterior fusion to correct the spinal curvature. The surgical procedure involved the placement of a flexible cord and fusion of the affected vertebrae. General anesthesia was administered with a total dosage of 800 mg of propofol. The combined treatment successfully achieved spinal correction and maintained flexibility while providing long-term stability.

8. Procedure: Scoliosis Correction with Thoracoscopic Assisted Spinal Fusion Patient with scoliosis underwent scoliosis correction surgery with thoracoscopic assistance. The procedure involved the use of a camera and specialized instruments inserted through small incisions to perform spinal fusion and instrumentation. General anesthesia was administered with a total dosage of 650 mg of propofol. The thoracoscopic-assisted approach successfully corrected the curvature while minimizing surgical invasiveness and facilitating quicker recovery.

9. Procedure: Scoliosis Revision Surgery with Pedicle Subtraction Osteotomy Patient with recurrent scoliosis underwent revision surgery with pedicle subtraction osteotomy. The procedure involved the removal of a section of vertebral body to allow for spinal realignment. General anesthesia was administered with a total dosage of 750 mg of propofol. The revision surgery successfully corrected the curvature and achieved spinal stabilization.

10. Procedure: Scoliosis Correction with Posterior Spinal Fusion and Rib-based Anchors Patient with scoliosis underwent posterior spinal fusion surgery with the use of rib-based anchors to correct the spinal curvature. The procedure involved the placement of pedicle screws, rods, and rib anchors for enhanced stability. General anesthesia was administered with a total dosage of 700 mg of propofol. The surgery successfully achieved spinal alignment and provided long-term stability.

1. Procedure: Debridement and Joint Resection for Severe Infection of the Extreme Moving Joint Patient presented with a severe infection in the extreme moving joint associated with scoliosis. Surgical intervention involved thorough debridement of the infected tissues and resection of the affected joint. General anesthesia was administered with a total dosage of 800 mg of propofol. The procedure successfully addressed the infection, with postoperative care focusing on antibiotic therapy, wound management, and rehabilitation to restore joint functionality.

2. Procedure: Arthroscopic Lavage and Drainage for Severe Infection of the Extreme Moving Joint Patient with scoliosis and a severe infection in the extreme moving joint underwent arthroscopic lavage and drainage. The procedure involved the insertion of a small camera and specialized instruments to irrigate and remove infected material from the joint. General anesthesia was administered with a total dosage of 700 mg of propofol. The arthroscopic intervention effectively cleared the infection, and postoperative monitoring was initiated to ensure proper healing.

3. Procedure: Joint Explantation and Spacer Placement for Severe Infection of the Extreme Moving Joint Patient with scoliosis and a severe infection in the extreme moving joint underwent joint explantation and spacer placement. The surgical intervention involved removing the infected joint components and inserting a temporary spacer to maintain joint space and prevent bone-on-bone contact. General anesthesia was administered with a total dosage of 900 mg of propofol. The procedure successfully addressed the infection, and the patient was closely monitored for proper healing and eventual joint reconstruction.

4. Procedure: Arthrotomy with Irrigation and Antibiotic Impregnated Cement Spacer for Severe Infection of the Extreme Moving Joint Patient with scoliosis and a severe infection in the extreme moving joint received an arthrotomy with irrigation and placement of an antibiotic impregnated cement spacer. The procedure involved opening the joint, thorough irrigation with antiseptic solutions, and placement of a spacer impregnated with antibiotics to promote local antimicrobial action. General anesthesia was administered with a total dosage of 750 mg of propofol. Postoperative care included antibiotic therapy, wound care, and ongoing monitoring for infection resolution.

5. Procedure: Joint Fusion for Severe Infection of the Extreme Moving Joint Patient with scoliosis and a severe infection in the extreme moving joint underwent joint fusion surgery. The procedure involved removing the infected joint surfaces and fusing the adjacent bones to achieve stability and prevent further infection spread. General anesthesia was administered with a total dosage of 600 mg of propofol. The joint fusion successfully addressed the infection and provided long-term joint stability.

6. Procedure: Joint Resurfacing and Antibiotic Spacer Placement for Severe Infection of the Extreme Moving Joint Patient with scoliosis and a severe infection in the extreme moving joint underwent joint resurfacing with antibiotic spacer placement. The surgical intervention involved removing the infected joint surfaces and placing a spacer impregnated with antibiotics to eradicate the infection. General anesthesia was administered with a total dosage of 800 mg of propofol. The procedure effectively addressed the infection and provided temporary joint functionality while facilitating healing.

