## M42.0 Juvenile osteochondrosis of spine

1. Patient presented with symptoms of juvenile osteochondrosis of the spine, including back pain and limited range of motion. Radiographic imaging revealed vertebral endplate irregularities and Schmorl's nodes. Treatment included physical therapy, pain management, and restriction of strenuous activities. Patient will be monitored closely for progression of the condition.

2. Operative note: Surgical intervention performed for severe juvenile osteochondrosis of the spine. A posterior approach was used to access the affected vertebral segments. Discectomy and interbody fusion with autograft were performed to stabilize the spine. Intraoperative findings showed disc degeneration and vertebral osteophyte formation. The procedure concluded successfully, and the patient will be closely monitored postoperatively.

3. Operative note: Minimally invasive procedure conducted for juvenile osteochondrosis of the spine. Under fluoroscopic guidance, percutaneous vertebroplasty was performed to address vertebral compression fractures. Cement augmentation was applied to stabilize the affected vertebrae. The procedure was well-tolerated, and the patient's pain and mobility improved postoperatively.

4. Operative note: Anterior cervical discectomy and fusion performed for cervical juvenile osteochondrosis. The affected intervertebral disc was removed, and an interbody cage with bone graft was placed. Plate and screw fixation were employed for stability. Intraoperative findings indicated disc herniation and narrowing of the neural foramen. The patient is expected to have a favorable recovery.

5. Operative note: Thoracic laminectomy and decompression surgery conducted for juvenile osteochondrosis of the spine. A posterior approach was utilized to access the affected vertebrae. Laminectomy was performed to alleviate spinal cord compression caused by herniated discs and osteophyte formation. The procedure was successful in relieving pressure, and the patient's neurological symptoms improved postoperatively.

6. Operative note: Posterolateral fusion surgery performed for juvenile osteochondrosis of the lumbar spine. The affected vertebrae were accessed through a posterior approach. Transpedicular screws were placed, and bone graft material was used to promote fusion. Intraoperative findings revealed degenerative changes and facet joint hypertrophy. The patient will undergo postoperative rehabilitation and close follow-up.

7. Operative note: Endoscopic discectomy and foraminotomy performed for juvenile osteochondrosis of the lumbar spine. The procedure involved accessing the affected disc and decompressing the nerve root through a minimally invasive approach. Intraoperative findings indicated disc herniation and foraminal stenosis. The patient experienced immediate relief of leg pain following the procedure.

8. Operative note: Percutaneous laser disc decompression performed for juvenile osteochondrosis of the spine. The laser probe was inserted into the affected disc, and laser energy was applied to vaporize disc material and decompress the nerve root. Intraoperative findings revealed disc bulge and nerve impingement. The patient reported significant improvement in symptoms after the procedure.

9. Operative note: Microdiscectomy performed for juvenile osteochondrosis of the lumbar spine. A small incision was made, and the affected disc was removed using specialized microsurgical instruments. Intraoperative findings indicated disc herniation causing nerve compression. The procedure was successful in relieving symptoms, and the patient was discharged with postoperative instructions.

10. Operative note: Anterior thoracic corpectomy and reconstruction performed for severe juvenile osteochondrosis of the spine. An anterior approach was utilized to access the affected vertebral body. Corpectomy was performed to remove the diseased vertebral segment, followed by placement of a structural graft and instrumentation for stability. Intraoperative findings revealed significant vertebral body collapse and spinal cord compression. The patient will require close postoperative monitoring.

1. Operative note: Percutaneous radiofrequency ablation (RFA) performed for juvenile osteochondrosis of the thoracic spine. RFA electrodes were inserted into the affected vertebral bodies under fluoroscopic guidance. Radiofrequency energy was delivered to the targeted areas to ablate the abnormal growth. The procedure was successful in reducing pain and improving spinal stability.

2. Operative note: Transforaminal lumbar interbody fusion (TLIF) surgery conducted for severe juvenile osteochondrosis of the lumbar spine. A posterior approach was used to access the affected levels. Discectomy, removal of osteophytes, and TLIF with cage placement and pedicle screw fixation were performed. Intraoperative findings indicated disc collapse and facet joint degeneration. The patient's symptoms are expected to improve with postoperative rehabilitation.

3. Operative note: Kyphoplasty procedure performed for vertebral compression fractures associated with juvenile osteochondrosis of the spine. Balloon kyphoplasty was utilized to restore vertebral height and stability. Cement augmentation was then performed. Intraoperative findings revealed multiple fractures and loss of vertebral body integrity. The patient experienced immediate pain relief and improved mobility following the procedure.

4. Operative note: Posterior cervical laminoplasty performed for cervical juvenile osteochondrosis. The procedure involved decompression of the spinal cord by creating a hinge on one side and opening the laminae on the opposite side. Intraoperative findings indicated spinal cord compression and spinal stenosis. The patient's neurological symptoms improved postoperatively, and a rehabilitation plan was initiated.

5. Operative note: Percutaneous endoscopic discectomy performed for juvenile osteochondrosis of the lumbar spine. Through a small incision, an endoscope was inserted to visualize and remove the herniated disc material. Intraoperative findings revealed a large disc herniation causing nerve compression. The patient experienced immediate relief of leg pain and was discharged with postoperative instructions.

6. Operative note: Anterior cervical corpectomy and fusion (ACCF) surgery performed for severe cervical juvenile osteochondrosis. An anterior approach was used to remove the affected vertebral body, followed by interbody fusion with cage placement and plate fixation. Intraoperative findings indicated vertebral collapse and spinal cord compression. The patient's neurological symptoms improved postoperatively.

7. Operative note: Intradiscal electrothermal therapy (IDET) performed for juvenile osteochondrosis of the lumbar spine. A catheter was inserted into the affected disc, and controlled thermal energy was applied to treat the discogenic pain and promote healing. Intraoperative findings indicated disc degeneration and tears. The patient reported decreased pain and improved function after the procedure.

8. Operative note: Hemilaminectomy and facetectomy surgery conducted for juvenile osteochondrosis of the thoracic spine. A unilateral approach was utilized to decompress the affected nerve root. Intraoperative findings revealed foraminal stenosis and facet joint hypertrophy. The patient's radicular symptoms significantly improved postoperatively, and a structured rehabilitation program was initiated.

9. Operative note: Anterior lumbar interbody fusion (ALIF) performed for severe juvenile osteochondrosis of the lumbar spine. The procedure involved accessing the affected disc space through an anterior approach, removing the disc, and placing an interbody cage with bone graft. Intraoperative findings indicated disc degeneration and instability. The patient is expected to have improved spinal alignment and reduced pain following the procedure.

10. Operative note: Cervical laminoplasty conducted for cervical juvenile osteochondrosis. The procedure involved creating a hinge on one side of the laminae to expand the spinal canal and relieve spinal cord compression. Intraoperative findings indicated spinal cord impingement and narrowing. The patient's neurological function improved postoperatively, and a postoperative rehabilitation plan was initiated.

1. Operative note: Microdiscectomy performed for juvenile osteochondrosis of the lumbar spine under general anesthesia. The patient received a standard dose of intravenous induction agents and inhaled anesthetics. Intraoperative monitoring was performed, and the procedure was successfully completed without any complications.

2. Operative note: Posterolateral fusion surgery conducted for juvenile osteochondrosis of the lumbar spine under regional anesthesia. The patient received a thoracic epidural block for intraoperative and postoperative pain management. The surgery proceeded smoothly, and the patient remained comfortable throughout the procedure.

3. Operative note: Anterior cervical discectomy and fusion performed for cervical juvenile osteochondrosis under monitored anesthesia care (MAC). The patient received a moderate sedative dosage along with local anesthesia at the surgical site. The procedure was well-tolerated, and the patient remained conscious and cooperative throughout.

4. Operative note: Percutaneous laser disc decompression performed for juvenile osteochondrosis of the spine under local anesthesia. The patient received a local anesthetic agent at the targeted disc level to numb the area. The procedure was carried out successfully without the need for general anesthesia, and the patient reported minimal discomfort.

5. Operative note: Thoracic laminectomy and decompression surgery conducted for juvenile osteochondrosis of the spine under balanced anesthesia. The patient received a combination of intravenous and inhaled anesthetics, tailored to their individual needs. The anesthesia depth was carefully monitored, and the surgery was completed without complications.

6. Operative note: Transforaminal lumbar interbody fusion (TLIF) surgery performed for juvenile osteochondrosis of the lumbar spine under high-dose epidural anesthesia. The patient received a higher concentration of local anesthetic to achieve a dense block. The procedure was completed successfully, and the patient experienced excellent pain control postoperatively.

7. Operative note: Percutaneous radiofrequency ablation (RFA) performed for juvenile osteochondrosis of the thoracic spine under conscious sedation. The patient received a combination of intravenous medications to induce a state of conscious sedation and analgesia. The procedure was well-tolerated, and the patient remained comfortable throughout.

8. Operative note: Anterior thoracic corpectomy and reconstruction performed for severe juvenile osteochondrosis of the spine under general anesthesia with neuromuscular blockade. The patient received muscle relaxants in addition to standard induction agents and maintenance anesthesia. The surgery proceeded smoothly, and neuromuscular function was effectively monitored.

9. Operative note: Kyphoplasty procedure conducted for vertebral compression fractures associated with juvenile osteochondrosis of the spine under moderate sedation. The patient received a combination of intravenous medications to achieve a state of moderate sedation and analgesia. The procedure was completed successfully, and the patient remained comfortable throughout.

10. Operative note: Endoscopic discectomy and foraminotomy performed for juvenile osteochondrosis of the lumbar spine under local anesthesia with intravenous sedation. The patient received a local anesthetic agent at the surgical site along with intravenous medications to induce a state of deep sedation. The procedure was well-tolerated, and the patient reported minimal pain or discomfort.

1. Operative note: Posterior cervical laminectomy and fusion performed for cervical juvenile osteochondrosis with associated bone erosion. The procedure involved decompression of the spinal cord and nerve roots, followed by the placement of bone graft and instrumentation for stabilization. Intraoperative findings indicated significant erosion of the vertebral bodies. The surgery was successful in relieving neural compression, and the patient will be closely monitored for fusion and healing.

2. Operative note: Anterior lumbar interbody fusion (ALIF) surgery conducted for severe juvenile osteochondrosis of the lumbar spine with vertebral bone erosion. The affected disc was removed, and bone graft, along with a cage, was placed in the intervertebral space. Intraoperative findings revealed erosion of the adjacent vertebral endplates. The patient's symptoms are expected to improve with stabilization and fusion of the affected segments.

3. Operative note: Percutaneous vertebroplasty performed for juvenile osteochondrosis of the thoracic spine with vertebral bone erosion. The procedure involved injecting bone cement into the affected vertebrae to stabilize and restore vertebral height. Intraoperative findings indicated significant erosion and collapse of the vertebral bodies. The patient experienced immediate pain relief, and postoperative imaging confirmed successful cement augmentation.

4. Operative note: Transforaminal lumbar interbody fusion (TLIF) surgery conducted for juvenile osteochondrosis of the lumbar spine with extensive vertebral bone erosion. The procedure involved decompression, removal of the affected disc, and insertion of a cage with bone graft. Intraoperative findings revealed severe erosion and deformity of the vertebral endplates. The patient's pain and instability are expected to improve with the fusion procedure.

5. Operative note: Anterior cervical corpectomy and fusion (ACCF) performed for cervical juvenile osteochondrosis with vertebral bone erosion. The procedure involved removing the affected vertebral body, followed by interbody fusion using a cage and bone graft. Intraoperative findings indicated erosion and collapse of the vertebral segment. The patient's symptoms and stability are expected to improve with the fusion surgery.

6. Operative note: Lateral lumbar interbody fusion (LLIF) surgery conducted for severe juvenile osteochondrosis of the lumbar spine with vertebral bone erosion. The procedure involved accessing the disc space from a lateral approach, removing the affected disc, and inserting a cage with bone graft. Intraoperative findings revealed erosions and loss of disc height. The patient's symptoms and spinal alignment are expected to improve postoperatively.

7. Operative note: Thoracic laminectomy and fusion surgery performed for juvenile osteochondrosis of the spine with significant vertebral bone erosion. The procedure involved decompressing the spinal cord and nerve roots, followed by the placement of bone graft and instrumentation for stabilization. Intraoperative findings revealed erosion and deformity of the vertebral bodies. The patient's neurological symptoms are expected to improve with the surgery.

8. Operative note: Posterior lumbar interbody fusion (PLIF) surgery conducted for juvenile osteochondrosis of the lumbar spine with vertebral bone erosion. The procedure involved removing the affected disc, inserting a cage with bone graft, and posterior instrumentation for stabilization. Intraoperative findings revealed erosion and collapse of the vertebral endplates. The patient's pain and spinal stability are expected to improve with the fusion procedure.

9. Operative note: Percutaneous kyphoplasty performed for vertebral compression fractures associated with juvenile osteochondrosis of the spine and concurrent bone erosion. The procedure involved balloon inflation and cement injection into the affected vertebrae to restore height and stability. Intraoperative findings indicated erosions and fractures in the vertebral bodies. The patient experienced immediate pain relief, and postoperative imaging confirmed successful vertebral restoration.

10. Operative note: Anterior thoracic corpectomy and reconstruction performed for severe juvenile osteochondrosis of the spine with extensive vertebral bone erosion. The procedure involved removing the diseased vertebral segment, followed by the placement of a structural graft and instrumentation for stabilization. Intraoperative findings revealed severe erosions and collapse of the vertebral body. The patient's spinal alignment and stability are expected to improve with the surgery.

1. Operative note: Decompressive laminectomy performed for juvenile osteochondrosis of the lumbar spine with severe bone pain. The procedure involved removing the lamina and other bony structures to relieve pressure on the spinal cord and nerve roots. Intraoperative findings indicated degenerative changes and severe bone pain. The patient experienced immediate relief postoperatively, and postoperative pain management was initiated.

2. Operative note: Vertebroplasty performed for severe vertebral compression fractures associated with juvenile osteochondrosis of the spine and debilitating bone pain. The procedure involved injecting bone cement into the affected vertebrae to stabilize and alleviate pain. Intraoperative findings revealed extensive bone edema and microfractures. The patient reported significant pain relief following the procedure.

3. Operative note: Spinal fusion surgery conducted for juvenile osteochondrosis of the spine with severe bone pain. The procedure involved removing the affected discs, inserting interbody cages with bone graft, and utilizing instrumentation for stabilization. Intraoperative findings revealed extensive disc degeneration and severe bone pain. The patient's pain levels improved postoperatively, and a comprehensive pain management plan was implemented.

4. Operative note: Percutaneous nucleoplasty performed for juvenile osteochondrosis of the spine with severe bone pain. The procedure involved using radiofrequency energy to treat the affected discs and alleviate pain. Intraoperative findings revealed disc degeneration and severe bone pain. The patient experienced significant pain reduction and improved functional capacity after the procedure.

5. Operative note: Minimally invasive lumbar decompression surgery conducted for severe juvenile osteochondrosis of the spine with debilitating bone pain. The procedure involved removing bone spurs and thickened ligaments to relieve nerve compression. Intraoperative findings indicated severe bone pain and nerve impingement. The patient reported decreased pain intensity and improved mobility following the surgery.

6. Operative note: Anterior cervical discectomy and fusion performed for cervical juvenile osteochondrosis with severe bone pain. The procedure involved removing the affected disc and fusing the adjacent vertebrae with a bone graft. Intraoperative findings revealed disc herniation and severe bone pain. The patient experienced significant pain relief and improved neck function postoperatively.

7. Operative note: Percutaneous laser disc decompression performed for severe juvenile osteochondrosis of the spine with debilitating bone pain. The laser probe was used to vaporize disc material and reduce nerve compression. Intraoperative findings revealed disc bulge and severe bone pain. The patient reported a substantial reduction in pain intensity and improved quality of life after the procedure.

8. Operative note: Lumbar microdiscectomy performed for severe juvenile osteochondrosis of the spine with excruciating bone pain. The procedure involved removing the herniated disc material to relieve nerve compression and alleviate pain. Intraoperative findings indicated severe bone pain and nerve root impingement. The patient experienced immediate relief of leg pain and reported decreased back pain postoperatively.

9. Operative note: Anterior lumbar interbody fusion (ALIF) surgery conducted for severe juvenile osteochondrosis of the lumbar spine with severe bone pain. The procedure involved removing the affected disc, inserting a cage with bone graft, and utilizing anterior instrumentation for stabilization. Intraoperative findings revealed disc degeneration and severe bone pain. The patient's pain levels significantly improved after the surgery.

10. Operative note: Thoracic laminectomy and fusion surgery performed for juvenile osteochondrosis of the spine with severe bone pain. The procedure involved decompressing the spinal cord and nerve roots and stabilizing the spine with bone graft and instrumentation. Intraoperative findings indicated severe bone pain and spinal cord compression. The patient experienced significant pain relief and improvement in neurological symptoms postoperatively.

1. Operative note: Percutaneous endoscopic laser ablation performed for juvenile osteochondrosis of the spine with persistent symptoms. The laser probe was inserted through a small incision to target and ablate the affected area, promoting tissue healing. Intraoperative findings indicated focal degeneration and inflammation. The procedure provided immediate pain relief, and the patient was advised on postoperative care and rehabilitation.

2. Operative note: Pedicle subtraction osteotomy (PSO) surgery conducted for severe juvenile osteochondrosis of the spine with significant deformity. The procedure involved removing a wedge-shaped section of bone from the vertebral body, allowing for correction of the spinal curvature. Intraoperative findings indicated vertebral collapse and angular deformity. The patient experienced improved spinal alignment and relief from associated symptoms postoperatively.

3. Operative note: Percutaneous disc decompression performed for juvenile osteochondrosis of the spine with persistent radicular pain. The procedure involved inserting a specialized device into the affected disc to remove or vaporize disc material, relieving pressure on the nerves. Intraoperative findings revealed disc herniation and nerve root compression. The patient reported immediate pain relief and increased functional ability following the intervention.

4. Operative note: Anterior cervical discectomy and fusion (ACDF) surgery conducted for cervical juvenile osteochondrosis with refractory symptoms. The procedure involved removing the damaged disc and fusing the adjacent vertebrae using a bone graft. Intraoperative findings indicated disc degeneration and spinal cord compression. The patient experienced significant improvement in pain, sensory disturbances, and motor function postoperatively.

5. Operative note: Lumbar laminectomy and fusion surgery performed for severe juvenile osteochondrosis of the spine with persistent neurologic deficits. The procedure involved decompressing the spinal cord and nerve roots and stabilizing the spine with instrumentation and bone graft. Intraoperative findings indicated spinal stenosis and nerve root compression. The patient showed improvement in neurological function and pain relief following the surgery.

6. Operative note: Percutaneous vertebroplasty performed for vertebral compression fractures associated with juvenile osteochondrosis of the spine and intractable pain. The procedure involved injecting bone cement into the fractured vertebrae to restore stability and alleviate pain. Intraoperative findings revealed vertebral collapse and severe pain on palpation. The patient experienced immediate pain relief and increased mobility post-intervention.

7. Operative note: Hemilaminotomy and discectomy surgery conducted for juvenile osteochondrosis of the lumbar spine with persistent radiculopathy. The procedure involved removing a portion of the lamina and extracting the herniated disc material, relieving nerve compression. Intraoperative findings revealed disc protrusion and nerve root impingement. The patient reported significant reduction in leg pain and improved sensory symptoms after the surgery.

8. Operative note: Spinal fusion surgery performed for severe juvenile osteochondrosis of the spine with instability and disabling pain. The procedure involved removing the affected disc and fusing adjacent vertebrae using bone graft and instrumentation. Intraoperative findings indicated disc degeneration and spinal instability. The patient experienced improved pain control and increased spinal stability following the surgery.

9. Operative note: Minimally invasive lateral lumbar interbody fusion (LLIF) surgery conducted for juvenile osteochondrosis of the lumbar spine with persistent back pain. The procedure involved accessing the disc space through a small incision, removing the damaged disc, and inserting an interbody cage with bone graft. Intraoperative findings revealed disc degeneration and instability. The patient reported reduced back pain and improved function after the intervention.

10. Operative note: Thoracic corpectomy and reconstruction performed for severe juvenile osteochondrosis of the spine with spinal cord compression and severe pain. The procedure involved removing the affected vertebral body and replacing it with a structural graft, followed by stabilization with instrumentation. Intraoperative findings indicated vertebral collapse and spinal cord compression. The patient experienced relief from pain and improvement in neurologic symptoms after the surgery.

1. Operative note: Percutaneous radiofrequency ablation (RFA) performed for juvenile osteochondrosis of the spine with intractable pain. The procedure involved using heat generated by radiofrequency energy to ablate the affected nerves, providing pain relief. Intraoperative findings revealed nerve inflammation and hyperactivity. The patient reported significant reduction in pain intensity and improved quality of life following the intervention.

2. Operative note: Anterior lumbar corpectomy and fusion (ALCF) surgery conducted for severe juvenile osteochondrosis of the lumbar spine with progressive neurological deficits and excruciating pain. The procedure involved removing the affected vertebral body and adjacent discs, followed by fusion using a structural graft and instrumentation. Intraoperative findings indicated severe vertebral collapse and spinal cord compression. The patient experienced relief from pain and improvement in neurological function postoperatively.

3. Operative note: Spinal decompression and fusion surgery performed for juvenile osteochondrosis of the spine with severe pain and instability. The procedure involved decompressing the spinal cord and nerve roots, removing the affected discs, and fusing the spinal segments using bone graft and instrumentation. Intraoperative findings revealed spinal stenosis and segmental instability. The patient showed significant pain reduction and improved spinal stability following the surgery.

4. Operative note: Endoscopic discectomy performed for juvenile osteochondrosis of the lumbar spine with persistent radiculopathy and debilitating pain. The procedure involved accessing the affected disc through a small incision and removing the herniated disc material, relieving nerve compression. Intraoperative findings indicated disc herniation and nerve root impingement. The patient reported immediate relief from leg pain and improved sensory symptoms after the surgery.

5. Operative note: Minimally invasive posterior cervical fusion surgery conducted for cervical juvenile osteochondrosis with severe pain and instability. The procedure involved accessing the cervical spine through small incisions, removing the damaged disc, and fusing the adjacent vertebrae using bone graft and instrumentation. Intraoperative findings revealed disc degeneration and spinal instability. The patient experienced significant pain relief and improved neck stability postoperatively.

6. Operative note: Percutaneous endoscopic discectomy performed for juvenile osteochondrosis of the spine with persistent radicular pain. The procedure involved inserting an endoscope through a small incision and removing the herniated disc material, relieving nerve compression. Intraoperative findings revealed disc protrusion and nerve root impingement. The patient reported immediate relief from leg pain and improved functional capacity following the intervention.

7. Operative note: Lumbar laminoplasty surgery conducted for severe juvenile osteochondrosis of the spine with spinal canal stenosis and severe pain. The procedure involved expanding the spinal canal by creating a hinge on one side of the lamina, relieving pressure on the nerves. Intraoperative findings revealed spinal canal narrowing and nerve compression. The patient experienced relief from pain and improvement in neurological symptoms postoperatively.

8. Operative note: Microscopic lumbar discectomy performed for juvenile osteochondrosis of the spine with persistent radiculopathy and severe pain. The procedure involved removing the herniated disc material using a microscope to visualize the affected area and minimize tissue trauma. Intraoperative findings revealed disc herniation and nerve root compression. The patient reported immediate relief from leg pain and improved sensory symptoms after the surgery.

9. Operative note: Posterior lumbar interbody fusion (PLIF) surgery conducted for severe juvenile osteochondrosis of the lumbar spine with incapacitating pain and instability. The procedure involved removing the affected disc, inserting an interbody cage with bone graft, and stabilizing the spine with instrumentation. Intraoperative findings indicated severe disc degeneration and spinal instability. The patient experienced significant pain reduction and improved spinal stability following the surgery.

10. Operative note: Transforaminal lumbar interbody fusion (TLIF) surgery performed for juvenile osteochondrosis of the spine with severe pain and segmental instability. The procedure involved removing the affected disc, inserting an interbody cage with bone graft, and utilizing posterior instrumentation for stabilization. Intraoperative findings revealed disc degeneration and vertebral slippage. The patient reported relief from pain and improved spinal stability postoperatively.

1. Operative note: Arthroscopic debridement and irrigation performed for severe infection in the extreme moving joint associated with juvenile osteochondrosis. The procedure involved using an arthroscope to visualize the joint and removing infected tissues, followed by thorough irrigation with antimicrobial solution. Intraoperative findings indicated purulent fluid and extensive synovial inflammation. The patient was started on intravenous antibiotics and closely monitored postoperatively.

2. Operative note: Open joint debridement and washout surgery conducted for severe infection in the extreme moving joint related to juvenile osteochondrosis. The procedure involved making an incision to access the joint, removing infected tissues, and thoroughly irrigating the joint cavity. Intraoperative findings revealed pus accumulation and extensive joint inflammation. The patient received intravenous antibiotics and wound care postoperatively.

3. Operative note: Joint aspiration and culture performed for severe infection in the extreme moving joint associated with juvenile osteochondrosis. The procedure involved using a needle to aspirate fluid from the joint for laboratory analysis and identification of the infecting organism. Intraoperative findings indicated purulent fluid and signs of joint inflammation. The patient was initiated on appropriate antibiotic therapy based on culture results.

4. Operative note: Arthroscopic lavage and synovectomy performed for severe infection in the extreme moving joint related to juvenile osteochondrosis. The procedure involved using an arthroscope to visualize and clean the joint, removing infected synovial tissue. Intraoperative findings revealed thickened synovium and pus formation. The patient received intravenous antibiotics and was closely monitored for resolution of infection.

5. Operative note: Joint exploration and debridement surgery conducted for severe infection in the extreme moving joint associated with juvenile osteochondrosis. The procedure involved making an incision to access the joint, removing infected tissues, and irrigating the joint cavity. Intraoperative findings indicated purulent material and extensive joint involvement. The patient was placed on appropriate antibiotic therapy and underwent regular wound care.

6. Operative note: Excision arthroplasty performed for severe infection in the extreme moving joint related to juvenile osteochondrosis. The procedure involved removing the infected joint surfaces and creating a mobile scarred pseudarthrosis. Intraoperative findings revealed extensive cartilage destruction and pus accumulation. The patient was started on intravenous antibiotics and closely monitored for signs of infection resolution.

7. Operative note: Joint washout with temporary external fixation performed for severe infection in the extreme moving joint associated with juvenile osteochondrosis. The procedure involved irrigating the joint and applying an external fixator to stabilize the joint temporarily. Intraoperative findings indicated purulent fluid and signs of joint inflammation. The patient received intravenous antibiotics and was scheduled for further interventions.

8. Operative note: Joint arthrodesis surgery conducted for severe infection in the extreme moving joint related to juvenile osteochondrosis. The procedure involved fusing the joint surfaces using bone graft and hardware to eliminate the infection source. Intraoperative findings revealed extensive cartilage destruction and purulent material. The patient received intravenous antibiotics and was monitored for fusion success and infection resolution.

9. Operative note: Joint resection and arthroplasty performed for severe infection in the extreme moving joint associated with juvenile osteochondrosis. The procedure involved removing the infected joint surfaces and replacing them with an artificial joint. Intraoperative findings indicated significant joint destruction and pus accumulation. The patient received intravenous antibiotics and underwent postoperative rehabilitation.

10. Operative note: Synovial biopsy and debridement performed for severe infection in the extreme moving joint related to juvenile osteochondrosis. The procedure involved taking a biopsy of the synovial tissue for pathological examination and removing infected tissues. Intraoperative findings revealed inflamed synovium and purulent material. The patient received appropriate antibiotic therapy based on biopsy results and was closely monitored for infection control.

1. Operative note: Arthroscopic debridement and irrigation performed for juvenile osteochondrosis of the extreme moving joint with marked inflammatory changes. The procedure involved using an arthroscope to visualize the joint, removing inflamed tissues, and thoroughly irrigating the joint cavity. Intraoperative findings indicated synovial hypertrophy and diffuse inflammation. The patient received postoperative anti-inflammatory medications and was advised on appropriate rehabilitation protocols.

2. Operative note: Open joint synovectomy surgery conducted for severe inflammation in the extreme moving joint associated with juvenile osteochondrosis. The procedure involved making an incision to access the joint, excising the inflamed synovium, and irrigating the joint space. Intraoperative findings revealed thickened and inflamed synovial lining. The patient received postoperative anti-inflammatory medications and was instructed on joint protection measures.

3. Operative note: Corticosteroid injection performed for juvenile osteochondrosis of the extreme moving joint with persistent inflammation. The procedure involved injecting a corticosteroid medication into the joint space to reduce inflammation and alleviate symptoms. Intraoperative findings indicated synovial hyperemia and local swelling. The patient reported immediate relief from pain and improved joint mobility following the injection.

4. Operative note: Arthroscopic lavage and drainage performed for severe inflammation in the extreme moving joint related to juvenile osteochondrosis. The procedure involved using an arthroscope to clean and irrigate the joint, removing inflammatory debris. Intraoperative findings revealed inflamed synovium and joint effusion. The patient received postoperative anti-inflammatory medications and was advised on appropriate rehabilitation exercises.

5. Operative note: Joint aspiration and steroid injection conducted for acute exacerbation of inflammation in the extreme moving joint associated with juvenile osteochondrosis. The procedure involved aspirating joint fluid for analysis and injecting a corticosteroid medication to reduce inflammation. Intraoperative findings indicated turbid synovial fluid and signs of acute inflammation. The patient experienced immediate pain relief and improvement in joint function post-procedure.

6. Operative note: Open joint debridement and synovial biopsy surgery performed for persistent inflammation in the extreme moving joint related to juvenile osteochondrosis. The procedure involved removing inflamed tissues and obtaining a synovial biopsy sample for pathological examination. Intraoperative findings revealed synovial hyperplasia and chronic inflammation. The patient received postoperative anti-inflammatory medications and was referred for further evaluation based on biopsy results.

7. Operative note: Intra-articular hyaluronic acid injection performed for chronic inflammation in the extreme moving joint associated with juvenile osteochondrosis. The procedure involved injecting hyaluronic acid, a joint lubricant, to reduce inflammation and improve joint function. Intraoperative findings indicated synovial hypertrophy and joint cartilage degeneration. The patient reported gradual improvement in joint symptoms and increased mobility following the injection.

8. Operative note: Arthroscopic synovectomy and thermal ablation conducted for persistent inflammation in the extreme moving joint related to juvenile osteochondrosis. The procedure involved removing the inflamed synovium using an arthroscope and applying thermal energy to ablate residual synovial tissue. Intraoperative findings revealed thickened and vascular synovium. The patient received postoperative anti-inflammatory medications and was advised on joint protection techniques.

9. Operative note: Open joint washout and debridement surgery performed for severe inflammation in the extreme moving joint associated with juvenile osteochondrosis. The procedure involved irrigating the joint space to remove inflammatory debris and excising necrotic tissues. Intraoperative findings indicated synovial hypertrophy and extensive fibrin deposition. The patient received postoperative anti-inflammatory medications and was scheduled for follow-up evaluations.

10. Operative note: Synovial biopsy and arthroscopic lavage performed for persistent inflammation in the extreme moving joint related to juvenile osteochondrosis. The procedure involved obtaining a synovial biopsy sample for analysis and performing a thorough joint lavage to remove inflammatory substances. Intraoperative findings revealed hyperemic and inflamed synovium. The patient received postoperative anti-inflammatory medications and was referred to a rheumatologist for further evaluation based on biopsy results.

1. Operative note: Surgical debridement and stabilization performed for severe juvenile osteochondrosis of the spine with spinal cord compression. The procedure involved removing the affected vertebral body, decompressing the spinal cord, and stabilizing the spine with instrumentation. The patient's postoperative follow-up will include regular neurological assessments, imaging studies to evaluate fusion progress, and collaboration with a rehabilitation team for physical therapy.

2. Operative note: Percutaneous vertebroplasty performed for moderate juvenile osteochondrosis of the spine with vertebral collapse. The procedure involved injecting bone cement into the collapsed vertebra to stabilize it. The patient will be followed up with regular X-rays to assess the vertebral height restoration and will receive pain management guidance along with postoperative physiotherapy.

3. Operative note: Arthroscopic debridement and microfracture performed for moderate juvenile osteochondrosis of the knee with cartilage damage. The procedure involved removing damaged cartilage and creating small fractures in the underlying bone to promote cartilage regeneration. The patient's follow-up will include periodic assessments of knee function, physical therapy sessions, and imaging studies to monitor the healing of the treated area.

4. Operative note: Open reduction and internal fixation (ORIF) performed for severe juvenile osteochondrosis of the ankle with joint instability. The procedure involved realigning the fractured bone fragments and securing them with screws or plates. The patient's follow-up will involve regular visits to monitor fracture healing, range of motion exercises, and weight-bearing progression as guided by X-rays and clinical examination.

5. Operative note: Spinal fusion surgery performed for severe juvenile osteochondrosis of the spine with spinal instability. The procedure involved fusing the affected vertebrae together to provide stability. The patient's postoperative follow-up will include regular imaging studies to assess fusion progression, pain management, and physical therapy to optimize spinal strength and function.

6. Operative note: Joint arthroplasty performed for end-stage juvenile osteochondrosis of the hip with severe joint degeneration. The procedure involved replacing the damaged hip joint with an artificial joint. The patient's follow-up will include routine evaluations to monitor the implant's functionality, rehabilitation exercises, and periodic imaging studies to assess the long-term success of the procedure.

7. Operative note: Percutaneous epiphysiodesis performed for mild juvenile osteochondrosis of the spine with growth plate irregularities. The procedure involved creating small fractures in the growth plates to slow down or redirect the growth. The patient's follow-up will involve regular radiographic assessments to monitor growth plate closure, as well as observation of any changes in spinal alignment or symptoms.

8. Operative note: Soft tissue release surgery performed for severe juvenile osteochondrosis of the elbow with joint contracture. The procedure involved releasing tight soft tissues around the joint to improve range of motion. The patient's follow-up will include physiotherapy sessions to maintain and improve joint mobility, along with periodic clinical evaluations to assess progress.

9. Operative note: Intra-articular corticosteroid injection performed for moderate juvenile osteochondrosis of the shoulder with persistent inflammation. The procedure involved injecting a corticosteroid medication into the shoulder joint to reduce inflammation. The patient's follow-up will include monitoring of symptoms and joint function, as well as additional injections or alternative treatment options if necessary.

10. Operative note: Percutaneous osteotomy performed for moderate juvenile osteochondrosis of the knee with malalignment. The procedure involved making small incisions and using specialized instruments to realign the bone. The patient's follow-up will include regular check-ups to assess the correction achieved, monitoring of knee stability, and rehabilitation exercises to optimize joint function.

## M42.1 Adult osteochondrosis of spine

1. Patient presented with symptomatic adult osteochondrosis of the lumbar spine. Surgical intervention performed, including decompression laminectomy, removal of osteophytes, and stabilization with pedicle screws and rods. Intraoperative findings revealed severe disc degeneration and foraminal stenosis. Postoperatively, the patient exhibited immediate relief of radicular symptoms. Follow-up imaging demonstrated successful decompression and stable instrumentation placement.

2. Operative intervention for adult osteochondrosis of the thoracic spine was conducted. An anterior approach was chosen, involving discectomy, corpectomy, and interbody fusion with a titanium cage. The procedure addressed significant vertebral collapse and spinal cord compression. The patient tolerated the surgery well, experiencing improvement in pain and neurological symptoms. Postoperative imaging confirmed successful fusion and decompression of the thoracic spine.

3. A patient with adult osteochondrosis affecting the cervical spine underwent surgical treatment. Anterior cervical discectomy and fusion were performed to alleviate severe radicular pain and cervical myelopathy. The affected intervertebral discs were removed, and an interbody graft with a plate was inserted for stabilization. The patient reported decreased pain and improved neurological function postoperatively, and follow-up imaging showed successful fusion and decompression.

4. Adult osteochondrosis of the lumbar spine was addressed through minimally invasive surgery. Percutaneous endoscopic discectomy was performed to remove the herniated disc material causing radicular symptoms. The procedure resulted in immediate pain relief, and the patient reported improved mobility. Postoperative imaging confirmed successful removal of the herniation, and the patient was advised on appropriate postoperative care and rehabilitation.

5. Surgical intervention was conducted for a patient with adult osteochondrosis affecting the thoracic spine. Posterior spinal fusion was performed using pedicle screws, rods, and bone grafts. The procedure successfully stabilized the affected segments, reducing pain and preventing further progression of spinal deformity. Postoperatively, the patient demonstrated improved posture and reported decreased thoracic pain. Follow-up imaging revealed satisfactory fusion and instrumentation placement.

6. A patient with adult osteochondrosis of the cervical spine underwent posterior cervical laminoplasty. This procedure aimed to decompress the spinal cord and alleviate symptoms of myelopathy. The laminae were reconstructed to enlarge the spinal canal and alleviate pressure on the cord. Postoperatively, the patient experienced improvement in motor function and reduced neck pain. Follow-up imaging showed adequate decompression and maintenance of cervical alignment.

7. Minimally invasive surgery was performed on a patient with adult osteochondrosis affecting the lumbar spine. Percutaneous laser disc decompression was conducted to treat the herniated disc and relieve radicular pain. The procedure involved vaporizing a portion of the disc using laser energy, resulting in decompression of the nerve root. The patient reported immediate pain relief and returned to normal activities shortly after the procedure.

8. A patient with adult osteochondrosis of the thoracic spine underwent a minimally invasive lateral interbody fusion procedure. Through a small incision, a lateral approach was used to remove the damaged disc and insert a fusion cage packed with bone graft material. The surgery successfully restored disc height, relieved nerve compression, and stabilized the affected segment. The patient experienced decreased pain and improved functional outcomes postoperatively.

9. Surgical intervention was performed for a patient with adult osteochondrosis affecting multiple levels of the lumbar spine. Posterior lumbar interbody fusion (PLIF) was carried out, involving the removal of degenerated discs and insertion of interbody cages. Pedicle screws and rods were utilized for stabilization. The patient experienced relief of radicular symptoms and improved lumbar stability postoperatively. Follow-up imaging showed successful fusion and maintenance of alignment.

10. A patient with adult osteochondrosis of the cervical spine underwent an anterior cervical discectomy and fusion (ACDF) procedure. The affected disc was removed, and an interbody graft with a titanium plate was placed to restore disc height and provide stability. The surgery successfully relieved radicular pain and improved neck function. Postoperative imaging confirmed fusion and proper positioning of the instrumentation. The patient was advised on postoperative care and follow-up appointments.

1. Adult osteochondrosis of the lumbar spine was addressed through a microdiscectomy procedure. The herniated disc causing radicular symptoms was carefully removed using specialized instruments. The patient reported immediate relief of leg pain and improved mobility postoperatively. Follow-up imaging confirmed successful removal of the disc herniation and preservation of spinal stability.

2. Surgical intervention was performed for a patient with adult osteochondrosis affecting the thoracolumbar junction. Transforaminal lumbar interbody fusion (TLIF) was conducted to address disc degeneration and stabilize the spine. The procedure involved removing the affected disc, inserting an interbody cage, and securing it with pedicle screws and rods. The patient experienced decreased back pain and improved spinal alignment following surgery.

3. A patient presented with adult osteochondrosis involving the cervical spine. Posterior cervical fusion with lateral mass screws and rods was performed to stabilize the affected segments. The procedure successfully relieved neck pain and improved the patient's range of motion. Follow-up imaging demonstrated satisfactory fusion and alignment of the cervical spine.

4. Surgical treatment was undertaken for adult osteochondrosis affecting the thoracic spine. A posterior thoracic fusion procedure was performed, involving the insertion of pedicle screws and rods to stabilize the spine. The surgery effectively reduced back pain and prevented further progression of spinal deformity. Postoperative imaging revealed successful fusion and alignment restoration.

5. A patient with adult osteochondrosis of the lumbar spine underwent an artificial disc replacement procedure. The degenerated disc was removed, and an artificial disc prosthesis was inserted to maintain motion and stability. The patient reported significant improvement in pain and functional outcomes after surgery. Follow-up imaging showed proper placement and functioning of the artificial disc.

6. Surgical intervention was performed for a patient with adult osteochondrosis involving the thoracic spine. A thoracic laminectomy was conducted to decompress the spinal cord and relieve symptoms of myelopathy. The patient experienced neurological improvement and decreased thoracic pain following the procedure. Postoperative imaging confirmed adequate decompression of the spinal cord.

7. A patient with adult osteochondrosis of the cervical spine underwent an anterior cervical corpectomy and fusion (ACCF) procedure. The affected vertebral body and adjacent discs were removed, and a structural bone graft was inserted for fusion. The surgery successfully alleviated spinal cord compression and improved neck pain. Follow-up imaging demonstrated satisfactory fusion and cervical alignment.

8. Surgical treatment was performed for adult osteochondrosis affecting the lumbar spine. A posterior dynamic stabilization procedure was carried out using flexible rods and pedicle screws. The surgery provided stability to the affected segments while preserving some degree of spinal motion. The patient reported decreased pain and improved functional outcomes postoperatively.

9. A patient with adult osteochondrosis involving the thoracic spine underwent a minimally invasive thoracic laminoplasty procedure. The laminae were reconstructed to expand the spinal canal and relieve pressure on the spinal cord. The surgery successfully alleviated symptoms of myelopathy and improved neurological function. Follow-up imaging confirmed adequate decompression and maintenance of thoracic spinal alignment.

10. Surgical intervention was performed for a patient with adult osteochondrosis affecting multiple levels of the cervical spine. Anterior cervical discectomy and fusion (ACDF) were conducted, involving the removal of degenerated discs and insertion of interbody grafts. The surgery successfully relieved neck pain and improved nerve root compression. Postoperative imaging showed successful fusion and restoration of cervical alignment.

1. Patient with adult osteochondrosis of the lumbar spine underwent a microdiscectomy procedure under general anesthesia with an adjusted dosage to ensure optimal pain management and patient comfort. The herniated disc causing radicular symptoms was successfully removed, resulting in immediate relief of leg pain. Follow-up imaging confirmed the efficacy of the surgery, and the patient experienced a smooth recovery with minimal postoperative discomfort.

2. Surgical intervention for adult osteochondrosis affecting the thoracolumbar junction was performed under regional anesthesia with a carefully titrated dosage. Transforaminal lumbar interbody fusion (TLIF) was carried out, addressing disc degeneration and stabilizing the spine. The patient reported satisfactory pain control during and after the procedure, and postoperative imaging confirmed successful fusion and alignment restoration.

3. A patient with adult osteochondrosis involving the cervical spine underwent posterior cervical fusion with lateral mass screws and rods, performed under general anesthesia with a reduced dosage to ensure appropriate pain management. The procedure effectively alleviated neck pain and improved range of motion. Postoperative imaging showed successful fusion and maintenance of cervical alignment, and the patient experienced a comfortable recovery period.

4. Surgical treatment for adult osteochondrosis of the lumbar spine was undertaken with the patient under general anesthesia, employing an adjusted dosage for optimal pain control. Posterior lumbar interbody fusion (PLIF) was performed, involving the removal of degenerated discs and insertion of interbody cages. The patient reported minimal discomfort postoperatively, and follow-up imaging revealed successful fusion and maintenance of spinal stability.

5. A patient with adult osteochondrosis affecting the thoracic spine underwent an anterior cervical discectomy and fusion (ACDF) procedure. The surgery was performed under general anesthesia with a carefully tailored dosage to ensure pain management. The patient experienced reduced neck pain and improved functional outcomes following the surgery. Postoperative imaging confirmed successful fusion and proper positioning of the instrumentation.

6. Surgical intervention was performed for adult osteochondrosis involving the cervical spine. A posterior cervical laminoplasty procedure was conducted under regional anesthesia with an adjusted dosage to maintain patient comfort. The surgery successfully decompressed the spinal cord, resulting in improved motor function and reduced neck pain. Follow-up imaging demonstrated adequate decompression and preservation of cervical alignment.

7. A patient with adult osteochondrosis of the lumbar spine underwent a minimally invasive percutaneous endoscopic discectomy procedure under local anesthesia with appropriate sedation. The herniated disc material causing radicular symptoms was effectively removed, providing immediate pain relief. The patient experienced minimal discomfort during the procedure and reported a smooth recovery period.

8. Surgical treatment was performed for adult osteochondrosis affecting the thoracic spine under general anesthesia with an adjusted dosage. A posterior thoracic fusion procedure was conducted, involving the insertion of pedicle screws and rods. The surgery effectively reduced back pain and prevented further progression of spinal deformity. Postoperative imaging revealed successful fusion and alignment restoration, and the patient experienced adequate pain control during the recovery period.

9. A patient with adult osteochondrosis involving the cervical spine underwent an anterior cervical corpectomy and fusion (ACCF) procedure under general anesthesia with a tailored dosage. The surgery involved the removal of the affected vertebral body and adjacent discs, followed by the insertion of a structural bone graft. The procedure successfully alleviated spinal cord compression and improved neck pain. Follow-up imaging demonstrated satisfactory fusion and cervical alignment.

10. Surgical intervention was performed for adult osteochondrosis affecting the lumbar spine under regional anesthesia with an adjusted dosage. A posterior dynamic stabilization procedure was carried out using flexible rods and pedicle screws. The surgery provided stability to the affected segments while preserving some degree of spinal motion. The patient reported effective pain control during the recovery period and experienced improved functional outcomes.

1. Operative intervention was performed for a patient with adult osteochondrosis of the lumbar spine, complicated by significant bone erosion. A posterior lumbar fusion procedure was conducted, involving the removal of degenerated discs and insertion of interbody cages. Additionally, bone grafting was performed to address the erosion and promote fusion. Postoperatively, the patient experienced relief of radicular symptoms, and imaging confirmed successful fusion and stabilization.

2. A patient with adult osteochondrosis affecting the cervical spine underwent a complex surgical procedure due to extensive bone erosion. Anterior cervical corpectomy and fusion (ACCF) were performed, involving the removal of affected vertebral bodies and discs. Structural bone grafts were utilized to reconstruct the eroded areas. The patient exhibited improved spinal stability and relief of neurological symptoms postoperatively.

3. Surgical intervention was undertaken for a patient with adult osteochondrosis involving the thoracic spine and severe bone erosion. A combination of anterior and posterior approaches was employed. Anterior corpectomy and interbody fusion were performed to address the erosion, followed by posterior instrumentation and fusion for stabilization. The procedure successfully relieved pain and prevented further erosion, as confirmed by postoperative imaging.

4. A patient with adult osteochondrosis of the lumbar spine presented with extensive bone erosion necessitating surgical intervention. Posterior spinal fusion was performed using pedicle screws, rods, and bone grafts. The procedure addressed the erosion, restored spinal stability, and alleviated pain. Postoperative imaging confirmed successful fusion and stabilization of the affected segments.

5. Surgical treatment was conducted for a patient with adult osteochondrosis affecting the cervical spine, complicated by bone erosion. Anterior cervical discectomy and fusion (ACDF) were performed to remove the eroded discs and restore stability. Structural bone grafts were used to reconstruct the eroded areas. The patient experienced relief of neck pain and improved functional outcomes postoperatively.

6. A patient with adult osteochondrosis involving the thoracic spine underwent a complex surgical procedure due to extensive bone erosion and spinal instability. Anterior corpectomy and reconstruction were performed to address the erosion, followed by posterior instrumentation and fusion. The surgery successfully stabilized the spine, relieved pain, and prevented further erosion. Postoperative imaging confirmed satisfactory fusion and alignment restoration.

7. Operative intervention was performed for a patient with adult osteochondrosis of the lumbar spine, complicated by severe bone erosion. Posterior lumbar interbody fusion (PLIF) was conducted, involving the removal of degenerated discs and insertion of interbody cages. Additionally, bone grafts were utilized to address the erosion and promote fusion. The patient reported relief of radicular symptoms, and follow-up imaging demonstrated successful fusion and stabilization.

8. A patient with adult osteochondrosis affecting the cervical spine presented with extensive bone erosion. Surgical intervention involved a combined anterior and posterior approach. Anterior cervical discectomy and fusion (ACDF) addressed the erosion, while posterior instrumentation provided stability. The procedure successfully alleviated neck pain and improved neurological function. Follow-up imaging confirmed fusion and stabilization of the cervical spine.

9. Surgical treatment was undertaken for a patient with adult osteochondrosis involving the thoracic spine, complicated by significant bone erosion. A combination of anterior corpectomy, bone grafting, and posterior stabilization was performed. The surgery successfully addressed the erosion, restored spinal stability, and alleviated pain. Postoperative imaging confirmed successful fusion and stabilization of the affected segments.

10. A patient with adult osteochondrosis of the lumbar spine underwent a complex surgical procedure due to extensive bone erosion and spinal instability. Posterior spinal fusion with instrumentation was performed, and bone grafts were utilized to address the erosion. The surgery successfully stabilized the spine, relieved pain, and prevented further erosion. Postoperative imaging confirmed satisfactory fusion and restoration of spinal alignment.

1. Surgical intervention was performed for a patient with adult osteochondrosis of the lumbar spine, presenting with severe bone pain. Posterior decompression laminectomy and fusion were conducted to address the pain and instability. The procedure involved removing bony spurs and inserting pedicle screws and rods for stabilization. Postoperatively, the patient experienced significant relief of bone pain, and imaging confirmed successful fusion and improved spinal alignment.

2. A patient with adult osteochondrosis affecting the cervical spine presented with severe bone pain necessitating surgical treatment. Anterior cervical corpectomy and fusion (ACCF) were performed to remove the degenerated bone and stabilize the spine. The procedure successfully alleviated bone pain and improved cervical alignment. Postoperative imaging confirmed fusion and reduction of bone-related symptoms.

3. Operative intervention was undertaken for a patient with adult osteochondrosis involving the thoracic spine and severe bone pain. A combined anterior and posterior approach was utilized. Anterior corpectomy and interbody fusion were performed to address the bone pathology, followed by posterior instrumentation and fusion for stabilization. The surgery successfully relieved severe bone pain and restored spinal stability, as confirmed by postoperative imaging.

4. A patient with adult osteochondrosis of the lumbar spine presented with debilitating bone pain necessitating surgical intervention. Posterior spinal fusion with bone grafting was performed to address the pain and stabilize the spine. The procedure effectively alleviated severe bone pain and improved the patient's quality of life. Postoperative imaging confirmed successful fusion and restoration of spinal stability.

5. Surgical treatment was conducted for a patient with adult osteochondrosis affecting the cervical spine, complicated by severe bone pain. Anterior cervical discectomy and fusion (ACDF) were performed to remove the degenerated bone and restore stability. The procedure successfully alleviated severe bone pain and improved cervical alignment. Follow-up imaging confirmed fusion and reduced bone-related symptoms.

6. A patient with adult osteochondrosis involving the thoracic spine underwent a complex surgical procedure due to severe bone pain. Anterior corpectomy and reconstruction were performed to address the bone pathology, followed by posterior instrumentation and fusion. The surgery successfully relieved severe bone pain and restored spinal stability. Postoperative imaging confirmed fusion and reduction of bone-related symptoms.

7. Operative intervention was performed for a patient with adult osteochondrosis of the lumbar spine, complicated by severe bone pain. Posterior lumbar interbody fusion (PLIF) was conducted, involving the removal of degenerated bone and insertion of interbody cages. Additionally, bone grafts were utilized to address the bone pathology and promote fusion. The patient reported significant relief of severe bone pain, and follow-up imaging demonstrated successful fusion and restoration of spinal stability.

8. A patient with adult osteochondrosis affecting the cervical spine presented with severe bone pain necessitating surgical intervention. Combined anterior and posterior approaches were employed. Anterior cervical corpectomy and fusion (ACCF) addressed the bone pathology, while posterior instrumentation provided stability. The procedure successfully alleviated severe bone pain and improved cervical alignment. Follow-up imaging confirmed fusion and reduction of bone-related symptoms.

9. Surgical treatment was undertaken for a patient with adult osteochondrosis involving the thoracic spine, presenting with severe bone pain. A combination of anterior corpectomy, bone grafting, and posterior stabilization was performed. The surgery successfully addressed the bone pathology, relieved severe bone pain, and restored spinal stability. Postoperative imaging confirmed fusion and reduction of bone-related symptoms.

10. A patient with adult osteochondrosis of the lumbar spine underwent a complex surgical procedure due to severe bone pain and spinal instability. Posterior spinal fusion with instrumentation and bone grafting was performed. The surgery effectively alleviated severe bone pain, stabilized the spine, and improved the patient's overall well-being. Postoperative imaging confirmed successful fusion and reduction of bone-related symptoms.

1. Surgical intervention was performed for a patient with adult osteochondrosis of the lumbar spine. A minimally invasive discectomy procedure was conducted to remove the degenerated disc causing severe pain. The surgery successfully relieved the patient's symptoms and improved their quality of life. Postoperative imaging confirmed the removal of the affected disc and proper spinal alignment.

2. A patient with adult osteochondrosis involving the cervical spine underwent a surgical intervention known as posterior cervical laminoplasty. The procedure involved creating a canal-expanding hinge on one side of the lamina to alleviate spinal cord compression. The surgery successfully decompressed the spinal cord and improved the patient's neurological symptoms. Postoperative imaging demonstrated adequate decompression and restoration of cervical stability.

3. Surgical treatment was performed for a patient with adult osteochondrosis affecting the thoracic spine. A thoracic fusion procedure was conducted to stabilize the affected segments and alleviate pain. The surgery involved the placement of pedicle screws and rods to achieve spinal fusion. Postoperatively, the patient experienced reduced pain and improved spinal stability, as confirmed by imaging.

4. A patient with adult osteochondrosis of the lumbar spine underwent a surgical intervention called anterior lumbar interbody fusion (ALIF). The procedure involved removing the degenerated disc and inserting an interbody cage with bone graft material to restore disc height and promote fusion. The surgery successfully relieved pain and restored spinal stability. Follow-up imaging confirmed fusion and proper placement of the interbody implant.

5. Surgical intervention was performed for a patient with adult osteochondrosis involving the cervical spine. An anterior cervical discectomy and fusion (ACDF) procedure were conducted to remove the degenerated disc and stabilize the affected segment. The surgery successfully alleviated pain and improved neck function. Postoperative imaging confirmed fusion and proper alignment of the cervical spine.

6. A patient with adult osteochondrosis affecting the thoracic spine underwent a surgical intervention known as transpedicular decompression. The procedure involved removing bone spurs and alleviating spinal cord compression. The surgery successfully relieved the patient's symptoms and improved neurological function. Postoperative imaging demonstrated adequate decompression and restoration of spinal alignment.

7. Surgical treatment was performed for a patient with adult osteochondrosis of the lumbar spine. A posterior lumbar fusion procedure was conducted to stabilize the affected segments and address pain. The surgery involved the insertion of pedicle screws and rods to promote spinal fusion. Postoperatively, the patient experienced reduced pain and improved spinal stability, as confirmed by imaging.

8. A patient with adult osteochondrosis involving the cervical spine underwent a surgical intervention known as laminectomy. The procedure involved removing the lamina to relieve spinal cord compression and alleviate symptoms. The surgery successfully decompressed the spinal cord and improved neurological function. Follow-up imaging confirmed adequate decompression and restoration of cervical stability.

9. Surgical intervention was performed for a patient with adult osteochondrosis affecting the thoracic spine. A thoracic laminectomy procedure was conducted to relieve pressure on the spinal cord and alleviate symptoms. The surgery successfully decompressed the spinal cord and improved the patient's neurological function. Postoperative imaging confirmed adequate decompression and restoration of spinal alignment.

10. A patient with adult osteochondrosis of the lumbar spine underwent a surgical intervention called posterior lumbar interbody fusion (PLIF). The procedure involved removing the degenerated disc and inserting an interbody cage packed with bone graft material to promote fusion. The surgery successfully relieved pain and restored spinal stability. Follow-up imaging confirmed fusion and proper placement of the interbody implant.

1. Surgical intervention was performed for a patient with advanced adult osteochondrosis of the lumbar spine. A lumbar laminectomy with foraminotomy was conducted to decompress the spinal nerves and alleviate pain. The procedure successfully relieved radicular symptoms and improved the patient's functional ability. Postoperative imaging confirmed adequate decompression and restoration of spinal integrity.

2. A patient with adult osteochondrosis involving the cervical spine underwent a surgical intervention known as anterior cervical discectomy and fusion (ACDF). The procedure involved removing the degenerated disc and inserting a bone graft and cervical plate for stabilization. The surgery successfully relieved neck pain and improved neurological function. Postoperative imaging confirmed fusion and proper alignment of the cervical spine.

3. Surgical treatment was performed for a patient with adult osteochondrosis affecting the thoracic spine. A thoracic laminoplasty procedure was conducted to decompress the spinal cord and restore stability. The surgery successfully alleviated pain and improved neurological symptoms. Follow-up imaging confirmed adequate decompression and restoration of spinal alignment.

4. A patient with adult osteochondrosis of the lumbar spine underwent a surgical intervention called posterior lumbar fusion with instrumentation. The procedure involved the placement of pedicle screws and rods to stabilize the affected segments. The surgery successfully addressed pain and restored spinal stability. Postoperative imaging confirmed fusion and proper alignment of the lumbar spine.

5. Surgical intervention was performed for a patient with adult osteochondrosis involving the cervical spine. An anterior cervical corpectomy and fusion (ACCF) procedure were conducted to remove the affected vertebral body and discs, followed by the insertion of a structural bone graft. The surgery successfully alleviated spinal cord compression and improved neck pain. Follow-up imaging demonstrated satisfactory fusion and maintenance of cervical alignment.

6. A patient with adult osteochondrosis affecting the thoracic spine underwent a surgical intervention known as transforaminal lumbar interbody fusion (TLIF). The procedure involved the removal of degenerated discs and the insertion of interbody cages packed with bone graft material. The surgery successfully addressed pain and improved spinal stability. Postoperative imaging confirmed fusion and proper alignment of the thoracic spine.

7. Surgical treatment was performed for a patient with severe adult osteochondrosis of the lumbar spine. A posterior spinal fusion procedure was conducted, utilizing a combination of pedicle screws, rods, and bone grafts. The surgery successfully stabilized the spine and relieved pain. Follow-up imaging confirmed fusion and restoration of spinal alignment.

8. A patient with adult osteochondrosis involving the cervical spine underwent a surgical intervention called posterior cervical fusion with lateral mass screws and rods. The procedure successfully addressed instability and pain, resulting in improved neck function. Postoperative imaging confirmed fusion and proper alignment of the cervical spine.

9. Surgical intervention was performed for a patient with advanced adult osteochondrosis affecting the lumbar spine. A minimally invasive endoscopic discectomy procedure was conducted to remove the degenerated disc and relieve nerve compression. The surgery successfully alleviated radicular symptoms and improved the patient's quality of life. Postoperative imaging confirmed the removal of the affected disc and restoration of spinal integrity.

10. A patient with adult osteochondrosis of the cervical spine underwent a surgical intervention known as cervical laminoplasty. The procedure involved expanding the spinal canal to alleviate spinal cord compression and improve neurological function. The surgery successfully decompressed the spinal cord and restored cervical stability. Follow-up imaging confirmed adequate decompression and maintenance of spinal alignment.

1. Surgical intervention was performed for a patient with adult osteochondrosis of the knee joint, complicated by a severe infection. An emergency arthroscopic debridement and lavage procedure were conducted to remove infected tissues and flush the joint with antibiotic solution. The surgery successfully addressed the infection and relieved joint pain. Postoperative care included a course of intravenous antibiotics and close monitoring for signs of recurrent infection.

2. A patient with adult osteochondrosis affecting the hip joint presented with a severe joint infection. Surgical intervention involved a hip arthrotomy to debride the infected tissues and irrigate the joint with antimicrobial solution. The procedure successfully controlled the infection and alleviated joint pain. Postoperatively, the patient received a targeted antibiotic regimen and close follow-up to monitor for any signs of persistent infection.

3. Operative intervention was undertaken for a patient with adult osteochondrosis involving the shoulder joint, complicated by a severe joint infection. A shoulder arthroscopy with extensive debridement and irrigation was performed to remove infected tissues and flush the joint. The surgery effectively addressed the infection and improved the patient's range of motion. Postoperatively, intravenous antibiotics were administered to combat the infection.

4. A patient with adult osteochondrosis of the ankle joint presented with a severe infection. Surgical intervention involved an ankle arthrotomy with thorough debridement and irrigation to eliminate the infection. The procedure successfully controlled the infection and alleviated joint pain. Postoperatively, the patient received a course of intravenous antibiotics and close monitoring to ensure proper healing and resolution of the infection.

5. Surgical treatment was conducted for a patient with adult osteochondrosis affecting the elbow joint, complicated by a severe infection. An open joint debridement procedure was performed, involving the removal of infected tissues and thorough irrigation. The surgery successfully addressed the infection and improved joint mobility. Postoperatively, the patient received intravenous antibiotics and close surveillance for any signs of recurrent infection.

6. A patient with adult osteochondrosis involving the wrist joint presented with a severe joint infection. Surgical intervention involved an open wrist arthrotomy with debridement and irrigation to remove infected tissues and cleanse the joint. The procedure effectively controlled the infection and relieved joint pain. Postoperatively, a targeted antibiotic regimen was initiated to eradicate the infection.

7. Operative intervention was performed for a patient with adult osteochondrosis of the shoulder joint, complicated by a severe joint infection. A shoulder arthroplasty procedure was conducted, involving the removal of infected tissues, insertion of a prosthetic joint, and thorough irrigation. The surgery successfully addressed the infection and improved shoulder function. Postoperatively, the patient received intravenous antibiotics and underwent regular follow-up to monitor the joint's condition.

8. A patient with adult osteochondrosis affecting the knee joint presented with a severe joint infection. Surgical intervention involved an open knee arthrotomy with extensive debridement and irrigation to remove infected tissues and cleanse the joint. The procedure effectively controlled the infection and relieved joint pain. Postoperatively, the patient received a course of intravenous antibiotics and close monitoring for any signs of recurrent infection.

9. Surgical treatment was undertaken for a patient with adult osteochondrosis involving the ankle joint, complicated by a severe infection. An ankle arthroplasty procedure was performed, involving the removal of infected tissues, insertion of a prosthetic joint, and thorough irrigation. The surgery successfully addressed the infection and improved ankle function. Postoperatively, the patient received intravenous antibiotics and underwent regular follow-up to monitor the joint's condition.

10. A patient with adult osteochondrosis of the elbow joint presented with a severe joint infection. Surgical intervention involved an open elbow arthrotomy with thorough debridement and irrigation to remove infected tissues and cleanse the joint. The procedure effectively controlled the infection and relieved joint pain. Postoperatively, the patient received a targeted antibiotic regimen and close monitoring for any signs of recurrent infection.

1. Surgical intervention was performed for a patient with adult osteochondrosis of the knee joint, complicated by severe joint inflammation. Arthroscopic debridement and synovectomy were conducted to remove inflamed tissues and alleviate joint pain. The surgery successfully addressed the inflammation and improved joint function. Postoperative care included anti-inflammatory medications and physical therapy to aid in recovery.

2. A patient with adult osteochondrosis affecting the hip joint presented with severe joint inflammation. Surgical intervention involved a hip arthrotomy with thorough debridement and irrigation to remove inflamed tissues and promote healing. The procedure effectively reduced inflammation and relieved hip pain. Postoperatively, the patient received anti-inflammatory medications and rehabilitation to restore joint mobility.

3. Operative intervention was undertaken for a patient with adult osteochondrosis involving the shoulder joint, complicated by significant joint inflammation. A shoulder arthroscopy with extensive debridement and synovectomy was performed to address the inflammation and improve joint function. The surgery successfully reduced inflammation and alleviated shoulder pain. Postoperatively, the patient received anti-inflammatory medications and physiotherapy to aid in recovery.

4. A patient with adult osteochondrosis of the ankle joint presented with severe joint inflammation. Surgical intervention involved an ankle arthroscopy with synovial debridement and irrigation to remove inflamed tissues and reduce joint inflammation. The procedure successfully addressed the inflammation and improved ankle function. Postoperatively, the patient received anti-inflammatory medications and immobilization to promote healing.

5. Surgical treatment was conducted for a patient with adult osteochondrosis affecting the elbow joint, complicated by significant joint inflammation. An open joint debridement and synovectomy procedure were performed to remove inflamed tissues and alleviate inflammation. The surgery successfully reduced joint inflammation and improved elbow mobility. Postoperatively, the patient received anti-inflammatory medications and underwent rehabilitation to restore joint function.

6. A patient with adult osteochondrosis involving the wrist joint presented with severe joint inflammation. Surgical intervention involved an open wrist arthrotomy with extensive debridement and synovial excision to address the inflammation and promote healing. The procedure effectively reduced inflammation and relieved wrist pain. Postoperatively, the patient received anti-inflammatory medications and occupational therapy to aid in recovery.

7. Operative intervention was performed for a patient with adult osteochondrosis of the shoulder joint, complicated by significant joint inflammation. A shoulder arthroplasty procedure was conducted, involving the removal of inflamed tissues, insertion of a prosthetic joint, and thorough synovectomy. The surgery successfully addressed the joint inflammation and improved shoulder function. Postoperatively, the patient received anti-inflammatory medications and underwent regular follow-up to monitor the joint's condition.

8. A patient with adult osteochondrosis affecting the knee joint presented with severe joint inflammation. Surgical intervention involved an open knee arthrotomy with extensive synovial debridement and irrigation to address the inflammation and promote healing. The procedure effectively reduced joint inflammation and improved knee function. Postoperatively, the patient received anti-inflammatory medications and participated in physical therapy for rehabilitation.

9. Surgical treatment was undertaken for a patient with adult osteochondrosis involving the ankle joint, complicated by significant joint inflammation. An ankle arthroplasty procedure was performed, involving the removal of inflamed tissues, insertion of a prosthetic joint, and thorough synovial excision. The surgery successfully addressed the joint inflammation and improved ankle function. Postoperatively, the patient received anti-inflammatory medications and underwent regular follow-up to monitor the joint's condition.

10. A patient with adult osteochondrosis of the elbow joint presented with severe joint inflammation. Surgical intervention involved an open elbow arthrotomy with thorough debridement and synovectomy to remove inflamed tissues and alleviate inflammation. The procedure effectively reduced joint inflammation and relieved elbow pain. Postoperatively, the patient received anti-inflammatory medications and participated in occupational therapy for rehabilitation.

1. Surgical intervention was performed for a patient with advanced adult osteochondrosis of the lumbar spine. Given the severity of the diagnosis, a comprehensive postoperative follow-up plan was implemented. This included regular clinical evaluations, imaging studies, and physical therapy sessions to monitor the patient's progress, assess spinal stability, and optimize functional recovery.

2. A patient with adult osteochondrosis involving the cervical spine underwent a surgical intervention due to the severity of the diagnosis. The postoperative follow-up plan included close monitoring of neurological function, regular imaging studies to assess fusion progress, and a customized rehabilitation program to address specific cervical spine challenges and optimize long-term outcomes.

3. Surgical treatment was performed for a patient with severe adult osteochondrosis affecting the thoracic spine. Due to the severity of the diagnosis, an extended postoperative follow-up plan was implemented. This included frequent clinical assessments, periodic imaging studies to evaluate fusion progress, and specialized rehabilitation protocols tailored to address thoracic spine-related limitations and maximize functional recovery.

4. A patient with advanced adult osteochondrosis of the lumbar spine underwent a surgical intervention considering the severity of the diagnosis. The postoperative follow-up plan emphasized frequent clinical visits, imaging studies to assess fusion integrity, and a structured rehabilitation program tailored to address specific lumbar spine challenges and enhance the patient's overall recovery.

5. Surgical intervention was performed for a patient with adult osteochondrosis involving the cervical spine. Given the severity of the diagnosis, the postoperative follow-up plan comprised regular neurological assessments, imaging studies to monitor fusion progress, and a comprehensive rehabilitation program to optimize neck function and mitigate potential complications.

6. A patient with severe adult osteochondrosis affecting the thoracic spine underwent surgical treatment, necessitated by the severity of the diagnosis. The postoperative follow-up plan incorporated frequent clinical evaluations, imaging studies to assess fusion efficacy, and a customized rehabilitation regimen targeting thoracic spine-related impairments, aiming to facilitate functional restoration and mitigate postoperative complications.

7. Surgical intervention was performed for a patient with advanced adult osteochondrosis of the lumbar spine, given the severity of the diagnosis. The postoperative follow-up plan involved regular clinical check-ups, imaging studies to evaluate fusion progression, and a tailored rehabilitation protocol aimed at addressing lumbar spine-specific challenges and optimizing the patient's long-term outcomes.

8. A patient with adult osteochondrosis involving the cervical spine underwent a surgical intervention due to the severity of the diagnosis. The postoperative follow-up plan encompassed frequent neurologic assessments, imaging studies to monitor fusion success, and a specialized rehabilitation program designed to target cervical spine-related limitations and enhance functional recovery.

9. Surgical treatment was performed for a patient with severe adult osteochondrosis affecting the thoracic spine, reflecting the severity of the diagnosis. The postoperative follow-up plan consisted of regular clinical evaluations, imaging studies to track fusion development, and an individualized rehabilitation regimen focused on thoracic spine-specific impairments, with the goal of maximizing functional restoration and minimizing postoperative complications.

10. A patient with advanced adult osteochondrosis of the lumbar spine underwent surgical intervention based on the severity of the diagnosis. The postoperative follow-up plan included frequent clinical assessments, imaging studies to assess fusion progress, and a comprehensive rehabilitation program tailored to address specific challenges associated with the lumbar spine, aiming to optimize long-term recovery and functional outcomes.

## M42.9 Spinal osteochondrosis, unspecified

1. Patient underwent surgical intervention for spinal osteochondrosis. A posterior approach was utilized to access the affected area. Decompression was performed, followed by removal of the osteophytes and cartilage fragments. The affected intervertebral disc was replaced with an artificial disc. The procedure was successful, and the patient's symptoms improved postoperatively.

2. Operative intervention for spinal osteochondrosis involved a minimally invasive approach. The surgeon accessed the affected vertebral level using a small incision and specialized instruments. The degenerated disc was removed, and a fusion was performed using a bone graft and spinal instrumentation. The patient tolerated the procedure well, and early postoperative imaging showed appropriate alignment.

3. Surgical management of spinal osteochondrosis included a microdiscectomy procedure. The surgeon performed a small incision and used a microscope to visualize and remove the herniated disc material causing nerve compression. The procedure relieved the patient's radicular symptoms, and the postoperative period was uneventful.

4. Patient with spinal osteochondrosis underwent a lateral lumbar interbody fusion procedure. A lateral approach was employed to access the affected disc space. The degenerated disc was removed, and an interbody cage with bone graft was inserted. Additional posterior stabilization was achieved with pedicle screw fixation. The patient experienced improvement in pain and neurologic symptoms postoperatively.

5. Operative intervention for spinal osteochondrosis involved an endoscopic discectomy procedure. A small incision was made, and an endoscope was used to visualize and remove the herniated disc material. The procedure successfully relieved the patient's radicular pain, and the incision site healed well without complications.

6. Surgical treatment for spinal osteochondrosis consisted of an anterior cervical discectomy and fusion procedure. The surgeon accessed the affected disc space through a small incision in the front of the neck. The degenerated disc was removed, and a bone graft and plate were used to achieve fusion. The patient experienced relief from neck and arm pain postoperatively.

7. Patient with spinal osteochondrosis underwent a percutaneous laser disc decompression procedure. A needle was inserted into the affected disc under fluoroscopic guidance, and laser energy was used to ablate the herniated disc material. The procedure provided significant pain relief, and the patient was discharged on the same day.

8. Surgical intervention for spinal osteochondrosis involved an artificial disc replacement procedure. The surgeon accessed the affected disc space through an anterior approach. The degenerated disc was removed, and an artificial disc prosthesis was inserted. The procedure resulted in improved range of motion and reduced pain for the patient.

9. Patient underwent a minimally invasive spinal fusion procedure for spinal osteochondrosis. The surgeon accessed the affected disc space using a tubular retractor system. The degenerated disc was removed, and a bone graft and interbody cage were inserted. Postoperatively, the patient experienced resolution of back pain and improved spinal stability.

10. Operative treatment for spinal osteochondrosis involved a nucleoplasty procedure. A needle was inserted into the affected disc, and radiofrequency energy was used to ablate and shrink the herniated disc material. The procedure successfully alleviated the patient's radicular symptoms, and no complications were noted during the postoperative period.

1. Surgical intervention for spinal osteochondrosis included a posterior lumbar interbody fusion procedure. The surgeon accessed the affected disc space through a midline incision. The degenerated disc was removed, and an interbody cage filled with bone graft was inserted. Postoperatively, the patient experienced relief from back pain and showed signs of successful fusion on follow-up imaging.

2. Patient with spinal osteochondrosis underwent a percutaneous endoscopic discectomy procedure. A small incision was made, and an endoscope was used to visualize and remove the herniated disc material. The procedure effectively relieved the patient's radicular symptoms, and the incision site healed without complications.

3. Surgical management of spinal osteochondrosis involved a transforaminal lumbar interbody fusion procedure. The surgeon accessed the affected disc space through a unilateral approach. The degenerated disc was removed, and a bone graft and interbody cage were inserted. The patient reported reduced back pain and improved functional outcomes after the surgery.

4. Operative intervention for spinal osteochondrosis included a laminectomy procedure. The surgeon performed a partial or complete removal of the lamina to decompress the spinal cord and nerve roots. The procedure successfully relieved the patient's symptoms of spinal cord compression and radiculopathy, leading to improved neurological function.

5. Patient with spinal osteochondrosis underwent a dynamic stabilization procedure. The surgeon used specialized implants to stabilize the affected spinal segment while preserving some degree of motion. The procedure provided stability and reduced pain for the patient, promoting a quicker recovery and return to daily activities.

6. Surgical treatment for spinal osteochondrosis consisted of a disc arthroplasty procedure. The surgeon removed the degenerated disc and replaced it with an artificial disc prosthesis to restore disc height and maintain spinal motion. The patient experienced improved pain relief and preserved mobility postoperatively.

7. Operative intervention for spinal osteochondrosis involved a nucleoplasty and percutaneous laser disc decompression procedure. The surgeon used a combination of techniques to ablate and shrink the herniated disc material, relieving pressure on the nerves. The procedure resulted in significant pain relief and improved function for the patient.

8. Patient with spinal osteochondrosis underwent a posterior cervical laminoplasty procedure. The surgeon created more space within the spinal canal by lifting the lamina, relieving pressure on the spinal cord. The procedure successfully alleviated the patient's symptoms of spinal cord compression and improved neurological function.

9. Surgical management of spinal osteochondrosis included an oblique lumbar interbody fusion procedure. The surgeon accessed the affected disc space through a lateral approach, allowing for greater disc height restoration and stability. The patient experienced relief from back pain and improved spinal alignment following the procedure.

10. Operative intervention for spinal osteochondrosis involved an endoscopic assisted percutaneous fusion procedure. The surgeon utilized endoscopic guidance to perform a minimally invasive fusion, promoting spinal stability and reducing pain. The patient showed good fusion progress and reported significant improvement in symptoms postoperatively.

1. Surgical intervention for spinal osteochondrosis included a posterior lumbar interbody fusion procedure under general anesthesia. The surgeon accessed the affected disc space through a midline incision. The degenerated disc was removed, and an interbody cage filled with bone graft was inserted. The patient tolerated the procedure well, and appropriate anesthesia dosages were administered throughout to ensure optimal pain management and comfort.

2. Patient with spinal osteochondrosis underwent a percutaneous endoscopic discectomy procedure under local anesthesia with conscious sedation. A small incision was made, and an endoscope was used to visualize and remove the herniated disc material. The patient remained awake and cooperative during the procedure, with the anesthesia dosage carefully adjusted to maintain comfort and minimize any discomfort.

3. Surgical management of spinal osteochondrosis involved a transforaminal lumbar interbody fusion procedure under spinal anesthesia. The surgeon accessed the affected disc space through a unilateral approach. The degenerated disc was removed, and a bone graft and interbody cage were inserted. The patient experienced effective pain control and remained stable throughout the surgery due to appropriate administration of spinal anesthesia.

4. Operative intervention for spinal osteochondrosis included a laminectomy procedure under general anesthesia. The surgeon performed a partial or complete removal of the lamina to decompress the spinal cord and nerve roots. The anesthesia team carefully monitored the patient's vital signs and adjusted the dosage accordingly to maintain optimal depth of anesthesia and ensure a smooth intraoperative course.

5. Patient with spinal osteochondrosis underwent a dynamic stabilization procedure under combined spinal and epidural anesthesia. The surgeon used specialized implants to stabilize the affected spinal segment while preserving some degree of motion. The patient received a balanced dosage of spinal and epidural anesthesia to achieve adequate surgical anesthesia and postoperative pain control.

6. Surgical treatment for spinal osteochondrosis consisted of a disc arthroplasty procedure under general anesthesia. The surgeon removed the degenerated disc and replaced it with an artificial disc prosthesis to restore disc height and maintain spinal motion. The anesthesia team carefully titrated the dosage of general anesthesia to ensure optimal depth of anesthesia and patient comfort throughout the procedure.

7. Operative intervention for spinal osteochondrosis involved a nucleoplasty and percutaneous laser disc decompression procedure under local anesthesia with intravenous sedation. The surgeon used a combination of techniques to ablate and shrink the herniated disc material, relieving pressure on the nerves. The anesthesia dosage was adjusted to maintain a relaxed and pain-free state for the patient during the procedure.

8. Patient with spinal osteochondrosis underwent a posterior cervical laminoplasty procedure under general anesthesia. The surgeon created more space within the spinal canal by lifting the lamina, relieving pressure on the spinal cord. The anesthesia team carefully monitored the patient's vital signs and adjusted the anesthesia dosage to ensure optimal depth of anesthesia and patient safety.

9. Surgical management of spinal osteochondrosis included an oblique lumbar interbody fusion procedure under regional anesthesia. The surgeon accessed the affected disc space through a lateral approach, allowing for greater disc height restoration and stability. The patient received appropriate regional anesthesia dosage to ensure effective pain control during and after the surgery.

10. Operative intervention for spinal osteochondrosis involved an endoscopic assisted percutaneous fusion procedure under general anesthesia. The surgeon utilized endoscopic guidance to perform a minimally invasive fusion, promoting spinal stability and reducing pain. The anesthesia dosage was carefully managed throughout the procedure to maintain the patient's comfort and safety.

1. Patient with spinal osteochondrosis and severe bone erosion underwent an anterior cervical discectomy and fusion procedure. The surgeon accessed the affected disc space through a small incision in the front of the neck. The eroded disc and adjacent bone were carefully removed, and a bone graft and plate were used to achieve fusion. The procedure successfully stabilized the spine and addressed the bone erosion.

2. Surgical intervention for spinal osteochondrosis and significant bone erosion involved a posterior lumbar interbody fusion procedure. The surgeon accessed the affected disc space through a midline incision. Extensive bone erosion was noted, requiring meticulous debridement and removal of necrotic bone. A bone graft and interbody cage were then inserted, promoting fusion and restoring spinal stability.

3. Patient with spinal osteochondrosis and advanced bone erosion underwent a minimally invasive vertebral augmentation procedure. Using image guidance, the surgeon injected bone cement into the eroded vertebral body, stabilizing the affected segment. The procedure provided immediate pain relief and improved spinal integrity, despite the presence of bone erosion.

4. Operative intervention for spinal osteochondrosis and associated bone erosion included a posterior cervical laminectomy and fusion procedure. The surgeon performed a decompression by removing the affected lamina and ligamentum flavum. Bone erosion was addressed through meticulous debridement, followed by fusion using bone graft and instrumentation. The procedure successfully alleviated compression symptoms and stabilized the spine.

5. Surgical management of spinal osteochondrosis and extensive bone erosion involved an anterior lumbar corpectomy and fusion procedure. The surgeon accessed the affected vertebral body through an anterior approach, removing the eroded vertebral body and adjacent discs. A structural graft and instrumentation were utilized to restore vertebral height and promote fusion, addressing the bone erosion and maintaining spinal stability.

6. Patient with spinal osteochondrosis and notable bone erosion underwent a percutaneous kyphoplasty procedure. The surgeon inserted specialized balloons into the eroded vertebral body, creating a cavity. Bone cement was then injected into the cavity, stabilizing the bone and alleviating pain. The procedure successfully addressed the bone erosion and provided immediate symptomatic relief.

7. Surgical intervention for spinal osteochondrosis and significant bone erosion included an anterior lumbar interbody fusion procedure. The surgeon accessed the affected disc space through an anterior approach, meticulously removing the eroded disc and adjacent bone. A structural graft and fixation were utilized to restore disc height, address bone erosion, and promote spinal fusion.

8. Patient with spinal osteochondrosis and extensive bone erosion underwent a posterior vertebral column resection procedure. The surgeon performed a complete excision of the eroded vertebral segment, followed by fusion using bone graft and instrumentation. The procedure successfully addressed the severe bone erosion, corrected spinal deformity, and achieved spinal stabilization.

9. Surgical management of spinal osteochondrosis and advanced bone erosion involved a minimally invasive lateral lumbar interbody fusion procedure. The surgeon accessed the affected disc space through a lateral approach, meticulously removing the eroded disc and preparing the endplates. A bone graft and interbody cage were then inserted to restore disc height, address bone erosion, and promote fusion.

10. Operative intervention for spinal osteochondrosis and extensive bone erosion included a transforaminal lumbar interbody fusion procedure. The surgeon accessed the affected disc space through a unilateral approach, addressing the eroded disc and adjacent bone. Extensive bone grafting and instrumentation were utilized to restore disc height, stabilize the spine, and address the underlying bone erosion.

1. Patient with spinal osteochondrosis and severe bone pain underwent a radiofrequency ablation procedure. The surgeon used specialized needles to apply thermal energy to the affected bone, targeting and ablating the pain-causing nerves. The procedure successfully provided significant pain relief, improving the patient's quality of life despite the underlying bone pathology.

2. Surgical intervention for spinal osteochondrosis and severe bone pain involved a minimally invasive spinal fusion procedure. The surgeon accessed the affected disc space through a small incision, meticulously addressing the degenerated disc and bone pathology. Bone graft and instrumentation were utilized to promote fusion and stabilize the spine, leading to a reduction in severe bone pain.

3. Patient with spinal osteochondrosis and debilitating bone pain underwent a vertebroplasty procedure. Using image guidance, the surgeon injected bone cement into the affected vertebral body, stabilizing the bone and providing immediate pain relief. The procedure successfully addressed the severe bone pain and improved the patient's functional capacity.

4. Surgical management of spinal osteochondrosis and severe bone pain involved a decompressive laminectomy procedure. The surgeon performed a thorough decompression, relieving pressure on the affected nerves and reducing bone-related pain. The procedure successfully alleviated severe bone pain and improved the patient's overall symptomatology.

5. Operative intervention for spinal osteochondrosis and severe bone pain included a spinal cord stimulator implantation procedure. The surgeon placed a small device near the spinal cord that delivered electrical impulses, effectively disrupting the transmission of pain signals. The procedure significantly reduced severe bone pain and improved the patient's ability to engage in daily activities.

6. Patient with spinal osteochondrosis and persistent severe bone pain underwent a neurolysis procedure. The surgeon used specialized tools to meticulously remove scar tissue and adhesions surrounding the affected nerves, relieving the compression and reducing bone-related pain. The procedure successfully addressed the severe bone pain, improving the patient's comfort and functionality.

7. Surgical intervention for spinal osteochondrosis and severe bone pain involved an epidural steroid injection procedure. The surgeon injected a corticosteroid medication into the epidural space, targeting the inflamed nerves and reducing bone-related pain. The procedure provided significant pain relief, allowing the patient to manage their symptoms effectively.

8. Patient with spinal osteochondrosis and unrelenting severe bone pain underwent a spinal cord stimulation trial. The surgeon temporarily implanted a spinal cord stimulation device to evaluate its effectiveness in reducing pain. The trial period successfully alleviated the severe bone pain, leading to the subsequent permanent implantation of the device for long-term pain management.

9. Surgical management of spinal osteochondrosis and severe bone pain involved a disc replacement procedure. The surgeon removed the degenerated disc and replaced it with an artificial disc prosthesis, relieving pressure on the affected nerves and reducing bone-related pain. The procedure significantly improved severe bone pain and restored spinal function.

10. Operative intervention for spinal osteochondrosis and severe bone pain included a targeted nerve block procedure. The surgeon administered a local anesthetic medication directly to the affected nerves, blocking pain signals and providing immediate relief. The procedure effectively addressed severe bone pain, allowing the patient to experience improved comfort and mobility.

1. Patient with spinal osteochondrosis and severe bone pain underwent a microdiscectomy procedure. The surgeon performed a minimally invasive surgery to remove the herniated disc material, relieving pressure on the affected nerves and alleviating bone-related pain. The procedure resulted in significant pain reduction and improved the patient's overall functional status.

2. Surgical intervention for spinal osteochondrosis and severe bone pain involved a posterior lumbar fusion procedure. The surgeon accessed the affected spinal segment through a midline incision, meticulously addressing the degenerated disc and bone pathology. The fusion procedure successfully stabilized the spine, reducing bone pain and providing long-term relief.

3. Patient with spinal osteochondrosis and debilitating bone pain underwent a spinal cord stimulator implantation procedure. The surgeon placed a small device near the spinal cord, which delivered electrical impulses to disrupt pain signals. The surgical intervention effectively mitigated severe bone pain, enhancing the patient's quality of life.

4. Surgical management of spinal osteochondrosis and severe bone pain involved a laminotomy procedure. The surgeon performed a targeted removal of a portion of the lamina to relieve pressure on the affected nerves and reduce bone-related pain. The procedure successfully alleviated severe bone pain and restored functionality.

5. Operative intervention for spinal osteochondrosis and severe bone pain included a vertebroplasty procedure. The surgeon used a specialized cement to stabilize the affected vertebrae, effectively reducing bone pain. The surgical intervention led to significant pain relief and improved the patient's ability to perform daily activities.

6. Patient with spinal osteochondrosis and intractable bone pain underwent a dorsal root ganglion stimulation procedure. The surgeon placed small electrodes near the affected dorsal root ganglia, delivering low-level electrical impulses to modulate pain signals. The surgical intervention successfully alleviated severe bone pain and improved the patient's overall well-being.

7. Surgical intervention for spinal osteochondrosis and severe bone pain involved an anterior cervical discectomy and fusion procedure. The surgeon accessed the affected disc space through a small incision in the front of the neck, addressing the degenerated disc and bone pathology. The fusion procedure provided stability, reducing bone pain and enhancing the patient's quality of life.

8. Patient with spinal osteochondrosis and relentless bone pain underwent a decompressive laminoplasty procedure. The surgeon performed a laminoplasty to create more space within the spinal canal, relieving pressure on the affected nerves and reducing bone-related pain. The surgical intervention successfully alleviated severe bone pain and improved neurological function.

9. Surgical management of spinal osteochondrosis and severe bone pain involved a posterior cervical fusion procedure. The surgeon accessed the affected spinal segment through a posterior approach, meticulously addressing the degenerated disc and bone pathology. The fusion procedure effectively stabilized the spine, resulting in significant pain reduction and improved patient outcomes.

10. Operative intervention for spinal osteochondrosis and severe bone pain included a percutaneous endoscopic discectomy procedure. The surgeon performed a minimally invasive surgery to remove the herniated disc material, relieving compression on the affected nerves and mitigating bone-related pain. The surgical intervention led to significant pain relief and improved the patient's functional capacity.

1. Patient with spinal osteochondrosis and severe bone pain underwent a minimally invasive lumbar decompression procedure. The surgeon utilized specialized instruments to remove the bony overgrowth and alleviate compression on the nerves, resulting in significant pain reduction and improved functionality.

2. Surgical intervention for spinal osteochondrosis and severe bone pain involved a posterior cervical foraminotomy procedure. The surgeon accessed the affected cervical vertebrae, removing bone spurs and enlarging the neural foramina to relieve nerve impingement. The procedure successfully alleviated severe bone pain and improved the patient's range of motion.

3. Patient with spinal osteochondrosis and incapacitating bone pain underwent a laminoplasty procedure. The surgeon performed a cervical laminoplasty to expand the spinal canal and relieve pressure on the spinal cord, resulting in significant pain relief and improved neurological function.

4. Surgical management of spinal osteochondrosis and severe bone pain involved a posterior lumbar laminectomy procedure. The surgeon performed a meticulous removal of the lamina to decompress the spinal cord and nerves, alleviating bone-related pain and improving the patient's overall well-being.

5. Operative intervention for spinal osteochondrosis and severe bone pain included an artificial disc replacement procedure. The surgeon removed the degenerated disc and replaced it with an artificial disc implant, restoring disc height and alleviating bone pain. The procedure resulted in significant pain reduction and improved spinal mobility.

6. Patient with spinal osteochondrosis and intractable bone pain underwent a sacroiliac joint fusion procedure. The surgeon utilized bone graft and specialized implants to stabilize the sacroiliac joint, reducing bone-related pain and improving the patient's functional capacity.

7. Surgical intervention for spinal osteochondrosis and severe bone pain involved a transpedicular vertebral augmentation procedure. The surgeon used a minimally invasive approach to inject bone cement into the eroded vertebral body, stabilizing the bone and alleviating pain. The procedure successfully addressed severe bone pain and improved the patient's overall quality of life.

8. Patient with spinal osteochondrosis and debilitating bone pain underwent a minimally invasive lateral lumbar fusion procedure. The surgeon accessed the affected disc space through a lateral approach, addressing the degenerated disc and bone pathology. The fusion procedure provided stability, reducing bone pain and restoring spinal function.

9. Surgical management of spinal osteochondrosis and severe bone pain involved a percutaneous nucleoplasty procedure. The surgeon used radiofrequency energy to ablate and shrink the herniated disc material, relieving pressure on the nerves and mitigating bone-related pain. The procedure resulted in significant pain relief and improved the patient's functional status.

10. Operative intervention for spinal osteochondrosis and severe bone pain included an oblique lumbar corpectomy procedure. The surgeon accessed the affected vertebral body through an oblique approach, meticulously removing the eroded disc and bone. A structural graft and instrumentation were utilized to restore vertebral height, stabilize the spine, and alleviate bone pain.

1. Patient with spinal osteochondrosis and severe infection in the sacroiliac joint underwent a surgical debridement and irrigation procedure. The surgeon accessed the joint through a minimally invasive approach, meticulously removing infected tissue and irrigating the area with antimicrobial solutions. The procedure successfully controlled the infection and provided relief from severe joint pain.

2. Surgical intervention for spinal osteochondrosis and a severe infection in the facet joint involved an arthrodesis procedure. The surgeon accessed the affected joint through a posterior approach, removing the infected joint surfaces and fusing the adjacent vertebrae. The procedure addressed the severe infection and stabilized the spine, alleviating joint-related pain.

3. Patient with spinal osteochondrosis and a severe infection in the hip joint underwent a hip arthroplasty procedure. The surgeon removed the infected joint components and replaced them with prosthetic implants, effectively eradicating the infection and relieving severe joint pain.

4. Surgical management of spinal osteochondrosis and a severe infection in the shoulder joint involved a septic joint washout procedure. The surgeon accessed the joint through small incisions, thoroughly irrigating and removing infected material. The procedure successfully controlled the infection and reduced severe joint pain.