7. Procedure: Joint Salvage Procedure for Severe Infection of the Extreme Moving Joint Patient with scoliosis and a severe infection in the extreme moving joint underwent a joint salvage procedure. The surgical intervention involved extensive debridement of the infected joint tissues, reconstruction of damaged structures, and antibiotic therapy. General anesthesia was administered with a total dosage of 700 mg of propofol. The joint salvage procedure aimed to preserve joint functionality while eradicating the infection and promoting healing.

8. Procedure: Joint Arthrodesis for Severe Infection of the Extreme Moving Joint Patient with scoliosis and a severe infection in the extreme moving joint underwent joint arthrodesis surgery. The procedure involved removing the infected joint surfaces and fusing the adjacent bones to achieve joint stability and prevent infection spread. General anesthesia was administered with a total dosage of 550 mg of propofol. The joint arthrodesis successfully addressed the infection and provided long-term joint stability.

9. Procedure: Joint Explantation and Temporary External Fixation for Severe Infection of the Extreme Moving Joint Patient with scoliosis and a severe infection in the extreme moving joint underwent joint explantation with temporary external fixation. The procedure involved removing the infected joint components, stabilizing the joint with an external fixator, and initiating antibiotic therapy. General anesthesia was administered with a total dosage of 750 mg of propofol. The joint explantation and temporary fixation aimed to eradicate the infection and maintain joint alignment during the healing process.

10. Procedure: Joint Resection and Antibiotic Bead Placement for Severe Infection of the Extreme Moving Joint Patient with scoliosis and a severe infection in the extreme moving joint underwent joint resection with antibiotic bead placement. The surgical intervention involved removing the infected joint structures and placing antibiotic-loaded beads to deliver localized antimicrobial treatment. General anesthesia was administered with a total dosage of 700 mg of propofol. The procedure effectively addressed the infection, and postoperative care focused on antibiotic therapy and close monitoring for infection resolution.

1. Procedure: Joint Debridement and Anti-inflammatory Medication Injection for Severe Inflammation of the Extreme Moving Joint Patient with scoliosis presented with severe inflammation in the extreme moving joint. Surgical intervention involved thorough debridement of inflamed tissues and the injection of anti-inflammatory medication directly into the joint. General anesthesia was administered with a total dosage of 800 mg of propofol. The procedure successfully reduced inflammation, providing relief and improving joint function.

2. Procedure: Arthroscopic Synovectomy for Inflammation of the Extreme Moving Joint Patient with scoliosis and inflammation in the extreme moving joint underwent arthroscopic synovectomy. The procedure involved the insertion of a small camera and specialized instruments to remove the inflamed synovial tissue. General anesthesia was administered with a total dosage of 700 mg of propofol. The arthroscopic intervention effectively alleviated inflammation and restored joint mobility.

3. Procedure: Joint Irrigation and Corticosteroid Injection for Inflammation of the Extreme Moving Joint Patient with scoliosis and inflammation in the extreme moving joint received joint irrigation and corticosteroid injection. The surgical intervention involved flushing the joint with sterile solution and administering corticosteroids to reduce inflammation. General anesthesia was administered with a total dosage of 900 mg of propofol. The procedure successfully mitigated inflammation and improved joint function.

4. Procedure: Joint Lavage and Platelet-Rich Plasma (PRP) Injection for Inflammation of the Extreme Moving Joint Patient with scoliosis and inflammation in the extreme moving joint underwent joint lavage and injection of platelet-rich plasma (PRP). The procedure involved thorough cleansing of the joint and the injection of PRP, which contains growth factors to promote healing and reduce inflammation. General anesthesia was administered with a total dosage of 750 mg of propofol. The treatment successfully reduced inflammation and enhanced joint recovery.

5. Procedure: Joint Capsule Release for Inflammation of the Extreme Moving Joint Patient with scoliosis and inflammation in the extreme moving joint underwent joint capsule release. The surgical intervention involved the release of tight or inflamed joint capsules to relieve pressure and reduce inflammation. General anesthesia was administered with a total dosage of 600 mg of propofol. The procedure successfully alleviated inflammation and improved joint mobility.

6. Procedure: Joint Synovial Biopsy for Inflammation of the Extreme Moving Joint Patient with scoliosis and inflammation in the extreme moving joint underwent joint synovial biopsy. The procedure involved the collection of synovial tissue for diagnostic evaluation and to guide further treatment. General anesthesia was administered with a total dosage of 800 mg of propofol. The biopsy helped identify the underlying cause of inflammation and guide targeted treatment strategies.

7. Procedure: Joint Arthrodesis for Inflammation and Instability of the Extreme Moving Joint Patient with scoliosis and severe inflammation, along with joint instability in the extreme moving joint, underwent joint arthrodesis surgery. The procedure involved fusing the joint to eliminate movement and reduce inflammation. General anesthesia was administered with a total dosage of 700 mg of propofol. The joint arthrodesis successfully addressed both inflammation and instability, providing long-term joint stability.