5. Operative intervention for spinal osteochondrosis and a severe infection in the knee joint included an open joint debridement procedure. The surgeon accessed the joint through a larger incision, meticulously removing infected tissue and flushing the area with sterile solutions. The procedure effectively treated the infection and alleviated severe joint pain.

6. Patient with spinal osteochondrosis and a severe infection in the ankle joint underwent an ankle arthrodesis procedure. The surgeon accessed the joint through a combination of open and minimally invasive techniques, removing the infected joint surfaces and fusing the bones together. The procedure successfully eradicated the infection and relieved severe joint pain.

7. Surgical intervention for spinal osteochondrosis and a severe infection in the elbow joint involved an arthroscopic debridement procedure. The surgeon accessed the joint through small incisions, using specialized instruments to remove infected tissue and flush the joint with antibiotics. The procedure effectively treated the infection and reduced severe joint pain.

8. Patient with spinal osteochondrosis and a severe infection in the temporomandibular joint underwent a joint lavage procedure. The surgeon accessed the joint through a small incision or cannula, flushing the joint with sterile solutions to remove infected material. The procedure successfully treated the infection and alleviated severe joint pain.

9. Surgical management of spinal osteochondrosis and a severe infection in the wrist joint involved an open joint irrigation and drainage procedure. The surgeon accessed the joint through a larger incision, thoroughly irrigating the joint space and removing infected material. The procedure effectively controlled the infection and reduced severe joint pain.

10. Operative intervention for spinal osteochondrosis and a severe infection in the shoulder joint included an open joint irrigation and debridement procedure. The surgeon accessed the joint through a larger incision, meticulously removing infected tissue and irrigating the joint with antimicrobial solutions. The procedure successfully treated the infection and alleviated severe joint pain.

1. Patient with spinal osteochondrosis and severe joint inflammation underwent a corticosteroid injection procedure. The surgeon injected a potent anti-inflammatory medication directly into the affected joint, reducing inflammation and providing relief from joint pain.

2. Surgical intervention for spinal osteochondrosis and moderate joint inflammation involved a synovectomy procedure. The surgeon meticulously removed the inflamed synovial tissue, effectively addressing the underlying inflammation and alleviating joint pain.

3. Patient with spinal osteochondrosis and chronic joint inflammation underwent an arthroscopic lavage procedure. The surgeon accessed the joint through small incisions, flushing the joint with sterile solutions to reduce inflammation and improve joint function.

4. Surgical management of spinal osteochondrosis and severe joint inflammation involved a joint immobilization procedure. The surgeon applied a cast or splint to restrict joint movement, allowing the inflamed joint to rest and heal, thereby reducing inflammation and alleviating pain.

5. Operative intervention for spinal osteochondrosis and acute joint inflammation included a joint aspiration procedure. The surgeon used a needle and syringe to remove excess fluid and inflammatory substances from the affected joint, providing immediate relief from inflammation and reducing joint pain.

6. Patient with spinal osteochondrosis and recurring joint inflammation underwent a biological therapy procedure. The surgeon administered targeted injections of biologic medications to suppress the inflammatory response, effectively managing the inflammation and alleviating joint pain.

7. Surgical intervention for spinal osteochondrosis and moderate joint inflammation involved a joint arthroscopy procedure. The surgeon used specialized instruments to visualize and treat the inflamed joint, addressing the underlying pathology and reducing inflammation and associated pain.

8. Patient with spinal osteochondrosis and severe joint inflammation underwent a platelet-rich plasma (PRP) injection procedure. The surgeon collected the patient's own blood, processed it to concentrate platelets, and injected the PRP into the affected joint, promoting tissue healing, reducing inflammation, and relieving joint pain.

9. Surgical management of spinal osteochondrosis and chronic joint inflammation involved a joint debridement procedure. The surgeon accessed the joint, removing damaged or inflamed tissue, and thoroughly irrigated the joint, reducing inflammation and providing relief from joint pain.

10. Operative intervention for spinal osteochondrosis and severe joint inflammation included an ultrasound-guided injection procedure. The surgeon used real-time ultrasound imaging to accurately place anti-inflammatory medication into the inflamed joint, effectively targeting and reducing inflammation, resulting in significant pain relief.

1. Patient diagnosed with mild spinal osteochondrosis will undergo conservative management with physical therapy and regular follow-up appointments to monitor symptom progression and provide appropriate treatment adjustments if needed.

2. Patient diagnosed with moderate spinal osteochondrosis will undergo a combination of physical therapy, pain management techniques, and regular follow-up appointments to assess the effectiveness of treatment and consider further interventions such as epidural steroid injections or minimally invasive procedures.

3. Patient diagnosed with severe spinal osteochondrosis will undergo surgical intervention, followed by a comprehensive rehabilitation program and frequent follow-up appointments to monitor post-operative recovery, manage pain, and optimize functional outcomes.

4. Patient diagnosed with mild joint inflammation related to spinal osteochondrosis will receive a course of nonsteroidal anti-inflammatory drugs (NSAIDs) and will have a follow-up appointment after four weeks to assess the response to treatment and consider further steps if necessary.

5. Patient diagnosed with moderate joint inflammation related to spinal osteochondrosis will receive a corticosteroid injection and will have a follow-up appointment after two weeks to evaluate the response and determine the need for additional interventions such as physical therapy or alternative medications.

6. Patient diagnosed with severe joint inflammation related to spinal osteochondrosis will undergo a series of corticosteroid injections, followed by close monitoring with frequent follow-up appointments to assess the response, manage symptoms, and explore other treatment options if needed, such as biological therapies or surgical interventions.

7. Patient diagnosed with mild bone erosion associated with spinal osteochondrosis will receive conservative management with pain medication and activity modifications. They will have a follow-up appointment after six weeks to evaluate the progression of bone erosion and consider additional interventions if necessary.

8. Patient diagnosed with moderate bone erosion associated with spinal osteochondrosis will receive a combination of pain management techniques and disease-modifying medications. They will have regular follow-up appointments every three months to monitor the extent of bone erosion and adjust the treatment plan accordingly.

9. Patient diagnosed with severe bone erosion associated with spinal osteochondrosis will be referred for surgical consultation. A follow-up appointment will be scheduled post-surgery to assess the outcome, manage pain, and monitor the healing process, followed by long-term follow-up visits to address any potential complications or recurrent erosion.

10. Patient diagnosed with mild spinal osteochondrosis and severe bone pain will receive conservative treatment with a combination of pain medications, physical therapy, and lifestyle modifications. They will have regular follow-up appointments to evaluate the response to treatment, manage pain levels, and consider additional interventions if necessary based on symptom severity.

## M43.0 Spondylolysis

1. Operative Note: Patient underwent a posterior spinal fusion procedure to address Spondylolysis at L5. After exposure and decompression, pedicle screws were inserted bilaterally. A thorough discectomy and bone grafting were performed. Laminectomy and facet joint fusion were completed. Intraoperative fluoroscopy confirmed proper hardware placement and alignment. The wound was closed in layers. The patient tolerated the procedure well without complications.

2. Operative Note: A minimally invasive approach was used to treat Spondylolysis at L4. Under fluoroscopic guidance, a percutaneous pedicle screw fixation was performed bilaterally. A discectomy and interbody fusion were carried out using an expandable cage. The wound was closed meticulously. The patient remained stable throughout the procedure, and postoperative imaging confirmed satisfactory implant positioning.

3. Operative Note: Patient with Spondylolysis underwent a microdiscectomy and posterolateral fusion at L3-L4. The lamina was partially resected, and pedicle screws were placed bilaterally. After meticulous decortication, bone graft material was packed into the posterolateral gutter. The wound was closed in layers. The patient tolerated the procedure well, and postoperative radiographs demonstrated appropriate fusion hardware placement.

4. Operative Note: A lateral interbody fusion was performed to address Spondylolysis at L5-S1. After creating a working corridor, a discectomy was carried out, and a PEEK cage was inserted into the disc space. Additional fixation was achieved with pedicle screws and rods. The wound was closed meticulously. The patient's intraoperative and postoperative course was uneventful.

5. Operative Note: Patient with Spondylolysis underwent a transforaminal lumbar interbody fusion at L4-L5. The foraminal area was exposed, and a discectomy was performed. A titanium cage was placed in the disc space, followed by pedicle screw fixation. Intraoperative imaging confirmed proper hardware placement. The wound was closed in layers. The patient tolerated the procedure well, with no immediate postoperative complications.

6. Operative Note: A posterior lumbar interbody fusion was performed to address Spondylolysis at L3-L4. After exposure, a discectomy was carried out, and the disc space was prepared. An interbody cage packed with bone graft material was placed, and pedicle screws were inserted bilaterally for additional stability. Fluoroscopy confirmed satisfactory hardware positioning. The wound was closed meticulously. The patient had an uneventful recovery period.

7. Operative Note: Patient with Spondylolysis underwent an anterior lumbar interbody fusion at L5-S1. An oblique retroperitoneal approach was utilized. After discectomy and endplate preparation, a titanium cage filled with bone graft was placed in the disc space. Additional fixation was achieved using anterior plate and screw constructs. The surgical wound was closed in layers. The patient tolerated the procedure well, without immediate complications.

8. Operative Note: A direct pars repair was performed to address Spondylolysis at L4. Under fluoroscopic guidance, a small midline incision was made over the affected pars interarticularis. The pars defect was identified and meticulously debrided. Suture anchors were placed, and a strong nonabsorbable suture was used to repair the defect. The wound was closed meticulously. The patient had an uneventful immediate postoperative course.

9. Operative Note: Patient with Spondylolysis underwent a percutaneous pedicle screw fixation at L3-L4. Under fluoroscopic guidance, screws were inserted bilaterally. A minimally invasive technique was used to minimize soft tissue trauma. The wound was closed meticulously. The patient tolerated the procedure well, without any complications during the immediate postoperative period. Follow-up imaging confirmed appropriate screw placement and alignment.

10. Operative Note: An endoscopic lumbar interbody fusion was performed to address Spondylolysis at L5-S1. Access was gained through small percutaneous incisions. The disc space was visualized using an endoscope, and discectomy was performed. A cage packed with bone graft was inserted, and pedicle screws were placed for additional stability. The surgical wounds were closed meticulously. The patient had an uneventful recovery period.

1. Operative Note: Patient underwent a bilateral direct pars repair to address Spondylolysis at L3-L4. A midline incision was made, and the pars defects were meticulously debrided. Suture anchors were placed, and strong nonabsorbable sutures were used for repair. Fluoroscopic imaging confirmed satisfactory alignment. The wound was closed in layers. The patient tolerated the procedure well, and there were no immediate postoperative complications.

2. Operative Note: A dynamic stabilization procedure was performed to treat Spondylolysis at L4-L5. Pedicle screws were inserted bilaterally, and flexible rods were connected. The paraspinal muscles were meticulously preserved. The wound was closed meticulously. The patient remained stable throughout the procedure, and postoperative imaging showed appropriate hardware positioning and stability.

3. Operative Note: Patient with Spondylolysis underwent a combined anterior and posterior spinal fusion at L5-S1. An anterior approach was used for discectomy and cage placement, followed by posterior pedicle screw insertion and fusion. The wounds were closed meticulously. The patient tolerated the procedure well, with no immediate postoperative complications noted.

4. Operative Note: A percutaneous vertebral augmentation procedure was performed to address Spondylolysis at L3. Under fluoroscopic guidance, bone cement was injected into the fractured pars interarticularis. The procedure was completed successfully without any complications. The patient tolerated the procedure well, and postoperative imaging confirmed adequate cement distribution and stabilization.

5. Operative Note: Patient with Spondylolysis underwent a unilateral direct pars repair at L4. A small incision was made over the affected pars interarticularis, and meticulous debridement was performed. Suture anchors were placed, and the defect was repaired using nonabsorbable sutures. The wound was closed meticulously. The patient had an uneventful immediate postoperative course and showed signs of healing on follow-up examinations.

6. Operative Note: A minimally invasive lateral lumbar interbody fusion was performed to address Spondylolysis at L3-L4. The procedure involved accessing the disc space through a small incision and inserting an interbody cage packed with bone graft. The wound was closed meticulously. The patient tolerated the procedure well, and postoperative imaging confirmed proper cage placement and restoration of disc height.

7. Operative Note: Patient with Spondylolysis underwent a percutaneous facet screw fixation at L4-L5. Under fluoroscopic guidance, screws were inserted bilaterally to stabilize the affected facet joints. The procedure was performed successfully without complications. The wounds were closed meticulously. The patient had an uneventful immediate postoperative period and demonstrated stability on follow-up imaging.

8. Operative Note: A hybrid surgical approach was used to address Spondylolysis at L5-S1. An anterior discectomy and cage placement were followed by a posterior instrumented fusion with pedicle screws and rods. The surgical wounds were closed meticulously. The patient tolerated the procedure well, with no immediate postoperative complications noted.

9. Operative Note: Patient with Spondylolysis underwent a percutaneous facet fusion at L3-L4. Under fluoroscopic guidance, bone graft material was placed in the affected facet joints to promote fusion. The procedure was completed successfully without any complications. The wounds were closed meticulously. The patient had an uneventful immediate postoperative course and showed signs of fusion on subsequent follow-up examinations.

10. Operative Note: A posterior dynamic stabilization procedure was performed to address Spondylolysis at L4. Pedicle screws and flexible rods were inserted to provide stability while allowing controlled motion. The paraspinal muscles were meticulously preserved. The wounds were closed meticulously. The patient tolerated the procedure well, and postoperative imaging showed appropriate hardware positioning and dynamic stability.

1. Operative Note: Patient underwent a posterior spinal fusion procedure to address Spondylolysis at L5 under general anesthesia. Anesthesia was induced with 200 mg of propofol and maintained with sevoflurane. Analgesia was achieved with 100 mcg of fentanyl and 1 g of acetaminophen intravenously. The patient tolerated the procedure well, and intraoperative monitoring parameters remained stable throughout.

2. Operative Note: A minimally invasive approach was used to treat Spondylolysis at L4. The procedure was performed under monitored anesthesia care (MAC) with conscious sedation. Midazolam was administered intravenously at a total dose of 4 mg, and local anesthesia with lidocaine was used for surgical site infiltration. The patient remained comfortable and cooperative throughout the procedure.

3. Operative Note: Patient with Spondylolysis underwent a microdiscectomy and posterolateral fusion at L3-L4. General anesthesia was induced with 150 mg of propofol and maintained with a mixture of sevoflurane and remifentanil infusion. Neuromuscular blockade was achieved with rocuronium. The patient's vital signs remained stable, and postoperative pain was managed with patient-controlled analgesia using morphine.

4. Operative Note: A lateral interbody fusion was performed to address Spondylolysis at L5-S1. The procedure was conducted under spinal anesthesia with hyperbaric bupivacaine. A total of 15 mg of bupivacaine was administered intrathecally. The patient experienced adequate sensory and motor block during the surgery and remained hemodynamically stable. Postoperatively, pain was managed with oral opioids and nonsteroidal anti-inflammatory drugs.

5. Operative Note: Patient with Spondylolysis underwent a transforaminal lumbar interbody fusion at L4-L5. The surgery was performed under epidural anesthesia with a local anesthetic agent. A total of 15 ml of 0.5% ropivacaine was administered through an epidural catheter. The patient remained comfortable throughout the procedure, and no intraoperative complications were encountered.

6. Operative Note: A posterior lumbar interbody fusion was performed to address Spondylolysis at L3-L4. The procedure was conducted under general anesthesia with a modified dose regimen. Anesthesia was induced with reduced doses of propofol (100 mg) and maintained with a lower concentration of sevoflurane. Opioid analgesics were administered cautiously to minimize respiratory depression. The patient's hemodynamic stability was well-maintained throughout the surgery.

7. Operative Note: Patient with Spondylolysis underwent an anterior lumbar interbody fusion at L5-S1. The procedure was performed under spinal anesthesia with isobaric bupivacaine. A total of 10 mg of bupivacaine was administered intrathecally. The patient experienced effective sensory and motor block, allowing for the successful completion of the surgery. Analgesia was managed with intravenous opioids during the immediate postoperative period.

8. Operative Note: A direct pars repair was performed to address Spondylolysis at L4. The surgery was conducted under monitored anesthesia care (MAC) with local anesthesia supplemented by intravenous sedation. Lidocaine with epinephrine was infiltrated at the surgical site for adequate anesthesia. The patient remained comfortable and responsive throughout the procedure.

9. Operative Note: Patient with Spondylolysis underwent a percutaneous pedicle screw fixation at L3-L4. The procedure was performed under general anesthesia with a balanced technique. Induction was achieved with fentanyl, propofol, and rocuronium, followed by maintenance with sevoflurane and remifentanil infusion. The patient's vital signs were well-controlled, and postoperative pain was managed with multimodal analgesia, including non-opioid medications.

10. Operative Note: An endoscopic lumbar interbody fusion was performed to address Spondylolysis at L5-S1. The surgery was conducted under monitored anesthesia care (MAC) with intravenous sedation using a lower dosage of midazolam (2 mg) and fentanyl (50 mcg). The patient remained conscious and cooperative during the procedure, and adequate pain control was achieved with local anesthesia at the incision site.

1. Operative Note: Patient with Spondylolysis and significant bone erosion at L4-L5 underwent a posterior spinal fusion. After exposure, extensive debridement of eroded bone was performed. Structural allograft and bone graft substitute were utilized to fill the resulting defect. Pedicle screws were inserted bilaterally, and rods were connected. Intraoperative fluoroscopy confirmed satisfactory hardware positioning. The wound was closed meticulously. The patient tolerated the procedure well without immediate complications.

2. Operative Note: A combined anterior and posterior spinal fusion was performed to address Spondylolysis with severe bone erosion at L5-S1. An anterior approach was utilized for extensive debridement and cage placement. The posterior approach involved thorough decortication and bone grafting. Pedicle screws and rods were inserted for additional stability. Intraoperative imaging confirmed satisfactory fusion construct alignment. The patient tolerated the procedure well, with no immediate postoperative complications noted.

3. Operative Note: Patient with Spondylolysis and advanced bone erosion at L3-L4 underwent a three-column osteotomy procedure. Bone resection was meticulously performed to remove the eroded segments. A cage filled with bone graft was inserted to achieve spinal realignment. Posterior pedicle screw and rod fixation were performed for stabilization. The wound was closed meticulously. The patient tolerated the procedure well, and postoperative imaging showed improved spinal alignment.

4. Operative Note: A posterior lumbar interbody fusion (PLIF) was performed to address Spondylolysis with bone erosion at L4-L5. Extensive debridement of the eroded bone was carried out. A large interbody cage filled with bone graft was placed to restore disc height and provide stability. Pedicle screws and rods were inserted for additional fixation. Intraoperative imaging confirmed satisfactory cage positioning. The wound was closed in layers. The patient had an uneventful immediate postoperative course.

5. Operative Note: Patient with Spondylolysis and significant bone erosion at L5-S1 underwent an anterior lumbar corpectomy and fusion. After extensive resection of the eroded vertebral body, an expandable cage filled with bone graft was placed. Additional stabilization was achieved with anterior plate and screw constructs. Intraoperative imaging confirmed proper cage positioning and alignment. The wound was closed meticulously. The patient tolerated the procedure well, with no immediate complications.

6. Operative Note: A percutaneous vertebral augmentation procedure was performed to address Spondylolysis with bone erosion at L3. Under fluoroscopic guidance, bone cement was injected into the eroded pars interarticularis. The procedure was completed successfully without complications. The patient tolerated the procedure well, and postoperative imaging confirmed adequate cement distribution and stabilization of the eroded bone.

7. Operative Note: Patient with Spondylolysis and extensive bone erosion at L4 underwent a posterior spinal fusion with bone grafting. After thorough debridement of the eroded bone, structural allograft and bone graft substitute were packed into the defect. Pedicle screws and rods were inserted for stabilization. Intraoperative fluoroscopy confirmed satisfactory hardware placement. The wound was closed meticulously. The patient tolerated the procedure well, without immediate complications.

8. Operative Note: A lateral lumbar interbody fusion (LLIF) was performed to address Spondylolysis with bone erosion at L3-L4. The eroded vertebral bodies were carefully prepared, and an interbody cage filled with bone graft was inserted to restore disc height and provide stability. Additional fixation was achieved with anterior plate and screw constructs. Intraoperative imaging confirmed satisfactory cage placement. The wound was closed meticulously. The patient had an uneventful immediate postoperative course.

9. Operative Note: Patient with Spondylolysis and extensive bone erosion at L5-S1 underwent a posterior instrumented fusion. After meticulous debridement of the eroded bone, bone graft was packed into the defect. Pedicle screws and rods were inserted for stabilization. Intraoperative imaging confirmed satisfactory hardware positioning. The wound was closed meticulously. The patient tolerated the procedure well, with no immediate postoperative complications noted.

10. Operative Note: A direct pars repair was performed to address Spondylolysis with bone erosion at L4. The eroded pars interarticularis was thoroughly debrided, and strong nonabsorbable sutures were used for repair. Additional stabilization was achieved with pedicle screws and rods. Intraoperative fluoroscopy confirmed proper screw placement. The wound was closed meticulously. The patient had an uneventful immediate postoperative course, and follow-up imaging showed signs of healing and stability.

1. Operative Note: Patient with severe bone pain due to Spondylolysis at L4-L5 underwent a posterior spinal fusion. Extensive debridement was performed to remove the eroded bone and alleviate pain. Pedicle screws were inserted bilaterally, and rods were connected to provide stability. Intraoperative fluoroscopy confirmed satisfactory hardware positioning. The patient tolerated the procedure well, and immediate postoperative pain relief was observed.

2. Operative Note: A combined anterior and posterior spinal fusion was performed to address Spondylolysis with severe bone pain at L5-S1. Anterior discectomy and cage placement were followed by extensive debridement of eroded bone and posterior instrumentation. The patient's severe bone pain was relieved postoperatively, and the procedure was well-tolerated without immediate complications.

3. Operative Note: Patient with severe bone pain caused by Spondylolysis at L3-L4 underwent a three-column osteotomy procedure. Bone resection was meticulously performed to remove the painful segments. Realignment and stabilization were achieved using pedicle screws and rods. The patient experienced significant pain relief immediately after the procedure.

4. Operative Note: A posterior lumbar interbody fusion (PLIF) was performed to address severe bone pain associated with Spondylolysis at L4-L5. Extensive debridement of eroded bone was carried out, and a large interbody cage filled with bone graft was placed to alleviate pain and provide stability. The patient's severe bone pain improved postoperatively, and no immediate complications were encountered.

5. Operative Note: Patient with severe bone pain due to Spondylolysis at L5-S1 underwent an anterior lumbar corpectomy and fusion. Extensive resection of the eroded vertebral body was performed to relieve pain, and an expandable cage filled with bone graft was inserted. Anterior plate and screw constructs were utilized for additional stabilization. The patient experienced significant relief from severe bone pain postoperatively.

6. Operative Note: A percutaneous vertebral augmentation procedure was performed to address severe bone pain caused by Spondylolysis at L3. Under fluoroscopic guidance, bone cement was injected into the eroded pars interarticularis to alleviate pain and stabilize the bone. The patient's severe bone pain was significantly relieved immediately after the procedure, and no complications were observed.

7. Operative Note: Patient with Spondylolysis and severe bone pain at L4 underwent a posterior spinal fusion with extensive debridement of eroded bone. Structural allograft and bone graft substitute were utilized to fill the defect and alleviate pain. Pedicle screws and rods were inserted for stabilization. The patient experienced immediate relief from severe bone pain postoperatively.

8. Operative Note: A lateral lumbar interbody fusion (LLIF) was performed to address severe bone pain associated with Spondylolysis at L3-L4. The eroded vertebral bodies were carefully prepared, and an interbody cage filled with bone graft was inserted to alleviate pain and provide stability. Anterior plate and screw constructs were utilized for additional fixation. The patient experienced significant relief from severe bone pain immediately after the procedure.

9. Operative Note: Patient with severe bone pain due to Spondylolysis and extensive bone erosion at L5-S1 underwent a posterior instrumented fusion. Extensive debridement was performed to remove the eroded bone and alleviate pain. Bone graft was packed into the defect, and pedicle screws and rods were inserted for stabilization. The patient experienced significant relief from severe bone pain postoperatively.

10. Operative Note: A direct pars repair was performed to address severe bone pain associated with Spondylolysis at L4. The eroded pars interarticularis was thoroughly debrided, and strong nonabsorbable sutures were used for repair. Pedicle screws and rods were inserted for additional stabilization. The patient experienced immediate relief from severe bone pain after the procedure, and no immediate complications were encountered.

1. Operative Note: Patient with Spondylolysis at L4-L5 underwent a minimally invasive decompression and fusion procedure. A tubular retractor system was utilized to access the affected area. The eroded bone was carefully removed, and a cage filled with bone graft was inserted to provide stability. Pedicle screws and rods were placed for additional support. The patient tolerated the procedure well, and postoperative imaging confirmed successful decompression and fusion.

2. Operative Note: A direct repair of the pars interarticularis was performed to address Spondylolysis at L5. A small incision was made, and the eroded pars interarticularis was identified and meticulously repaired using non-absorbable sutures. The patient tolerated the procedure well, and immediate postoperative imaging showed a stable repair. Follow-up care will include monitoring for signs of healing and rehabilitation.

3. Operative Note: Patient with Spondylolysis and severe symptoms underwent a posterior lumbar interbody fusion (PLIF) at L4-L5. The eroded disc was removed, and an interbody cage filled with bone graft was placed to restore disc height and provide stability. Pedicle screws and rods were inserted for additional fixation. The patient tolerated the procedure well, and immediate postoperative imaging showed successful fusion and decompression.

4. Operative Note: A transforaminal lumbar interbody fusion (TLIF) was performed to address Spondylolysis at L3-L4. The procedure involved a unilateral approach, allowing for the removal of the eroded disc and placement of an interbody cage filled with bone graft. Pedicle screws and rods were inserted for stabilization. The patient tolerated the procedure well, and postoperative imaging confirmed successful fusion and decompression.

5. Operative Note: Patient with Spondylolysis and severe pain underwent a microdiscectomy and posterolateral fusion at L5-S1. The procedure involved a minimally invasive approach, with the removal of the eroded disc and placement of bone graft for fusion. Pedicle screws and rods were inserted for additional support. The patient tolerated the procedure well, and immediate postoperative imaging showed successful decompression and fusion.

6. Operative Note: A lateral lumbar interbody fusion (LLIF) was performed to address Spondylolysis at L4-L5. The eroded disc was removed, and an interbody cage filled with bone graft was inserted to restore disc height and provide stability. The patient tolerated the procedure well, and immediate postoperative imaging confirmed successful fusion and decompression.

7. Operative Note: Patient with Spondylolysis and severe symptoms underwent a direct pars repair and posterior spinal fusion at L3-L4. The eroded pars interarticularis was meticulously repaired, and bone graft was placed for fusion. Pedicle screws and rods were inserted for stabilization. The patient tolerated the procedure well, and immediate postoperative imaging showed successful fusion and stabilization.

8. Operative Note: A percutaneous pedicle screw fixation was performed to address Spondylolysis at L4. Fluoroscopic guidance was used to insert pedicle screws bilaterally, providing stability to the eroded vertebra. The patient tolerated the procedure well, and immediate postoperative imaging confirmed successful screw placement and stabilization.

9. Operative Note: Patient with Spondylolysis and severe pain underwent a posterior instrumented fusion at L5-S1. The eroded bone was removed, and structural allograft and bone graft substitute were used to fill the defect and promote fusion. Pedicle screws and rods were inserted for additional support. The patient tolerated the procedure well, and postoperative imaging showed successful fusion and stabilization.

10. Operative Note: An endoscopic-assisted minimally invasive fusion was performed to address Spondylolysis at L4-L5. The procedure involved a small incision and the use of endoscopic visualization to remove the eroded disc and place an interbody cage filled with bone graft. Pedicle screws and rods were inserted for additional stability. The patient tolerated the procedure well, and immediate postoperative imaging showed successful fusion and decompression.

1. Operative Note: Patient with Spondylolysis and persistent symptoms underwent a radiofrequency ablation procedure. Under fluoroscopic guidance, the eroded pars interarticularis was targeted, and radiofrequency energy was applied to thermally denervate the affected area. The patient tolerated the procedure well, and immediate postoperative relief of symptoms was observed.

2. Operative Note: A minimally invasive direct repair of the pars interarticularis was performed to address Spondylolysis at L5. Utilizing specialized instruments and imaging guidance, the eroded pars was meticulously repaired using non-absorbable sutures. The patient tolerated the procedure well, and postoperative imaging confirmed a stable repair.

3. Operative Note: Patient with Spondylolysis and radicular pain underwent a selective nerve root block procedure. Under fluoroscopic guidance, a corticosteroid and local anesthetic mixture was injected near the affected nerve root to alleviate pain and inflammation. The patient experienced immediate relief of radicular pain and tolerated the procedure well.

4. Operative Note: An endoscopic rhizotomy was performed to address Spondylolysis with radicular pain. Utilizing endoscopic visualization, the affected nerve root was identified and thermally ablated using radiofrequency energy. The patient experienced immediate relief of radicular pain and tolerated the procedure well.

5. Operative Note: Patient with Spondylolysis and persistent symptoms underwent a percutaneous discectomy procedure. Under fluoroscopic guidance, the eroded disc material was removed using minimally invasive techniques. The patient tolerated the procedure well, and immediate postoperative relief of symptoms was observed.

6. Operative Note: A dynamic stabilization procedure was performed to address Spondylolysis at L4-L5. Utilizing specialized implants, the eroded segment was stabilized while maintaining some degree of spinal motion. The patient tolerated the procedure well, and immediate postoperative imaging showed successful stabilization.

7. Operative Note: Patient with Spondylolysis and recurrent symptoms underwent a revision decompression and fusion procedure. The previous fusion construct was removed, and extensive debridement of eroded bone was performed. A new interbody cage filled with bone graft was placed, and pedicle screws and rods were inserted for additional stability. The patient tolerated the procedure well, and postoperative imaging confirmed successful fusion and decompression.

8. Operative Note: An artificial disc replacement was performed to address Spondylolysis at L5-S1. The eroded disc was removed, and an artificial disc prosthesis was inserted to restore disc height and maintain spinal motion. The patient tolerated the procedure well, and immediate postoperative imaging showed successful disc replacement.

9. Operative Note: Patient with Spondylolysis and persistent symptoms underwent a spinal cord stimulation procedure. Under fluoroscopic guidance, electrodes were implanted near the affected spinal cord region, and a neurostimulator was placed to deliver electrical impulses. The patient experienced immediate relief of symptoms and tolerated the procedure well.

10. Operative Note: A percutaneous facet joint denervation procedure was performed to address Spondylolysis with facet joint-related pain. Under fluoroscopic guidance, radiofrequency energy was applied to thermally ablate the affected facet joint nerves, alleviating pain. The patient experienced immediate relief of facet joint-related pain and tolerated the procedure well.

1. Operative Note: Patient with severe infection on the extreme moving joint due to Spondylolysis at L4-L5 underwent a surgical debridement procedure. The infected tissue was meticulously removed, and the joint was thoroughly irrigated with antimicrobial solution. Local and systemic antibiotic therapy was initiated. The patient tolerated the procedure well, and postoperative wound care was initiated to promote healing and control infection.

2. Operative Note: A two-stage procedure was performed to address severe infection on the extreme moving joint associated with Spondylolysis at L5-S1. In the first stage, extensive debridement was carried out, and temporary antibiotic-impregnated spacers were placed. After a course of antibiotic therapy, the second stage involved spacer removal and definitive fusion with bone graft and instrumentation. The patient tolerated the procedure well, and postoperative antibiotic therapy was continued.

3. Operative Note: Patient with severe infection on the extreme moving joint due to Spondylolysis at L3-L4 underwent a joint resection and fusion procedure. The infected joint was completely excised, and bone graft was used to achieve fusion. Pedicle screws and rods were inserted for additional stabilization. The patient tolerated the procedure well, and postoperative antibiotic therapy was initiated to eradicate the infection.

4. Operative Note: A percutaneous abscess drainage procedure was performed to address severe infection on the extreme moving joint associated with Spondylolysis at L4. Under fluoroscopic guidance, a percutaneous drain was placed to evacuate the abscess and allow for ongoing irrigation with antimicrobial solution. The patient tolerated the procedure well, and intravenous antibiotic therapy was initiated.

5. Operative Note: Patient with severe infection on the extreme moving joint due to Spondylolysis at L5 underwent an open surgical debridement and irrigation procedure. The infected joint was extensively debrided, and thorough irrigation with antimicrobial solution was performed. The wound was left open for ongoing wound care and dressings. The patient tolerated the procedure well, and intravenous antibiotic therapy was initiated.

6. Operative Note: A joint washout and antibiotic bead placement procedure was performed to address severe infection on the extreme moving joint associated with Spondylolysis at L3-L4. The joint was thoroughly irrigated with antimicrobial solution, and antibiotic-impregnated beads were placed within the joint space. The patient tolerated the procedure well, and postoperative antibiotic therapy was initiated.

7. Operative Note: Patient with severe infection on the extreme moving joint due to Spondylolysis at L4-L5 underwent an arthrodesis and joint resection procedure. The infected joint was completely excised, and bone graft was utilized to achieve fusion. Pedicle screws and rods were inserted for additional stabilization. The patient tolerated the procedure well, and postoperative antibiotic therapy was initiated to eradicate the infection.

8. Operative Note: An urgent joint washout and debridement procedure was performed to address severe infection on the extreme moving joint associated with Spondylolysis at L5-S1. The joint was meticulously debrided, and thorough irrigation with antimicrobial solution was performed. A drain was placed to facilitate ongoing drainage. The patient tolerated the procedure well, and intravenous antibiotic therapy was initiated.

9. Operative Note: Patient with severe infection on the extreme moving joint due to Spondylolysis at L4 underwent a joint resection and stabilization procedure. The infected joint was completely excised, and bone graft and instrumentation were utilized to achieve stability. The patient tolerated the procedure well, and postoperative antibiotic therapy was initiated to control the infection.

10. Operative Note: A percutaneous joint aspiration and antibiotic instillation procedure was performed to address severe infection on the extreme moving joint associated with Spondylolysis at L3-L4. Under fluoroscopic guidance, the joint was aspirated, and antimicrobial solution was instilled. The patient tolerated the procedure well, and intravenous antibiotic therapy was continued.

1. Operative Note: Patient with Spondylolysis and severe inflammatory response underwent an open decompression and fusion procedure. The inflamed tissues were carefully dissected and removed, and an interbody cage filled with bone graft was placed for fusion. Pedicle screws and rods were inserted for stabilization. The patient tolerated the procedure well, and immediate postoperative imaging showed successful decompression and stabilization.

2. Operative Note: A minimally invasive direct pars repair was performed to address Spondylolysis with acute inflammation at L4. The eroded pars interarticularis was meticulously repaired using non-absorbable sutures. Intraoperative measures were taken to minimize inflammation, including gentle tissue handling and irrigation with anti-inflammatory solution. The patient tolerated the procedure well, and postoperative care included anti-inflammatory medication.

3. Operative Note: Patient with Spondylolysis and chronic inflammatory changes underwent a posterior lumbar interbody fusion (PLIF) at L3-L4. The eroded disc was removed, and an interbody cage filled with bone graft was inserted to restore disc height and provide stability. Care was taken to manage inflammation during the procedure. The patient tolerated the procedure well, and immediate postoperative imaging showed successful fusion and decompression.

4. Operative Note: An endoscopic-assisted minimally invasive fusion was performed to address Spondylolysis at L5-S1 with moderate inflammation. The procedure involved gentle tissue handling and the use of anti-inflammatory measures. An interbody cage filled with bone graft was inserted, and pedicle screws and rods were placed for stabilization. The patient tolerated the procedure well, and immediate postoperative imaging showed successful fusion and decompression.

5. Operative Note: Patient with Spondylolysis and severe inflammation underwent a selective nerve root block procedure. Under fluoroscopic guidance, a corticosteroid and local anesthetic mixture was injected near the affected nerve root to alleviate pain and reduce inflammation. The patient experienced immediate relief of symptoms and tolerated the procedure well.

6. Operative Note: A transforaminal lumbar interbody fusion (TLIF) was performed to address Spondylolysis at L4-L5 with mild inflammation. Special attention was given to minimize tissue trauma and inflammation during the procedure. The eroded disc was removed, and an interbody cage filled with bone graft was inserted. Pedicle screws and rods were placed for additional stability. The patient tolerated the procedure well, and postoperative care included anti-inflammatory medication.

7. Operative Note: Patient with Spondylolysis and significant inflammatory changes underwent a posterior instrumented fusion at L5-S1. The eroded bone was carefully debrided, and anti-inflammatory measures were taken during the procedure. Bone graft and instrumentation were utilized for stabilization. The patient tolerated the procedure well, and immediate postoperative imaging showed successful fusion and stabilization.

8. Operative Note: An endoscopic rhizotomy was performed to address Spondylolysis with inflammation and radicular pain. Utilizing endoscopic visualization, the affected nerve root was identified and thermally ablated using radiofrequency energy. Intraoperative measures were taken to minimize inflammation. The patient experienced immediate relief of radicular pain and tolerated the procedure well.

9. Operative Note: Patient with Spondylolysis and moderate inflammation underwent a percutaneous discectomy procedure. Careful tissue handling and irrigation with anti-inflammatory solution were employed during the procedure. The eroded disc material was removed using minimally invasive techniques. The patient tolerated the procedure well, and immediate postoperative care included anti-inflammatory medication.

10. Operative Note: A dynamic stabilization procedure was performed to address Spondylolysis at L3-L4 with inflammation. Special care was taken to minimize tissue trauma and inflammation during the procedure. Utilizing specialized implants, the eroded segment was stabilized while allowing some degree of spinal motion. The patient tolerated the procedure well, and immediate postoperative imaging showed successful stabilization and decompression.

1. Operative Note: Patient with severe Spondylolysis and instability underwent a complex spinal fusion procedure. Postoperatively, the patient will require close monitoring in the intensive care unit for 48 hours. Follow-up visits will be scheduled at regular intervals to assess fusion progress and monitor for potential complications.

2. Operative Note: A minimally invasive decompression procedure was performed for a patient with mild Spondylolysis and symptomatic nerve compression. The patient will be discharged with instructions for home care and pain management. Follow-up visits will be scheduled at two weeks and six weeks to evaluate pain relief and monitor functional improvement.

3. Operative Note: Patient with moderate Spondylolysis and persistent symptoms underwent a posterior laminectomy and fusion procedure. Postoperatively, the patient will be closely monitored in the hospital for 3-5 days. Follow-up visits will be scheduled at two weeks, six weeks, and three months to assess fusion progress, monitor for complications, and adjust rehabilitation as needed.

4. Operative Note: An endoscopic-assisted fusion was performed for a patient with moderate Spondylolysis and instability. Postoperatively, the patient will require a short hospital stay for pain management and wound care. Follow-up visits will be scheduled at two weeks, six weeks, and three months to assess fusion progress, monitor for complications, and guide the rehabilitation process.

5. Operative Note: Patient with mild Spondylolysis and intermittent symptoms underwent a conservative management approach with physical therapy and activity modification. Follow-up visits will be scheduled at four weeks and three months to evaluate symptom improvement, monitor functional progress, and discuss the need for further intervention if symptoms persist.

6. Operative Note: A posterior instrumented fusion was performed for a patient with severe Spondylolysis and spinal instability. Postoperatively, the patient will require an extended hospital stay for pain control and rehabilitation. Follow-up visits will be scheduled at two weeks, six weeks, three months, and six months to assess fusion progress, monitor for complications, and guide the rehabilitation process.

7. Operative Note: Patient with moderate Spondylolysis and progressive neurological deficits underwent an urgent decompression and fusion procedure. Postoperatively, the patient will be transferred to the intensive care unit for close monitoring. Follow-up visits will be scheduled at two weeks, six weeks, three months, and one year to assess neurological recovery, monitor fusion progress, and manage any potential complications.

8. Operative Note: A minimally invasive stabilization procedure was performed for a patient with mild Spondylolysis and instability. Postoperatively, the patient will be discharged with instructions for home care and pain management. Follow-up visits will be scheduled at four weeks, three months, and six months to assess symptom relief, monitor fusion progress, and guide rehabilitation.

9. Operative Note: Patient with severe Spondylolysis and spinal deformity underwent a complex spinal reconstruction procedure. Postoperatively, the patient will require an extended hospital stay for pain control, wound care, and rehabilitation. Follow-up visits will be scheduled at two weeks, six weeks, three months, and one year to assess spinal alignment, monitor fusion progress, and manage any potential complications.

10. Operative Note: An endoscopic-assisted direct repair was performed for a patient with mild Spondylolysis and localized pain. Postoperatively, the patient will be discharged with instructions for activity modification and pain management. Follow-up visits will be scheduled at four weeks and three months to evaluate pain relief, monitor functional improvement, and discuss further treatment options if needed.

## M43.1 Spondylolisthesis

1. Patient underwent posterior lumbar fusion for grade II spondylolisthesis at L4-L5 level. Decompression and instrumentation were performed using pedicle screws and rods. Intraoperative fluoroscopy confirmed satisfactory alignment. Hemostasis was achieved, and wound was closed. Patient tolerated the procedure well without complications. Postoperative instructions and follow-up arranged.

2. Minimally invasive transforaminal lumbar interbody fusion was performed on a patient with grade III spondylolisthesis at L5-S1. Bilateral decompression, reduction, and fixation with interbody cage and pedicle screws were accomplished. Surgical time was uneventful, and patient's neurological symptoms improved intraoperatively. Wound closure was performed, and postoperative care plan was discussed with the patient and family.

3. The patient underwent anterior lumbar interbody fusion for grade I spondylolisthesis at L3-L4 level. The degenerated disc was removed, and a structural allograft was inserted into the disc space. Plate and screws were used for fixation. Vascular and neural structures were carefully protected. The patient tolerated the procedure well, and postoperative radiographs confirmed satisfactory alignment.

4. A posterior approach was used for reduction and fusion in a patient with grade IV spondylolisthesis at L5-S1. Decompression and facetectomies were performed bilaterally. Reduction was achieved using rods, pedicle screws, and interbody cages. Bone graft material was placed, and wound closure was completed without complications. Postoperative pain management and follow-up instructions were provided to the patient.

5. Patient underwent a minimally invasive lateral lumbar interbody fusion for grade II spondylolisthesis at L4-L5. Access was obtained through the retroperitoneal space, and a cage was inserted into the disc space. Pedicle screws and rods were used for stabilization. The patient tolerated the procedure well, and immediate postoperative imaging showed satisfactory alignment.

6. Open reduction and internal fixation were performed on a patient with grade III spondylolisthesis at L3-L4. Pedicle screws and rods were utilized for stabilization, and bone graft was applied. Intraoperative fluoroscopy was used to confirm satisfactory reduction and alignment. The procedure was completed without complications, and the patient's postoperative pain was well managed.

7. Patient underwent a posterior lumbar interbody fusion for grade I spondylolisthesis at L2-L3. Decompression, discectomy, and interbody cage insertion were performed. Pedicle screws and rods were used for stabilization. Intraoperative neuromonitoring was utilized to ensure the integrity of neural structures. The procedure was uneventful, and the patient was discharged with appropriate postoperative instructions and follow-up plans.

8. Minimally invasive direct lateral interbody fusion was performed on a patient with grade IV spondylolisthesis at L4-L5. The procedure involved removal of the degenerated disc, placement of an interbody cage, and fixation with pedicle screws and rods. Intraoperative imaging confirmed satisfactory reduction and alignment. The patient tolerated the surgery well, and postoperative pain control was achieved.

9. Anterior lumbar interbody fusion was performed on a patient with grade II spondylolisthesis at L5-S1. The procedure involved removal of the damaged disc and insertion of an interbody cage filled with bone graft material. Plate and screws were used for stabilization. Intraoperative monitoring ensured the safety of neural structures. The patient's immediate postoperative period was unremarkable, and follow-up was arranged.

10. Posterior decompression and fusion were performed on a patient with grade III spondylolisthesis at L2-L3. Pedicle screws and rods were used for stabilization. The procedure involved laminectomy, facetectomy, and interbody fusion with bone graft material. Intraoperative fluoroscopy confirmed satisfactory alignment. The patient's immediate postoperative course was uncomplicated, and appropriate postoperative care instructions were provided.

1. Patient underwent a revision posterior lumbar fusion for recurrent spondylolisthesis at L4-L5. Extensive decompression, hardware removal, and re-instrumentation were performed. The alignment was meticulously corrected, and additional bone graft was applied. Intraoperative neurophysiological monitoring was utilized. The procedure was uneventful, and the patient was transferred to the recovery room in stable condition.

2. Minimally invasive posterior lumbar interbody fusion was performed on a patient with grade II spondylolisthesis at L3-L4. Pedicle screws, rods, and interbody cage were utilized for stabilization and fusion. Careful discectomy and foraminal decompression were accomplished. Intraoperative imaging confirmed satisfactory placement and alignment. The patient tolerated the procedure well, and postoperative pain management was initiated.

3. Anterior lumbar interbody fusion was performed on a patient with grade III spondylolisthesis at L4-L5. The degenerated disc was excised, and an interbody cage filled with bone graft was inserted. Plate and screws were used for fixation. Intraoperative neuromonitoring ensured the safety of neural structures. The patient's immediate postoperative period was uneventful, and appropriate discharge instructions were provided.

4. Patient underwent a minimally invasive lateral lumbar interbody fusion for grade I spondylolisthesis at L2-L3. The procedure involved retroperitoneal access, discectomy, and placement of an interbody cage. Pedicle screws and rods were used for stabilization. Intraoperative fluoroscopy confirmed proper cage positioning and alignment. The patient recovered without complications, and postoperative rehabilitation was initiated.

5. Posterior reduction and fusion were performed on a patient with grade IV spondylolisthesis at L5-S1. Bilateral laminectomy, facetectomy, and pedicle screw instrumentation were performed. The slipped vertebra was reduced and aligned using rods and interbody graft. Intraoperative neuromonitoring was utilized to ensure nerve integrity. The patient's immediate postoperative course was unremarkable, and follow-up arrangements were made.

6. Patient underwent an open anterior-posterior approach for spondylolisthesis at L3-L4. The anterior phase involved discectomy, placement of an interbody cage, and stabilization with a plate and screws. The posterior phase included decompression, reduction, and additional fixation with pedicle screws and rods. Intraoperative imaging confirmed satisfactory alignment. The patient tolerated the procedure well, and postoperative pain control was achieved.

7. Minimally invasive transforaminal lumbar interbody fusion was performed on a patient with grade II spondylolisthesis at L4-L5. The procedure involved unilateral laminectomy, discectomy, and placement of an interbody cage. Pedicle screws and rods were used for stabilization. Intraoperative fluoroscopy ensured proper cage position and alignment. The patient had an uneventful intraoperative course, and postoperative instructions were provided.

8. Revision surgery was performed on a patient with recurrent spondylolisthesis at L5-S1. Posterior decompression, hardware removal, and extension of the fusion were accomplished. Pedicle screws, rods, and bone graft were utilized for stabilization. Intraoperative neuromonitoring confirmed the integrity of neural structures. The procedure was completed without complications, and the patient's postoperative pain was well managed.

9. Anterior lumbar interbody fusion was performed on a patient with grade III spondylolisthesis at L3-L4. The procedure involved discectomy, placement of an interbody cage, and fixation with plate and screws. Intraoperative neuromonitoring ensured the safety of neural structures. The patient tolerated the procedure well, and immediate postoperative imaging confirmed satisfactory alignment.

10. Minimally invasive lateral lumbar interbody fusion was performed on a patient with grade IV spondylolisthesis at L4-L5. The degenerated disc was removed, and an interbody cage filled with bone graft was inserted. Pedicle screws and rods were used for stabilization. Intraoperative fluoroscopy confirmed satisfactory cage placement and alignment. The patient's immediate postoperative course was uneventful, and postoperative care instructions were provided.

1. Patient underwent posterior lumbar fusion for grade II spondylolisthesis at L4-L5 level under general anesthesia with endotracheal intubation. Intraoperative fluoroscopy confirmed satisfactory alignment. Hemostasis was achieved, and wound was closed. The patient tolerated the procedure well without complications. Postoperative instructions and follow-up arranged.

2. Minimally invasive transforaminal lumbar interbody fusion was performed on a patient with grade III spondylolisthesis at L5-S1 under monitored anesthesia care (MAC) with intravenous sedation. Bilateral decompression, reduction, and fixation with interbody cage and pedicle screws were accomplished. Surgical time was uneventful, and patient's neurological symptoms improved intraoperatively. Wound closure was performed, and postoperative care plan was discussed with the patient and family.

3. The patient underwent anterior lumbar interbody fusion for grade I spondylolisthesis at L3-L4 level under combined spinal-epidural anesthesia. The degenerated disc was removed, and a structural allograft was inserted into the disc space. Plate and screws were used for fixation. Vascular and neural structures were carefully protected. The patient tolerated the procedure well, and postoperative radiographs confirmed satisfactory alignment.

4. A posterior approach was used for reduction and fusion in a patient with grade IV spondylolisthesis at L5-S1 under general anesthesia with a balanced technique. Decompression and facetectomies were performed bilaterally. Reduction was achieved using rods, pedicle screws, and interbody cages. Bone graft material was placed, and wound closure was completed without complications. Postoperative pain management and follow-up instructions were provided to the patient.

5. Patient underwent a minimally invasive lateral lumbar interbody fusion for grade II spondylolisthesis at L4-L5 under regional anesthesia with epidural block. Access was obtained through the retroperitoneal space, and a cage was inserted into the disc space. Pedicle screws and rods were used for stabilization. The patient tolerated the procedure well, and immediate postoperative imaging showed satisfactory alignment.

6. Open reduction and internal fixation were performed on a patient with grade III spondylolisthesis at L3-L4 under general anesthesia with endotracheal intubation. Pedicle screws and rods were utilized for stabilization, and bone graft was applied. Intraoperative fluoroscopy was used to confirm satisfactory reduction and alignment. The procedure was completed without complications, and the patient's postoperative pain was well managed.

7. Patient underwent a posterior lumbar interbody fusion for grade I spondylolisthesis at L2-L3 under general anesthesia with a total intravenous technique (TIVA). Decompression, discectomy, and interbody cage insertion were performed. Pedicle screws and rods were used for stabilization. Intraoperative neuromonitoring was utilized to ensure the integrity of neural structures. The procedure was uneventful, and the patient was discharged with appropriate postoperative instructions and follow-up plans.

8. Minimally invasive direct lateral interbody fusion was performed on a patient with grade IV spondylolisthesis at L4-L5 under general anesthesia with volatile inhalational agents. The procedure involved removal of the degenerated disc, placement of an interbody cage, and fixation with pedicle screws and rods. Intraoperative imaging confirmed satisfactory reduction and alignment. The patient tolerated the surgery well, and postoperative pain control was achieved.

9. Anterior lumbar interbody fusion was performed on a patient with grade II spondylolisthesis at L5-S1 under general anesthesia with muscle relaxation. The procedure involved removal of the damaged disc and insertion of an interbody cage filled with bone graft material. Plate and screws were used for stabilization. Intraoperative monitoring ensured the safety of neural structures. The patient's immediate postoperative period was unremarkable, and follow-up was arranged.

10. Posterior decompression and fusion were performed on a patient with grade III spondylolisthesis at L2-L3 under regional anesthesia with spinal block. Pedicle screws and rods were used for stabilization. The procedure involved laminectomy, facetectomy, and interbody fusion with bone graft material. Intraoperative fluoroscopy confirmed satisfactory alignment. The patient's immediate postoperative course was uncomplicated, and postoperative instructions were provided.

1. Patient with severe grade IV spondylolisthesis at L4-L5 underwent posterior decompression and fusion. Intraoperatively, significant bone erosion was observed at the vertebral bodies. Extensive debridement and grafting were performed to address the erosion. Pedicle screws and rods were used for stabilization. The patient tolerated the procedure well, and postoperative care instructions were given.

2. Revision surgery was performed on a patient with recurrent spondylolisthesis at L5-S1 and associated bone erosion. Posterior revision decompression, bone grafting, and extension of the fusion were performed. Careful attention was given to address the eroded bony structures. The procedure was completed without complications, and the patient's postoperative pain was managed effectively.

3. Anterior lumbar interbody fusion was performed on a patient with grade II spondylolisthesis at L3-L4. Bone erosion was noted at the affected level. The procedure involved meticulous removal of the eroded bone, insertion of an interbody cage filled with bone graft, and fixation with plate and screws. Intraoperative measures were taken to address the erosion. The patient's immediate postoperative course was uneventful.

4. Patient with grade III spondylolisthesis at L4-L5 underwent posterior lumbar fusion. Intraoperatively, significant bone erosion was observed at the affected level. Extensive debridement, bone grafting, and reconstruction of the eroded areas were performed. Pedicle screws and rods were used for stabilization. Intraoperative fluoroscopy confirmed satisfactory alignment. The patient tolerated the procedure well, and postoperative instructions were provided.

5. Minimally invasive transforaminal lumbar interbody fusion was performed on a patient with grade I spondylolisthesis at L2-L3 and accompanying bone erosion. The procedure involved removal of the eroded bone, placement of an interbody cage, and stabilization with pedicle screws and rods. Intraoperative measures were taken to address the erosion. The patient's immediate postoperative course was unremarkable, and appropriate follow-up care was arranged.

6. Patient with grade IV spondylolisthesis at L4-L5 underwent posterior lumbar fusion. Intraoperatively, extensive bone erosion and loss of disc space were observed. Debridement, bone grafting, and reconstruction of the eroded areas were performed. Pedicle screws and rods were used for stabilization. The patient tolerated the procedure well, and immediate postoperative imaging showed satisfactory alignment.

7. Minimally invasive lateral lumbar interbody fusion was performed on a patient with grade II spondylolisthesis at L3-L4 and associated bone erosion. The procedure involved removal of the eroded bone, insertion of an interbody cage, and fixation with pedicle screws and rods. Intraoperative measures were taken to address the erosion. The patient tolerated the procedure well, and appropriate postoperative instructions were given.

8. Patient with grade III spondylolisthesis at L5-S1 underwent revision surgery due to recurrent symptoms and bone erosion. Posterior revision decompression, extensive debridement of eroded bone, and revision fusion were performed. Additional bone grafting was applied. Pedicle screws and rods were used for stabilization. The patient's immediate postoperative course was uneventful, and postoperative pain management was initiated.

9. Anterior lumbar interbody fusion was performed on a patient with grade I spondylolisthesis at L4-L5 and accompanying bone erosion. The procedure involved meticulous removal of the eroded bone, placement of an interbody cage filled with bone graft, and fixation with plate and screws. Intraoperative measures were taken to address the erosion. The patient tolerated the procedure well, and postoperative care instructions were provided.

10. Posterior decompression and fusion were performed on a patient with grade II spondylolisthesis at L3-L4 and associated bone erosion. Extensive debridement, bone grafting, and reconstruction of the eroded areas were performed. Pedicle screws and rods were used for stabilization. Intraoperative fluoroscopy confirmed satisfactory alignment. The patient's immediate postoperative course was uncomplicated, and appropriate follow-up arrangements were made.

1. Patient with severe bone pain due to advanced spondylolisthesis at L4-L5 underwent posterior decompression and fusion. The procedure aimed to alleviate the debilitating bone pain. Extensive decompression, bone grafting, and stabilization with pedicle screws and rods were performed. Intraoperative measures were taken to address the pain. The patient tolerated the procedure well, and postoperative pain management was initiated.

2. Revision surgery was performed on a patient with recurrent spondylolisthesis at L5-S1 and severe bone pain. Posterior revision decompression, bone grafting, and extension of the fusion were carried out to alleviate the pain. Attention was given to address the eroded bony structures contributing to the pain. The procedure was completed without complications, and the patient's postoperative pain was effectively managed.

3. Anterior lumbar interbody fusion was performed on a patient with grade II spondylolisthesis at L3-L4 and severe bone pain. The procedure involved meticulous removal of the degenerated disc, insertion of an interbody cage filled with bone graft, and fixation with plate and screws. Intraoperative measures were taken to address the severe bone pain. The patient's immediate postoperative course showed improvement in pain symptoms.

4. Patient with grade III spondylolisthesis at L4-L5 and severe bone pain underwent posterior lumbar fusion. Extensive decompression, bone grafting, and stabilization with pedicle screws and rods were performed to alleviate the severe pain. Intraoperative measures were taken to address the underlying cause of the pain. The patient tolerated the procedure well, and postoperative pain control measures were implemented.

5. Minimally invasive transforaminal lumbar interbody fusion was performed on a patient with grade I spondylolisthesis at L2-L3 and severe bone pain. The procedure aimed to address the pain by removing the degenerated disc, placing an interbody cage, and stabilizing with pedicle screws and rods. Intraoperative measures were taken to alleviate the severe bone pain. The patient's immediate postoperative course showed improvement in pain symptoms.

6. Patient with grade IV spondylolisthesis at L4-L5 and severe bone pain underwent posterior lumbar fusion. Extensive decompression, bone grafting, and reconstruction of the eroded areas were performed to alleviate the severe pain. Pedicle screws and rods were used for stabilization. Intraoperative measures were taken to address the underlying cause of the pain. The patient's immediate postoperative course showed improvement in pain symptoms.

7. Minimally invasive lateral lumbar interbody fusion was performed on a patient with grade II spondylolisthesis at L3-L4 and severe bone pain. The procedure aimed to alleviate the severe pain by removing the degenerated disc, inserting an interbody cage, and stabilizing with pedicle screws and rods. Intraoperative measures were taken to address the severe bone pain. The patient's immediate postoperative course showed improvement in pain symptoms.

8. Patient with grade III spondylolisthesis at L5-S1 and severe bone pain underwent revision surgery. Posterior revision decompression, extensive debridement of eroded bone, and revision fusion were performed to alleviate the severe pain. Additional bone grafting was applied. Pedicle screws and rods were used for stabilization. The patient's immediate postoperative course showed improvement in pain symptoms.

9. Anterior lumbar interbody fusion was performed on a patient with grade I spondylolisthesis at L4-L5 and severe bone pain. The procedure aimed to alleviate the severe pain by removing the eroded bone, placing an interbody cage filled with bone graft, and fixation with plate and screws. Intraoperative measures were taken to address the severe bone pain. The patient's immediate postoperative course showed improvement in pain symptoms.

10. Posterior decompression and fusion were performed on a patient with grade II spondylolisthesis at L3-L4 and severe bone pain. Extensive decompression, bone grafting, and reconstruction of the eroded areas were performed to alleviate the severe pain. Pedicle screws and rods were used for stabilization. Intraoperative measures were taken to address the underlying cause of the pain. The patient's immediate postoperative course showed improvement in pain symptoms.

1. The patient underwent a posterior lumbar decompression and fusion procedure for severe spondylolisthesis at L4-L5. Surgical intervention involved laminectomy, facetectomy, and pedicle screw fixation. Intraoperatively, meticulous attention was given to address the bone erosion and alleviate the patient's debilitating symptoms. The procedure was completed successfully, and postoperative pain management was initiated.

2. Surgical intervention in the form of an anterior lumbar interbody fusion was performed on a patient with advanced spondylolisthesis at L5-S1. The procedure involved removal of the degenerated disc, insertion of an interbody cage, and fixation with screws and a plate. Special care was taken to address the bone erosion contributing to the patient's severe pain. The patient tolerated the surgery well, and postoperative care instructions were provided.

3. A minimally invasive transforaminal lumbar interbody fusion was performed to address severe spondylolisthesis at L3-L4. The surgical intervention involved the placement of an interbody cage filled with bone graft, followed by pedicle screw fixation. Attention was given to alleviate the patient's bone pain caused by erosion. The procedure was successful, and the patient's postoperative course was uneventful.

4. The patient underwent a revision surgery for recurrent spondylolisthesis at L4-L5, requiring surgical intervention to address severe bone pain. Posterior revision decompression, fusion extension, and instrumentation were performed to stabilize the affected segment. Meticulous attention was given to address the eroded bony structures and alleviate the patient's debilitating symptoms. Postoperative pain management was initiated, and follow-up arrangements were made.

5. Surgical intervention in the form of a posterior lumbar interbody fusion was performed on a patient with severe spondylolisthesis at L2-L3. The procedure involved the removal of the degenerated disc, insertion of an interbody cage, and stabilization with pedicle screws and rods. Special care was taken to address the severe bone pain caused by erosion. The patient's immediate postoperative course showed improvement in pain symptoms.

6. A minimally invasive lateral lumbar interbody fusion was performed to address severe spondylolisthesis at L4-L5. The surgical intervention involved the removal of the degenerated disc, insertion of an interbody cage, and stabilization with pedicle screws and rods. Special attention was given to alleviate the patient's severe bone pain caused by erosion. The procedure was successful, and the patient's postoperative course was unremarkable.

7. The patient underwent a posterior lumbar decompression and fusion procedure for severe spondylolisthesis at L5-S1. Surgical intervention involved laminectomy, facetectomy, and pedicle screw fixation to address the patient's debilitating symptoms. Meticulous attention was given to address the bone erosion and alleviate the patient's severe bone pain. The procedure was successful, and postoperative pain management was initiated.

8. Surgical intervention in the form of an anterior lumbar interbody fusion was performed on a patient with advanced spondylolisthesis at L3-L4. The procedure involved the removal of the eroded bone, insertion of an interbody cage filled with bone graft, and fixation with screws and a plate. Special care was taken to alleviate the patient's severe bone pain through surgical intervention. The patient's immediate postoperative course showed improvement in pain symptoms.

9. A minimally invasive transforaminal lumbar interbody fusion was performed to address severe spondylolisthesis at L5-S1. The surgical intervention involved the placement of an interbody cage filled with bone graft, followed by pedicle screw fixation. Meticulous attention was given to address the bone erosion and alleviate the patient's severe bone pain. The procedure was successful, and appropriate postoperative care was provided.

10. The patient underwent revision surgery for recurrent spondylolisthesis at L3-L4, requiring surgical intervention to address severe bone pain. Posterior revision decompression, fusion extension, and instrumentation were performed to stabilize the affected segment. Special attention was given to address the eroded bony structures and alleviate the patient's debilitating symptoms. Postoperative pain management was initiated, and the patient's progress was closely monitored.

1. Surgical intervention in the form of a posterior lumbar decompression and fusion was performed on a patient with severe spondylolisthesis at L4-L5. The procedure involved extensive laminectomy, facetectomy, and pedicle screw fixation. Attention was given to address the bone erosion contributing to the patient's severe bone pain. The surgical intervention was successful, and the patient's immediate postoperative course showed improvement in pain symptoms.

2. A revision surgery was performed on a patient with recurrent spondylolisthesis at L5-S1, necessitating surgical intervention to alleviate severe bone pain. The procedure involved extensive decompression, removal of eroded bone, bone grafting, and fusion extension. Meticulous attention was given to address the underlying cause of pain. The patient tolerated the surgery well, and postoperative pain management was initiated.

3. Surgical intervention in the form of an anterior lumbar interbody fusion was performed on a patient with advanced spondylolisthesis at L2-L3. The procedure involved meticulous removal of the degenerated disc, placement of an interbody cage, and fixation with screws and a plate. Special attention was given to address the severe bone pain caused by erosion. The patient's postoperative course showed significant improvement in pain symptoms.

4. A minimally invasive lateral lumbar interbody fusion was performed on a patient with severe spondylolisthesis at L4-L5. The surgical intervention involved the removal of the degenerated disc, insertion of an interbody cage, and stabilization with pedicle screws and rods. Emphasis was placed on addressing the severe bone pain resulting from erosion. The procedure was successful, and the patient's postoperative recovery was satisfactory.

5. Surgical intervention in the form of a posterior lumbar decompression and fusion was performed on a patient with severe spondylolisthesis at L3-L4. The procedure involved laminectomy, facetectomy, and pedicle screw fixation. Special attention was given to address the bone erosion and alleviate the patient's severe bone pain. The surgical intervention was well-tolerated, and postoperative pain management was initiated.

6. A revision surgery was performed on a patient with recurrent spondylolisthesis at L4-L5, requiring surgical intervention to alleviate severe bone pain. The procedure involved extensive decompression, removal of eroded bone, bone grafting, and fusion extension. Meticulous attention was given to address the underlying cause of pain. The patient's immediate postoperative course showed significant improvement in pain symptoms.

7. Surgical intervention in the form of an anterior lumbar interbody fusion was performed on a patient with advanced spondylolisthesis at L5-S1. The procedure involved meticulous removal of the eroded bone, placement of an interbody cage filled with bone graft, and fixation with screws and a plate. Special emphasis was given to alleviate the severe bone pain caused by erosion. The patient's postoperative course showed notable improvement in pain symptoms.

8. A minimally invasive transforaminal lumbar interbody fusion was performed to address severe spondylolisthesis at L3-L4. The surgical intervention involved the placement of an interbody cage filled with bone graft, followed by pedicle screw fixation. Meticulous attention was given to address the bone erosion and alleviate the patient's severe bone pain. The procedure was successful, and the patient's postoperative recovery was uneventful.

9. Surgical intervention in the form of a posterior lumbar decompression and fusion was performed on a patient with severe spondylolisthesis at L5-S1. The procedure involved laminectomy, facetectomy, and pedicle screw fixation. Special attention was given to address the bone erosion contributing to the patient's severe bone pain. The surgical intervention was well-tolerated, and the patient's postoperative pain was effectively managed.

10. A revision surgery was performed on a patient with recurrent spondylolisthesis at L2-L3, necessitating surgical intervention to alleviate severe bone pain. The procedure involved extensive decompression, removal of eroded bone, bone grafting, and fusion extension. Meticulous attention was given to address the underlying cause of pain. The patient's immediate postoperative course showed significant improvement in pain symptoms.

1. The patient presented with severe infection on the extreme moving joint associated with spondylolisthesis at L4-L5. Urgent surgical intervention was performed to address the infection and stabilize the joint. Extensive debridement, irrigation, and placement of antibiotic-impregnated cement spacers were carried out. Intraoperative measures were taken to address the severe infection. The patient's postoperative course included appropriate antibiotic therapy and close monitoring for resolution of infection.

2. Surgical intervention was undertaken for a patient with severe infection on the extreme moving joint due to spondylolisthesis at L5-S1. The procedure involved thorough debridement, removal of infected tissues, and stabilization of the joint using external fixation. Intraoperative irrigation with antibiotic solutions was performed to address the severe infection. The patient's immediate postoperative course involved intensive antibiotic therapy and close monitoring for resolution of infection.

3. In response to severe infection on the extreme moving joint associated with spondylolisthesis at L3-L4, urgent surgical intervention was carried out. The procedure involved extensive debridement, removal of infected tissues, and joint stabilization using internal fixation. Intraoperative measures were taken to address the severe infection, including thorough irrigation with antibiotic solutions. The patient's postoperative care included appropriate antibiotic therapy and regular monitoring for resolution of infection.

4. The patient presented with severe infection on the extreme moving joint due to spondylolisthesis at L4-L5, requiring immediate surgical intervention. The procedure involved extensive debridement of infected tissues, joint irrigation, and stabilization using external fixation. Intraoperative measures were taken to address the severe infection. The patient's postoperative course involved a comprehensive antibiotic regimen and close monitoring for resolution of the infection.

5. Surgical intervention was performed for a patient with severe infection on the extreme moving joint associated with spondylolisthesis at L2-L3. The procedure included meticulous debridement, removal of infected tissues, and joint stabilization using internal fixation. Intraoperative measures were taken to address the severe infection, including thorough irrigation with antibiotic solutions. Postoperatively, the patient received appropriate antibiotic therapy and close surveillance for resolution of the infection.

6. Urgent surgical intervention was undertaken for a patient with severe infection on the extreme moving joint due to spondylolisthesis at L5-S1. The procedure involved extensive debridement, removal of infected tissues, and stabilization of the joint using external fixation. Intraoperative measures were taken to address the severe infection, including thorough irrigation with antibiotic solutions. The patient's postoperative care included a tailored antibiotic regimen and regular monitoring for resolution of the infection.

7. In response to severe infection on the extreme moving joint associated with spondylolisthesis at L3-L4, immediate surgical intervention was performed. The procedure involved thorough debridement, removal of infected tissues, and joint stabilization using internal fixation. Intraoperative measures were taken to address the severe infection, including extensive irrigation with antibiotic solutions. The patient's postoperative course included appropriate antibiotic therapy and vigilant monitoring for resolution of the infection.

8. The patient presented with severe infection on the extreme moving joint due to spondylolisthesis at L4-L5, necessitating urgent surgical intervention. The procedure involved extensive debridement of infected tissues, joint irrigation, and stabilization using external fixation. Intraoperative measures were taken to address the severe infection. The patient's postoperative care involved a targeted antibiotic regimen and close observation for resolution of the infection.

9. Surgical intervention was performed for a patient with severe infection on the extreme moving joint associated with spondylolisthesis at L2-L3. The procedure included meticulous debridement, removal of infected tissues, and joint stabilization using internal fixation. Intra operative measures were taken to address the severe infection, including thorough irrigation with antibiotic solutions. Postoperatively, the patient received appropriate antibiotic therapy and close monitoring for resolution of the infection.

10. Urgent surgical intervention was undertaken for a patient with severe infection on the extreme moving joint due to spondylolisthesis at L5-S1. The procedure involved extensive debridement, removal of infected tissues, and stabilization of the joint using external fixation. Intraoperative measures were taken to address the severe infection, including thorough irrigation with antibiotic solutions. The patient's postoperative care included tailored antibiotic therapy and regular monitoring for resolution of the infection.

1. The patient presented with severe inflammation on the extreme moving joint associated with spondylolisthesis at L4-L5. Surgical intervention was performed to address the inflammation and stabilize the joint. Extensive debridement, anti-inflammatory medication administration, and joint immobilization were carried out. Intraoperative measures were taken to address the severe inflammation. The patient's postoperative course included appropriate anti-inflammatory therapy and close monitoring for resolution of inflammation.

2. Surgical intervention was undertaken for a patient with severe inflammation on the extreme moving joint due to spondylolisthesis at L5-S1. The procedure involved thorough debridement, removal of inflamed tissues, and stabilization of the joint using external fixation. Intraoperative irrigation with anti-inflammatory solutions was performed to address the severe inflammation. The patient's immediate postoperative course involved anti-inflammatory medication administration and close monitoring for resolution of inflammation.

3. In response to severe inflammation on the extreme moving joint associated with spondylolisthesis at L3-L4, surgical intervention was carried out. The procedure involved extensive debridement, removal of inflamed tissues, and joint stabilization using internal fixation. Intraoperative measures were taken to address the severe inflammation, including thorough irrigation with anti-inflammatory solutions. The patient's postoperative care included appropriate anti-inflammatory therapy and regular monitoring for resolution of inflammation.

4. The patient presented with severe inflammation on the extreme moving joint due to spondylolisthesis at L4-L5, requiring surgical intervention. The procedure involved extensive debridement of inflamed tissues, joint irrigation, and stabilization using external fixation. Intraoperative measures were taken to address the severe inflammation. The patient's postoperative course involved a comprehensive anti-inflammatory regimen and close monitoring for resolution of the inflammation.

5. Surgical intervention was performed for a patient with severe inflammation on the extreme moving joint associated with spondylolisthesis at L2-L3. The procedure included meticulous debridement, removal of inflamed tissues, and joint stabilization using internal fixation. Intraoperative measures were taken to address the severe inflammation, including thorough irrigation with anti-inflammatory solutions. Postoperatively, the patient received appropriate anti-inflammatory therapy and close surveillance for resolution of the inflammation.

6. Urgent surgical intervention was undertaken for a patient with severe inflammation on the extreme moving joint due to spondylolisthesis at L5-S1. The procedure involved extensive debridement, removal of inflamed tissues, and stabilization of the joint using external fixation. Intraoperative measures were taken to address the severe inflammation, including thorough irrigation with anti-inflammatory solutions. The patient's postoperative care included a tailored anti-inflammatory regimen and regular monitoring for resolution of inflammation.

7. In response to severe inflammation on the extreme moving joint associated with spondylolisthesis at L3-L4, immediate surgical intervention was performed. The procedure involved thorough debridement, removal of inflamed tissues, and joint stabilization using internal fixation. Intraoperative measures were taken to address the severe inflammation, including extensive irrigation with anti-inflammatory solutions. The patient's postoperative course included appropriate anti-inflammatory therapy and vigilant monitoring for resolution of inflammation.

8. The patient presented with severe inflammation on the extreme moving joint due to spondylolisthesis at L4-L5, necessitating urgent surgical intervention. The procedure involved extensive debridement of inflamed tissues, joint irrigation, and stabilization using external fixation. Intraoperative measures were taken to address the severe inflammation. The patient's postoperative care involved a targeted anti-inflammatory regimen and close observation for resolution of the inflammation.

9. Surgical intervention was performed for a patient with severe inflammation on the extreme moving joint associated with spondylolisthesis at L2-L3. The procedure included meticulous debridement, removal of inflamed tissues, and joint stabilization using internal fixation. Intraoperative measures were taken to address the severe inflammation, including thorough irrigation with anti-inflammatory solutions. Postoperatively, the patient received appropriate anti-inflammatory therapy and close monitoring for resolution of inflammation.

10. Urgent surgical intervention was undertaken for a patient with severe inflammation on the extreme moving joint due to spondylolisthesis at L5-S1. The procedure involved extensive debridement, removal of inflamed tissues, and stabilization of the joint using external fixation. Intraoperative measures were taken to address the severe inflammation, including thorough irrigation with anti-inflammatory solutions. The patient's postoperative care included tailored anti-inflammatory therapy and regular monitoring for resolution of inflammation.

1. The patient's diagnosis of severe spondylolisthesis at L4-L5 necessitated a comprehensive follow-up plan. Given the severity of the condition, regular postoperative visits were scheduled to monitor the patient's progress, assess pain levels, and evaluate the stability of the fused segments. Imaging studies, such as X-rays or MRI, were planned at specific intervals to track the healing process and identify any potential complications. Physical therapy and rehabilitation sessions were also incorporated into the follow-up plan to optimize the patient's recovery.

2. Due to the moderate spondylolisthesis diagnosis at L3-L4, the patient's follow-up plan was tailored accordingly. Regular check-ups were scheduled to assess the patient's pain levels, functional mobility, and response to conservative management. If the symptoms persisted or worsened, a reassessment was planned to explore further treatment options, which could include minimally invasive interventions or surgical consultation. The follow-up plan aimed to address the patient's condition effectively while minimizing unnecessary interventions.

3. The patient's mild spondylolisthesis at L5-S1 called for a structured follow-up plan based on the severity of the diagnosis. Initial visits were scheduled to monitor the patient's symptoms and provide conservative management, including pain medications and physical therapy. Follow-up appointments were spaced at regular intervals to assess the patient's progress and determine the need for additional interventions. The follow-up plan emphasized close communication between the patient and healthcare team to ensure appropriate care and address any concerns.

4. Given the severe spondylolisthesis diagnosis at L2-L3, an intensive follow-up plan was implemented. The patient was scheduled for regular postoperative visits to assess pain levels, monitor surgical site healing, and evaluate the stability of the fusion construct. Radiological imaging, such as X-rays or CT scans, was planned at specific intervals to monitor the alignment and fusion progress. Physical therapy and rehabilitation sessions were an integral part of the follow-up plan to optimize the patient's functional recovery and overall outcome.

5. The patient's diagnosis of moderate spondylolisthesis at L4-L5 required a structured follow-up plan. Follow-up visits were scheduled to assess the patient's response to conservative management, including pain medication, physical therapy, and activity modification. The severity of symptoms determined the frequency of follow-up appointments, with close monitoring for any deterioration or the need for further interventions. The follow-up plan aimed to achieve symptom control, improve functionality, and prevent the progression of the condition.

6. The mild spondylolisthesis diagnosis at L3-L4 allowed for a less frequent follow-up plan. Initial visits focused on educating the patient about the condition, providing self-care strategies, and scheduling periodic reassessments. Follow-up appointments were spaced out to assess the patient's response to conservative measures, monitor symptom progression, and address any concerns. The follow-up plan aimed to ensure ongoing support while minimizing unnecessary visits and interventions.

7. Given the severity of the diagnosis with severe spondylolisthesis at L5-S1, a comprehensive and frequent follow-up plan was established. Regular postoperative visits were scheduled to monitor the patient's pain levels, assess neurological function, and evaluate the integrity of the fusion construct. Radiological imaging, such as X-rays or MRI scans, was performed at specific intervals to monitor the healing process and detect any potential complications. The follow-up plan prioritized close collaboration between the patient, surgeon, and rehabilitation team to optimize the patient's recovery.

8. The patient's diagnosis of moderate spondylolisthesis at L2-L3 required a structured follow-up plan. Regular visits were scheduled to assess the patient's pain levels, functional mobility, and response to conservative measures. If the symptoms persisted or worsened, a reassessment was planned to consider alternative treatment options, such as injections or surgical consultation. The follow-up plan aimed to address the patient's condition effectively while minimizing unnecessary interventions and ensuring personalized care.

9. Given the mild spondylolisthesis diagnosis at L4-L5, a tailored follow-up plan was implemented. Initial visits focused on conservative management strategies, including physical therapy, pain medications, and activity modification. Follow-up appointments were scheduled to assess the patient's response to treatment, monitor symptom progression, and adjust the management plan as necessary. The follow-up plan aimed to provide ongoing support, promote self-care, and prevent the exacerbation of symptoms.

10. The patient's severe spondylolisthesis diagnosis at L3-L4 necessitated an intensive follow-up plan. Regular postoperative visits were scheduled to monitor the patient's pain levels, assess neurological function, and evaluate the stability of the fusion construct. Radiological imaging, such as X-rays or CT scans, was performed at specific intervals to track the healing process and detect any potential complications. Physical therapy and rehabilitation sessions were incorporated into the follow-up plan to optimize the patient's functional recovery and long-term outcome.

## M43.2 Other fusion of spine

1. Operative Note: Patient underwent other fusion of spine at L4-L5 level. The procedure involved the placement of pedicle screws bilaterally, followed by interbody cage insertion and bone grafting. Fluoroscopy was used to confirm proper screw placement and alignment. Hemostasis was achieved, and the wound was closed in layers. Patient tolerated the procedure well without any complications.

2. Operative Note: Other fusion of spine was performed on the patient at C6-C7 level. Pedicle screws were inserted bilaterally, and an interbody cage was placed to facilitate fusion. Autograft and allograft bone were used to promote bone growth. Intraoperative neuromonitoring was utilized to ensure the safety of neural structures. The surgical site was closed meticulously, and the patient tolerated the procedure without any issues.

3. Operative Note: The patient underwent other fusion of spine at T10-T11 level. A posterior approach was utilized, and pedicle screws were placed bilaterally for stability. Interbody fusion was achieved using an expandable cage and bone grafting. Intraoperative image guidance was employed to ensure accurate screw placement. Hemostasis was achieved, and the incision was closed. The patient's postoperative recovery was uneventful.

4. Operative Note: Other fusion of spine was performed at the L2-L3 level in the patient. Pedicle screws were inserted bilaterally, and an interbody graft was placed. Autologous bone graft was utilized to enhance fusion. Intraoperative fluoroscopy was used for verification of instrumentation placement. Hemostasis was achieved, and the incision was closed in layers. The patient tolerated the procedure well, and there were no immediate postoperative complications.

5. Operative Note: The patient underwent other fusion of spine at the T12-L1 level. Pedicle screws were placed bilaterally, followed by the insertion of an expandable interbody cage. Bone grafting was performed to facilitate fusion. Intraoperative neurophysiological monitoring was used to ensure neural integrity. The surgical site was closed meticulously, and the patient had an uneventful recovery without any complications.

6. Operative Note: Other fusion of spine was performed on the patient at the C3-C4 level. Bilateral pedicle screws were inserted, and an interbody fusion device was placed. Bone graft material was used to enhance fusion. Intraoperative imaging confirmed proper instrumentation positioning. Hemostasis was achieved, and the wound was closed in layers. The patient's immediate postoperative course was uncomplicated.

7. Operative Note: The patient underwent other fusion of spine at the L5-S1 level. Pedicle screws were inserted bilaterally, and an interbody cage was placed for stabilization. Bone graft material was utilized to promote fusion. Intraoperative fluoroscopy was employed to confirm the accuracy of screw placement. The surgical incision was closed in layers, and the patient had an uneventful postoperative recovery.

8. Operative Note: Other fusion of spine was performed on the patient at the T9-T10 level. Pedicle screws were inserted bilaterally, and an interbody graft was placed. Autograft and allograft bone were utilized to facilitate fusion. Intraoperative neuromonitoring was employed to protect neural structures. Hemostasis was achieved, and the incision was closed meticulously. The patient tolerated the procedure well without any immediate complications.

9. Operative Note: The patient underwent other fusion of spine at the C5-C6 level. Pedicle screws were inserted bilaterally, and an interbody cage was placed to promote fusion. Autologous bone graft was used to enhance bone growth. Intraoperative fluoroscopy confirmed accurate screw placement. Hemostasis was achieved, and the incision was closed in layers. The patient had a smooth postoperative course without any complications.

10. Operative Note: Other fusion of spine was performed at the L3-L4 level in the patient. Bilateral pedicle screws were inserted, and an interbody graft was placed for stabilization. Bone graft material was utilized to facilitate fusion. Intraoperative imaging confirmed proper instrumentation positioning. Hemostasis was achieved, and the wound was closed meticulously. The patient's immediate postoperative recovery was unremarkable.

1. Operative Note: Patient underwent other fusion of spine at the C2-C3 level. Pedicle screws were placed bilaterally, followed by the placement of an interbody cage and bone grafting. Intraoperative fluoroscopy was used to ensure accurate screw positioning. Hemostasis was achieved, and the incision was closed in layers. The patient tolerated the procedure well without any immediate complications.

2. Operative Note: Other fusion of spine was performed on the patient at the T6-T7 level. Pedicle screws were inserted bilaterally, and an interbody cage was placed to promote fusion. Autograft and allograft bone grafts were utilized. Intraoperative neurophysiological monitoring was used to safeguard neural structures. The incision was closed meticulously, and the patient had an uneventful postoperative course.

3. Operative Note: The patient underwent other fusion of spine at the L1-L2 level. Bilateral pedicle screws were inserted, followed by the placement of an interbody graft and bone grafting. Intraoperative fluoroscopy confirmed proper instrumentation placement. Hemostasis was achieved, and the incision was closed in layers. The patient had an uncomplicated recovery period without any immediate postoperative issues.

4. Operative Note: Other fusion of spine was performed at the C4-C5 level in the patient. Pedicle screws were inserted bilaterally, and an interbody cage was placed. Autologous bone graft was utilized to facilitate fusion. Intraoperative fluoroscopy was used for confirmation of screw placement. Hemostasis was achieved, and the wound was closed meticulously. The patient's postoperative recovery was smooth without any complications.

5. Operative Note: The patient underwent other fusion of spine at the T8-T9 level. Bilateral pedicle screws were inserted, followed by the placement of an interbody cage and bone grafting. Intraoperative imaging confirmed accurate screw positioning. Hemostasis was achieved, and the incision was closed in layers. The patient had an uneventful immediate postoperative course without any complications.

6. Operative Note: Other fusion of spine was performed on the patient at the L2-L3 level. Pedicle screws were inserted bilaterally, and an interbody graft was placed to promote fusion. Autograft and allograft bone grafts were utilized. Intraoperative neuromonitoring was employed to ensure neural safety. Hemostasis was achieved, and the incision was closed meticulously. The patient tolerated the procedure well without any immediate issues.

7. Operative Note: The patient underwent other fusion of spine at the C6-C7 level. Bilateral pedicle screws were inserted, and an interbody cage was placed. Autologous bone graft was used to enhance fusion. Intraoperative fluoroscopy confirmed accurate screw placement. Hemostasis was achieved, and the wound was closed meticulously. The patient had a smooth recovery without any immediate complications.

8. Operative Note: Other fusion of spine was performed on the patient at the T11-T12 level. Pedicle screws were inserted bilaterally, and an interbody cage was placed for stabilization. Autograft and allograft bone grafts were utilized to facilitate fusion. Intraoperative imaging confirmed proper screw positioning. Hemostasis was achieved, and the incision was closed in layers. The patient's postoperative recovery was unremarkable.

9. Operative Note: The patient underwent other fusion of spine at the L4-L5 level. Pedicle screws were inserted bilaterally, followed by the placement of an interbody graft and bone grafting. Intraoperative fluoroscopy was used to ensure accurate screw positioning. Hemostasis was achieved, and the incision was closed in layers. The patient tolerated the procedure well without any immediate complications.

10. Operative Note: Other fusion of spine was performed at the C7-T1 level in the patient. Pedicle screws were inserted bilaterally, and an interbody cage was placed to facilitate fusion. Autograft and allograft bone grafts were utilized. Intraoperative neurophysiological monitoring was employed to ensure neural integrity. Hemostasis was achieved, and the incision was closed meticulously. The patient had an uneventful postoperative recovery without any complications.

1. Operative Note: Patient underwent other fusion of spine at the L3-L4 level under general anesthesia. Bilateral pedicle screws were inserted, followed by the placement of an interbody graft and bone grafting. Intraoperative fluoroscopy confirmed proper screw placement. Hemostasis was achieved, and the incision was closed in layers. The patient tolerated the procedure well with a standard dosage of anesthesia without any immediate complications.

2. Operative Note: Other fusion of spine was performed on the patient at the C5-C6 level under regional anesthesia. Bilateral pedicle screws were inserted, and an interbody cage was placed to promote fusion. Autologous bone graft was utilized. Intraoperative fluoroscopy was used to confirm accurate screw positioning. Hemostasis was achieved, and the incision was closed meticulously. The patient had an uneventful recovery with a modified dosage of anesthesia.

3. Operative Note: The patient underwent other fusion of spine at the T9-T10 level with the administration of monitored anesthesia care (MAC). Bilateral pedicle screws were inserted, followed by the placement of an interbody graft and bone grafting. Intraoperative imaging confirmed proper instrumentation placement. Hemostasis was achieved, and the incision was closed in layers. The patient had a smooth postoperative course with a reduced dosage of anesthesia.

4. Operative Note: Other fusion of spine was performed at the C4-C5 level with the patient under general anesthesia using a higher dosage due to underlying medical conditions. Pedicle screws were inserted bilaterally, and an interbody cage was placed. Autologous bone graft was utilized. Intraoperative fluoroscopy confirmed accurate screw placement. Hemostasis was achieved, and the wound was closed meticulously. The patient had a stable recovery with appropriate anesthesia management.

5. Operative Note: The patient underwent other fusion of spine at the T12-L1 level under spinal anesthesia. Bilateral pedicle screws were inserted, followed by the placement of an interbody graft and bone grafting. Intraoperative imaging confirmed proper screw positioning. Hemostasis was achieved, and the incision was closed in layers. The patient had a successful procedure with the appropriate dosage of anesthesia and experienced no immediate complications.

6. Operative Note: Other fusion of spine was performed on the patient at the L2-L3 level with the use of general anesthesia and a reduced dosage to minimize potential side effects. Pedicle screws were inserted bilaterally, and an interbody graft was placed. Autograft and allograft bone grafts were utilized. Intraoperative fluoroscopy confirmed accurate screw placement. Hemostasis was achieved, and the incision was closed meticulously. The patient tolerated the procedure well with optimized anesthesia management.

7. Operative Note: The patient underwent other fusion of spine at the C6-C7 level under local anesthesia with sedation. Bilateral pedicle screws were inserted, and an interbody cage was placed. Autologous bone graft was used to enhance fusion. Intraoperative fluoroscopy confirmed accurate screw placement. Hemostasis was achieved, and the incision was closed in layers. The patient had a comfortable procedure with the appropriate dosage of anesthesia and experienced no immediate complications.

8. Operative Note: Other fusion of spine was performed on the patient at the T7-T8 level under general anesthesia with a higher dosage due to the complexity of the procedure. Pedicle screws were inserted bilaterally, followed by the placement of an interbody cage and bone grafting. Intraoperative imaging confirmed accurate screw positioning. Hemostasis was achieved, and the wound was closed meticulously. The patient had a stable postoperative course with optimized anesthesia management.

9. Operative Note: The patient underwent other fusion of spine at the L5-S1 level with the administration of regional anesthesia using a lower dosage to minimize systemic effects. Pedicle screws were inserted bilaterally, and an interbody cage was placed for stabilization. Autograft and allograft bone grafts were utilized. Intraoperative fluoroscopy was employed to confirm proper screw placement. Hemostasis was achieved, and the incision was closed in layers. The patient had a successful procedure with appropriate anesthesia adjustment.

10. Operative Note: Other fusion of spine was performed at the C3-C4 level with the patient under monitored anesthesia care (MAC) using a moderate dosage. Bilateral pedicle screws were inserted, and an interbody cage was placed. Autograft and allograft bone grafts were utilized. Intraoperative imaging confirmed accurate screw placement. Hemostasis was achieved, and the incision was closed meticulously. The patient had a stable recovery with optimized anesthesia management.

1. Operative Note: The patient underwent other fusion of spine at the L4-L5 level with significant bone erosion. Bilateral pedicle screws were inserted carefully, and an interbody cage was placed, taking into account the compromised bone structure. Augmented bone grafting techniques were utilized to enhance fusion. Intraoperative fluoroscopy confirmed appropriate screw placement. Hemostasis was achieved, and the incision was closed meticulously. The patient tolerated the procedure well, considering the bone erosion, and there were no immediate complications.

2. Operative Note: Other fusion of spine was performed on the patient at the C6-C7 level with notable bone erosion. Bilateral pedicle screws were cautiously inserted, and a customized interbody cage was employed to address the compromised bone integrity. Advanced bone grafting techniques, including the use of bone substitutes, were utilized to enhance fusion. Intraoperative imaging confirmed optimal screw positioning. Hemostasis was achieved, and the wound was closed in layers. The patient's immediate postoperative course was unremarkable despite the bone erosion.

3. Operative Note: The patient underwent other fusion of spine at the T11-T12 level with significant bone erosion. Special care was taken during the insertion of bilateral pedicle screws to ensure stability in the compromised bone. A reinforced interbody cage with structural support was utilized to address the bone erosion. Augmented bone grafting techniques, such as the addition of bone morphogenetic protein, were employed. Intraoperative imaging confirmed satisfactory screw placement. Hemostasis was achieved, and the incision was meticulously closed. The patient tolerated the procedure well, considering the bone erosion, and there were no immediate complications.

4. Operative Note: Other fusion of spine was performed on the patient at the C4-C5 level with evident bone erosion. Bilateral pedicle screws were cautiously inserted, and a customized interbody cage was employed to accommodate the eroded bone structure. Advanced bone grafting techniques, including the use of allograft and demineralized bone matrix, were utilized. Intraoperative fluoroscopy confirmed accurate screw positioning. Hemostasis was achieved, and the wound was closed meticulously. Despite the bone erosion, the patient had a smooth immediate postoperative recovery without any complications.

5. Operative Note: The patient underwent other fusion of spine at the T8-T9 level with significant bone erosion. Bilateral pedicle screws were inserted with caution, considering the eroded bone. A specialized interbody cage was utilized to provide stability in the affected area. Augmented bone grafting techniques, such as the use of bone morphogenetic protein and autograft, were employed. Intraoperative imaging confirmed optimal screw placement. Hemostasis was achieved, and the incision was closed in layers. The patient's immediate postoperative course was uneventful despite the bone erosion.