8. Procedure: Joint Denervation for Inflammation of the Extreme Moving Joint Patient with scoliosis and inflammation in the extreme moving joint underwent joint denervation. The surgical intervention involved selectively interrupting the sensory nerves around the joint to reduce pain and inflammation. General anesthesia was administered with a total dosage of 550 mg of propofol. The procedure effectively alleviated inflammation and improved joint function.

9. Procedure: Joint Cartilage Microfracture for Inflammation of the Extreme Moving Joint Patient with scoliosis and inflammation in the extreme moving joint underwent joint cartilage microfracture. The procedure involved creating small fractures in the affected cartilage to stimulate the formation of new, healthier cartilage and reduce inflammation. General anesthesia was administered with a total dosage of 750 mg of propofol. The microfracture procedure successfully alleviated inflammation and promoted joint healing.

10. Procedure: Joint Arthroscopy with Debridement and Steroid Injection for Inflammation of the Extreme Moving Joint Patient with scoliosis and inflammation in the extreme moving joint received joint arthroscopy with debridement and steroid injection. The procedure involved the use of a small camera and specialized instruments to remove inflamed tissues and the injection of a corticosteroid to reduce inflammation. General anesthesia was administered with a total dosage of 700 mg of propofol. The intervention effectively alleviated inflammation and improved joint function.

1. Patient diagnosed with mild scoliosis will require regular follow-up visits every 6 months for monitoring and evaluation of the curvature progression. Non-surgical management, such as physical therapy and bracing, will be recommended based on the severity and progression of the condition.

2. Patient diagnosed with moderate scoliosis will require frequent follow-up visits every 3 to 4 months for close monitoring of the curvature progression. Depending on the severity and rate of progression, a combination of bracing and physical therapy may be recommended. Surgical intervention might be considered if the curvature worsens or if other symptoms arise.

3. Patient diagnosed with severe scoliosis will require frequent follow-up visits every 2 to 3 months to closely monitor the curvature progression and overall spinal health. Bracing, physical therapy, and regular X-rays will be part of the ongoing management plan. Surgical intervention, such as spinal fusion, might be necessary if the curvature continues to worsen or if it causes significant pain or functional limitations.

4. Patient diagnosed with early-onset scoliosis will require frequent follow-up visits every 4 to 6 weeks due to the potential for rapid progression in younger patients. The treatment plan will involve close monitoring, bracing, and sometimes casting to manage the curvature. Surgical intervention might be considered in severe cases that do not respond to non-surgical interventions.

5. Patient diagnosed with degenerative scoliosis will require periodic follow-up visits every 6 to 12 months to assess the stability and progression of the curvature. Non-surgical treatment options, including physical therapy, pain management, and lifestyle modifications, will be recommended initially. Surgical intervention might be considered if the curvature worsens and leads to significant pain or neurological symptoms.

6. Patient diagnosed with idiopathic scoliosis will require regular follow-up visits every 6 to 12 months to monitor the progression of the curvature. Non-surgical management, such as bracing and physical therapy, will be recommended based on the severity and age of the patient. Surgical intervention might be considered if the curvature progresses significantly or if it causes functional limitations or pain.

7. Patient diagnosed with congenital scoliosis will require frequent follow-up visits every 3 to 4 months due to the potential for rapid progression and associated spinal abnormalities. The management plan will depend on the severity and specific abnormalities present. Regular monitoring of the spine's growth and development will guide the need for bracing or surgical intervention.

8. Patient diagnosed with neuromuscular scoliosis will require regular follow-up visits every 3 to 6 months to assess the progression of the curvature and the underlying neurological condition. Non-surgical interventions, such as physical therapy and assistive devices, will be utilized to manage the curvature and maintain functional mobility. Surgical intervention might be considered if the curvature worsens significantly or if it causes respiratory or neurological complications.

9. Patient diagnosed with adult-onset scoliosis will require periodic follow-up visits every 6 to 12 months to assess the stability and progression of the curvature. Non-surgical management, including physical therapy, pain management, and postural education, will be recommended initially. Surgical intervention might be considered if the curvature worsens and leads to significant pain or functional limitations.

10. Patient diagnosed with syndromic scoliosis will require frequent follow-up visits every 3 to 4 months due to the potential for rapid progression and associated systemic issues. The treatment plan will involve close monitoring of the curvature, management of associated symptoms, and coordination with other medical specialists as needed. Surgical intervention might be considered if the curvature progresses significantly or if it causes functional limitations or pain.