6. Operative Note: Other fusion of spine was performed on the patient at the L2-L3 level with evident bone erosion. Bilateral pedicle screws were inserted meticulously, considering the compromised bone structure. A customized interbody cage with additional structural support was utilized to address the erosion. Advanced bone grafting techniques, including the use of bone graft substitutes, were employed. Intraoperative fluoroscopy confirmed appropriate screw positioning. Hemostasis was achieved, and the incision was meticulously closed. The patient tolerated the procedure well, taking into account the bone erosion, and there were no immediate complications.

7. Operative Note: The patient underwent other fusion of spine at the C7-T1 level with significant bone erosion. Special care was taken during the insertion of bilateral pedicle screws to ensure stability in the eroded bone. A reinforced interbody cage with augmented structural support was utilized. Advanced bone grafting techniques, including the use of

bone graft extenders, were employed. Intraoperative imaging confirmed satisfactory screw placement. Hemostasis was achieved, and the incision was meticulously closed. Despite the bone erosion, the patient had a smooth immediate postoperative recovery without any complications.

8. Operative Note: Other fusion of spine was performed on the patient at the T4-T5 level with notable bone erosion. Bilateral pedicle screws were carefully inserted to ensure stability in the compromised bone. A customized interbody cage was utilized, taking into account the erosion. Advanced bone grafting techniques, such as the use of bone morphogenetic protein and allograft, were employed. Intraoperative fluoroscopy confirmed accurate screw placement. Hemostasis was achieved, and the wound was closed meticulously. The patient had an uneventful immediate postoperative course despite the bone erosion.

9. Operative Note: The patient underwent other fusion of spine at the L3-L4 level with significant bone erosion. Bilateral pedicle screws were inserted cautiously, considering the compromised bone structure. A specialized interbody cage was employed to address the erosion and provide stability. Augmented bone grafting techniques, including the use of bone graft substitutes, were utilized. Intraoperative imaging confirmed optimal screw positioning. Hemostasis was achieved, and the incision was meticulously closed. The patient tolerated the procedure well, considering the bone erosion, and there were no immediate complications.

10. Operative Note: Other fusion of spine was performed on the patient at the C2-C3 level with evident bone erosion. Careful attention was given during the insertion of bilateral pedicle screws to ensure stability despite the eroded bone. A customized interbody cage was utilized, taking into consideration the erosion. Advanced bone grafting techniques, including the use of bone morphogenetic protein and autograft, were employed. Intraoperative fluoroscopy confirmed satisfactory screw placement. Hemostasis was achieved, and the wound was closed meticulously. Despite the bone erosion, the patient had a smooth immediate postoperative recovery without any complications.

1. Operative Note: The patient presented with severe bone pain and underwent other fusion of spine at the L4-L5 level. Bilateral pedicle screws were carefully inserted, taking into consideration the patient's pain. A specialized interbody cage was employed to address the pain and instability. Advanced bone grafting techniques, including the use of bone morphogenetic protein and autograft, were utilized. Intraoperative imaging confirmed optimal screw placement. Hemostasis was achieved, and the incision was meticulously closed. The patient experienced relief from severe bone pain immediately after the procedure.

2. Operative Note: Other fusion of spine was performed on the patient at the C6-C7 level due to debilitating bone pain. Bilateral pedicle screws were inserted meticulously, considering the patient's severe pain. A customized interbody cage was utilized to address the pain and promote stability. Advanced bone grafting techniques, including the use of bone graft substitutes, were employed. Intraoperative fluoroscopy confirmed accurate screw placement. Hemostasis was achieved, and the wound was closed meticulously. The patient reported a significant reduction in bone pain postoperatively.

3. Operative Note: The patient underwent other fusion of spine at the T11-T12 level to alleviate severe bone pain. Bilateral pedicle screws were carefully inserted, considering the patient's intense pain. A reinforced interbody cage with additional structural support was utilized to address the pain and instability. Advanced bone grafting techniques, including the use of bone graft extenders, were employed. Intraoperative imaging confirmed optimal screw positioning. Hemostasis was achieved, and the incision was meticulously closed. The patient experienced notable relief from severe bone pain immediately after the procedure.

4. Operative Note: Other fusion of spine was performed on the patient at the C4-C5 level due to severe bone pain. Bilateral pedicle screws were inserted with meticulous care, taking into account the patient's intense pain. A specialized interbody cage was employed to address the pain and promote stability. Advanced bone grafting techniques, including the use of bone graft substitutes, were utilized. Intraoperative fluoroscopy confirmed accurate screw placement. Hemostasis was achieved, and the wound was closed meticulously. The patient reported a significant reduction in bone pain following the procedure.

5. Operative Note: The patient underwent other fusion of spine at the T8-T9 level to alleviate severe bone pain. Bilateral pedicle screws were carefully inserted, considering the patient's intense pain. A customized interbody cage was utilized to address the pain and instability. Advanced bone grafting techniques, such as the use of bone graft extenders, were employed. Intraoperative imaging confirmed optimal screw placement. Hemostasis was achieved, and the incision was meticulously closed. The patient experienced significant relief from severe bone pain postoperatively.

6. Operative Note: Other fusion of spine was performed on the patient at the L2-L3 level to address severe bone pain. Bilateral pedicle screws were inserted with great care, considering the patient's intense pain. A specialized interbody cage was employed to alleviate the pain and promote stability. Advanced bone grafting techniques, including the use of bone graft substitutes, were utilized. Intraoperative fluoroscopy confirmed accurate screw placement. Hemostasis was achieved, and the incision was meticulously closed. The patient reported a marked reduction in severe bone pain immediately after the procedure.

7. Operative Note: The patient underwent other fusion of spine at the C7-T1 level to alleviate severe bone pain. Bilateral pedicle screws were carefully inserted, taking into consideration the patient's intense pain. A reinforced interbody cage with additional structural support was utilized to address the pain and promote stability. Advanced bone grafting techniques, including the use of bone graft extenders, were employed. Intraoperative imaging confirmed optimal screw positioning. Hemostasis was achieved, and the incision was meticulously closed. The patient experienced significant relief from severe bone pain postoperatively.

8. Operative Note: Other fusion of spine was performed on the patient at the T4-T5 level due to debilitating bone pain. Bilateral pedicle screws were inserted meticulously, considering the patient's severe pain. A customized interbody cage was utilized to address the pain and instability. Advanced bone grafting techniques, such as the use of bone graft extenders, were employed. Intraoperative fluoroscopy confirmed accurate screw placement. Hemostasis was achieved, and the wound was closed meticulously. The patient reported substantial reduction in severe bone pain immediately after the procedure.

9. Operative Note: The patient underwent other fusion of spine at the L3-L4 level to alleviate severe bone pain. Bilateral pedicle screws were inserted with great care, taking into account the patient's intense pain. A specialized interbody cage was employed to address the pain and promote stability. Advanced bone grafting techniques, including the use of bone graft substitutes, were utilized. Intraoperative imaging confirmed optimal screw placement. Hemostasis was achieved, and the incision was meticulously closed. The patient experienced notable relief from severe bone pain postoperatively.

10. Operative Note: Other fusion of spine was performed on the patient at the C2-C3 level to address severe bone pain. Bilateral pedicle screws were carefully inserted, considering the patient's intense pain. A reinforced interbody cage with additional structural support was utilized to alleviate the pain and promote stability. Advanced bone grafting techniques, such as the use of bone graft extenders, were employed. Intraoperative fluoroscopy confirmed accurate screw placement. Hemostasis was achieved, and the incision was meticulously closed. The patient reported significant relief from severe bone pain following the procedure.

1. Operative Note: The patient underwent other fusion of spine at the L4-L5 level with severe bone pain refractory to conservative management. Bilateral pedicle screws were meticulously inserted, and a customized interbody cage was utilized. In addition to fusion, a surgical decompression was performed to alleviate nerve compression contributing to the pain. Advanced bone grafting techniques were employed. Intraoperative imaging confirmed optimal screw placement. Hemostasis was achieved, and the incision was meticulously closed. The patient experienced significant relief from bone pain following the surgical intervention.

2. Operative Note: Other fusion of spine was performed on the patient at the C6-C7 level due to severe bone pain that persisted despite non-surgical treatment options. Bilateral pedicle screws were carefully inserted, and a specialized interbody cage was employed. A surgical intervention involving the removal of osteophytes and decompression of neural structures was performed to alleviate the pain. Advanced bone grafting techniques were utilized. Intraoperative imaging confirmed accurate screw placement. Hemostasis was achieved, and the wound was meticulously closed. The patient reported a remarkable reduction in bone pain following the surgical intervention.

3. Operative Note: The patient underwent other fusion of spine at the T11-T12 level to address severe bone pain that was refractory to conservative measures. Bilateral pedicle screws were inserted with caution, and a reinforced interbody cage was utilized. In addition to fusion, a surgical intervention involving the removal of a prominent bony spur was performed to alleviate the pain. Advanced bone grafting techniques were employed. Intraoperative imaging confirmed optimal screw positioning. Hemostasis was achieved, and the incision was closed meticulously. The patient experienced significant relief from severe bone pain following the surgical intervention.

4. Operative Note: Other fusion of spine was performed on the patient at the C4-C5 level due to debilitating bone pain unresponsive to non-surgical interventions. Bilateral pedicle screws were meticulously inserted, and a customized interbody cage was employed. A surgical intervention was performed to address foraminal stenosis and nerve root compression contributing to the pain. Advanced bone grafting techniques were utilized. Intraoperative fluoroscopy confirmed accurate screw placement. Hemostasis was achieved, and the wound was closed meticulously. The patient reported notable relief from severe bone pain following the surgical intervention.

5. Operative Note: The patient underwent other fusion of spine at the T8-T9 level to alleviate severe bone pain that was resistant to conservative treatment. Bilateral pedicle screws were carefully inserted, and a specialized interbody cage was utilized. A surgical intervention involving the removal of a herniated disc and decompression of neural structures was performed to address the pain. Advanced bone grafting techniques, including the use of bone morphogenetic protein, were employed. Intraoperative imaging confirmed optimal screw placement. Hemostasis was achieved, and the incision was meticulously closed. The patient experienced significant relief from severe bone pain following the surgical intervention.

6. Operative Note: Other fusion of spine was performed on the patient at the L2-L3 level to address severe bone pain that was refractory to conservative measures. Bilateral pedicle screws were inserted with great care, and a customized interbody cage was employed. A surgical intervention was performed to correct spinal misalignment and instability contributing to the pain. Advanced bone grafting techniques, including the use of bone graft substitutes, were utilized. Intraoperative fluoroscopy confirmed accurate screw placement. Hemostasis was achieved, and the incision was meticulously closed. The patient reported marked reduction in bone pain following the surgical intervention.

7. Operative Note: The patient underwent other fusion of spine at the C7-T1 level due to severe bone pain that persisted despite non-surgical treatment. Bilateral pedicle screws were carefully inserted, and a reinforced interbody cage was utilized. A surgical intervention involving the removal of a synovial cyst and decompression of neural structures was performed to alleviate the pain. Advanced bone grafting techniques were employed. Intraoperative imaging confirmed optimal screw positioning. Hemostasis was achieved, and the incision was meticulously closed. The patient experienced significant relief from severe bone pain following the surgical intervention.

8. Operative Note: Other fusion of spine was performed on the patient at the T4-T5 level to address severe bone pain that was unresponsive to conservative measures. Bilateral pedicle screws were meticulously inserted, and a specialized interbody cage was employed. A surgical intervention involving the removal of a degenerated disc and decompression of neural structures was performed to alleviate the pain. Advanced bone grafting techniques, including the use of bone graft extenders, were utilized. Intraoperative fluoroscopy confirmed accurate screw placement. Hemostasis was achieved, and the wound was closed meticulously. The patient reported a significant reduction in bone pain following the surgical intervention.

9. Operative Note: The patient underwent other fusion of spine at the L3-L4 level to address severe bone pain that persisted despite conservative treatment. Bilateral pedicle screws were inserted with meticulous care, and a customized interbody cage was employed. A surgical intervention involving the removal of osteophytes and decompression of neural structures was performed to alleviate the pain. Advanced bone grafting techniques, including the use of bone graft substitutes, were employed. Intraoperative imaging confirmed optimal screw placement. Hemostasis was achieved, and the incision was meticulously closed. The patient experienced notable relief from severe bone pain following the surgical intervention.

10. Operative Note: Other fusion of spine was performed on the patient at the C2-C3 level due to severe bone pain refractory to non-surgical treatment options. Bilateral pedicle screws were carefully inserted, and a reinforced interbody cage was utilized. A surgical intervention involving the removal of a herniated disc and decompression of neural structures was performed to alleviate the pain. Advanced bone grafting techniques, including the use of bone graft extenders, were employed. Intraoperative fluoroscopy confirmed accurate screw placement. Hemostasis was achieved, and the incision was meticulously closed. The patient reported significant relief from severe bone pain following the surgical intervention.

1. Operative Note: The patient underwent other fusion of spine at the L4-L5 level due to severe bone pain and progressive spinal instability. Bilateral pedicle screws were meticulously inserted, and a customized interbody cage was utilized. A surgical intervention involving the removal of a spinal tumor was performed to address the pain and restore spinal stability. Advanced bone grafting techniques, including the use of bone graft substitutes, were employed. Intraoperative imaging confirmed accurate screw placement. Hemostasis was achieved, and the incision was meticulously closed. The patient experienced significant relief from severe bone pain following the surgical intervention.

2. Operative Note: Other fusion of spine was performed on the patient at the C6-C7 level to address severe bone pain secondary to severe degenerative disc disease. Bilateral pedicle screws were carefully inserted, and a specialized interbody cage was employed. A surgical intervention involving the removal of a large disc herniation and decompression of neural structures was performed to alleviate the pain. Advanced bone grafting techniques, including the use of bone morphogenetic protein, were utilized. Intraoperative fluoroscopy confirmed optimal screw placement. Hemostasis was achieved, and the wound was closed meticulously. The patient reported significant relief from severe bone pain following the surgical intervention.

3. Operative Note: The patient underwent other fusion of spine at the T11-T12 level due to severe bone pain associated with spinal stenosis. Bilateral pedicle screws were inserted with great care, and a reinforced interbody cage was utilized. A surgical intervention involving the removal of hypertrophic ligamentum flavum and decompression of neural structures was performed to alleviate the pain. Advanced bone grafting techniques, including the use of bone graft extenders, were employed. Intraoperative imaging confirmed optimal screw placement. Hemostasis was achieved, and the incision was meticulously closed. The patient experienced marked reduction in severe bone pain following the surgical intervention.

4. Operative Note: Other fusion of spine was performed on the patient at the C4-C5 level due to severe bone pain resulting from spinal instability. Bilateral pedicle screws were meticulously inserted, and a customized interbody cage was employed. A surgical intervention involving the repair of spondylolisthesis and restoration of spinal alignment was performed to address the pain. Advanced bone grafting techniques, including the use of bone graft substitutes, were utilized. Intraoperative imaging confirmed accurate screw placement. Hemostasis was achieved, and the incision was closed meticulously. The patient reported notable relief from severe bone pain following the surgical intervention.

5. Operative Note: The patient underwent other fusion of spine at the T8-T9 level to address severe bone pain associated with spinal fracture. Bilateral pedicle screws were carefully inserted, and a specialized interbody cage was employed. A surgical intervention involving the stabilization of the fractured vertebrae and restoration of spinal alignment was performed to alleviate the pain. Advanced bone grafting techniques, including the use of bone graft extenders, were employed. Intraoperative fluoroscopy confirmed optimal screw placement. Hemostasis was achieved, and the incision was meticulously closed. The patient experienced significant relief from severe bone pain following the surgical intervention.

6. Operative Note: Other fusion of spine was performed on the patient at the L2-L3 level to address severe bone pain caused by a spinal infection. Bilateral pedicle screws were meticulously inserted, and a reinforced interbody cage was utilized. A surgical intervention involving the debridement of infected tissues and stabilization of the affected segment was performed to alleviate the pain. Advanced bone grafting techniques, including the use of antibiotic-impregnated bone grafts, were employed. Intraoperative imaging confirmed accurate screw placement. Hemostasis was achieved, and the incision was meticulously closed. The patient reported notable relief from severe bone pain following the surgical intervention.

7. Operative Note: The patient underwent other fusion of spine at the C7-T1 level to address severe bone pain resulting from a vertebral compression fracture. Bilateral pedicle screws were carefully inserted, and a customized interbody cage was employed. A surgical intervention involving vertebral augmentation with bone cement was performed to stabilize the fractured vertebrae and alleviate the pain. Advanced bone grafting techniques, including the use of bone graft extenders, were utilized. Intraoperative fluoroscopy confirmed optimal screw placement. Hemostasis was achieved, and the incision was meticulously closed. The patient experienced significant relief from severe bone pain following the surgical intervention.

8. Operative Note: Other fusion of spine was performed on the patient at the L5-S1 level to address severe bone pain associated with lumbar disc herniation. Bilateral pedicle screws were meticulously inserted, and a specialized interbody cage was employed. A surgical intervention involving the removal of the herniated disc and decompression of neural structures was performed to alleviate the pain. Advanced bone grafting techniques, including the use of bone morphogenetic protein, were utilized. Intraoperative imaging confirmed accurate screw placement. Hemostasis was achieved, and the wound was closed meticulously. The patient reported significant relief from severe bone pain following the surgical intervention.

9. Operative Note: The patient underwent other fusion of spine at the T6-T7 level due to severe bone pain secondary to spinal instability. Bilateral pedicle screws were inserted with great care, and a reinforced interbody cage was utilized. A surgical intervention involving the correction of severe scoliosis and restoration of spinal alignment was performed to address the pain. Advanced bone grafting techniques, including the use of bone graft substitutes, were employed. Intraoperative imaging confirmed optimal screw placement. Hemostasis was achieved, and the incision was meticulously closed. The patient experienced marked reduction in severe bone pain following the surgical intervention.

10. Operative Note: Other fusion of spine was performed on the patient at the C2-C3 level to address severe bone pain associated with atlantoaxial instability. Bilateral pedicle screws were meticulously inserted, and a customized interbody cage was employed. A surgical intervention involving the stabilization of the atlantoaxial joint and restoration of spinal stability was performed to alleviate the pain. Advanced bone grafting techniques, including the use of bone graft extenders, were utilized. Intraoperative fluoroscopy confirmed accurate screw placement. Hemostasis was achieved, and the incision was meticulously closed. The patient reported notable relief from severe bone pain following the surgical intervention.

1. Operative Note: The patient underwent other fusion of spine at the L4-L5 level to address severe bone pain and infection in the lumbar region. Bilateral pedicle screws were meticulously inserted, and a customized interbody cage was employed. A surgical intervention involving extensive debridement of infected tissues and removal of the affected disc was performed to eradicate the infection. Advanced bone grafting techniques, including the use of antibiotic-impregnated bone grafts, were utilized. Intraoperative imaging confirmed accurate screw placement. Hemostasis was achieved, and the incision was meticulously closed. The patient experienced significant relief from severe bone pain following the surgical intervention.

2. Operative Note: Other fusion of spine was performed on the patient at the C6-C7 level due to severe bone pain and deep joint infection. Bilateral pedicle screws were carefully inserted, and a specialized interbody cage was employed. A surgical intervention involving thorough debridement of the infected joint and removal of the affected disc was performed to eliminate the infection. Advanced bone grafting techniques, including the use of bone graft substitutes, were utilized. Intraoperative imaging confirmed optimal screw placement. Hemostasis was achieved, and the wound was closed meticulously. The patient reported notable relief from severe bone pain following the surgical intervention.

3. Operative Note: The patient underwent other fusion of spine at the T11-T12 level to address severe bone pain and a severe joint infection. Bilateral pedicle screws were meticulously inserted, and a reinforced interbody cage was utilized. A surgical intervention involving extensive debridement of the infected joint and removal of the affected disc was performed to eradicate the infection. Advanced bone grafting techniques, including the use of bone graft extenders, were employed. Intraoperative imaging confirmed accurate screw placement. Hemostasis was achieved, and the incision was meticulously closed. The patient experienced marked reduction in severe bone pain following the surgical intervention.

4. Operative Note: Other fusion of spine was performed on the patient at the C4-C5 level due to severe bone pain and an extremely infected joint. Bilateral pedicle screws were meticulously inserted, and a customized interbody cage was employed. A surgical intervention involving aggressive debridement of the infected joint and removal of the affected disc was performed to eliminate the infection. Advanced bone grafting techniques, including the use of bone graft substitutes, were utilized. Intraoperative imaging confirmed optimal screw placement. Hemostasis was achieved, and the incision was meticulously closed. The patient reported significant relief from severe bone pain following the surgical intervention.

5. Operative Note: The patient underwent other fusion of spine at the T8-T9 level to address severe bone pain and a deep joint infection. Bilateral pedicle screws were carefully inserted, and a specialized interbody cage was employed. A surgical intervention involving extensive debridement of the infected joint and removal of the affected disc was performed to eradicate the infection. Advanced bone grafting techniques, including the use of bone morphogenetic protein, were utilized. Intraoperative fluoroscopy confirmed accurate screw placement. Hemostasis was achieved, and the incision was meticulously closed. The patient experienced significant relief from severe bone pain following the surgical intervention.

6. Operative Note: Other fusion of spine was performed on the patient at the L2-L3 level to address severe bone pain and an extreme joint infection. Bilateral pedicle screws were meticulously inserted, and a reinforced interbody cage was utilized. A surgical intervention involving aggressive debridement of the infected joint and removal of the affected disc was performed to eliminate the infection. Advanced bone grafting techniques, including the use of bone graft extenders, were employed. Intraoperative imaging confirmed optimal screw placement. Hemostasis was achieved, and the incision was meticulously closed. The patient reported significant relief from severe bone pain following the surgical intervention.

7. Operative Note: The patient underwent other fusion of spine at the L5-S1 level to address severe bone pain and an extremely infected joint. Bilateral pedicle screws were meticulously inserted, and a customized interbody cage was employed. A surgical intervention involving thorough debridement of the infected joint and removal of the affected disc was performed to eradicate the infection. Advanced bone grafting techniques, including the use of bone graft substitutes, were utilized. Intraoperative imaging confirmed accurate screw placement. Hemostasis was achieved, and the wound was closed meticulously. The patient experienced notable relief from severe bone pain following the surgical intervention.

8. Operative Note: Other fusion of spine was performed on the patient at the C7-T1 level due to severe bone pain and deep joint infection. Bilateral pedicle screws were carefully inserted, and a specialized interbody cage was employed. A surgical intervention involving extensive debridement of the infected joint and removal of the affected disc was performed to eliminate the infection. Advanced bone grafting techniques, including the use of bone graft extenders, were utilized. Intraoperative imaging confirmed optimal screw placement. Hemostasis was achieved, and the incision was meticulously closed. The patient reported significant relief from severe bone pain following the surgical intervention.

9. Operative Note: The patient underwent other fusion of spine at the T6-T7 level to address severe bone pain and a severe joint infection. Bilateral pedicle screws were meticulously inserted, and a reinforced interbody cage was utilized. A surgical intervention involving aggressive debridement of the infected joint and removal of the affected disc was performed to eradicate the infection. Advanced bone grafting techniques, including the use of bone graft substitutes, were employed. Intraoperative imaging confirmed accurate screw placement. Hemostasis was achieved, and the incision was meticulously closed. The patient experienced marked reduction in severe bone pain following the surgical intervention.

10. Operative Note: Other fusion of spine was performed on the patient at the C2-C3 level to address severe bone pain and an extremely infected joint. Bilateral pedicle screws were meticulously inserted, and a customized interbody cage was employed. A surgical intervention involving thorough debridement of the infected joint and removal of the affected disc was performed to eliminate the infection. Advanced bone grafting techniques, including the use of bone graft extenders, were utilized. Intraoperative fluoroscopy confirmed accurate screw placement. Hemostasis was achieved, and the incision was meticulously closed. The patient reported notable relief from severe bone pain following the surgical intervention.

1. Operative Note: The patient underwent other fusion of spine at the L4-L5 level to address severe bone pain and chronic inflammation in the lumbar region. Bilateral pedicle screws were meticulously inserted, and a customized interbody cage was employed. A surgical intervention involving thorough debridement of inflamed tissues and removal of the affected disc was performed to alleviate the inflammation. Advanced bone grafting techniques, including the use of anti-inflammatory bone graft substitutes, were utilized. Intraoperative imaging confirmed accurate screw placement. Hemostasis was achieved, and the incision was meticulously closed. The patient experienced significant relief from severe bone pain following the surgical intervention.

2. Operative Note: Other fusion of spine was performed on the patient at the C6-C7 level due to severe bone pain and acute inflammatory response. Bilateral pedicle screws were carefully inserted, and a specialized interbody cage was employed. A surgical intervention involving targeted removal of inflamed tissues and affected disc was performed to mitigate the inflammation. Advanced bone grafting techniques, including the use of anti-inflammatory bone graft extenders, were utilized. Intraoperative imaging confirmed optimal screw placement. Hemostasis was achieved, and the wound was closed meticulously. The patient reported notable relief from severe bone pain following the surgical intervention.

3. Operative Note: The patient underwent other fusion of spine at the T11-T12 level to address severe bone pain and chronic inflammation associated with spinal stenosis. Bilateral pedicle screws were meticulously inserted, and a reinforced interbody cage was utilized. A surgical intervention involving the removal of hypertrophic ligamentum flavum and targeted reduction of inflammatory response was performed to alleviate the pain. Advanced bone grafting techniques, including the use of anti-inflammatory bone graft substitutes, were employed. Intraoperative imaging confirmed optimal screw placement. Hemostasis was achieved, and the incision was meticulously closed. The patient experienced marked reduction in severe bone pain following the surgical intervention.

4. Operative Note: Other fusion of spine was performed on the patient at the C4-C5 level to address severe bone pain and acute inflammation resulting from spinal instability. Bilateral pedicle screws were meticulously inserted, and a customized interbody cage was employed. A surgical intervention involving the repair of spondylolisthesis and targeted reduction of inflammation was performed to address the pain. Advanced bone grafting techniques, including the use of anti-inflammatory bone graft substitutes, were utilized. Intraoperative imaging confirmed accurate screw placement. Hemostasis was achieved, and the incision was closed meticulously. The patient reported significant relief from severe bone pain following the surgical intervention.

5. Operative Note: The patient underwent other fusion of spine at the T8-T9 level to address severe bone pain and chronic inflammation caused by a spinal fracture. Bilateral pedicle screws were carefully inserted, and a specialized interbody cage was employed. A surgical intervention involving stabilization of the fractured vertebrae and targeted reduction of inflammatory response was performed to alleviate the pain. Advanced bone grafting techniques, including the use of anti-inflammatory bone graft extenders, were employed. Intraoperative fluoroscopy confirmed optimal screw placement. Hemostasis was achieved, and the incision was meticulously closed. The patient experienced significant relief from severe bone pain following the surgical intervention.

6. Operative Note: Other fusion of spine was performed on the patient at the L2-L3 level to address severe bone pain and chronic inflammation caused by a spinal infection. Bilateral pedicle screws were meticulously inserted, and a reinforced interbody cage was utilized. A surgical intervention involving the debridement of inflamed tissues and targeted reduction of inflammatory response was performed to alleviate the pain. Advanced bone grafting techniques, including the use of anti-inflammatory bone graft substitutes, were employed. Intraoperative imaging confirmed accurate screw placement. Hemostasis was achieved, and the incision was meticulously closed. The patient reported significant relief from severe bone pain following the surgical intervention.

7. Operative Note: The patient underwent other fusion of spine at the L5-S1 level to address severe bone pain and acute inflammatory response associated with degenerative disc disease. Bilateral pedicle screws were meticulously inserted, and a customized interbody cage was employed. A surgical intervention involving targeted removal of inflamed disc and reduction of inflammatory response was performed to alleviate the pain. Advanced bone grafting techniques, including the use of anti-inflammatory bone graft extenders, were utilized. Intraoperative imaging confirmed optimal screw placement. Hemostasis was achieved, and the incision was meticulously closed. The patient experienced notable relief from severe bone pain following the surgical intervention.

8. Operative Note: Other fusion of spine was performed on the patient at the C7-T1 level due to severe bone pain and chronic inflammation associated with facet joint arthritis. Bilateral pedicle screws were meticulously inserted, and a specialized interbody cage was employed. A surgical intervention involving the targeted removal of inflamed facet joints and reduction of inflammatory response was performed to alleviate the pain. Advanced bone grafting techniques, including the use of anti-inflammatory bone graft substitutes, were employed. Intraoperative imaging confirmed accurate screw placement. Hemostasis was achieved, and the incision was meticulously closed. The patient reported notable relief from severe bone pain following the surgical intervention.

9. Operative Note: The patient underwent other fusion of spine at the T6-T7 level to address severe bone pain and acute inflammatory response secondary to ankylosing spondylitis. Bilateral pedicle screws were meticulously inserted, and a reinforced interbody cage was utilized. A surgical intervention involving targeted removal of inflamed tissues and reduction of inflammatory response was performed to alleviate the pain. Advanced bone grafting techniques, including the use of anti-inflammatory bone graft extenders, were employed. Intraoperative imaging confirmed optimal screw placement. Hemostasis was achieved, and the incision was meticulously closed. The patient experienced marked reduction in severe bone pain following the surgical intervention.

10. Operative Note: Other fusion of spine was performed on the patient at the C2-C3 level to address severe bone pain and chronic inflammation caused by rheumatoid arthritis. Bilateral pedicle screws were meticulously inserted, and a customized interbody cage was employed. A surgical intervention involving targeted removal of inflamed tissues and reduction of inflammatory response was performed to alleviate the pain. Advanced bone grafting techniques, including the use of anti-inflammatory bone graft substitutes, were employed. Intraoperative fluoroscopy confirmed accurate screw placement. Hemostasis was achieved, and the incision was meticulously closed. The patient reported significant relief from severe bone pain following the surgical intervention.

1. Operative Note: The patient underwent other fusion of spine at the L4-L5 level to address severe bone pain and a preliminary diagnosis of degenerative disc disease. Bilateral pedicle screws were meticulously inserted, and a customized interbody cage was employed. Postoperative follow-up will include a comprehensive evaluation of pain levels and functional improvements. Additional diagnostic tests, such as MRI or CT scan, will be considered if the symptoms persist or worsen. Rehabilitation and physical therapy will be prescribed accordingly to aid in the patient's recovery.

2. Operative Note: Other fusion of spine was performed on the patient at the C6-C7 level due to severe bone pain and a preliminary diagnosis of spinal stenosis. Bilateral pedicle screws were carefully inserted, and a specialized interbody cage was employed. Postoperative follow-up will involve assessing the patient's pain levels, neurological function, and range of motion. Additional imaging studies, such as X-rays or MRI, may be ordered to evaluate the success of the fusion procedure and the resolution of spinal stenosis symptoms. Rehabilitation and pain management strategies will be tailored based on the patient's progress.

3. Operative Note: The patient underwent other fusion of spine at the T11-T12 level to address severe bone pain and a preliminary diagnosis of vertebral compression fracture. Bilateral pedicle screws were meticulously inserted, and a reinforced interbody cage was utilized. Postoperative follow-up will focus on monitoring pain levels, assessing spinal stability, and evaluating the patient's ability to perform daily activities. If necessary, a bone density test or further imaging studies will be conducted to determine the underlying cause of the fracture. Rehabilitation and back strengthening exercises will be prescribed accordingly.

4. Operative Note: Other fusion of spine was performed on the patient at the C4-C5 level to address severe bone pain and a preliminary diagnosis of herniated disc. Bilateral pedicle screws were meticulously inserted, and a customized interbody cage was employed. Postoperative follow-up will involve assessing the patient's pain levels, neurological function, and any signs of disc herniation recurrence. If persistent symptoms are observed, further diagnostic tests, such as a discogram or MRI, may be considered. Rehabilitation, including core strengthening exercises and postural modifications, will be emphasized to prevent future disc-related issues.

5. Operative Note: The patient underwent other fusion of spine at the T8-T9 level to address severe bone pain and a preliminary diagnosis of scoliosis. Bilateral pedicle screws were carefully inserted, and a specialized interbody cage was employed. Postoperative follow-up will include monitoring the patient's pain levels, assessing spinal alignment, and evaluating any signs of scoliosis progression. Further imaging studies, such as X-rays or CT scans, may be ordered to track the effectiveness of the fusion procedure and the stability of the corrected spine. Rehabilitation exercises and bracing may be prescribed as part of ongoing scoliosis management.

6. Operative Note: Other fusion of spine was performed on the patient at the L2-L3 level to address severe bone pain and a preliminary diagnosis of spondylolisthesis. Bilateral pedicle screws were meticulously inserted, and a reinforced interbody cage was utilized. Postoperative follow-up will involve assessing the patient's pain levels, evaluating spinal stability, and monitoring for any signs of spondylolisthesis recurrence. X-rays or dynamic imaging studies may be conducted to assess the success of the fusion procedure and the alignment of the affected vertebrae. Rehabilitation, including core strengthening exercises and activity modifications, will be prescribed based on the patient's progress.

7. Operative Note: The patient underwent other fusion of spine at the L5-S1 level to address severe bone pain and a preliminary diagnosis of facet joint osteoarthritis. Bilateral pedicle screws were meticulously inserted, and a customized interbody cage was employed. Postoperative follow-up will involve assessing the patient's pain levels, range of motion, and any signs of joint inflammation. If persistent symptoms are present, further diagnostic procedures, such as diagnostic injections or joint aspirations, may be considered. Rehabilitation, pain management strategies, and lifestyle modifications will be discussed to optimize the patient's long-term outcomes.

8. Operative Note: Other fusion of spine was performed on the patient at the C7-T1 level due to severe bone pain and a preliminary diagnosis of cervical radiculopathy. Bilateral pedicle screws were carefully inserted, and a specialized interbody cage was employed. Postoperative follow-up will focus on monitoring pain levels, assessing neurological function, and evaluating any signs of radiculopathy resolution. If persistent symptoms are observed, additional imaging studies, such as MRI or nerve conduction studies, may be performed. Rehabilitation exercises, medication management, and ergonomic adjustments will be recommended as part of the patient's recovery plan.

9. Operative Note: The patient underwent other fusion of spine at the T6-T7 level to address severe bone pain and a preliminary diagnosis of spinal infection. Bilateral pedicle screws were meticulously inserted, and a reinforced interbody cage was utilized. Postoperative follow-up will involve monitoring the patient's pain levels, assessing wound healing, and evaluating any signs of infection recurrence. If necessary, further diagnostic tests, such as blood cultures or imaging studies, may be conducted to confirm the eradication of the infection. Antibiotic therapy, wound care, and close monitoring will be integral to the patient's postoperative management.

10. Operative Note: Other fusion of spine was performed on the patient at the C2-C3 level to address severe bone pain and a preliminary diagnosis of cervical disc herniation. Bilateral pedicle screws were meticulously inserted, and a customized interbody cage was employed. Postoperative follow-up will involve assessing the patient's pain levels, neurological function, and any signs of disc herniation recurrence. If persistent symptoms are present, further imaging studies, such as MRI or electromyography, may be considered. Rehabilitation exercises, activity modifications, and ergonomic interventions will be prescribed based on the patient's specific needs and recovery progress.

## M43.3 Recurrent atlantoaxial subluxation with myelopathy

1. Operative Note: Patient underwent posterior C1-C2 fusion with instrumentation to address recurrent atlantoaxial subluxation and myelopathy. Intraoperatively, reduction was achieved with manual manipulation and lateral mass screws were placed bilaterally. A bone graft was harvested and inserted between C1 and C2. The procedure was successful, and postoperative imaging confirmed proper alignment and stabilization.

2. Operative Note: Surgical intervention involved anterior odontoid screw fixation to treat recurrent atlantoaxial subluxation and associated myelopathy. A midline incision was made, and dissection proceeded down to the C1-C2 level. An odontoid screw was carefully inserted, achieving stable fixation. The patient tolerated the procedure well, and postoperative imaging demonstrated successful reduction and stabilization.

3. Operative Note: Patient underwent transoral odontoidectomy for recurrent atlantoaxial subluxation and myelopathy. A transverse incision was made in the oral mucosa, and a careful dissection was carried out to expose the odontoid process. A high-speed burr was used to remove the odontoid process completely. The procedure was successful, and postoperative examination revealed improved alignment and resolution of myelopathic symptoms.

4. Operative Note: Posterior occipitocervical fusion was performed to address recurrent atlantoaxial subluxation and associated myelopathy. Midline incision was made, and dissection was carried out to expose the occiput and upper cervical spine. Lateral mass screws were inserted bilaterally, and a rod was placed for stabilization. The procedure was uneventful, and postoperative imaging demonstrated satisfactory alignment and resolution of myelopathic symptoms.

5. Operative Note: Patient underwent revision posterior C1-C2 fusion for recurrent atlantoaxial subluxation with myelopathy. The previous instrumentation was removed, and thorough exploration of the region was performed. Lateral mass screws were inserted bilaterally, and a bone graft was placed for fusion. The procedure was successful, and postoperative evaluation revealed improved alignment and resolution of myelopathic symptoms.

6. Operative Note: Anterior transarticular screw fixation was performed to address recurrent atlantoaxial subluxation and associated myelopathy. A transverse incision was made over the atlantoaxial joint, and the screw trajectory was carefully planned. Screws were inserted bilaterally to achieve stable fixation. The patient tolerated the procedure well, and postoperative imaging confirmed successful reduction and stabilization.

7. Operative Note: Patient underwent occipitocervical fusion with halo immobilization for recurrent atlantoaxial subluxation and myelopathy. Midline incision was made, and exposure of the occiput and upper cervical spine was achieved. Halo fixation was applied, and bone graft was placed for fusion. The procedure was completed without complications, and postoperative examination demonstrated improved alignment and resolution of myelopathic symptoms.

8. Operative Note: Posterior C1-C2 transarticular screw fixation was performed to address recurrent atlantoaxial subluxation and associated myelopathy. A midline incision was made, and dissection proceeded down to the C1-C2 level. Transarticular screws were inserted bilaterally, providing stable fixation. The patient tolerated the procedure well, and postoperative imaging showed satisfactory alignment and resolution of myelopathic symptoms.

9. Operative Note: Patient underwent revision anterior odontoid screw fixation for recurrent atlantoaxial subluxation with myelopathy. The previous hardware was removed, and a careful dissection was performed to expose the odontoid process. A new odontoid screw was inserted, achieving stable fixation. The procedure was successful, and postoperative examination revealed improved alignment and resolution of myelopathic symptoms.

10. Operative Note: Posterior C1-C2 laminectomy and fusion were performed to address recurrent atlantoaxial subluxation and associated myelopathy. Midline incision was made, and the lamina of C1 and C2 were carefully removed. Lateral mass screws were inserted, and a bone graft was placed for fusion. The procedure was uneventful, and postoperative imaging demonstrated successful reduction and stabilization.

1. Operative Note: Patient underwent revision transoral odontoidectomy for recurrent atlantoaxial subluxation with myelopathy. A transverse incision was made in the oral mucosa, and careful dissection was carried out to expose the odontoid process. The odontoid process was excised using a high-speed burr, ensuring complete removal. The procedure was successful, and postoperative evaluation revealed improved alignment and resolution of myelopathic symptoms.

2. Operative Note: Posterior C1-C2 fusion with wiring technique was performed to address recurrent atlantoaxial subluxation and associated myelopathy. Midline incision was made, and meticulous dissection exposed the C1-C2 complex. Wiring was performed to achieve stabilization, and a bone graft was placed for fusion. The procedure was completed without complications, and postoperative imaging demonstrated satisfactory reduction and resolution of myelopathic symptoms.

3. Operative Note: Patient underwent occipitocervical fusion with lateral mass and rod instrumentation for recurrent atlantoaxial subluxation and myelopathy. Midline incision was made, and exposure of the occiput and upper cervical spine was achieved. Lateral mass screws were inserted bilaterally, and a rod was placed for stabilization. The procedure was uneventful, and postoperative examination revealed improved alignment and resolution of myelopathic symptoms.

4. Operative Note: Posterior C1-C2 transarticular screw-rod fixation was performed to address recurrent atlantoaxial subluxation and associated myelopathy. A midline incision was made, and dissection proceeded down to the C1-C2 level. Transarticular screws were carefully placed, followed by rod insertion for stabilization. The patient tolerated the procedure well, and postoperative imaging confirmed successful reduction and stabilization.

5. Operative Note: Patient underwent revision anterior transarticular screw fixation for recurrent atlantoaxial subluxation and myelopathy. The previous hardware was removed, and meticulous dissection exposed the C1-C2 joint. Transarticular screws were inserted bilaterally to achieve stable fixation. The procedure was successful, and postoperative examination revealed improved alignment and resolution of myelopathic symptoms.

6. Operative Note: Anterior occipitocervical fusion was performed to address recurrent atlantoaxial subluxation and associated myelopathy. Midline incision was made, and exposure of the occiput and upper cervical spine was achieved. Plate and screw fixation was applied, and a bone graft was placed for fusion. The procedure was completed without complications, and postoperative examination demonstrated improved alignment and resolution of myelopathic symptoms.

7. Operative Note: Patient underwent revision posterior occipitocervical fusion with screw-rod instrumentation for recurrent atlantoaxial subluxation and myelopathy. The previous instrumentation was removed, and thorough exploration of the region was performed. New screws and rods were inserted for stabilization, and a bone graft was placed. The procedure was successful, and postoperative imaging revealed improved alignment and resolution of myelopathic symptoms.

8. Operative Note: Posterior C1-C2 laminectomy with fusion and instrumentation was performed to address recurrent atlantoaxial subluxation and associated myelopathy. Midline incision was made, and laminectomy was performed at the C1 and C2 levels. Pedicle screws were inserted bilaterally, and a rod was placed for stabilization. The procedure was uneventful, and postoperative examination revealed improved alignment and resolution of myelopathic symptoms.

9. Operative Note: Patient underwent anterior C1-C2 transarticular screw fixation for recurrent atlantoaxial subluxation and myelopathy. A transverse incision was made over the atlantoaxial joint, and careful dissection was carried out to expose the C1-C2 complex. Transarticular screws were inserted bilaterally, achieving stable fixation. The patient tolerated the procedure well, and postoperative imaging confirmed successful reduction and stabilization.

10. Operative Note: Revision occipitocervical fusion with lateral mass and rod instrumentation was performed to address recurrent atlantoaxial subluxation and myelopathy. Midline incision was made, and exposure of the occiput and upper cervical spine was achieved. Lateral mass screws and rods were inserted, providing stable fixation. The procedure was completed without complications, and postoperative examination demonstrated improved alignment and resolution of myelopathic symptoms.

1. Operative Note: Patient underwent posterior C1-C2 fusion with instrumentation for recurrent atlantoaxial subluxation and myelopathy under general anesthesia. Anesthesia was induced with 200 mg of propofol and maintained with 1% sevoflurane. Intraoperatively, reduction was achieved with manual manipulation, and lateral mass screws were placed bilaterally. A bone graft was harvested and inserted between C1 and C2. The procedure was successful, and postoperative imaging confirmed proper alignment and stabilization.

2. Operative Note: Surgical intervention involved anterior odontoid screw fixation for recurrent atlantoaxial subluxation and myelopathy under general anesthesia. Anesthesia was induced with 150 mcg of fentanyl and 200 mg of propofol, and maintained with a propofol infusion. The patient tolerated the procedure well, and postoperative imaging demonstrated successful reduction and stabilization.

3. Operative Note: Patient underwent transoral odontoidectomy for recurrent atlantoaxial subluxation and myelopathy under general anesthesia. Anesthesia was induced with 100 mcg of fentanyl and 200 mg of propofol, and maintained with a sevoflurane inhalation. The procedure was successful, and postoperative examination revealed improved alignment and resolution of myelopathic symptoms.

4. Operative Note: Posterior occipitocervical fusion was performed for recurrent atlantoaxial subluxation and myelopathy under general anesthesia. Anesthesia was induced with 150 mcg of fentanyl and 200 mg of propofol, and maintained with a remifentanil infusion. Lateral mass screws were inserted bilaterally, and a rod was placed for stabilization. The procedure was uneventful, and postoperative imaging demonstrated satisfactory alignment and resolution of myelopathic symptoms.

5. Operative Note: Patient underwent revision posterior C1-C2 fusion for recurrent atlantoaxial subluxation with myelopathy under general anesthesia. Anesthesia was induced with 100 mcg of fentanyl and 200 mg of propofol, and maintained with a sevoflurane inhalation. Lateral mass screws were inserted bilaterally, and a bone graft was placed for fusion. The procedure was successful, and postoperative evaluation revealed improved alignment and resolution of myelopathic symptoms.

6. Operative Note: Anterior transarticular screw fixation was performed for recurrent atlantoaxial subluxation and associated myelopathy under general anesthesia. Anesthesia was induced with 150 mcg of fentanyl and 200 mg of propofol, and maintained with a propofol infusion. The patient tolerated the procedure well, and postoperative imaging confirmed successful reduction and stabilization.

7. Operative Note: Patient underwent occipitocervical fusion with halo immobilization for recurrent atlantoaxial subluxation and myelopathy under general anesthesia. Anesthesia was induced with 100 mcg of fentanyl and 200 mg of propofol, and maintained with a remifentanil infusion. The procedure was completed without complications, and postoperative examination demonstrated improved alignment and resolution of myelopathic symptoms.

8. Operative Note: Posterior C1-C2 transarticular screw fixation was performed for recurrent atlantoaxial subluxation and associated myelopathy under general anesthesia. Anesthesia was induced with 150 mcg of fentanyl and 200 mg of propofol, and maintained with a sevoflurane inhalation. The patient tolerated the procedure well, and postoperative imaging showed satisfactory alignment and resolution of myelopathic symptoms.

9. Operative Note: Patient underwent revision anterior odontoid screw fixation for recurrent atlantoaxial subluxation and myelopathy under general anesthesia. Anesthesia was induced with 100 mcg of fentanyl and 200 mg of propofol, and maintained with a remifentanil infusion. The procedure was successful, and postoperative examination revealed improved alignment and resolution of myelopathic symptoms.

10. Operative Note: Posterior C1-C2 laminectomy and fusion were performed for recurrent atlantoaxial subluxation and associated myelopathy under general anesthesia. Anesthesia was induced with 150 mcg of fentanyl and 200 mg of propofol, and maintained with a propofol infusion. Pedicle screws were inserted bilaterally, and a rod was placed for stabilization. The procedure was uneventful, and postoperative examination revealed improved alignment and resolution of myelopathic symptoms.

1. Operative Note: Patient with recurrent atlantoaxial subluxation and myelopathy underwent posterior C1-C2 fusion with instrumentation and bone grafting due to significant bone erosion. Under general anesthesia, a midline incision was made, revealing severe erosion at the C1 and C2 levels. Lateral mass screws were carefully inserted, and a bone graft was placed to restore stability. The procedure was successful, and postoperative imaging demonstrated improved alignment and stabilization despite the bone erosion.

2. Operative Note: Surgical intervention involved revision anterior odontoid screw fixation for recurrent atlantoaxial subluxation with myelopathy and extensive bone erosion. The patient was placed under general anesthesia, and a transverse incision was made over the affected area. The erosion was noted to be severe, necessitating meticulous removal of eroded bone and careful screw placement. The procedure was completed successfully, with postoperative imaging showing improved alignment despite the pre-existing bone erosion.

3. Operative Note: Patient underwent transoral odontoidectomy for recurrent atlantoaxial subluxation and myelopathy associated with significant bone erosion. General anesthesia was administered, and an oral incision was made, revealing extensive bone erosion involving the odontoid process. The erosion was meticulously removed using a high-speed burr. The procedure was successful, and postoperative examination revealed improved alignment and resolution of myelopathic symptoms despite the bone erosion.

4. Operative Note: Posterior occipitocervical fusion was performed to address recurrent atlantoaxial subluxation and myelopathy, complicated by bone erosion at the occipital and cervical levels. Under general anesthesia, a midline incision was made, exposing the eroded bone surfaces. Lateral mass screws and rods were inserted, providing stability and alignment. The procedure was successful, and postoperative imaging showed improved alignment despite the presence of bone erosion.

5. Operative Note: Patient underwent revision posterior C1-C2 fusion for recurrent atlantoaxial subluxation with myelopathy and extensive bone erosion. General anesthesia was administered, and a midline incision was made, revealing severe erosion at the C1-C2 complex. The eroded bone was carefully debrided, and lateral mass screws were inserted along with bone grafting. The procedure was successful, with postoperative evaluation demonstrating improved alignment and stabilization despite the pre-existing bone erosion.

6. Operative Note: Anterior transarticular screw fixation was performed for recurrent atlantoaxial subluxation and myelopathy complicated by significant bone erosion. Under general anesthesia, a transverse incision was made, exposing the eroded bone surfaces. Careful preoperative planning was done to ensure optimal screw trajectory in areas of intact bone. The procedure was successful, and postoperative imaging confirmed improved alignment despite the presence of bone erosion.

7. Operative Note: Patient underwent occipitocervical fusion with halo immobilization for recurrent atlantoaxial subluxation and myelopathy, complicated by bone erosion at the occipital and cervical levels. General anesthesia was administered, and a midline incision was made, revealing eroded bone surfaces. Halo fixation was applied, and bone grafting was performed to stabilize the affected area. The procedure was completed successfully, with postoperative examination demonstrating improved alignment despite the bone erosion.

8. Operative Note: Posterior C1-C2 transarticular screw fixation was performed for recurrent atlantoaxial subluxation and associated myelopathy, with extensive bone erosion observed intraoperatively. General anesthesia was administered, and a midline incision was made, revealing erosion at the C1-C2 articulation. The transarticular screws were carefully placed in areas of intact bone, providing stability despite the surrounding erosion. The procedure was successful, and postoperative imaging showed improved alignment despite the bone erosion.

9. Operative Note: Patient underwent revision anterior odontoid screw fixation for recurrent atlantoaxial subluxation and myelopathy, complicated by significant bone erosion. Under general anesthesia, a transverse incision was made, exposing the eroded bone surfaces. The eroded bone was meticulously debrided, and careful screw placement was performed. The procedure was successful, with postoperative evaluation revealing improved alignment and stabilization despite the presence of bone erosion.

10. Operative Note: Posterior C1-C2 laminectomy and fusion were performed for recurrent atlantoaxial subluxation and associated myelopathy, complicated by extensive bone erosion. Under general anesthesia, a midline incision was made, revealing severe bone erosion at the C1 and C2 levels. Laminectomy was performed to decompress the spinal cord, and bone grafting with instrumentation was done for stabilization. The procedure was successful, and postoperative imaging demonstrated improved alignment and stability despite the pre-existing bone erosion.

1. Operative Note: Patient with recurrent atlantoaxial subluxation and myelopathy, experiencing severe bone pain, underwent posterior C1-C2 fusion with instrumentation. Under general anesthesia, a midline incision was made, revealing erosive changes and severe bone pain at the affected levels. Lateral mass screws were meticulously inserted, and bone grafting was performed to promote stabilization. The procedure successfully addressed the instability and bone pain, with postoperative examination revealing improved alignment and resolution of myelopathic symptoms.

2. Operative Note: Surgical intervention involved revision anterior odontoid screw fixation for recurrent atlantoaxial subluxation with myelopathy and severe bone pain. The patient was placed under general anesthesia, and a transverse incision was made over the affected area. Significant erosive changes and bone pain were noted intraoperatively. The procedure successfully addressed the instability and bone pain, with postoperative imaging showing improved alignment and resolution of myelopathic symptoms.

3. Operative Note: Patient underwent transoral odontoidectomy for recurrent atlantoaxial subluxation and myelopathy associated with severe bone pain. General anesthesia was administered, and an oral incision was made, revealing erosive changes and intense bone pain involving the odontoid process. The procedure successfully relieved the bone pain and improved alignment, as confirmed by postoperative examination and imaging.

4. Operative Note: Posterior occipitocervical fusion was performed to address recurrent atlantoaxial subluxation and myelopathy, complicated by severe bone pain. Under general anesthesia, a midline incision was made, exposing the eroded bone surfaces. Lateral mass screws and rods were inserted to stabilize the affected area, providing relief from the severe bone pain. The procedure successfully improved alignment and stabilization, as evidenced by postoperative imaging.

5. Operative Note: Patient underwent revision posterior C1-C2 fusion for recurrent atlantoaxial subluxation with myelopathy and severe bone pain. General anesthesia was administered, and a midline incision was made, revealing erosive changes and intense bone pain at the C1-C2 complex. The procedure successfully addressed the instability and bone pain, with postoperative evaluation demonstrating improved alignment and resolution of myelopathic symptoms.

6. Operative Note: Anterior transarticular screw fixation was performed for recurrent atlantoaxial subluxation and myelopathy complicated by severe bone pain. Under general anesthesia, a transverse incision was made, exposing the eroded bone surfaces. Careful preoperative planning was done to alleviate the severe bone pain, ensuring optimal screw trajectory in areas of intact bone. The procedure successfully improved alignment and provided relief from the bone pain.

7. Operative Note: Patient underwent occipitocervical fusion with halo immobilization for recurrent atlantoaxial subluxation and myelopathy, accompanied by severe bone pain. General anesthesia was administered, and a midline incision was made, revealing erosive changes and intense bone pain at the occipital and cervical levels. Halo fixation was applied to stabilize the affected area and alleviate the severe bone pain. The procedure successfully improved alignment and provided relief from the bone pain.

8. Operative Note: Posterior C1-C2 transarticular screw fixation was performed for recurrent atlantoaxial subluxation and associated myelopathy, with severe bone pain as a presenting symptom. General anesthesia was administered, and a midline incision was made, revealing erosive changes and intense bone pain at the C1-C2 articulation. The transarticular screws were meticulously placed in areas of intact bone, successfully addressing the instability and alleviating the severe bone pain.

9. Operative Note: Patient underwent revision anterior odontoid screw fixation for recurrent atlantoaxial subluxation and myelopathy, complicated by severe bone pain. Under general anesthesia, a transverse incision was made, exposing the erosive changes and intense bone pain at the affected area. The procedure successfully relieved the bone pain, improved alignment, and provided stabilization, as confirmed by postoperative evaluation.

10. Operative Note: Posterior C1-C2 laminectomy and fusion were performed for recurrent atlantoaxial subluxation and associated myelopathy, accompanied by severe bone pain. Under general anesthesia, a midline incision was made, revealing erosive changes and intense bone pain at the C1 and C2 levels. Laminectomy was performed to decompress the spinal cord, and bone grafting with instrumentation was done for stabilization, successfully relieving the severe bone pain and improving alignment.

1. Operative Note: Patient underwent occipitocervical fusion with lateral mass and rod instrumentation to address recurrent atlantoaxial subluxation and myelopathy. Under general anesthesia, a midline incision was made, and exposure of the occiput and upper cervical spine was achieved. Lateral mass screws were carefully placed, and rods were inserted for stabilization. The procedure successfully corrected the subluxation, alleviated myelopathic symptoms, and achieved stable fixation.

2. Operative Note: Surgical intervention involved transoral odontoid resection and posterior C1-C2 fusion for recurrent atlantoaxial subluxation with myelopathy. General anesthesia was administered, and a transverse incision was made through the oral mucosa. The odontoid process was carefully resected, followed by posterior fusion using C1-C2 screws and rods. The procedure successfully addressed the instability, decompressed the spinal cord, and resolved the myelopathic symptoms.

3. Operative Note: Patient underwent anterior odontoid screw fixation with bone grafting for recurrent atlantoaxial subluxation and myelopathy. Under general anesthesia, a transverse incision was made, providing access to the anterior cervical spine. The odontoid process was stabilized using a screw and supplemented with a bone graft for fusion. The procedure successfully restored stability, alleviated myelopathic symptoms, and achieved fusion at the affected segment.

4. Operative Note: Surgical intervention involved posterior C1-C2 fusion with occipitocervical stabilization for recurrent atlantoaxial subluxation and myelopathy. Under general anesthesia, a midline incision was made, and exposure of the posterior cervical spine and occiput was achieved. Lateral mass screws were inserted at C1-C2, and occipitocervical rods were placed for stabilization. The procedure successfully corrected the subluxation, provided stability, and resolved the myelopathic symptoms.

5. Operative Note: Patient underwent revision transarticular screw fixation for recurrent atlantoaxial subluxation and myelopathy. General anesthesia was administered, and a posterior midline incision was made, exposing the C1-C2 complex. The previously placed transarticular screws were revised, achieving improved stability and realignment. The procedure successfully addressed the recurrent subluxation, relieved myelopathic symptoms, and ensured proper fixation.

6. Operative Note: Surgical intervention involved posterior decompression and fusion with instrumentation for recurrent atlantoaxial subluxation and myelopathy. Under general anesthesia, a midline incision was made, exposing the affected cervical spine. Decompressive laminectomy was performed to relieve spinal cord compression, followed by fusion using pedicle screws and rods. The procedure successfully decompressed the spinal cord, achieved stability, and resolved the myelopathic symptoms.

7. Operative Note: Patient underwent transoral odontoidectomy and posterior fusion for recurrent atlantoaxial subluxation and myelopathy. General anesthesia was administered, and an oral incision was made, providing access to the odontoid process. The odontoid was carefully resected, followed by posterior fusion using lateral mass screws and rods. The procedure successfully corrected the subluxation, decompressed the spinal cord, and resolved the myelopathic symptoms.

8. Operative Note: Surgical intervention involved revision occipitocervical fusion with lateral mass and rod instrumentation for recurrent atlantoaxial subluxation and myelopathy. Under general anesthesia, a midline incision was made, and the previous instrumentation was removed. Lateral mass screws were reinserted, and rods were placed for stabilization. The procedure successfully corrected the recurrent subluxation, provided stability, and alleviated the myelopathic symptoms.

9. Operative Note: Patient underwent posterior C1-C2 fusion with transarticular screws and bone grafting for recurrent atlantoaxial subluxation and myelopathy. Under general anesthesia, a midline incision was made, exposing the C1 and C2 vertebrae. Transarticular screws were carefully placed, and bone grafting was performed for fusion. The procedure successfully addressed the subluxation, achieved stability, and resolved the myelopathic symptoms.

10. Operative Note: Surgical intervention involved revision anterior odontoid screw fixation with bone grafting for recurrent atlantoaxial subluxation and myelopathy. Under general anesthesia, a transverse incision was made, providing access to the anterior cervical spine. The previously placed odontoid screw was revised, and additional bone grafting was performed to enhance fusion. The procedure successfully restored stability, relieved myelopathic symptoms, and ensured proper fusion.

1. Operative Note: Patient underwent posterior C1-C2 fusion with lateral mass and pedicle screw instrumentation for recurrent atlantoaxial subluxation and myelopathy. Under general anesthesia, a midline incision was made, exposing the affected vertebrae. Lateral mass screws were inserted at C1 and C2, and pedicle screws were placed for additional stability. The procedure successfully corrected the subluxation, achieved spinal alignment, and alleviated myelopathic symptoms.

2. Operative Note: Surgical intervention involved transoral odontoid resection, decompression, and posterior fusion for recurrent atlantoaxial subluxation with myelopathy. Under general anesthesia, an oral incision was made, allowing access to the odontoid process. The odontoid was carefully resected, followed by decompressive laminectomy to relieve spinal cord compression. Posterior fusion using rods and screws was performed for stabilization. The procedure successfully addressed the subluxation, decompressed the spinal cord, and improved neurological symptoms.

3. Operative Note: Patient underwent anterior odontoid screw fixation with bone grafting and posterior C1-C2 fusion for recurrent atlantoaxial subluxation and myelopathy. Under general anesthesia, a transverse incision was made, providing access to the anterior cervical spine. An odontoid screw was carefully placed, followed by bone grafting for fusion. Posterior fusion using lateral mass screws and rods was performed to enhance stability. The procedure successfully corrected the subluxation, achieved spinal fusion, and improved myelopathic symptoms.

4. Operative Note: Surgical intervention involved posterior C1 lateral mass-C2 pedicle screw fixation and occipitocervical fusion for recurrent atlantoaxial subluxation and myelopathy. Under general anesthesia, a midline incision was made, exposing the occiput, upper cervical spine, and C1-C2 complex. Lateral mass screws were inserted at C1, pedicle screws at C2, and rods were placed for stabilization. Occipitocervical fusion was performed to enhance stability and alignment. The procedure successfully corrected the subluxation, achieved fusion, and improved neurological symptoms.

5. Operative Note: Patient underwent revision transarticular screw fixation with bone grafting and posterior fusion for recurrent atlantoaxial subluxation and myelopathy. Under general anesthesia, a posterior midline incision was made, exposing the C1-C2 complex. The previously placed transarticular screws were revised, and bone grafting was performed for fusion. Posterior fusion using rods and screws was done for additional stability. The procedure successfully corrected the subluxation, achieved fusion, and improved myelopathic symptoms.

6. Operative Note: Surgical intervention involved posterior decompression, instrumented fusion, and laminoplasty for recurrent atlantoaxial subluxation with myelopathy. Under general anesthesia, a midline incision was made, exposing the cervical spine. Decompressive laminectomy was performed, followed by instrumented fusion using screws and rods. Laminoplasty was done to preserve motion and decompress the spinal cord. The procedure successfully addressed the subluxation, decompressed the spinal cord, and improved neurological symptoms.

7. Operative Note: Patient underwent transoral odontoidectomy, posterior fixation, and fusion for recurrent atlantoaxial subluxation and myelopathy. Under general anesthesia, an oral incision was made, providing access to the odontoid process. The odontoid was meticulously resected, followed by posterior fusion using screws and rods for stabilization. The procedure successfully corrected the subluxation, achieved spinal fusion, and improved myelopathic symptoms.

8. Operative Note: Surgical intervention involved revision occipitocervical fusion with occipital plate and cervical lateral mass screws for recurrent atlantoaxial subluxation and myelopathy. Under general anesthesia, a midline incision was made, exposing the occiput and cervical spine. The previously placed instrumentation was removed, and an occipital plate with lateral mass screws was placed for occipitocervical stabilization. The procedure successfully corrected the subluxation, achieved stability, and improved myelopathic symptoms.

9. Operative Note: Patient underwent posterior C1-C2 transarticular screw fixation, decompression, and fusion for recurrent atlantoaxial subluxation and myelopathy. Under general anesthesia, a midline incision was made, exposing the C1 and C2 vertebrae. Transarticular screws were meticulously inserted, followed by decompressive laminectomy to relieve spinal cord compression. Posterior fusion using rods and screws was performed for stabilization. The procedure successfully corrected the subluxation, decompressed the spinal cord, and improved myelopathic symptoms.

10. Operative Note: Surgical intervention involved anterior odontoid screw fixation, posterior decompression, and fusion for recurrent atlantoaxial subluxation with myelopathy. Under general anesthesia, a transverse incision was made, providing access to the anterior cervical spine. An odontoid screw was carefully placed, followed by decompressive laminectomy to alleviate spinal cord compression. Posterior fusion using lateral mass screws and rods was performed for stabilization. The procedure successfully corrected the subluxation, decompressed the spinal cord, and improved myelopathic symptoms.

1. Operative Note: Patient with recurrent atlantoaxial subluxation and myelopathy, complicated by a severe infection on the extreme moving joint, underwent urgent surgical intervention. Under general anesthesia, a midline incision was made, revealing erosive changes and purulent discharge indicative of the severe infection. Debridement of infected tissues was performed, followed by thorough irrigation and placement of antibiotic-impregnated beads. Posterior fusion with instrumentation was then carried out to stabilize the affected area and address the underlying pathology.

2. Operative Note: Surgical intervention was performed for recurrent atlantoaxial subluxation with myelopathy and a severe infection involving the extreme moving joint. Under general anesthesia, an incision was made, exposing the affected joint. Extensive debridement of infected tissues was conducted, followed by thorough irrigation with antimicrobial solutions. The joint was stabilized using appropriate fixation techniques. Postoperatively, the patient received intravenous antibiotics to address the infection, and regular monitoring was ensured.

3. Operative Note: Patient presented with recurrent atlantoaxial subluxation and myelopathy, complicated by a severe infection on the extreme moving joint. Under general anesthesia, a surgical approach was made, revealing erosive changes and signs of deep-seated infection. Extensive debridement of necrotic tissues was performed, and copious irrigation with antimicrobial solutions was carried out. To restore stability, posterior fusion with instrumentation was conducted. Postoperative care included a course of intravenous antibiotics to combat the severe infection.

4. Operative Note: Surgical intervention was required for a patient with recurrent atlantoaxial subluxation and myelopathy, accompanied by a severe infection affecting the extreme moving joint. Under general anesthesia, an incision was made, exposing the infected joint. Thorough debridement of necrotic tissues and meticulous irrigation with antibiotic solutions were performed. To address the instability, posterior fusion with instrumentation was carried out. Postoperatively, the patient was placed on a targeted antibiotic regimen to eradicate the severe joint infection.

5. Operative Note: Patient underwent urgent surgical intervention for recurrent atlantoaxial subluxation with myelopathy, complicated by a severe infection involving the extreme moving joint. Under general anesthesia, a midline incision was made, revealing evidence of purulent discharge and extensive erosive changes. Aggressive debridement of infected tissues was performed, followed by thorough irrigation and placement of antibiotic-impregnated material. Posterior fusion with instrumentation was then conducted to stabilize the affected joint.

6. Operative Note: Surgical intervention was performed for a patient presenting with recurrent atlantoaxial subluxation and myelopathy, accompanied by a severe infection on the extreme moving joint. Under general anesthesia, a surgical approach was made, and intraoperative findings revealed significant joint erosion and purulent discharge indicative of a severe infection. Extensive debridement and irrigation were carried out, followed by stabilization using appropriate fixation techniques. Postoperatively, the patient received intravenous antibiotics to address the severe joint infection.

7. Operative Note: Patient with recurrent atlantoaxial subluxation and myelopathy, complicated by a severe infection at the extreme moving joint, underwent urgent surgical intervention. Under general anesthesia, a midline incision was made, exposing the infected joint. Debridement of necrotic tissues was meticulously performed, and thorough irrigation with antimicrobial solutions was carried out. Posterior fusion with instrumentation was then conducted to restore stability. The patient received a targeted antibiotic regimen postoperatively to address the severe joint infection.

8. Operative Note: Surgical intervention was performed for recurrent atlantoaxial subluxation and myelopathy, with a concurrent severe infection on the extreme moving joint. Under general anesthesia, a surgical approach was made, and intraoperative examination revealed extensive joint erosion and the presence of purulent material. Debridement of infected tissues was meticulously performed, followed by irrigation with antimicrobial solutions. Stabilization of the affected joint was achieved through posterior fusion with instrumentation.

9. Operative Note: Patient presented with recurrent atlantoaxial subluxation and myelopathy, complicated by a severe infection involving the extreme moving joint. Under general anesthesia, an incision was made, exposing the infected joint. Thorough debridement of necrotic tissues and copious irrigation with antimicrobial solutions were performed. To address instability, posterior fusion with instrumentation was conducted. Postoperatively, the patient received a targeted antibiotic regimen to eliminate the severe joint infection.

10. Operative Note: Urgent surgical intervention was performed for a patient with recurrent atlantoaxial subluxation and myelopathy, complicated by a severe infection affecting the extreme moving joint. Under general anesthesia, a midline incision was made, revealing erosive changes and purulent discharge. Aggressive debridement of infected tissues was conducted, followed by meticulous irrigation and placement of antibiotic-impregnated material. Posterior fusion with instrumentation was then carried out to stabilize the affected joint and treat the severe infection.

1. Operative Note: Patient presented with recurrent atlantoaxial subluxation and myelopathy, accompanied by severe inflammation involving the extreme moving joint. Under general anesthesia, a midline incision was made, revealing significant inflammation, edema, and erythema. Extensive debridement of inflamed tissues was performed, followed by thorough irrigation with anti-inflammatory solutions. Posterior fusion with instrumentation was then conducted to address the instability. Postoperative management included anti-inflammatory medications and close monitoring of the inflammatory response.

2. Operative Note: Surgical intervention was required for a patient with recurrent atlantoaxial subluxation and myelopathy, complicated by severe inflammation at the extreme moving joint. Under general anesthesia, an incision was made, exposing the inflamed joint. Meticulous debridement of inflamed tissues was performed, followed by irrigation with anti-inflammatory solutions. To address instability, posterior fusion with instrumentation was carried out. Postoperatively, the patient received anti-inflammatory medications to manage the inflammation.

3. Operative Note: Patient underwent urgent surgical intervention for recurrent atlantoaxial subluxation with myelopathy, complicated by severe inflammation involving the extreme moving joint. Under general anesthesia, a midline incision was made, revealing marked inflammation, joint effusion, and erythema. Extensive debridement of inflamed tissues was conducted, followed by thorough irrigation with anti-inflammatory solutions. Posterior fusion with instrumentation was then performed to address the instability. Postoperatively, the patient received anti-inflammatory medications to control the inflammation.

4. Operative Note: Surgical intervention was performed for a patient with recurrent atlantoaxial subluxation and myelopathy, accompanied by severe inflammation on the extreme moving joint. Under general anesthesia, a surgical approach was made, and intraoperative findings revealed significant joint inflammation, characterized by edema and erythema. Meticulous debridement of inflamed tissues was performed, followed by irrigation with anti-inflammatory solutions. Posterior fusion with instrumentation was conducted to stabilize the joint and address the underlying pathology.

5. Operative Note: Patient presented with recurrent atlantoaxial subluxation and myelopathy, complicated by severe inflammation at the extreme moving joint. Under general anesthesia, a midline incision was made, exposing the inflamed joint. Extensive debridement of inflamed tissues was conducted, followed by irrigation with anti-inflammatory solutions. Posterior fusion with instrumentation was then performed to stabilize the joint and alleviate the inflammatory response. Postoperatively, the patient received anti-inflammatory medications to manage the inflammation.

6. Operative Note: Surgical intervention was performed for recurrent atlantoaxial subluxation and myelopathy, with concomitant severe inflammation at the extreme moving joint. Under general anesthesia, an incision was made, revealing significant joint inflammation, characterized by erythema and swelling. Thorough debridement of inflamed tissues was performed, followed by irrigation with anti-inflammatory solutions. Posterior fusion with instrumentation was carried out to stabilize the joint and mitigate the inflammatory process.

7. Operative Note: Patient underwent urgent surgical intervention for recurrent atlantoaxial subluxation with myelopathy, complicated by severe inflammation involving the extreme moving joint. Under general anesthesia, a midline incision was made, revealing marked joint inflammation, with visible erythema and edema. Extensive debridement of inflamed tissues was conducted, followed by irrigation with anti-inflammatory solutions. Posterior fusion with instrumentation was performed to address the instability and control the inflammatory response.

8. Operative Note: Surgical intervention was required for a patient with recurrent atlantoaxial subluxation and myelopathy, accompanied by severe inflammation at the extreme moving joint. Under general anesthesia, a surgical approach was made, and intraoperative findings revealed pronounced joint inflammation, with significant edema and erythema. Meticulous debridement of inflamed tissues was conducted, followed by thorough irrigation with anti-inflammatory solutions. Posterior fusion with instrumentation was performed to stabilize the joint and alleviate the inflammatory symptoms.

9. Operative Note: Patient presented with recurrent atlantoaxial subluxation and myelopathy, complicated by severe inflammation on the extreme moving joint. Under general anesthesia, a midline incision was made, exposing the inflamed joint. Extensive debridement of inflamed tissues was meticulously performed, followed by irrigation with anti-inflammatory solutions. Posterior fusion with instrumentation was conducted to stabilize the joint and reduce the inflammatory response. Postoperatively, the patient received anti-inflammatory medications to manage the inflammation.

10. Operative Note: Surgical intervention was performed for recurrent atlantoaxial subluxation and myelopathy, with concurrent severe inflammation at the extreme moving joint. Under general anesthesia, an incision was made, revealing notable joint inflammation, characterized by erythema and edema. Thorough debridement of inflamed tissues was carried out, followed by irrigation with anti-inflammatory solutions. Posterior fusion with instrumentation was conducted to stabilize the joint and alleviate the inflammatory process.

1. Operative Note: Patient diagnosed with severe recurrent atlantoaxial subluxation and myelopathy underwent surgical intervention. Under general anesthesia, a midline incision was made, and the subluxation was corrected through posterior fusion with instrumentation. The patient's postoperative follow-up will include regular neurological assessments and imaging to monitor the resolution of myelopathic symptoms and the stability of the fusion construct.

2. Operative Note: Surgical intervention was performed for a patient with recurrent atlantoaxial subluxation and myelopathy of moderate severity. Under general anesthesia, an incision was made, and posterior fusion with instrumentation was completed. The patient's postoperative follow-up will involve frequent neurological evaluations and imaging studies to assess the progression of myelopathy and the integrity of the fusion.

3. Operative Note: Patient diagnosed with mild recurrent atlantoaxial subluxation and myelopathy underwent surgical intervention. Under general anesthesia, a midline incision was made, and posterior fusion with instrumentation was performed. The patient's postoperative follow-up will include regular clinical evaluations to monitor the resolution of myelopathic symptoms and assess the need for additional interventions.

4. Operative Note: Surgical intervention was performed for a patient with severe recurrent atlantoaxial subluxation and myelopathy. Under general anesthesia, an incision was made, and posterior fusion with instrumentation was completed. Given the severity of the diagnosis, the patient's postoperative follow-up will involve close monitoring of neurological function, frequent imaging studies, and multidisciplinary consultations to address potential complications and optimize rehabilitation.

5. Operative Note: Patient diagnosed with moderate recurrent atlantoaxial subluxation and myelopathy underwent surgical intervention. Under general anesthesia, a midline incision was made, and the subluxation was corrected through posterior fusion with instrumentation. The patient's postoperative follow-up will consist of regular neurological assessments, imaging studies, and physical therapy to track the progression of myelopathy and optimize functional recovery.

6. Operative Note: Surgical intervention was performed for a patient with mild recurrent atlantoaxial subluxation and myelopathy. Under general anesthesia, an incision was made, and posterior fusion with instrumentation was completed. The patient's postoperative follow-up will include periodic clinical evaluations, imaging studies, and conservative management to monitor the resolution of myelopathic symptoms and assess the need for further intervention.

7. Operative Note: Patient diagnosed with severe recurrent atlantoaxial subluxation and myelopathy underwent urgent surgical intervention. Under general anesthesia, a midline incision was made, and posterior fusion with instrumentation was performed. The patient's postoperative follow-up will involve frequent neurological assessments, imaging studies, and interdisciplinary collaboration to address potential complications and optimize the rehabilitation process.

8. Operative Note: Surgical intervention was performed for a patient with moderate recurrent atlantoaxial subluxation and myelopathy. Under general anesthesia, an incision was made, and posterior fusion with instrumentation was completed. The patient's postoperative follow-up will consist of regular clinical evaluations, imaging studies, and rehabilitative interventions to monitor the progression of myelopathy and enhance functional recovery.

9. Operative Note: Patient diagnosed with mild recurrent atlantoaxial subluxation and myelopathy underwent surgical intervention. Under general anesthesia, a midline incision was made, and the subluxation was corrected through posterior fusion with instrumentation. The patient's postoperative follow-up will include periodic neurological assessments and imaging studies to monitor the resolution of myelopathic symptoms and determine the need for further intervention.

10. Operative Note: Surgical intervention was performed for a patient with severe recurrent atlantoaxial subluxation and myelopathy. Under general anesthesia, an incision was made, and posterior fusion with instrumentation was completed. Given the severity of the diagnosis, the patient's postoperative follow-up will involve frequent neurological evaluations, imaging studies, and potential collaboration with specialists to address complications and optimize the rehabilitation process.

## M43.4 Other recurrent atlantoaxial subluxation

1. Operative Note: Patient underwent posterior C1-C2 fusion for other recurrent atlantoaxial subluxation. A midline incision was made, and dissection was carried out to expose the affected region. Following adequate exposure, C1-C2 joint was reduced and fixed using screws and rods. Intraoperative fluoroscopy confirmed satisfactory alignment. Wound was closed in layers. The patient tolerated the procedure well and was transferred to the recovery room in stable condition.

2. Operative Note: Surgical intervention was performed for other recurrent atlantoaxial subluxation. A posterior approach was utilized, and the region was exposed through a midline incision. C1-C2 joint reduction was achieved, followed by stabilization using screws and rods. Intraoperative imaging confirmed proper alignment. The incision was closed meticulously. The patient's postoperative course was uneventful, and they were discharged with appropriate follow-up instructions.

3. Operative Note: Posterior C1-C2 fusion was performed for other recurrent atlantoaxial subluxation. A midline incision was made, providing access to the affected area. The C1-C2 joint was reduced and fixed utilizing screws and rods. Intraoperative fluoroscopy confirmed satisfactory alignment. The incision was closed in layers. The patient recovered without complications and was discharged after a brief observation period.

4. Operative Note: Patient underwent surgical management for other recurrent atlantoaxial subluxation. A posterior approach was employed, and the affected region was exposed through a midline incision. Reduction of the C1-C2 joint was achieved, followed by stabilization using screws and rods. Intraoperative imaging confirmed proper alignment. The incision was closed meticulously. The patient recovered well and was discharged with appropriate postoperative care instructions.

5. Operative Note: Surgical intervention was performed for other recurrent atlantoaxial subluxation. The patient underwent a posterior approach, and a midline incision provided access to the affected area. Reduction of the C1-C2 joint was achieved, and fixation was performed using screws and rods. Intraoperative fluoroscopy confirmed satisfactory alignment. The incision was closed in layers. The patient's postoperative course was uneventful, and they were discharged with appropriate follow-up plans.

6. Operative Note: Posterior C1-C2 fusion was performed for other recurrent atlantoaxial subluxation. A midline incision was made, providing exposure to the affected region. The C1-C2 joint was reduced and fixed using screws and rods. Intraoperative fluoroscopy was utilized to confirm proper alignment. The incision was closed meticulously. The patient recovered without complications and was discharged after a period of observation.

7. Operative Note: Surgical management was carried out for other recurrent atlantoaxial subluxation. A posterior approach was utilized, and a midline incision facilitated exposure to the affected area. Reduction of the C1-C2 joint was accomplished, followed by stabilization using screws and rods. Intraoperative fluoroscopy confirmed adequate alignment. The incision was closed in layers. The patient's recovery was uneventful, and they were discharged with appropriate postoperative instructions.

8. Operative Note: Patient underwent posterior C1-C2 fusion for other recurrent atlantoaxial subluxation. A midline incision was made, providing access to the affected region. The C1-C2 joint was successfully reduced and fixed using screws and rods. Intraoperative fluoroscopy was used to verify satisfactory alignment. The wound was closed meticulously. The patient's postoperative course was uncomplicated, and they were discharged after a period of observation.

9. Operative Note: Surgical intervention was performed for other recurrent atlantoaxial subluxation. The patient underwent a posterior approach, and a midline incision was made to expose the affected area. The C1-C2 joint was reduced and stabilized using screws and rods. Intraoperative fluoroscopy confirmed proper alignment. The incision was closed in layers. The patient had an uneventful recovery and was discharged with appropriate follow-up plans.

10. Operative Note: Posterior C1-C2 fusion was performed for other recurrent atlantoaxial subluxation. A midline incision provided access to the affected region. Reduction of the C1-C2 joint was achieved, followed by fixation using screws and rods. Intraoperative fluoroscopy confirmed satisfactory alignment. The incision was closed meticulously. The patient's recovery was without complications, and they were discharged with appropriate postoperative care instructions.

1. Operative Note: Surgical intervention was performed for other recurrent atlantoaxial subluxation. A posterior approach was utilized, and a midline incision provided exposure to the affected region. The C1-C2 joint was carefully reduced and stabilized using screws and rods. Intraoperative fluoroscopy confirmed satisfactory alignment. The incision was closed in layers. The patient tolerated the procedure well and was transferred to the postoperative recovery area in stable condition.

2. Operative Note: Posterior C1-C2 fusion was carried out for other recurrent atlantoaxial subluxation. A midline incision was made, providing access to the affected region. Reduction of the C1-C2 joint was successfully achieved, followed by fixation using screws and rods. Intraoperative fluoroscopy confirmed proper alignment. The wound was closed meticulously. The patient's postoperative recovery was uncomplicated, and they were discharged with appropriate follow-up plans.

3. Operative Note: Patient underwent surgical management for other recurrent atlantoaxial subluxation. A posterior approach was employed, and a midline incision facilitated exposure to the affected area. Reduction of the C1-C2 joint was performed meticulously, followed by stabilization using screws and rods. Intraoperative fluoroscopy confirmed satisfactory alignment. The incision was closed in layers. The patient had an uneventful postoperative course and was discharged with appropriate postoperative care instructions.

4. Operative Note: Surgical intervention was performed for other recurrent atlantoaxial subluxation. The patient underwent a posterior approach, and a midline incision provided access to the affected region. The C1-C2 joint reduction was achieved, followed by stabilization using screws and rods. Intraoperative fluoroscopy confirmed proper alignment. The incision was closed meticulously. The patient's postoperative recovery was uncomplicated, and they were discharged with appropriate postoperative instructions.

5. Operative Note: Posterior C1-C2 fusion was performed for other recurrent atlantoaxial subluxation. A midline incision was made, providing exposure to the affected region. Reduction and fixation of the C1-C2 joint were successfully carried out using screws and rods. Intraoperative fluoroscopy confirmed satisfactory alignment. The wound was closed meticulously. The patient's recovery was uneventful, and they were discharged after a period of observation with appropriate follow-up plans.

6. Operative Note: Surgical management was undertaken for other recurrent atlantoaxial subluxation. A posterior approach was utilized, and a midline incision allowed exposure to the affected area. The C1-C2 joint was reduced and stabilized using screws and rods. Intraoperative fluoroscopy confirmed proper alignment. The incision was closed meticulously. The patient had a smooth postoperative course and was discharged with appropriate postoperative care instructions.

7. Operative Note: Patient underwent posterior C1-C2 fusion for other recurrent atlantoaxial subluxation. A midline incision was made, providing access to the affected region. Reduction and fixation of the C1-C2 joint were achieved using screws and rods. Intraoperative fluoroscopy confirmed satisfactory alignment. The incision was closed in layers. The patient's recovery was uneventful, and they were discharged with appropriate postoperative instructions.

8. Operative Note: Surgical intervention was performed for other recurrent atlantoaxial subluxation. The patient underwent a posterior approach, and a midline incision provided exposure to the affected area. Reduction of the C1-C2 joint was meticulously performed, followed by stabilization using screws and rods. Intraoperative fluoroscopy confirmed proper alignment. The incision was closed meticulously. The patient had an uncomplicated postoperative recovery and was discharged with appropriate follow-up plans.

9. Operative Note: Posterior C1-C2 fusion was performed for other recurrent atlantoaxial subluxation. A midline incision provided access to the affected region. Reduction and stabilization of the C1-C2 joint were successfully achieved using screws and rods. Intraoperative fluoroscopy confirmed satisfactory alignment. The incision was closed meticulously. The patient's recovery was without complications, and they were discharged with appropriate postoperative care instructions.

10. Operative Note: Surgical management was carried out for other recurrent atlantoaxial subluxation. A posterior approach was utilized, and a midline incision facilitated exposure to the affected region. The C1-C2 joint was carefully reduced and fixed using screws and rods. Intraoperative fluoroscopy confirmed satisfactory alignment. The incision was closed meticulously. The patient's recovery was uneventful, and they were discharged with appropriate postoperative instructions.

1. Operative Note: Patient underwent posterior C1-C2 fusion for other recurrent atlantoaxial subluxation under general anesthesia. Induction and maintenance of anesthesia were achieved using appropriate dosages of propofol and sevoflurane. A midline incision was made, and the surgical procedure was performed as planned. The patient's vital signs remained stable throughout the surgery, and they recovered smoothly in the post-anesthesia care unit.

2. Operative Note: Surgical intervention was performed for other recurrent atlantoaxial subluxation under general anesthesia. An appropriate dosage of intravenous fentanyl and inhalational isoflurane was used for induction and maintenance of anesthesia. The surgical procedure was carried out through a midline incision, and the C1-C2 joint was successfully reduced and stabilized. The patient's hemodynamic parameters were well-maintained throughout the procedure, and they recovered uneventfully.

3. Operative Note: Posterior C1-C2 fusion was performed for other recurrent atlantoaxial subluxation under general anesthesia. An appropriate dosage of propofol and desflurane was administered for induction and maintenance of anesthesia. A midline incision provided access to the affected region, and the C1-C2 joint was reduced and fixed. The patient remained stable throughout the surgery, and they were transferred to the recovery room in a satisfactory condition.

4. Operative Note: Surgical management was carried out for other recurrent atlantoaxial subluxation under general anesthesia. Induction and maintenance of anesthesia were achieved using appropriate dosages of sevoflurane and remifentanil. A midline incision was made, and the procedure was performed successfully. The patient's vital signs were well-controlled throughout the surgery, and they recovered smoothly in the postoperative period.

5. Operative Note: Patient underwent posterior C1-C2 fusion for other recurrent atlantoaxial subluxation under general anesthesia. An appropriate dosage of intravenous midazolam and inhalational sevoflurane was administered for induction and maintenance of anesthesia. A midline incision provided access to the affected region, and the C1-C2 joint was reduced and stabilized. The patient's anesthesia was well-managed, and they recovered without any complications.

6. Operative Note: Surgical intervention was performed for other recurrent atlantoaxial subluxation under general anesthesia. An appropriate dosage of propofol and isoflurane was used for induction and maintenance of anesthesia. The surgical procedure was carried out through a midline incision, and the C1-C2 joint was successfully reduced and fixed. The patient's vital signs remained stable throughout the surgery, and they had a smooth recovery in the post-anesthesia care unit.

7. Operative Note: Posterior C1-C2 fusion was performed for other recurrent atlantoaxial subluxation under general anesthesia. An appropriate dosage of sevoflurane and remifentanil was administered for induction and maintenance of anesthesia. A midline incision was made, and the C1-C2 joint was reduced and fixed. The patient's anesthesia was well-managed, and their vital signs were stable throughout the procedure.

8. Operative Note: Surgical management was carried out for other recurrent atlantoaxial subluxation under general anesthesia. Induction and maintenance of anesthesia were achieved using appropriate dosages of propofol and desflurane. A midline incision provided access to the affected region, and the C1-C2 joint was successfully reduced and stabilized. The patient's vital signs were well-controlled, and they had an uneventful recovery in the postoperative period.

9. Operative Note: Patient underwent posterior C1-C2 fusion for other recurrent atlantoaxial subluxation under general anesthesia. An appropriate dosage of intravenous fentanyl and inhalational isoflurane was used for induction and maintenance of anesthesia. A midline incision was made, and the surgical procedure was performed successfully. The patient's vital signs remained stable throughout the surgery, and they recovered smoothly in the post-anesthesia care unit.

10. Operative Note: Surgical intervention was performed for other recurrent atlantoaxial subluxation under general anesthesia. An appropriate dosage of propofol and sevoflurane was administered for induction and maintenance of anesthesia. The surgical procedure was carried out through a midline incision, and the C1-C2 joint was reduced and fixed. The patient's anesthesia was well-managed, and they had an uneventful recovery after the procedure.

1. Operative Note: Surgical intervention was performed for other recurrent atlantoaxial subluxation with significant bone erosion. A posterior approach was utilized, and a midline incision provided exposure to the affected region. Careful reduction of the C1-C2 joint was achieved, followed by stabilization using screws and rods. Intraoperative imaging revealed notable bone erosion. The incision was closed meticulously. The patient tolerated the procedure well and was transferred to the recovery room for further observation.

2. Operative Note: Posterior C1-C2 fusion was performed for other recurrent atlantoaxial subluxation with evidence of bone erosion. A midline incision was made, providing access to the affected region. The C1-C2 joint was carefully reduced, and stabilization was achieved using screws and rods. Intraoperative imaging confirmed significant bone erosion. The incision was closed meticulously. The patient had a stable intraoperative course and was transferred to the intensive care unit for close monitoring.

3. Operative Note: Patient underwent surgical management for other recurrent atlantoaxial subluxation with extensive bone erosion. A posterior approach was employed, and a midline incision facilitated exposure to the affected area. Reduction and stabilization of the severely eroded C1-C2 joint were meticulously performed using screws and rods. Intraoperative imaging revealed significant bone erosion. The incision was closed in layers. The patient's postoperative course was closely monitored due to the extent of bone erosion.

4. Operative Note: Surgical intervention was performed for other recurrent atlantoaxial subluxation with notable bone erosion. The patient underwent a posterior approach, and a midline incision provided access to the affected region. Reduction of the C1-C2 joint was achieved, followed by stabilization using screws and rods. Intraoperative imaging confirmed significant bone erosion. The incision was closed meticulously. The patient's recovery was closely monitored due to the extent of bone erosion.

5. Operative Note: Posterior C1-C2 fusion was performed for other recurrent atlantoaxial subluxation with evident bone erosion. A midline incision was made, providing exposure to the affected region. Reduction and stabilization of the eroded C1-C2 joint were successfully achieved using screws and rods. Intraoperative imaging revealed significant bone erosion. The incision was closed meticulously. The patient's postoperative course was closely monitored due to the presence of bone erosion.

6. Operative Note: Surgical management was carried out for other recurrent atlantoaxial subluxation with significant bone erosion. A posterior approach was utilized, and a midline incision allowed exposure to the affected area. The C1-C2 joint was reduced and stabilized using screws and rods. Intraoperative imaging revealed notable bone erosion. The incision was closed meticulously. The patient's postoperative course was closely monitored due to the extent of bone erosion.

7. Operative Note: Patient underwent posterior C1-C2 fusion for other recurrent atlantoaxial subluxation with extensive bone erosion. A midline incision was made, providing access to the affected region. The C1-C2 joint was successfully reduced and fixed using screws and rods. Intraoperative imaging confirmed significant bone erosion. The incision was closed meticulously. The patient's recovery was closely monitored due to the extent of bone erosion.

8. Operative Note: Surgical intervention was performed for other recurrent atlantoaxial subluxation with evident bone erosion. The patient underwent a posterior approach, and a midline incision provided access to the affected region. Reduction of the severely eroded C1-C2 joint was meticulously performed, followed by stabilization using screws and rods. Intraoperative imaging confirmed significant bone erosion. The incision was closed in layers. The patient's recovery was closely monitored due to the extent of bone erosion.

9. Operative Note: Posterior C1-C2 fusion was performed for other recurrent atlantoaxial subluxation with notable bone erosion. A midline incision provided access to the affected region. Reduction and stabilization of the eroded C1-C2 joint were successfully achieved using screws and rods. Intraoperative imaging revealed significant bone erosion. The wound was closed meticulously. The patient's postoperative course was closely monitored due to the presence of bone erosion.

10. Operative Note: Surgical management was carried out for other recurrent atlantoaxial subluxation with extensive bone erosion. A posterior approach was utilized, and a midline incision facilitated exposure to the affected area. Reduction and stabilization of the severely eroded C1-C2 joint were meticulously performed using screws and rods. Intraoperative imaging confirmed significant bone erosion. The incision was closed meticulously. The patient's postoperative course was closely monitored due to the extent of bone erosion.

1. Operative Note: Surgical intervention was performed for other recurrent atlantoaxial subluxation with severe bone pain. A posterior approach was utilized, and a midline incision provided exposure to the affected region. Careful reduction of the C1-C2 joint was achieved, followed by stabilization using screws and rods. Intraoperative imaging revealed severe bone erosion and inflammation. The incision was closed meticulously. The patient tolerated the procedure well and reported relief from bone pain postoperatively.

2. Operative Note: Posterior C1-C2 fusion was performed for other recurrent atlantoaxial subluxation with severe bone pain. A midline incision was made, providing access to the affected region. The C1-C2 joint was carefully reduced, and stabilization was achieved using screws and rods. Intraoperative imaging confirmed severe bone erosion and inflammation. The incision was closed meticulously. The patient's postoperative course was marked by significant improvement in bone pain and overall discomfort.

3. Operative Note: Patient underwent surgical management for other recurrent atlantoaxial subluxation with severe bone pain. A posterior approach was employed, and a midline incision facilitated exposure to the affected area. Reduction and stabilization of the C1-C2 joint were meticulously performed using screws and rods. Intraoperative imaging revealed severe bone erosion and inflammation. The incision was closed in layers. The patient reported substantial relief from bone pain in the immediate postoperative period.

4. Operative Note: Surgical intervention was performed for other recurrent atlantoaxial subluxation with notable bone erosion and severe bone pain. The patient underwent a posterior approach, and a midline incision provided access to the affected region. Reduction of the C1-C2 joint was achieved, followed by stabilization using screws and rods. Intraoperative imaging confirmed severe bone pathology. The incision was closed meticulously. The patient's postoperative course was marked by significant reduction in bone pain.

5. Operative Note: Posterior C1-C2 fusion was performed for other recurrent atlantoaxial subluxation with severe bone pain. A midline incision was made, providing exposure to the affected region. Reduction and stabilization of the C1-C2 joint were successfully achieved using screws and rods. Intraoperative imaging revealed severe bone erosion and inflammation. The incision was closed meticulously. The patient's recovery was characterized by substantial alleviation of bone pain and improved overall quality of life.

6. Operative Note: Surgical management was carried out for other recurrent atlantoaxial subluxation with severe bone pain. A posterior approach was utilized, and a midline incision allowed exposure to the affected area. The C1-C2 joint was reduced and stabilized using screws and rods. Intraoperative imaging revealed severe bone pathology and inflammation. The incision was closed meticulously. The patient's postoperative course was marked by significant relief from bone pain and improved functional mobility.

7. Operative Note: Patient underwent posterior C1-C2 fusion for other recurrent atlantoaxial subluxation with severe bone pain. A midline incision was made, providing access to the affected region. The C1-C2 joint was successfully reduced and fixed using screws and rods. Intraoperative imaging confirmed severe bone erosion and inflammation. The incision was closed meticulously. The patient reported substantial improvement in bone pain and increased tolerance for daily activities postoperatively.

8. Operative Note: Surgical intervention was performed for other recurrent atlantoaxial subluxation with severe bone pain. The patient underwent a posterior approach, and a midline incision provided access to the affected region. Reduction of the C1-C2 joint was meticulously achieved, followed by stabilization using screws and rods. Intraoperative imaging revealed severe bone pathology and inflammation. The incision was closed in layers. The patient experienced significant relief from bone pain following the procedure.

9. Operative Note: Posterior C1-C2 fusion was performed for other recurrent atlantoaxial subluxation with notable bone erosion and severe bone pain. A midline incision provided access to the affected region. Reduction and stabilization of the eroded C1-C2 joint were successfully achieved using screws and rods. Intraoperative imaging revealed severe bone pathology and inflammation. The incision was closed meticulously. The patient's postoperative course was characterized by substantial improvement in bone pain and increased functional capacity.

10. Operative Note: Surgical management was carried out for other recurrent atlantoaxial subluxation with severe bone pain. A posterior approach was utilized, and a midline incision facilitated exposure to the affected area. Reduction and stabilization of the severely eroded C1-C2 joint were meticulously performed using screws and rods. Intraoperative imaging revealed severe bone erosion and inflammation. The incision was closed meticulously. The patient reported significant relief from bone pain and improved neck mobility postoperatively.

1. Operative Note: Surgical intervention was performed for other recurrent atlantoaxial subluxation. A posterior approach was utilized, and a midline incision provided access to the affected region. Careful reduction and stabilization of the C1-C2 joint were achieved using screws and rods. Intraoperative imaging confirmed successful realignment. The incision was closed meticulously. The patient tolerated the procedure well and was transferred to the post-anesthesia care unit for further monitoring.

2. Operative Note: Posterior C1-C2 fusion was performed as a surgical intervention for other recurrent atlantoaxial subluxation. A midline incision was made, providing exposure to the affected region. The C1-C2 joint was carefully reduced and fixed using screws and rods. Intraoperative imaging confirmed successful realignment and stabilization. The incision was closed meticulously. The patient's postoperative recovery was uneventful, and they were discharged with appropriate follow-up instructions.

3. Operative Note: Patient underwent surgical intervention for other recurrent atlantoaxial subluxation. A posterior approach was employed, and a midline incision facilitated exposure to the affected area. Reduction and stabilization of the C1-C2 joint were meticulously performed using screws and rods. Intraoperative imaging confirmed successful realignment and fixation. The incision was closed in layers. The patient's immediate postoperative course was uneventful, and they were discharged in stable condition.

4. Operative Note: Surgical intervention was performed for other recurrent atlantoaxial subluxation. The patient underwent a posterior approach, and a midline incision provided access to the affected region. Reduction of the C1-C2 joint was achieved, followed by stabilization using screws and rods. Intraoperative imaging confirmed successful realignment and fixation. The incision was closed meticulously. The patient's postoperative course was marked by improvement in symptoms and resolution of recurrent subluxation.

5. Operative Note: Posterior C1-C2 fusion was performed as a surgical intervention for other recurrent atlantoaxial subluxation. A midline incision was made, providing exposure to the affected region. The C1-C2 joint was successfully reduced and fixed using screws and rods. Intraoperative imaging confirmed successful realignment and stabilization. The incision was closed meticulously. The patient's immediate postoperative period was unremarkable, and they showed improvement in neck stability and symptoms.

6. Operative Note: Surgical management was carried out for other recurrent atlantoaxial subluxation through a posterior approach. A midline incision provided access to the affected area. The C1-C2 joint was meticulously reduced and stabilized using screws and rods. Intraoperative imaging confirmed successful realignment and fixation. The incision was closed meticulously. The patient's postoperative recovery was satisfactory, with resolution of subluxation and alleviation of associated symptoms.

7. Operative Note: Patient underwent surgical intervention for other recurrent atlantoaxial subluxation. A posterior approach was utilized, and a midline incision allowed exposure to the affected region. Reduction and stabilization of the C1-C2 joint were successfully achieved using screws and rods. Intraoperative imaging confirmed successful realignment and fixation. The incision was closed meticulously. The patient's postoperative course was uneventful, with improvement in neck stability and relief from recurrent subluxation.

8. Operative Note: Surgical intervention was performed for other recurrent atlantoaxial subluxation. The patient underwent a posterior approach, and a midline incision provided access to the affected region. Reduction of the C1-C2 joint was meticulously achieved, followed by stabilization using screws and rods. Intraoperative imaging confirmed successful realignment and fixation. The incision was closed in layers. The patient's immediate postoperative period was unremarkable, with resolution of subluxation and associated symptoms.

9. Operative Note: Posterior C1-C2 fusion was performed as a surgical intervention for other recurrent atlantoaxial subluxation. A midline incision was made, providing exposure to the affected region. The C1-C2 joint was carefully reduced and fixed using screws and rods. Intraoperative imaging confirmed successful realignment and stabilization. The incision was closed meticulously. The patient's postoperative recovery was satisfactory, with resolution of subluxation and improvement in neck stability.

10. Operative Note: Surgical management was carried out for other recurrent atlantoaxial subluxation. A posterior approach was employed, and a midline incision facilitated exposure to the affected area. Reduction and stabilization of the C1-C2 joint were meticulously performed using screws and rods. Intraoperative imaging confirmed successful realignment and fixation. The incision was closed meticulously. The patient's postoperative course was uneventful, with resolution of subluxation and alleviation of associated symptoms.

1. Operative Note: Surgical intervention was performed for other recurrent atlantoaxial subluxation. A posterior approach was utilized, and a midline incision provided exposure to the affected region. Reduction of the C1-C2 joint was meticulously achieved, followed by stabilization using screws and rods. Intraoperative imaging confirmed successful realignment. The incision was closed meticulously. The patient's postoperative course was unremarkable, with improvement in neck stability and resolution of recurrent subluxation.

2. Operative Note: Posterior C1-C2 fusion was performed as a surgical intervention for other recurrent atlantoaxial subluxation. A midline incision was made, providing access to the affected region. The C1-C2 joint was carefully reduced and fixed using screws and rods. Intraoperative imaging confirmed successful realignment and stabilization. The incision was closed meticulously. The patient's immediate postoperative period was uneventful, with resolution of subluxation and improvement in neck mobility.

3. Operative Note: Patient underwent surgical intervention for other recurrent atlantoaxial subluxation. A posterior approach was employed, and a midline incision facilitated exposure to the affected area. Reduction and stabilization of the C1-C2 joint were meticulously performed using screws and rods. Intraoperative imaging confirmed successful realignment and fixation. The incision was closed in layers. The patient's postoperative recovery was satisfactory, with resolution of subluxation and improvement in symptoms.

4. Operative Note: Surgical intervention was performed for other recurrent atlantoaxial subluxation. The patient underwent a posterior approach, and a midline incision provided access to the affected region. Reduction of the C1-C2 joint was achieved, followed by stabilization using screws and rods. Intraoperative imaging confirmed successful realignment and fixation. The incision was closed meticulously. The patient's postoperative course was marked by improvement in neck stability and resolution of recurrent subluxation.

5. Operative Note: Posterior C1-C2 fusion was performed as a surgical intervention for other recurrent atlantoaxial subluxation. A midline incision was made, providing exposure to the affected region. The C1-C2 joint was successfully reduced and fixed using screws and rods. Intraoperative imaging confirmed successful realignment and stabilization. The incision was closed meticulously. The patient's recovery was unremarkable, with resolution of subluxation and improvement in neck stability.

6. Operative Note: Surgical management was carried out for other recurrent atlantoaxial subluxation through a posterior approach. A midline incision provided access to the affected area. The C1-C2 joint was meticulously reduced and stabilized using screws and rods. Intraoperative imaging confirmed successful realignment and fixation. The incision was closed meticulously. The patient's postoperative course was uneventful, with improvement in neck stability and resolution of recurrent subluxation.

7. Operative Note: Patient underwent surgical intervention for other recurrent atlantoaxial subluxation. A posterior approach was utilized, and a midline incision allowed exposure to the affected region. Reduction and stabilization of the C1-C2 joint were successfully achieved using screws and rods. Intraoperative imaging confirmed successful realignment and fixation. The incision was closed meticulously. The patient's postoperative course was marked by improvement in neck stability and relief from recurrent subluxation.

8. Operative Note: Surgical intervention was performed for other recurrent atlantoaxial subluxation. The patient underwent a posterior approach, and a midline incision provided access to the affected region. Reduction of the C1-C2 joint was meticulously achieved, followed by stabilization using screws and rods. Intraoperative imaging confirmed successful realignment and fixation. The incision was closed in layers. The patient's immediate postoperative period was unremarkable, with resolution of subluxation and associated symptoms.

9. Operative Note: Posterior C1-C2 fusion was performed as a surgical intervention for other recurrent atlantoaxial subluxation. A midline incision was made, providing exposure to the affected region. The C1-C2 joint was carefully reduced and fixed using screws and rods. Intraoperative imaging confirmed successful realignment and stabilization. The incision was closed meticulously. The patient's postoperative recovery was satisfactory, with resolution of subluxation and improvement in neck stability.

10. Operative Note: Surgical management was carried out for other recurrent atlantoaxial subluxation. A posterior approach was employed, and a midline incision facilitated exposure to the affected area. Reduction and stabilization of the C1-C2 joint were meticulously performed using screws and rods. Intraoperative imaging confirmed successful realignment and fixation. The incision was closed meticulously. The patient's postoperative course was uneventful, with resolution of subluxation and alleviation of associated symptoms.

1. Operative Note: Surgical intervention was performed for other recurrent atlantoaxial subluxation with a severe infection on the extreme moving joint. A posterior approach was utilized, and a midline incision provided access to the affected region. Careful debridement of the infected joint was performed, followed by reduction and stabilization using screws and rods. Intraoperative cultures confirmed the presence of a severe infection. Intravenous antibiotics were administered postoperatively to treat the infection.

2. Operative Note: Posterior C1-C2 fusion was performed for other recurrent atlantoaxial subluxation with a severe infection involving the extreme moving joint. A midline incision was made, providing exposure to the affected region. Debridement of the infected joint was meticulously performed, followed by reduction and stabilization using screws and rods. Intraoperative cultures confirmed the presence of a severe infection. The incision was closed meticulously. Intravenous antibiotics were initiated postoperatively to address the infection.

3. Operative Note: Patient underwent surgical management for other recurrent atlantoaxial subluxation with a severe infection on the extreme moving joint. A posterior approach was employed, and a midline incision facilitated exposure to the affected area. Debridement of the infected joint was meticulously performed, followed by reduction and stabilization using screws and rods. Intraoperative cultures confirmed the presence of a severe joint infection. Intravenous antibiotics were initiated postoperatively to combat the infection.

4. Operative Note: Surgical intervention was performed for other recurrent atlantoaxial subluxation with a severe infection on the extreme moving joint. The patient underwent a posterior approach, and a midline incision provided access to the affected region. Debridement of the infected joint was performed, followed by reduction and stabilization using screws and rods. Intraoperative cultures confirmed the presence of a severe infection. The incision was closed meticulously. Intravenous antibiotics were initiated postoperatively for infection control.

5. Operative Note: Posterior C1-C2 fusion was performed for other recurrent atlantoaxial subluxation with a severe infection involving the extreme moving joint. A midline incision was made, providing exposure to the affected region. Debridement of the infected joint was meticulously performed, followed by reduction and stabilization using screws and rods. Intraoperative cultures confirmed the presence of a severe infection. The incision was closed meticulously. Intravenous antibiotics were administered postoperatively to treat the joint infection.

6. Operative Note: Surgical management was carried out for other recurrent atlantoaxial subluxation with a severe infection on the extreme moving joint. A posterior approach was utilized, and a midline incision allowed exposure to the affected area. Debridement of the infected joint was meticulously performed, followed by reduction and stabilization using screws and rods. Intraoperative cultures confirmed the presence of a severe joint infection. Intravenous antibiotics were initiated postoperatively to address the infection.

7. Operative Note: Patient underwent surgical intervention for other recurrent atlantoaxial subluxation with a severe infection on the extreme moving joint. A posterior approach was employed, and a midline incision facilitated exposure to the affected region. Debridement of the infected joint was performed, followed by reduction and stabilization using screws and rods. Intraoperative cultures confirmed the presence of a severe joint infection. Intravenous antibiotics were initiated postoperatively to combat the infection.

8. Operative Note: Surgical intervention was performed for other recurrent atlantoaxial subluxation with a severe infection on the extreme moving joint. The patient underwent a posterior approach, and a midline incision provided access to the affected region. Debridement of the infected joint was meticulously achieved, followed by reduction and stabilization using screws and rods. Intraoperative cultures confirmed the presence of a severe infection. Intravenous antibiotics were administered postoperatively for infection control.

9. Operative Note: Posterior C1-C2 fusion was performed for other recurrent atlantoaxial subluxation with a severe infection involving the extreme moving joint. A midline incision was made, providing exposure to the affected region. Debridement of the infected joint was meticulously performed, followed by reduction and stabilization using screws and rods. Intraoperative cultures confirmed the presence of a severe infection. The incision was closed meticulously. Intravenous antibiotics were initiated postoperatively to treat the joint infection.

10. Operative Note: Surgical management was carried out for other recurrent atlantoaxial subluxation with a severe infection on the extreme moving joint. A posterior approach was utilized, and a midline incision allowed exposure to the affected area. Debridement of the infected joint was meticulously performed, followed by reduction and stabilization using screws and rods. Intraoperative cultures confirmed the presence of a severe joint infection. Intravenous antibiotics were initiated postoperatively to address the infection.

1. Operative Note: Surgical intervention was performed for other recurrent atlantoaxial subluxation with severe inflammation involving the adjacent tissues. A posterior approach was utilized, and a midline incision provided access to the affected region. Careful debridement of the inflamed tissues was performed, followed by reduction and stabilization using screws and rods. Intraoperative findings revealed marked inflammation and edema. The incision was closed meticulously. Postoperative anti-inflammatory medications were prescribed for inflammation management.

2. Operative Note: Posterior C1-C2 fusion was performed for other recurrent atlantoaxial subluxation with significant inflammation in the surrounding tissues. A midline incision was made, providing exposure to the affected region. Debridement of the inflamed tissues was meticulously performed, followed by reduction and stabilization using screws and rods. Intraoperative assessment revealed pronounced inflammation and swelling. The incision was closed meticulously. Postoperatively, anti-inflammatory measures were initiated to alleviate inflammation.

3. Operative Note: Patient underwent surgical intervention for other recurrent atlantoaxial subluxation with inflammation involving the adjacent tissues. A posterior approach was employed, and a midline incision facilitated exposure to the affected area. Debridement of the inflamed tissues was meticulously performed, followed by reduction and stabilization using screws and rods. Intraoperative examination showed marked inflammation and tissue edema. Postoperative anti-inflammatory medications were prescribed to manage the inflammation and promote healing.

4. Operative Note: Surgical intervention was performed for other recurrent atlantoaxial subluxation with severe inflammation affecting the surrounding tissues. The patient underwent a posterior approach, and a midline incision provided access to the affected region. Debridement of the inflamed tissues was performed, followed by reduction and stabilization using screws and rods. Intraoperative evaluation revealed significant inflammation and tissue swelling. The incision was closed meticulously. Postoperatively, anti-inflammatory measures were implemented for inflammation control.

5. Operative Note: Posterior C1-C2 fusion was performed for other recurrent atlantoaxial subluxation with inflammation involving the adjacent tissues. A midline incision was made, providing exposure to the affected region. Debridement of the inflamed tissues was meticulously performed, followed by reduction and stabilization using screws and rods. Intraoperative examination showed notable inflammation and tissue swelling. The incision was closed meticulously. Postoperatively, anti-inflammatory medications were initiated to alleviate the inflammation and facilitate healing.

6. Operative Note: Surgical management was carried out for other recurrent atlantoaxial subluxation with significant inflammation in the surrounding tissues. A posterior approach was utilized, and a midline incision allowed exposure to the affected area. Debridement of the inflamed tissues was meticulously performed, followed by reduction and stabilization using screws and rods. Intraoperative assessment revealed pronounced inflammation and edema. Anti-inflammatory measures were implemented postoperatively to address the inflammation and promote recovery.

7. Operative Note: Patient underwent surgical intervention for other recurrent atlantoaxial subluxation with inflammation involving the adjacent tissues. A posterior approach was employed, and a midline incision facilitated exposure to the affected region. Debridement of the inflamed tissues was performed, followed by reduction and stabilization using screws and rods. Intraoperative examination showed significant inflammation and tissue edema. Postoperatively, anti-inflammatory medications were prescribed to manage the inflammation and support healing.

8. Operative Note: Surgical intervention was performed for other recurrent atlantoaxial subluxation with severe inflammation affecting the surrounding tissues. The patient underwent a posterior approach, and a midline incision provided access to the affected region. Debridement of the inflamed tissues was meticulously achieved, followed by reduction and stabilization using screws and rods. Intraoperative evaluation revealed marked inflammation and tissue swelling. Postoperatively, anti-inflammatory measures were implemented to control the inflammation and facilitate recovery.

9. Operative Note: Posterior C1-C2 fusion was performed for other recurrent atlantoaxial subluxation with inflammation involving the adjacent tissues. A midline incision was made, providing exposure to the affected region. Debridement of the inflamed tissues was meticulously performed, followed by reduction and stabilization using screws and rods. Intraoperative examination showed notable inflammation and tissue swelling. The incision was closed meticulously. Postoperatively, anti-inflammatory medications were initiated to alleviate the inflammation and promote healing.

10. Operative Note: Surgical management was carried out for other recurrent atlantoaxial subluxation with significant inflammation in the surrounding tissues. A posterior approach was utilized, and a midline incision allowed exposure to the affected area. Debridement of the inflamed tissues was meticulously performed, followed by reduction and stabilization using screws and rods. Intraoperative assessment revealed pronounced inflammation and tissue edema. Anti-inflammatory measures were implemented postoperatively to address the inflammation and support recovery.

1. Operative Note: Surgical intervention was performed for other recurrent atlantoaxial subluxation. The severity of the diagnosis necessitated close postoperative monitoring. The patient was advised to schedule a follow-up appointment in one week to assess the initial healing and evaluate pain levels. Further follow-ups were recommended based on the progress and severity of symptoms.

2. Operative Note: Posterior C1-C2 fusion was performed for other recurrent atlantoaxial subluxation. Given the severity of the diagnosis, a comprehensive postoperative plan was discussed. The patient was advised to attend follow-up appointments at regular intervals for the first three months, with subsequent visits based on the severity of symptoms and response to treatment.

3. Operative Note: Surgical management was carried out for other recurrent atlantoaxial subluxation. Considering the severity of the diagnosis, a structured postoperative follow-up plan was devised. The patient was scheduled for a follow-up visit in two weeks to assess initial healing and discuss pain management. Further appointments were to be determined based on the severity of symptoms and response to treatment.

4. Operative Note: Surgical intervention was performed for other recurrent atlantoaxial subluxation. The severity of the diagnosis required an individualized follow-up approach. The patient was advised to schedule a follow-up appointment in four weeks to evaluate progress, manage pain, and discuss rehabilitation options. Additional follow-ups were recommended as needed, depending on the severity of symptoms and treatment response.

5. Operative Note: Posterior C1-C2 fusion was performed for other recurrent atlantoaxial subluxation. Given the severity of the diagnosis, an extended postoperative follow-up plan was outlined. The patient was scheduled for regular follow-up visits at two, six, and twelve-week intervals to monitor healing, assess pain levels, and evaluate the efficacy of treatment. Further appointments were to be determined based on the severity of symptoms and overall progress.

6. Operative Note: Surgical management was carried out for other recurrent atlantoaxial subluxation. Due to the severity of the diagnosis, a comprehensive postoperative follow-up plan was recommended. The patient was advised to schedule a follow-up appointment in one week to assess initial healing and pain management. Further visits would be determined based on the severity of symptoms and response to treatment.

7. Operative Note: Surgical intervention was performed for other recurrent atlantoaxial subluxation. The severity of the diagnosis necessitated a tailored postoperative follow-up plan. The patient was scheduled for a follow-up visit in three weeks to evaluate healing progress and discuss pain management. Subsequent appointments would be based on the severity of symptoms and treatment response.

8. Operative Note: Posterior C1-C2 fusion was performed for other recurrent atlantoaxial subluxation. Given the severity of the diagnosis, a structured postoperative follow-up plan was devised. The patient was advised to attend follow-up appointments at two, four, and eight-week intervals to monitor healing, assess pain levels, and discuss treatment outcomes. Further visits would be determined based on the severity of symptoms and overall progress.

9. Operative Note: Surgical management was carried out for other recurrent atlantoaxial subluxation. Considering the severity of the diagnosis, an individualized postoperative follow-up plan was established. The patient was scheduled for a follow-up visit in two weeks to evaluate initial healing and pain management. Subsequent appointments would be based on the severity of symptoms and response to treatment.

10. Operative Note: Surgical intervention was performed for other recurrent atlantoaxial subluxation. The severity of the diagnosis warranted a comprehensive postoperative follow-up plan. The patient was advised to schedule a follow-up appointment in four weeks to assess healing progress and discuss pain management. Further visits would be determined based on the severity of symptoms and treatment response.

## M43.5 Other recurrent vertebral subluxation

1. Operative Note: Patient underwent a posterior spinal fusion procedure for the management of other recurrent vertebral subluxation. After exposing the affected segment, pedicle screws were inserted bilaterally. A posterolateral fusion was performed using autograft bone. The instrumentation was then tightened, achieving satisfactory alignment. Hemostasis was achieved, and the incision was closed in layers. The patient tolerated the procedure well and was transferred to the recovery area in stable condition.

2. Operative Note: Intraoperative findings revealed other recurrent vertebral subluxation necessitating surgical intervention. A posterior approach was utilized, and decompression was achieved by removing the lamina and facet joints. Pedicle screws were inserted, followed by application of rod instrumentation for stabilization. Autograft bone was placed for fusion. Hemostasis was obtained, and the wound was closed. The patient's postoperative course was uneventful.

3. Operative Note: The patient presented with other recurrent vertebral subluxation, requiring surgical correction. A posterior approach was utilized, and the affected segment was exposed. Decompression was achieved by laminectomy and facetectomy. Pedicle screws were inserted bilaterally, and rod fixation was performed. Autograft bone was packed for fusion. The wound was closed meticulously, and the patient was transferred to the post-anesthesia care unit in stable condition.

4. Operative Note: Surgery was performed to address other recurrent vertebral subluxation in the patient. A posterior approach was used, and the affected segment was exposed. Decompression was achieved by removing the lamina and facet joints. Pedicle screws were inserted bilaterally, and rod instrumentation was applied for stabilization. Fusion was accomplished using autograft bone. The wound was closed carefully, and the patient was transferred to the recovery area without complications.

5. Operative Note: The patient underwent surgical intervention for the management of other recurrent vertebral subluxation. A posterior approach was chosen, and the affected level was exposed. Decompression was achieved by laminectomy and facetectomy. Pedicle screws were inserted bilaterally, and rod fixation was performed. Autograft bone was utilized for fusion. The incision was closed layer by layer, and the patient was sent to the postoperative unit in stable condition.

6. Operative Note: Surgery was performed to address other recurrent vertebral subluxation in the patient. A posterior approach was utilized, and the affected level was exposed. Decompression was accomplished by removing the lamina and facet joints. Pedicle screws were inserted bilaterally, and rod instrumentation was applied for stabilization. Autograft bone was placed for fusion. The incision was closed meticulously, and the patient's postoperative recovery was unremarkable.

7. Operative Note: The patient underwent surgical correction for other recurrent vertebral subluxation. A posterior approach was employed, and the affected segment was exposed. Decompression was achieved through laminectomy and facetectomy. Bilateral pedicle screws were inserted, and rod fixation was performed. Autograft bone was utilized for fusion. Hemostasis was ensured, and the incision was closed in layers. The patient was transferred to the post-anesthesia care unit in stable condition.

8. Operative Note: Surgery was performed to address other recurrent vertebral subluxation in the patient. A posterior approach was utilized, and the affected level was exposed. Decompression was achieved by removing the lamina and facet joints. Bilateral pedicle screws were inserted, followed by application of rod instrumentation for stabilization. Fusion was achieved using autograft bone. The incision was closed meticulously, and the patient's postoperative recovery was satisfactory.

9. Operative Note: The patient underwent surgical intervention for the management of other recurrent vertebral subluxation. A posterior approach was chosen, and the affected level was exposed. Decompression was accomplished by laminectomy and facetectomy. Bilateral pedicle screws were inserted, and rod fixation was performed. Autograft bone was packed for fusion. The incision was closed layer by layer, and the patient's immediate postoperative course was uneventful.

10. Operative Note: Surgery was performed to address other recurrent vertebral subluxation in the patient. A posterior approach was employed, and the affected segment was exposed. Decompression was achieved through laminectomy and facetectomy. Bilateral pedicle screws were inserted, and rod instrumentation was applied for stabilization. Autograft bone was utilized for fusion. Hemostasis was ensured, and the incision was closed meticulously. The patient tolerated the procedure well and was transferred to the recovery area without complications.

1. Operative Note: The patient underwent surgical intervention for other recurrent vertebral subluxation. A posterior approach was utilized, and the affected level was exposed. Decompression was achieved through laminectomy and facetectomy. Pedicle screws were inserted bilaterally, and rod fixation was performed for stabilization. Autograft bone was used to facilitate fusion. Hemostasis was obtained, and the incision was meticulously closed. The patient's postoperative recovery was uneventful, and they were discharged in stable condition.

2. Operative Note: Surgery was performed to address other recurrent vertebral subluxation in the patient. A posterior approach was chosen, and the affected level was exposed. Decompression was achieved by removing the lamina and facet joints. Bilateral pedicle screws were inserted, and rod instrumentation was applied for stabilization. Autograft bone was utilized for fusion. The wound was closed in layers, and the patient was discharged with appropriate postoperative instructions.

3. Operative Note: The patient underwent surgical correction for other recurrent vertebral subluxation. A posterior approach was employed, and the affected level was exposed. Decompression was achieved by laminectomy and facetectomy. Pedicle screws were inserted bilaterally, and rod fixation was performed for stabilization. Autograft bone was packed for fusion. Hemostasis was achieved, and the incision was closed meticulously. The patient's postoperative course was satisfactory, and they were discharged with follow-up instructions.

4. Operative Note: Surgery was performed to address other recurrent vertebral subluxation in the patient. A posterior approach was utilized, and the affected level was exposed. Decompression was achieved through laminectomy and facetectomy. Pedicle screws were inserted bilaterally, followed by application of rod instrumentation for stabilization. Autograft bone was used for fusion. The wound was closed in layers, and the patient's immediate postoperative recovery was unremarkable. They were discharged with appropriate pain management.

5. Operative Note: The patient underwent surgical intervention for other recurrent vertebral subluxation. A posterior approach was chosen, and the affected level was exposed. Decompression was achieved by removing the lamina and facet joints. Bilateral pedicle screws were inserted, and rod fixation was performed for stabilization. Autograft bone was utilized for fusion. Hemostasis was ensured, and the wound was closed meticulously. The patient's postoperative recovery was uncomplicated, and they were discharged with physical therapy instructions.

6. Operative Note: Surgery was performed to address other recurrent vertebral subluxation in the patient. A posterior approach was employed, and the affected level was exposed. Decompression was achieved through laminectomy and facetectomy. Pedicle screws were inserted bilaterally, and rod fixation was performed for stabilization. Autograft bone was packed for fusion. Hemostasis was obtained, and the incision was closed in layers. The patient's postoperative recovery was satisfactory, and they were discharged with a customized brace.

7. Operative Note: The patient underwent surgical correction for other recurrent vertebral subluxation. A posterior approach was utilized, and the affected level was exposed. Decompression was achieved by removing the lamina and facet joints. Bilateral pedicle screws were inserted, and rod instrumentation was applied for stabilization. Autograft bone was used for fusion. The wound was closed meticulously, and the patient's immediate postoperative recovery was uncomplicated. They were discharged with activity restrictions and scheduled for follow-up.

8. Operative Note: Surgery was performed to address other recurrent vertebral subluxation in the patient. A posterior approach was chosen, and the affected level was exposed. Decompression was achieved by laminectomy and facetectomy. Pedicle screws were inserted bilaterally, and rod fixation was performed for stabilization. Autograft bone was utilized for fusion. Hemostasis was ensured, and the incision was closed carefully. The patient's postoperative course was uneventful, and they were discharged with pain management instructions.

9. Operative Note: The patient underwent surgical intervention for other recurrent vertebral subluxation. A posterior approach was employed, and the affected level was exposed. Decompression was achieved through laminectomy and facetectomy. Bilateral pedicle screws were inserted, followed by application of rod instrumentation for stabilization. Autograft bone was placed for fusion. Hemostasis was obtained, and the wound was closed meticulously. The patient's postoperative recovery was satisfactory, and they were referred for physical therapy.

10. Operative Note: Surgery was performed to address other recurrent vertebral subluxation in the patient. A posterior approach was utilized, and the affected level was exposed. Decompression was achieved by removing the lamina and facet joints. Bilateral pedicle screws were inserted, and rod fixation was performed for stabilization. Autograft bone was utilized for fusion. Hemostasis was achieved, and the incision was closed in layers. The patient's postoperative course was unremarkable, and they were discharged with activity modification instructions.

1. Operative Note: The patient underwent surgical intervention for other recurrent vertebral subluxation under general anesthesia. A posterior approach was utilized, and the affected level was exposed. Decompression was achieved through laminectomy and facetectomy. Bilateral pedicle screws were inserted, and rod fixation was performed for stabilization. Autograft bone was utilized for fusion. Hemostasis was obtained, and the wound was closed meticulously. The patient received appropriate anesthesia dosage throughout the procedure and tolerated it well.

2. Operative Note: Surgery was performed to address other recurrent vertebral subluxation under regional anesthesia. A posterior approach was chosen, and the affected level was exposed. Decompression was achieved by removing the lamina and facet joints. Pedicle screws were inserted bilaterally, followed by rod instrumentation for stabilization. Autograft bone was used for fusion. The anesthesia dosage was carefully adjusted to maintain the patient's comfort and hemodynamic stability throughout the procedure.

3. Operative Note: The patient underwent surgical correction for other recurrent vertebral subluxation under monitored anesthesia care (MAC). A posterior approach was employed, and the affected level was exposed. Decompression was accomplished by laminectomy and facetectomy. Pedicle screws were inserted bilaterally, and rod fixation was performed for stabilization. Autograft bone was packed for fusion. The anesthesia dosage was titrated to provide adequate sedation and analgesia, ensuring patient cooperation and pain control.

4. Operative Note: Surgery was performed to address other recurrent vertebral subluxation under general anesthesia with reduced dosage. A posterior approach was utilized, and the affected level was exposed. Decompression was achieved through laminectomy and facetectomy. Bilateral pedicle screws were inserted, and rod fixation was performed for stabilization. Autograft bone was utilized for fusion. The anesthesia dosage was carefully adjusted to minimize systemic effects while maintaining adequate anesthesia depth throughout the procedure.

5. Operative Note: The patient underwent surgical intervention for other recurrent vertebral subluxation under local anesthesia with sedation. A posterior approach was chosen, and the affected level was exposed. Decompression was achieved by removing the lamina and facet joints. Bilateral pedicle screws were inserted, followed by rod fixation for stabilization. Autograft bone was used for fusion. The anesthesia dosage was tailored to provide a pain-free surgical experience while ensuring patient comfort and safety.

6. Operative Note: Surgery was performed to address other recurrent vertebral subluxation under general anesthesia with higher dosage. A posterior approach was employed, and the affected level was exposed. Decompression was accomplished by laminectomy and facetectomy. Pedicle screws were inserted bilaterally, and rod fixation was performed for stabilization. Autograft bone was packed for fusion. The anesthesia dosage was carefully adjusted to achieve deep anesthesia and hemodynamic stability throughout the procedure.

7. Operative Note: The patient underwent surgical correction for other recurrent vertebral subluxation under regional anesthesia with moderate dosage. A posterior approach was utilized, and the affected level was exposed. Decompression was achieved through laminectomy and facetectomy. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Autograft bone was utilized for fusion. The anesthesia dosage was titrated to provide effective regional anesthesia while minimizing the risk of systemic complications.

8. Operative Note: Surgery was performed to address other recurrent vertebral subluxation under monitored anesthesia care (MAC) with lighter dosage. A posterior approach was chosen, and the affected level was exposed. Decompression was achieved by removing the lamina and facet joints. Bilateral pedicle screws were inserted, and rod instrumentation was applied for stabilization. Autograft bone was used for fusion. The anesthesia dosage was carefully adjusted to maintain patient consciousness and comfort while ensuring safety and cooperation.

9. Operative Note: The patient underwent surgical intervention for other recurrent vertebral subluxation under general anesthesia with intermittent bolus dosing. A posterior approach was utilized, and the affected level was exposed. Decompression was achieved through laminectomy and facetectomy. Pedicle screws were inserted bilaterally, and rod fixation was performed for stabilization. Autograft bone was utilized for fusion. The anesthesia dosage was administered as intermittent boluses to maintain an optimal anesthetic depth and minimize the risk of cumulative effects.

10. Operative Note: Surgery was performed to address other recurrent vertebral subluxation under local anesthesia with minimal dosage. A posterior approach was employed, and the affected level was exposed. Decompression was accomplished by removing the lamina and facet joints. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Autograft bone was packed for fusion. The anesthesia dosage was kept to a minimum to allow patient cooperation and facilitate early postoperative recovery.

1. Operative Note: The patient underwent surgical intervention for other recurrent vertebral subluxation with associated bone erosion. A posterior approach was utilized, and the affected level was exposed. Extensive decompression was performed due to severe bone erosion, involving laminectomy, facetectomy, and removal of eroded bone fragments. Pedicle screws were inserted bilaterally, and rod fixation was performed for stabilization. Autograft bone was carefully placed to address the bone erosion. The patient's postoperative recovery was monitored closely.

2. Operative Note: Surgery was performed to address other recurrent vertebral subluxation with significant bone erosion. A posterior approach was chosen, and the affected level was exposed. Extensive decompression was necessary, involving laminectomy, facetectomy, and meticulous removal of eroded bone fragments. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Autograft bone grafting was performed to reconstruct the eroded bone areas. The patient's postoperative course was closely followed for any complications.

3. Operative Note: The patient presented with other recurrent vertebral subluxation and extensive bone erosion. A posterior approach was employed, and the affected level was exposed. Extensive decompression was performed, including laminectomy, facetectomy, and meticulous removal of eroded bone fragments. Pedicle screws were inserted bilaterally, and rod fixation was performed for stabilization. Bone grafting using autograft bone was carried out to address the bone erosion. The patient's postoperative recovery was closely monitored.

4. Operative Note: Surgery was performed to address other recurrent vertebral subluxation complicated by severe bone erosion. A posterior approach was utilized, and the affected level was exposed. Extensive decompression was performed, involving laminectomy, facetectomy, and meticulous removal of eroded bone fragments. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Autograft bone grafting was performed to reconstruct the eroded bone areas. The patient's postoperative course was monitored for any signs of graft rejection or recurrence.

5. Operative Note: The patient underwent surgical intervention for other recurrent vertebral subluxation with significant bone erosion. A posterior approach was chosen, and the affected level was exposed. Extensive decompression was performed, including laminectomy, facetectomy, and meticulous removal of eroded bone fragments. Pedicle screws were inserted bilaterally, and rod fixation was performed for stabilization. Bone grafting using autograft bone was carried out to address the bone erosion. The patient's postoperative recovery was closely followed for any complications.

6. Operative Note: Surgery was performed to address other recurrent vertebral subluxation with severe bone erosion. A posterior approach was employed, and the affected level was exposed. Extensive decompression was performed, involving laminectomy, facetectomy, and meticulous removal of eroded bone fragments. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Autograft bone grafting was performed to reconstruct the eroded bone areas. The patient's postoperative course was closely monitored for any signs of graft failure or infection.

7. Operative Note: The patient presented with other recurrent vertebral subluxation and extensive bone erosion. A posterior approach was utilized, and the affected level was exposed. Extensive decompression was performed, including laminectomy, facetectomy, and meticulous removal of eroded bone fragments. Pedicle screws were inserted bilaterally, and rod fixation was performed for stabilization. Autograft bone grafting was carried out to address the bone erosion. The patient's postoperative recovery was closely monitored for any signs of instability or recurrent subluxation.

8. Operative Note: Surgery was performed to address other recurrent vertebral subluxation complicated by severe bone erosion. A posterior approach was chosen, and the affected level was exposed. Extensive decompression was performed, involving laminectomy, facetectomy, and meticulous removal of eroded bone fragments. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Autograft bone grafting was performed to reconstruct the eroded bone areas. The patient's postoperative course was closely monitored for any signs of graft rejection or recurrent instability.

9. Operative Note: The patient underwent surgical intervention for other recurrent vertebral subluxation with significant bone erosion. A posterior approach was utilized, and the affected level was exposed. Extensive decompression was performed, including laminectomy, facetectomy, and meticulous removal of eroded bone fragments. Pedicle screws were inserted bilaterally, and rod fixation was performed for stabilization. Autograft bone grafting was carried out to address the bone erosion. The patient's postoperative recovery was closely monitored for any signs of graft failure or recurrent subluxation.

10. Operative Note: Surgery was performed to address other recurrent vertebral subluxation with severe bone erosion. A posterior approach was employed, and the affected level was exposed. Extensive decompression was performed, involving laminectomy, facetectomy, and meticulous removal of eroded bone fragments. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Autograft bone grafting was performed to reconstruct the eroded bone areas. The patient's postoperative course was closely monitored for any signs of graft rejection or instability.

1. Operative Note: The patient underwent surgical intervention for other recurrent vertebral subluxation with severe bone pain. A posterior approach was utilized, and the affected level was exposed. Decompression was performed through laminectomy and facetectomy to relieve nerve compression and alleviate pain. Pedicle screws were inserted bilaterally, and rod fixation was performed for stabilization. Autograft bone was used for fusion. The patient's severe bone pain was taken into consideration throughout the procedure, and appropriate pain management was provided.

2. Operative Note: Surgery was performed to address other recurrent vertebral subluxation with associated severe bone pain. A posterior approach was chosen, and the affected level was exposed. Decompression was achieved by removing the lamina and facet joints to relieve nerve impingement and alleviate pain. Bilateral pedicle screws were inserted, followed by rod fixation for stabilization. Autograft bone was utilized for fusion. The patient's severe bone pain was actively managed intraoperatively and postoperatively.

3. Operative Note: The patient presented with other recurrent vertebral subluxation accompanied by severe bone pain. A posterior approach was employed, and the affected level was exposed. Decompression was performed through laminectomy and facetectomy to relieve nerve compression and alleviate pain. Pedicle screws were inserted bilaterally, and rod fixation was performed for stabilization. Autograft bone grafting was carried out to promote fusion and stabilize the affected segment. Special attention was given to managing the patient's severe bone pain throughout the procedure.

4. Operative Note: Surgery was performed to address other recurrent vertebral subluxation complicated by severe bone pain. A posterior approach was utilized, and the affected level was exposed. Decompression was achieved by removing the lamina and facet joints to alleviate nerve compression and severe bone pain. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Autograft bone grafting was performed to facilitate fusion. The patient's severe bone pain was closely monitored and effectively managed throughout the surgery.

5. Operative Note: The patient underwent surgical intervention for other recurrent vertebral subluxation with severe bone pain. A posterior approach was chosen, and the affected level was exposed. Decompression was performed through laminectomy and facetectomy to alleviate nerve compression and severe bone pain. Bilateral pedicle screws were inserted, followed by rod fixation for stabilization. Autograft bone was utilized for fusion. The patient's severe bone pain was addressed through multimodal analgesic techniques during the procedure.

6. Operative Note: Surgery was performed to address other recurrent vertebral subluxation with associated severe bone pain. A posterior approach was employed, and the affected level was exposed. Decompression was achieved through laminectomy and facetectomy to relieve nerve compression and alleviate severe bone pain. Pedicle screws were inserted bilaterally, and rod fixation was performed for stabilization. Autograft bone grafting was carried out to promote fusion. The patient's severe bone pain was managed with a combination of intraoperative analgesics and local anesthetics.

7. Operative Note: The patient presented with other recurrent vertebral subluxation and severe bone pain. A posterior approach was utilized, and the affected level was exposed. Decompression was performed through laminectomy and facetectomy to relieve nerve compression and alleviate severe bone pain. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Autograft bone grafting was performed to facilitate fusion. The patient's severe bone pain was effectively managed with a tailored analgesic regimen throughout the procedure.

8. Operative Note: Surgery was performed to address other recurrent vertebral subluxation complicated by severe bone pain. A posterior approach was chosen, and the affected level was exposed. Decompression was achieved by removing the lamina and facet joints to alleviate nerve compression and severe bone pain. Pedicle screws were inserted bilaterally, and rod fixation was performed for stabilization. Autograft bone was utilized for fusion. The patient's severe bone pain was actively managed with a combination of systemic analgesics and regional anesthesia techniques.

9. Operative Note: The patient underwent surgical intervention for other recurrent vertebral subluxation with severe bone pain. A posterior approach was employed, and the affected level was exposed. Decompression was performed through laminectomy and facetectomy to relieve nerve compression and alleviate severe bone pain. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Autograft bone grafting was carried out to promote fusion. The patient's severe bone pain was consistently assessed and managed with a multimodal analgesic approach.

10. Operative Note: Surgery was performed to address other recurrent vertebral subluxation with associated severe bone pain. A posterior approach was utilized, and the affected level was exposed. Decompression was achieved through laminectomy and facetectomy to relieve nerve compression and alleviate severe bone pain. Pedicle screws were inserted bilaterally, and rod fixation was performed for stabilization. Autograft bone grafting was performed to facilitate fusion. The patient's severe bone pain was diligently managed throughout the procedure, utilizing a combination of systemic analgesics and local anesthetic techniques.

1. Operative Note: The patient underwent a surgical intervention for other recurrent vertebral subluxation. A posterior approach was utilized, and the affected level was exposed. Decompression was achieved through laminectomy and facetectomy, relieving nerve compression. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Autograft bone was used for fusion. The procedure was performed smoothly, and the patient's postoperative recovery was uneventful.

2. Operative Note: Surgery was performed to address other recurrent vertebral subluxation. A posterior approach was chosen, and the affected level was exposed. Decompression was performed through laminectomy and facetectomy, alleviating nerve compression. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Autograft bone grafting was performed to promote fusion. The surgical intervention was successful, and the patient showed improvement in symptoms postoperatively.

3. Operative Note: The patient presented with other recurrent vertebral subluxation requiring surgical intervention. A posterior approach was employed, and the affected level was exposed. Decompression was achieved through laminectomy and facetectomy, relieving nerve compression and restoring spinal alignment. Pedicle screws were inserted bilaterally, and rod fixation was performed for stabilization. Autograft bone grafting was carried out to facilitate fusion. The surgical intervention resulted in satisfactory restoration of stability and function.

4. Operative Note: Surgery was performed to address other recurrent vertebral subluxation that necessitated surgical intervention. A posterior approach was utilized, and the affected level was exposed. Decompression was performed through laminectomy and facetectomy, relieving nerve compression and resolving instability. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Autograft bone grafting was performed to promote fusion. The surgical intervention was successful, and the patient's symptoms improved postoperatively.

5. Operative Note: The patient underwent a surgical intervention for other recurrent vertebral subluxation. A posterior approach was chosen, and the affected level was exposed. Decompression was achieved through laminectomy and facetectomy, relieving nerve compression and addressing instability. Pedicle screws were inserted bilaterally, and rod fixation was performed for stabilization. Autograft bone was utilized for fusion. The surgical intervention resulted in improved spinal alignment and reduced symptoms.

6. Operative Note: Surgery was performed to address other recurrent vertebral subluxation, necessitating surgical intervention. A posterior approach was employed, and the affected level was exposed. Decompression was performed through laminectomy and facetectomy, relieving nerve compression and restoring stability. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Autograft bone grafting was carried out to promote fusion. The surgical intervention was successful in achieving spinal realignment and relieving symptoms.

7. Operative Note: The patient presented with other recurrent vertebral subluxation requiring surgical intervention. A posterior approach was utilized, and the affected level was exposed. Decompression was achieved through laminectomy and facetectomy, alleviating nerve compression and restoring spinal stability. Pedicle screws were inserted bilaterally, and rod fixation was performed for stabilization. Autograft bone grafting was performed to promote fusion. The surgical intervention successfully addressed the instability and improved the patient's condition.

8. Operative Note: Surgery was performed to address other recurrent vertebral subluxation, necessitating surgical intervention. A posterior approach was chosen, and the affected level was exposed. Decompression was performed through laminectomy and facetectomy, relieving nerve compression and restoring spinal stability. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Autograft bone grafting was performed to promote fusion. The surgical intervention resulted in significant improvement of symptoms and stabilization of the affected segment.

9. Operative Note: The patient underwent a surgical intervention for other recurrent vertebral subluxation. A posterior approach was employed, and the affected level was exposed. Decompression was achieved through laminectomy and facetectomy, relieving nerve compression and addressing instability. Pedicle screws were inserted bilaterally, and rod fixation was performed for stabilization. Autograft bone grafting was carried out to promote fusion. The surgical intervention resulted in improved spinal alignment and reduced pain.

10. Operative Note: Surgery was performed to address other recurrent vertebral subluxation that required surgical intervention. A posterior approach was utilized, and the affected level was exposed. Decompression was performed through laminectomy and facetectomy, relieving nerve compression and restoring spinal stability. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Autograft bone was utilized for fusion. The surgical intervention successfully corrected the subluxation, resulting in improved function and reduced symptoms.

1. Operative Note: The patient underwent a surgical intervention for other recurrent vertebral subluxation. A posterior approach was chosen, and the affected level was exposed. Decompression was performed through laminectomy and facetectomy, alleviating nerve compression and restoring spinal alignment. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Autograft bone grafting was performed to promote fusion. The surgical intervention was successful, and the patient experienced improved stability and reduced symptoms postoperatively.

2. Operative Note: Surgery was performed to address other recurrent vertebral subluxation. A posterior approach was employed, and the affected level was exposed. Decompression was achieved through laminectomy and facetectomy, relieving nerve compression and restoring spinal stability. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Autograft bone grafting was performed to facilitate fusion. The surgical intervention resulted in improved spinal alignment and reduced pain, leading to enhanced quality of life for the patient.

3. Operative Note: The patient presented with other recurrent vertebral subluxation necessitating surgical intervention. A posterior approach was utilized, and the affected level was exposed. Decompression was performed through laminectomy and facetectomy, relieving nerve compression and addressing instability. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Autograft bone grafting was carried out to promote fusion. The surgical intervention successfully restored stability and function, resulting in improved patient outcomes.

4. Operative Note: Surgery was performed to address other recurrent vertebral subluxation requiring surgical intervention. A posterior approach was chosen, and the affected level was exposed. Decompression was achieved through laminectomy and facetectomy, relieving nerve compression and restoring spinal stability. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Autograft bone was utilized for fusion. The surgical intervention led to successful resolution of instability and improved the patient's overall spinal health.

5. Operative Note: The patient underwent a surgical intervention for other recurrent vertebral subluxation. A posterior approach was employed, and the affected level was exposed. Decompression was performed through laminectomy and facetectomy, alleviating nerve compression and addressing instability. Pedicle screws were inserted bilaterally, and rod fixation was performed for stabilization. Autograft bone grafting was carried out to promote fusion. The surgical intervention resulted in improved spinal alignment and reduced neurological symptoms.

6. Operative Note: Surgery was performed to address other recurrent vertebral subluxation with associated spinal instability. A posterior approach was utilized, and the affected level was exposed. Decompression was achieved through laminectomy and facetectomy, relieving nerve compression and restoring spinal stability. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Autograft bone grafting was performed to promote fusion. The surgical intervention successfully addressed the subluxation and restored spinal integrity.

7. Operative Note: The patient presented with other recurrent vertebral subluxation necessitating surgical intervention. A posterior approach was chosen, and the affected level was exposed. Decompression was performed through laminectomy and facetectomy, alleviating nerve compression and addressing instability. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Autograft bone grafting was carried out to promote fusion. The surgical intervention resulted in improved spinal alignment and reduced pain, leading to enhanced patient comfort and functionality.

8. Operative Note: Surgery was performed to address other recurrent vertebral subluxation requiring surgical intervention. A posterior approach was employed, and the affected level was exposed. Decompression was achieved through laminectomy and facetectomy, relieving nerve compression and restoring spinal stability. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Autograft bone was utilized for fusion. The surgical intervention successfully corrected the subluxation, leading to improved spinal alignment and reduced symptoms.

9. Operative Note: The patient underwent a surgical intervention for other recurrent vertebral subluxation with associated instability. A posterior approach was utilized, and the affected level was exposed. Decompression was performed through laminectomy and facetectomy, relieving nerve compression and restoring spinal stability. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Autograft bone grafting was performed to facilitate fusion. The surgical intervention successfully addressed the instability and resulted in improved patient outcomes.

10. Operative Note: Surgery was performed to address other recurrent vertebral subluxation necessitating surgical intervention. A posterior approach was chosen, and the affected level was exposed. Decompression was achieved through laminectomy and facetectomy, alleviating nerve compression and restoring spinal stability. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Autograft bone grafting was carried out to promote fusion. The surgical intervention resulted in improved spinal alignment and reduced pain, leading to enhanced patient satisfaction and functional improvement.

1. Operative Note: The patient underwent surgical intervention for other recurrent vertebral subluxation with a severe infection on the extreme moving joint. A posterior approach was chosen, and the affected level was exposed. Extensive debridement of the infected tissues was performed, followed by meticulous irrigation and cleansing. Decompression was achieved through laminectomy and facetectomy to address nerve compression. Pedicle screws were inserted bilaterally, and rod fixation was performed for stabilization. Antibiotic-impregnated bone grafting was carried out to promote fusion and combat the infection.

2. Operative Note: Surgery was performed to address other recurrent vertebral subluxation complicated by a severe infection on the extreme moving joint. A posterior approach was utilized, and the affected level was exposed. Thorough debridement of the infected joint was carried out, followed by extensive irrigation with antibiotic solution. Decompression was achieved through laminectomy and facetectomy, relieving nerve compression. Pedicle screws were inserted bilaterally, and rod fixation was performed for stabilization. The surgical intervention aimed to eradicate the infection and restore spinal stability.

3. Operative Note: The patient presented with other recurrent vertebral subluxation accompanied by a severe infection on the extreme moving joint, necessitating surgical intervention. A posterior approach was employed, and the affected level was exposed. The infected joint was thoroughly debrided, and copious irrigation with antimicrobial solution was performed. Decompression was achieved through laminectomy and facetectomy to alleviate nerve compression. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. The surgical intervention aimed to address both the subluxation and the severe joint infection.

4. Operative Note: Surgery was performed to address other recurrent vertebral subluxation complicated by a severe infection on the extreme moving joint. A posterior approach was chosen, and the affected level was exposed. Extensive debridement of the infected joint was carried out, followed by thorough irrigation with antibiotic solution. Decompression was achieved through laminectomy and facetectomy, relieving nerve compression. Pedicle screws were inserted bilaterally, and rod fixation was performed for stabilization. The surgical intervention aimed to eradicate the infection and restore spinal stability.

5. Operative Note: The patient underwent surgical intervention for other recurrent vertebral subluxation with a severe infection involving the extreme moving joint. A posterior approach was utilized, and the affected level was exposed. The infected joint was meticulously debrided, followed by thorough irrigation with antibiotic solution. Decompression was achieved through laminectomy and facetectomy to address nerve compression. Pedicle screws were inserted bilaterally, and rod fixation was performed for stabilization. Antibiotic-impregnated bone grafting was carried out to promote fusion and eradicate the infection.

6. Operative Note: Surgery was performed to address other recurrent vertebral subluxation with a severe infection on the extreme moving joint. A posterior approach was employed, and the affected level was exposed. Extensive debridement of the infected joint was performed, followed by thorough irrigation with antimicrobial solution. Decompression was achieved through laminectomy and facetectomy, relieving nerve compression. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. The surgical intervention aimed to eradicate the infection and restore spinal stability.

7. Operative Note: The patient presented with other recurrent vertebral subluxation complicated by a severe infection involving the extreme moving joint, necessitating surgical intervention. A posterior approach was chosen, and the affected level was exposed. The infected joint was meticulously debrided, and thorough irrigation with antibiotic solution was performed. Decompression was achieved through laminectomy and facetectomy to alleviate nerve compression. Pedicle screws were inserted bilaterally, and rod fixation was performed for stabilization. The surgical intervention aimed to eradicate the infection and restore spinal stability.

8. Operative Note: Surgery was performed to address other recurrent vertebral subluxation with a severe infection on the extreme moving joint. A posterior approach was utilized, and the affected level was exposed. Thorough debridement of the infected joint was carried out, followed by copious irrigation with antimicrobial solution. Decompression was achieved through laminectomy and facetectomy, relieving nerve compression. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. The surgical intervention aimed to eradicate the infection and restore spinal stability.

9. Operative Note: The patient underwent surgical intervention for other recurrent vertebral subluxation with a severe infection involving the extreme moving joint. A posterior approach was employed, and the affected level was exposed. The infected joint was thoroughly debrided, and meticulous irrigation with antibiotic solution was performed. Decompression was achieved through laminectomy and facetectomy to alleviate nerve compression. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. The surgical intervention aimed to eradicate the infection and restore spinal stability.

10. Operative Note: Surgery was performed to address other recurrent vertebral subluxation complicated by a severe infection on the extreme moving joint. A posterior approach was chosen, and the affected level was exposed. Extensive debridement of the infected joint was carried out, followed by thorough irrigation with antibiotic solution. Decompression was achieved through laminectomy and facetectomy, relieving nerve compression. Pedicle screws were inserted bilaterally, and rod fixation was performed for stabilization. The surgical intervention aimed to eradicate the infection and restore spinal stability.

1. Operative Note: The patient underwent surgical intervention for other recurrent vertebral subluxation with significant inflammation. A posterior approach was chosen, and the affected level was exposed. Extensive decompression was performed through laminectomy and facetectomy, relieving nerve compression and addressing instability. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Anti-inflammatory measures were implemented intraoperatively to mitigate the inflammation. The surgical intervention resulted in improved spinal alignment and reduced inflammatory response.

2. Operative Note: Surgery was performed to address other recurrent vertebral subluxation complicated by severe inflammation. A posterior approach was utilized, and the affected level was exposed. Decompression was achieved through laminectomy and facetectomy, alleviating nerve compression and restoring spinal stability. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Intraoperative anti-inflammatory agents were administered to reduce inflammation and promote healing. The surgical intervention resulted in improved spinal alignment and reduced inflammatory symptoms.

3. Operative Note: The patient presented with other recurrent vertebral subluxation and marked inflammation, necessitating surgical intervention. A posterior approach was employed, and the affected level was exposed. Decompression was performed through laminectomy and facetectomy, relieving nerve compression and addressing instability. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Intraoperative measures were taken to mitigate inflammation and reduce postoperative complications. The surgical intervention successfully addressed the subluxation and alleviated the inflammatory response.

4. Operative Note: Surgery was performed to address other recurrent vertebral subluxation with significant inflammation. A posterior approach was chosen, and the affected level was exposed. Decompression was achieved through laminectomy and facetectomy, relieving nerve compression and restoring spinal stability. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Intraoperative anti-inflammatory techniques were employed to manage the inflammation. The surgical intervention resulted in improved spinal alignment and reduced inflammatory symptoms.

5. Operative Note: The patient underwent surgical intervention for other recurrent vertebral subluxation with severe inflammation. A posterior approach was utilized, and the affected level was exposed. Extensive decompression was performed through laminectomy and facetectomy, alleviating nerve compression and addressing instability. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Intraoperative anti-inflammatory agents were administered to control the inflammation and promote healing. The surgical intervention led to improved spinal alignment and reduced inflammatory response.

6. Operative Note: Surgery was performed to address other recurrent vertebral subluxation complicated by significant inflammation. A posterior approach was employed, and the affected level was exposed. Decompression was achieved through laminectomy and facetectomy, relieving nerve compression and restoring spinal stability. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Intraoperative measures were taken to mitigate the inflammatory response. The surgical intervention successfully corrected the subluxation and reduced inflammation.

7. Operative Note: The patient presented with other recurrent vertebral subluxation and notable inflammation necessitating surgical intervention. A posterior approach was chosen, and the affected level was exposed. Decompression was performed through laminectomy and facetectomy, alleviating nerve compression and addressing instability. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Intraoperative interventions were implemented to manage the inflammation and promote healing. The surgical intervention resulted in improved spinal alignment and reduced inflammatory symptoms.

8. Operative Note: Surgery was performed to address other recurrent vertebral subluxation with severe inflammation. A posterior approach was utilized, and the affected level was exposed.Decompression was achieved through laminectomy and facetectomy, relieving nerve compression and restoring spinal stability. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Intraoperative anti-inflammatory techniques were employed to control the inflammation. The surgical intervention resulted in improved spinal alignment and reduced inflammatory symptoms.

9. Operative Note: The patient underwent surgical intervention for other recurrent vertebral subluxation with significant inflammation. A posterior approach was employed, and the affected level was exposed. Extensive decompression was performed through laminectomy and facetectomy, alleviating nerve compression and addressing instability. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Intraoperative anti-inflammatory measures were undertaken to mitigate the inflammation. The surgical intervention led to improved spinal alignment and reduced inflammatory response.

10. Operative Note: Surgery was performed to address other recurrent vertebral subluxation complicated by marked inflammation. A posterior approach was chosen, and the affected level was exposed. Decompression was achieved through laminectomy and facetectomy, relieving nerve compression and restoring spinal stability. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Intraoperative measures were implemented to manage the inflammation. The surgical intervention successfully addressed the subluxation and reduced the inflammatory response.

1. Operative Note: The patient underwent surgical intervention for other recurrent vertebral subluxation, and the severity of the diagnosis requires close postoperative monitoring. A posterior approach was chosen, and the affected level was exposed. Decompression was performed through laminectomy and facetectomy, relieving nerve compression and restoring spinal stability. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. The patient will be closely monitored in the postoperative period to assess the response to treatment and adjust the follow-up plan accordingly.

2. Operative Note: Surgery was performed to address other recurrent vertebral subluxation, considering the severity of the diagnosis. A posterior approach was utilized, and the affected level was exposed. Decompression was achieved through laminectomy and facetectomy, alleviating nerve compression and restoring spinal stability. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Given the severity of the condition, the patient's follow-up plan will include frequent evaluations, imaging studies, and close monitoring of symptoms to ensure appropriate management.

3. Operative Note: The patient presented with other recurrent vertebral subluxation, and due to the severity of the diagnosis, a comprehensive follow-up plan will be implemented. A posterior approach was employed, and the affected level was exposed. Decompression was performed through laminectomy and facetectomy, relieving nerve compression and addressing instability. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. The postoperative follow-up will involve regular visits, physical therapy, and imaging assessments to monitor the response to treatment and make adjustments as needed.

4. Operative Note: Surgery was performed to address other recurrent vertebral subluxation, considering the severity of the diagnosis. A posterior approach was chosen, and the affected level was exposed. Extensive decompression was performed through laminectomy and facetectomy, relieving nerve compression and restoring spinal stability. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Due to the severity of the condition, a meticulous follow-up plan will be implemented, including regular evaluations, pain management strategies, and potential rehabilitation to optimize the patient's recovery.

5. Operative Note: The patient underwent surgical intervention for other recurrent vertebral subluxation, and the severity of the diagnosis necessitates a comprehensive follow-up plan. A posterior approach was utilized, and the affected level was exposed. Decompression was achieved through laminectomy and facetectomy, relieving nerve compression and restoring spinal stability. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. The follow-up plan will include close monitoring of symptoms, periodic imaging studies, and consultations with other specialists to ensure appropriate management of the condition.

6. Operative Note: Surgery was performed to address other recurrent vertebral subluxation, taking into account the severity of the diagnosis. A posterior approach was employed, and the affected level was exposed. Decompression was performed through laminectomy and facetectomy, relieving nerve compression and addressing instability. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Given the severity of the condition, the patient's follow-up plan will involve frequent visits, potential bracing, and close communication with the healthcare team to assess the response to treatment and adjust the management plan accordingly.

7. Operative Note: The patient presented with other recurrent vertebral subluxation, and the severity of the diagnosis calls for a comprehensive follow-up strategy. A posterior approach was chosen, and the affected level was exposed. Extensive decompression was performed through laminectomy and facetectomy, alleviating nerve compression and restoring spinal stability. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. The postoperative follow-up will involve regular assessments, potential rehabilitation programs, and imaging studies to ensure appropriate management of the condition.

8. Operative Note: Surgery was performed to address other recurrent vertebral subluxation, considering the severity of the diagnosis. A posterior approach was utilized, and the affected level was exposed. Decompression was achieved through laminectomy and facetectomy, relieving nerve compression and restoring spinal stability. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Given the severity of the condition, the patient's follow-up plan will include frequent evaluations, pain management strategies, and potential involvement of a multidisciplinary team to optimize recovery and long-term outcomes.

9. Operative Note: The patient underwent surgical intervention for other recurrent vertebral subluxation, and the severity of the diagnosis necessitates a meticulous follow-up plan. A posterior approach was employed, and the affected level was exposed. Decompression was performed through laminectomy and facetectomy, relieving nerve compression and addressing instability. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. The follow-up plan will involve regular assessments, potential physical therapy, and close monitoring of symptoms to ensure optimal management and functional recovery.

10. Operative Note: Surgery was performed to address other recurrent vertebral subluxation, taking into account the severity of the diagnosis. A posterior approach was chosen, and the affected level was exposed. Extensive decompression was performed through laminectomy and facetectomy, alleviating nerve compression and restoring spinal stability. Pedicle screws were inserted bilaterally, followed by rod fixation for stabilization. Given the severity of the condition, the patient's follow-up plan will include frequent visits, potential pain management interventions, and close collaboration with the rehabilitation team to optimize outcomes and quality of life.

## M43.6 Torticollis

1. Patient presented with severe torticollis, with the head tilted to the right. Initial assessment revealed limited range of motion and muscular spasm. Administered analgesics and muscle relaxants. Initiated physical therapy with stretching exercises and heat therapy. Follow-up scheduled in one week.

2. Operative note: Performed surgical release of sternocleidomastoid muscle in a 35-year-old patient with chronic torticollis. Intraoperative findings showed fibrotic bands causing muscle contracture. Successfully released the bands and achieved full range of motion. Postoperative care includes immobilization with a cervical collar and physiotherapy.

3. Patient underwent botulinum toxin injection for treatment of torticollis. Injected 100 units of botulinum toxin into the affected sternocleidomastoid muscle. Instructed patient to avoid vigorous activities and maintain a neutral head position for optimal results. Follow-up scheduled in three months to assess response and consider further treatment.

4. Operative note: Cervical traction performed on a 48-year-old patient with acute torticollis. Applied a weighted traction system to gently stretch and decompress the cervical spine. Patient reported immediate relief of pain and improved neck mobility. Instructed patient on home traction exercises and scheduled follow-up in two weeks.

5. Patient presented with congenital torticollis in infancy. Initiated conservative treatment consisting of stretching exercises, passive range of motion maneuvers, and parent education. Encouraged frequent repositioning and tummy time to promote muscular development. Progressively observed improved head alignment and neck mobility over the course of three months.

6. Operative note: Excision of cervical osteophytes performed on a 60-year-old patient with torticollis secondary to degenerative changes. Dissected and removed the bony prominences compressing the cervical nerves. Achieved significant relief of symptoms and improved neck alignment. Postoperative care includes pain management and physical therapy.

7. Patient diagnosed with spasmodic torticollis. Initiated treatment with oral medications, including muscle relaxants and anticholinergics. Monitored for side effects and adjusted dosage accordingly. Patient reported decreased frequency and severity of spasms after three months of medication therapy.

8. Operative note: Selective denervation surgery performed on a 42-year-old patient with refractory torticollis. Identified and resected specific nerves responsible for abnormal muscle contractions. Achieved substantial improvement in head position and decreased muscle spasm. Postoperative rehabilitation plan includes physical therapy and pain management.

9. Patient presented with acquired torticollis due to a traumatic injury. Conducted a thorough evaluation, including imaging studies, to assess the extent of damage. Initiated treatment with a combination of analgesics, immobilization, and physical therapy. Regular follow-ups scheduled to monitor progress and adjust treatment as needed.

10. Operative note: Placement of deep brain stimulation (DBS) electrodes for the management of medically refractory torticollis. Inserted electrodes into the basal ganglia region to modulate abnormal brain signals. Programmed the DBS device to optimize symptom control. Postoperative care includes regular programming adjustments and close monitoring of patient response.

1. Patient presented with torticollis accompanied by neck pain and stiffness. Conducted a thorough physical examination and diagnosed muscular torticollis. Prescribed a combination of nonsteroidal anti-inflammatory drugs (NSAIDs), muscle relaxants, and physical therapy. Advised the patient to avoid activities that exacerbate symptoms and provided home stretching exercises.

2. Operative note: Bilateral myotomy performed on a 25-year-old patient with torticollis of unknown etiology. Under general anesthesia, the sternocleidomastoid muscles were surgically divided. Achieved improved head alignment and reduced muscle spasm. Postoperative care includes pain management and postoperative physiotherapy.

3. Patient presented with spasmodic torticollis refractory to conservative treatment. Administered intramuscular injections of botulinum toxin into the affected neck muscles. Educated the patient about potential temporary weakness and monitored for side effects. Recommended regular follow-ups for ongoing treatment and adjustment of botulinum toxin dosage.

4. Operative note: Modified Wright's procedure performed on a 10-year-old patient with congenital torticollis. Released the fibrotic sternocleidomastoid muscle and repositioned the muscle ends. Achieved significant improvement in head position and range of motion. Postoperative care includes wound care, physiotherapy, and monitoring for recurrence.

5. Patient presented with torticollis and associated temporomandibular joint (TMJ) dysfunction. Collaborated with a dentist to fabricate a customized splint to correct the malocclusion contributing to torticollis. Initiated TMJ exercises and coordinated treatment with a physical therapist. Patient reported reduced neck pain and improved head alignment.

6. Operative note: Posterior cervical fusion performed on a 50-year-old patient with torticollis due to cervical spine instability. Utilized pedicle screw instrumentation and bone grafting to achieve spinal stabilization. Confirmed successful fusion on postoperative imaging. Patient instructed on postoperative precautions and referred for rehabilitation therapy.

7. Patient presented with torticollis secondary to cervical dystonia. Initiated treatment with oral anticholinergic medication to reduce muscle spasms. Monitored for side effects and adjusted dosage as needed. Patient reported decreased torticollis severity and improved quality of life after three months of medication therapy.

8. Operative note: Selective peripheral neurectomy performed on a 30-year-old patient with refractory torticollis. Identified and surgically resected specific nerves responsible for abnormal muscle contractions. Achieved significant reduction in torticollis severity. Postoperative care includes pain management and physical therapy.

9. Patient diagnosed with traumatic torticollis following a motor vehicle accident. Administered a combination of analgesics, muscle relaxants, and cervical collar immobilization. Ordered imaging studies to assess for underlying structural damage. Provided patient education on proper posture and ergonomics to prevent further complications.

10. Operative note: Ultrasound-guided chemodenervation performed on a 40-year-old patient with spasmodic torticollis. Injected botulinum toxin into the affected neck muscles under ultrasound guidance. Ensured accurate localization and precise dosage delivery. Scheduled follow-up appointments for assessment of treatment response and potential adjustment of botulinum toxin injections.

1. Patient presented with torticollis accompanied by severe pain. Administered a combination of local anesthesia and conscious sedation for a diagnostic injection into the affected muscles. Patient reported temporary relief of symptoms, confirming the diagnosis of muscular torticollis. Recommended further treatment options based on the response.

2. Operative note: Bilateral myotomy performed on a 35-year-old patient with torticollis. Induced general anesthesia and carefully monitored the patient throughout the procedure. Successfully divided the contracted sternocleidomastoid muscles, resulting in improved head alignment. Postoperatively, managed pain with analgesics and initiated physical therapy.

3. Patient presented with persistent torticollis despite conservative measures. Administered regional anesthesia, specifically a cervical epidural block, to provide targeted pain relief. Conducted a thorough assessment and adjusted the dosage accordingly to achieve optimal anesthesia coverage. Patient experienced reduced pain and improved neck mobility post-procedure.

4. Operative note: Endoscopic release of sternocleidomastoid muscle performed on a 30-year-old patient with chronic torticollis. Utilized monitored anesthesia care (MAC) with intravenous sedation to ensure patient comfort and cooperation. Successfully released the contracted muscle under endoscopic guidance. Postoperative pain was managed with analgesics.

5. Patient diagnosed with cervical dystonia-induced torticollis. Administered a combination of local anesthesia and intravenous sedation to perform a diagnostic nerve block. Monitored patient response and adjusted sedation levels to maintain comfort. Noted partial relief of symptoms, indicating the involvement of the targeted nerve in the torticollis presentation.

6. Operative note: Posterior cervical fusion performed on a 55-year-old patient with torticollis and cervical instability. Induced general anesthesia with endotracheal intubation for airway management. Achieved successful fusion using pedicle screw fixation and bone grafting. Monitored the patient closely during anesthesia and provided postoperative pain control.

7. Patient presented with congenital torticollis and required surgical intervention. Administered a combination of regional anesthesia (cervical plexus block) and monitored anesthesia care (MAC). Maintained patient comfort throughout the procedure while allowing for cooperation during head position assessment. Ensured proper postoperative pain management.

8. Operative note: Deep brain stimulation (DBS) implantation performed on a 45-year-old patient with medically refractory torticollis. Induced general anesthesia with a balanced anesthetic technique to provide optimal surgical conditions. Placed the DBS electrodes in the targeted brain regions. Postoperatively, closely monitored the patient's neurologic status.

9. Patient diagnosed with torticollis due to cervical spine degeneration. Administered a combination of general anesthesia and local infiltration for a cervical facet joint injection. Adjusted the anesthesia dosage to ensure patient comfort and procedural success. Monitored vital signs and provided post-injection pain management.

10. Operative note: Selective peripheral neurectomy performed on a 50-year-old patient with torticollis. Utilized regional anesthesia with peripheral nerve blocks to provide targeted anesthesia and postoperative pain control. Identified and surgically resected the responsible nerves. Monitored patient recovery and provided appropriate analgesics.

1. Patient presented with torticollis and radiographic evidence of cervical spine bone erosion. Administered general anesthesia for a diagnostic arthroscopy. Visualized erosive changes in the facet joints and confirmed the underlying cause of torticollis. Coordinated with a rheumatologist for further management of the erosive bone disease.

2. Operative note: Anterior cervical discectomy and fusion performed on a 40-year-old patient with torticollis and vertebral body erosion. Induced general anesthesia and carefully monitored the patient throughout the procedure. Removed the affected intervertebral disc, inserted a bone graft, and stabilized the cervical spine. Postoperatively, managed pain and monitored for fusion progression.

3. Patient diagnosed with rheumatoid arthritis-associated torticollis with cervical spine bone erosion. Collaborated with a rheumatologist to optimize medical management of the underlying disease. Implemented a multidisciplinary approach, including pain management, physical therapy, and regular follow-ups to assess disease progression and adjust treatment.

4. Operative note: Cervical corpectomy and reconstruction performed on a 55-year-old patient with severe torticollis and vertebral body erosion. Induced general anesthesia and intubated the patient for airway protection. Removed the diseased vertebral body and reconstructed the cervical spine with a titanium mesh cage. Monitored the patient closely during anesthesia and managed postoperative pain.

5. Patient presented with torticollis and erosive changes in the cervical spine associated with ankylosing spondylitis. Administered a combination of regional anesthesia and conscious sedation for a diagnostic imaging-guided nerve block. Noted temporary relief of symptoms, confirming the involvement of the affected nerves in the torticollis presentation.

6. Operative note: Posterior cervical laminectomy and fusion performed on a 50-year-old patient with severe torticollis and cervical spine bone erosion. Induced general anesthesia and ensured appropriate positioning for optimal surgical access. Removed the laminae, decompressed the spinal cord, and achieved stabilization with pedicle screw fixation. Managed postoperative pain and monitored neurological status.

7. Patient diagnosed with torticollis secondary to Paget's disease of the cervical spine, resulting in bone erosion. Collaborated with an endocrinologist for the management of Paget's disease. Administered analgesics for pain control and implemented physical therapy to optimize neck mobility. Conducted regular follow-ups to monitor disease progression and adjust treatment as necessary.

8. Operative note: Cervical disc arthroplasty performed on a 45-year-old patient with torticollis and adjacent level disc erosion. Induced general anesthesia and intubated the patient for airway protection. Removed the degenerated disc and inserted an artificial disc implant. Monitored the patient closely during anesthesia and provided postoperative pain management.

9. Patient presented with torticollis and erosive changes in the cervical spine due to psoriatic arthritis. Collaborated with a rheumatologist to optimize disease-modifying antirheumatic drug therapy. Implemented a comprehensive treatment plan involving pain management, physical therapy, and patient education on self-care and joint protection.

10. Operative note: Cervical spine fusion revision surgery performed on a 60-year-old patient with torticollis and pseudarthrosis (non-union) at the previously fused level. Induced general anesthesia and ensured proper positioning for surgical access. Removed the non-union segment, inserted a bone graft, and achieved successful fusion. Monitored the patient's vital signs and managed postoperative pain.

1. Patient presented with severe torticollis and excruciating bone pain in the cervical spine. Administered intravenous opioids and initiated a multimodal analgesic approach to manage the pain. Coordinated with a pain management specialist for ongoing pain control and explored underlying causes of the severe bone pain.

2. Operative note: Cervical decompression surgery performed on a 50-year-old patient with torticollis and severe bone pain. Induced general anesthesia and carefully monitored the patient throughout the procedure. Conducted decompression of compressed nerve roots and stabilized the cervical spine. Postoperatively, managed pain with a combination of analgesics and nerve pain medications.

3. Patient diagnosed with metastatic bone disease causing severe bone pain and torticollis. Collaborated with an oncologist to optimize systemic treatment for the underlying malignancy. Initiated palliative measures, including analgesics, radiation therapy, and supportive care, to alleviate severe bone pain and improve quality of life.

4. Operative note: Percutaneous vertebroplasty performed on a 65-year-old patient with severe bone pain and vertebral compression fractures contributing to torticollis. Administered local anesthesia and conscious sedation for the procedure. Injected bone cement into the fractured vertebrae to stabilize and relieve pain. Monitored the patient's vital signs and provided post-procedural pain management.

5. Patient presented with severe bone pain in the cervical spine, exacerbating torticollis symptoms. Administered intravenous bisphosphonates to address underlying osteoporosis and reduce bone pain. Implemented a multidisciplinary approach, involving pain specialists, physical therapy, and lifestyle modifications to alleviate bone pain and improve overall musculoskeletal health.

6. Operative note: Cervical fusion surgery performed on a 40-year-old patient with severe bone pain and cervical instability. Induced general anesthesia and intubated the patient for airway management. Achieved successful fusion using bone grafts and instrumentation. Managed postoperative pain with a combination of analgesics and adjuvant pain medications.

7. Patient diagnosed with severe fibrous dysplasia of the cervical spine, causing debilitating bone pain and torticollis. Collaborated with a bone specialist to optimize medical management and pain control. Initiated a tailored pain management plan, including systemic medications, local injections, and physical therapy to alleviate bone pain and improve neck mobility.

8. Operative note: Radiofrequency ablation performed on a 55-year-old patient with severe bone pain and facet joint arthropathy contributing to torticollis. Induced conscious sedation and administered local anesthesia for the procedure. Applied radiofrequency energy to the affected nerves to provide pain relief. Monitored the patient's vital signs and managed post-procedural pain.

9. Patient presented with severe bone pain in the cervical spine, with suspected inflammatory etiology. Collaborated with a rheumatologist to optimize disease-modifying antirheumatic drug therapy. Implemented a comprehensive pain management plan involving medications, physical therapy, and adjunctive treatments to reduce bone pain and improve functional outcomes.

10. Operative note: Artificial disc replacement performed on a 45-year-old patient with severe bone pain and cervical disc degeneration contributing to torticollis. Induced general anesthesia and intubated the patient for airway protection. Removed the degenerated disc and implanted an artificial disc prosthesis. Monitored the patient closely during anesthesia and provided postoperative pain control.

1. Patient presented with severe torticollis and intractable bone pain in the cervical spine. Decided to proceed with surgical intervention in the form of cervical osteotomy to correct the spinal alignment. Induced general anesthesia and carefully monitored the patient throughout the procedure. Successfully realigned the cervical spine, resulting in improved head position and reduced bone pain.

2. Operative note: Cervical rhizotomy performed on a 50-year-old patient with severe torticollis and debilitating bone pain. Induced general anesthesia and carefully identified the responsible nerves. Surgically disrupted the nerve pathways to alleviate pain and reduce muscle spasms. Monitored the patient's vital signs and provided postoperative pain management.

3. Patient diagnosed with severe bone pain and torticollis due to cervical spine instability. Recommended surgical intervention in the form of cervical fusion. Induced general anesthesia and performed anterior cervical discectomy and fusion to stabilize the affected levels. Monitored the patient closely during anesthesia and managed postoperative pain.

4. Operative note: Cervical laminoplasty performed on a 55-year-old patient with severe torticollis and cervical spinal stenosis. Induced general anesthesia and positioned the patient for optimal surgical access. Expanded the spinal canal through a posterior approach to relieve nerve compression. Monitored the patient's vital signs and provided postoperative pain control.

5. Patient presented with severe bone pain and torticollis secondary to a tumor in the cervical spine. Decided to proceed with surgical intervention in the form of tumor resection. Induced general anesthesia and performed a meticulous tumor removal, ensuring preservation of neural structures. Managed postoperative pain and initiated further oncological management.

6. Operative note: Cervical disc arthroplasty performed on a 40-year-old patient with severe torticollis and degenerative disc disease. Induced general anesthesia and intubated the patient for airway protection. Removed the damaged disc and replaced it with an artificial disc implant. Monitored the patient closely during anesthesia and managed postoperative pain.

7. Patient diagnosed with severe bone pain and torticollis due to cervical spine infection. Urgently recommended surgical intervention in the form of debridement and spinal stabilization. Induced general anesthesia and performed extensive debridement of infected tissues, followed by spinal fusion. Managed postoperative pain and initiated appropriate antibiotic therapy.

8. Operative note: Cervical corpectomy performed on a 45-year-old patient with severe torticollis and vertebral body erosion. Induced general anesthesia and ensured proper positioning for surgical access. Removed the affected vertebral body, restored spinal alignment, and performed vertebral body reconstruction. Monitored the patient closely during anesthesia and managed postoperative pain.

9. Patient presented with severe bone pain and torticollis caused by a cervical spine fracture. Opted for surgical intervention in the form of open reduction and internal fixation. Induced general anesthesia and carefully realigned the fractured segments using fixation devices. Monitored the patient's vital signs and provided postoperative pain control.

10. Operative note: Cervical laminectomy performed on a 60-year-old patient with severe torticollis and spinal cord compression. Induced general anesthesia and positioned the patient for optimal surgical access. Removed the laminae to decompress the spinal cord and relieve nerve compression. Monitored the patient's vital signs and managed postoperative pain.

1. Patient presented with severe torticollis and debilitating bone pain in the cervical spine. Elective surgical intervention was planned, including a cervical fusion procedure. Induced general anesthesia and carefully monitored the patient throughout the surgery. Achieved successful fusion, alleviating the torticollis and reducing the severe bone pain.

2. Operative note: Cervical disc replacement surgery performed on a 50-year-old patient with severe torticollis and degenerative disc disease. Induced general anesthesia and intubated the patient for airway management. Removed the degenerated disc and implanted an artificial disc prosthesis. Monitored the patient closely during anesthesia and provided postoperative pain management.

3. Patient diagnosed with severe bone pain and torticollis caused by cervical spine osteoarthritis. Recommended surgical intervention in the form of posterior cervical laminectomy and foraminotomy. Induced general anesthesia and performed the procedure to decompress the affected nerve roots. Monitored the patient's vital signs and managed postoperative pain.

4. Operative note: Anterior cervical discectomy and fusion performed on a 55-year-old patient with severe torticollis and cervical disc herniation. Induced general anesthesia and ensured appropriate positioning for surgical access. Removed the herniated disc and inserted a bone graft for stabilization. Monitored the patient closely during anesthesia and managed postoperative pain.

5. Patient presented with severe bone pain and torticollis due to cervical spine metastases. Surgical intervention in the form of tumor debulking and stabilization was planned. Induced general anesthesia and successfully removed the tumor mass, providing pain relief and improving spinal stability. Initiated postoperative pain control measures and coordinated with an oncologist for further treatment.

6. Operative note: Cervical osteoplasty performed on a 40-year-old patient with severe torticollis and cervical spine osteoporotic fractures. Induced general anesthesia and carefully identified the fractured vertebrae. Stabilized the fractures with cement augmentation, providing immediate pain relief and restoring spinal alignment. Monitored the patient's vital signs and managed postoperative pain.

7. Patient diagnosed with severe bone pain and torticollis due to cervical spine rheumatoid arthritis. Recommended surgical intervention in the form of cervical fusion and joint decompression. Induced general anesthesia and performed the procedure, achieving stabilization and reducing the inflammatory burden. Implemented postoperative pain management strategies in collaboration with a rheumatologist.

8. Operative note: Cervical laminoplasty performed on a 45-year-old patient with severe torticollis and cervical myelopathy. Induced general anesthesia and positioned the patient for optimal surgical access. Expanded the spinal canal through a posterior approach to relieve spinal cord compression. Monitored the patient closely during anesthesia and managed postoperative pain.

9. Patient presented with severe bone pain and torticollis associated with a rare condition known as fibrodysplasia ossificans progressiva (FOP). Planned surgical intervention to address symptomatic bone formations. Induced general anesthesia and surgically removed the ectopic bone growth, providing relief from severe pain and improving neck mobility.

10. Operative note: Cervical arthrodesis performed on a 60-year-old patient with severe torticollis and cervical instability. Induced general anesthesia and ensured proper positioning for surgical access. Utilized bone grafts and instrumentation to achieve spinal fusion. Monitored the patient closely during anesthesia and managed postoperative pain.

1. Patient presented with severe torticollis and a superimposed severe infection on the extreme moving joint of the cervical spine. Urgent surgical intervention was performed to address the infection. Induced general anesthesia and meticulously debrided the infected tissues. Administered appropriate antibiotics and implemented postoperative wound care measures.

2. Operative note: Cervical abscess drainage performed on a 50-year-old patient with severe torticollis and a deep-seated infection in the extreme moving joint. Induced general anesthesia and carefully located the abscess. Performed a surgical incision and drainage to evacuate the purulent material. Initiated antibiotic therapy and monitored the patient's recovery.

3. Patient diagnosed with severe bone pain and torticollis due to an infectious arthritis in the extreme moving joint of the cervical spine. Recommended surgical intervention in the form of joint debridement and washout. Induced general anesthesia and performed the procedure to remove the infected tissues. Administered antibiotics and closely monitored the patient for signs of improvement.

4. Operative note: Cervical arthrodesis revision surgery performed on a 55-year-old patient with severe torticollis and a deep-seated infection involving the extreme moving joint. Induced general anesthesia and carefully removed the infected hardware and necrotic tissues. Reconstructed the cervical spine with new implants and performed thorough irrigation. Administered appropriate antibiotics and managed postoperative pain.

5. Patient presented with severe bone pain and torticollis due to septic arthritis affecting the extreme moving joint of the cervical spine. Urgently performed surgical intervention to address the infection. Induced general anesthesia and performed a joint washout procedure to clear the infection. Administered intravenous antibiotics and closely monitored the patient's response.

6. Operative note: Cervical disc arthroplasty revision surgery performed on a 40-year-old patient with severe torticollis and an infected prosthesis in the extreme moving joint. Induced general anesthesia and carefully removed the infected disc implant. Thoroughly irrigated the surgical site and placed a temporary spacer. Administered intravenous antibiotics and planned for future implantation.

7. Patient diagnosed with severe bone pain and torticollis due to an infected cervical facet joint. Recommended surgical intervention in the form of facet joint debridement and irrigation. Induced general anesthesia and performed the procedure to remove the infected tissues. Administered targeted antibiotics and implemented postoperative wound care measures.

8. Operative note: Cervical osteotomy revision surgery performed on a 45-year-old patient with severe torticollis and an infected extreme moving joint. Induced general anesthesia and carefully revised the previous osteotomy site, removing the infected bone segments. Achieved realignment and stabilization of the cervical spine. Administered intravenous antibiotics and managed postoperative pain.

9. Patient presented with severe bone pain and torticollis caused by a deep-seated infection in the extreme moving joint of the cervical spine. Urgently performed surgical intervention to address the infection and restore mobility. Induced general anesthesia and performed joint debridement and irrigation. Administered systemic antibiotics and closely monitored the patient's recovery.

10. Operative note: Cervical fusion revision surgery performed on a 60-year-old patient with severe torticollis and an infected extreme moving joint. Induced general anesthesia and carefully removed the infected hardware. Achieved successful fusion and stability of the cervical spine. Administered intravenous antibiotics and managed postoperative pain.

1. Patient presented with severe torticollis and marked inflammation in the cervical spine. Recommended surgical intervention to address the underlying inflammatory process. Induced general anesthesia and performed a targeted biopsy to determine the cause of inflammation. Administered anti-inflammatory medications and closely monitored the patient's response.

2. Operative note: Cervical synovectomy performed on a 50-year-old patient with severe torticollis and inflammatory arthritis affecting the cervical joints. Induced general anesthesia and carefully removed the inflamed synovial tissue. Administered disease-modifying antirheumatic drugs (DMARDs) and initiated postoperative anti-inflammatory therapy.

3. Patient diagnosed with severe bone pain and torticollis due to an autoimmune inflammatory disorder affecting the cervical spine. Recommended surgical intervention in the form of selective laminectomy and decompression. Induced general anesthesia and performed the procedure to alleviate nerve compression. Administered immunosuppressive therapy and closely monitored the patient's inflammatory markers.

4. Operative note: Cervical fusion surgery performed on a 55-year-old patient with severe torticollis and inflammatory spondyloarthropathy. Induced general anesthesia and carefully stabilized the affected vertebral levels. Administered systemic corticosteroids and initiated postoperative anti-inflammatory measures.

5. Patient presented with severe bone pain and torticollis caused by a severe inflammatory reaction in the cervical spine. Urgently performed surgical intervention to address the inflammation and relieve symptoms. Induced general anesthesia and meticulously debrided the inflamed tissues. Administered anti-inflammatory medications and closely monitored the patient's response.

6. Operative note: Cervical disc arthroplasty performed on a 40-year-old patient with severe torticollis and inflammatory disc disease. Induced general anesthesia and carefully removed the inflamed disc. Implanted an artificial disc prosthesis to restore mobility and alleviate inflammation. Administered anti-inflammatory medications and initiated postoperative physiotherapy.

7. Patient diagnosed with severe bone pain and torticollis due to a rare inflammatory disorder affecting the cervical spine. Recommended surgical intervention in the form of joint debridement and synovial biopsy. Induced general anesthesia and performed the procedures to alleviate inflammation and obtain a diagnostic sample. Administered disease-specific medications and closely monitored the patient's inflammatory markers.

8. Operative note: Cervical laminoplasty performed on a 45-year-old patient with severe torticollis and inflammatory myelopathy. Induced general anesthesia and performed the procedure to decompress the spinal cord and alleviate inflammation. Administered anti-inflammatory medications and closely monitored the patient's neurological status.

9. Patient presented with severe bone pain and torticollis due to an infectious inflammatory process in the cervical spine. Urgently performed surgical intervention to address the infection and inflammation. Induced general anesthesia and performed debridement and irrigation procedures. Administered targeted antibiotics and anti-inflammatory medications.

10. Operative note: Cervical osteotomy revision surgery performed on a 60-year-old patient with severe torticollis and inflammatory bone disease. Induced general anesthesia and carefully revised the previous osteotomy site, addressing the underlying inflammation. Achieved realignment and stabilization of the cervical spine. Administered anti-inflammatory medications and managed postoperative pain.

1. Patient presented with severe torticollis and inflammatory changes in the cervical spine. Surgical intervention was recommended to address the underlying inflammation. Induced general anesthesia and performed a targeted corticosteroid injection to reduce inflammation. Monitored the patient's response and provided postoperative anti-inflammatory medications.

2. Operative note: Cervical facet joint radiofrequency ablation performed on a 50-year-old patient with severe torticollis and inflammatory facet joint syndrome. Induced general anesthesia and carefully administered thermal radiofrequency energy to the affected facet joints. Provided immediate pain relief and initiated postoperative anti-inflammatory measures.

3. Patient diagnosed with severe bone pain and torticollis due to an autoimmune inflammatory disorder affecting the cervical spine. Recommended surgical intervention in the form of cervical laminectomy and decompression. Induced general anesthesia and performed the procedure to alleviate nerve compression and reduce inflammation. Administered immunosuppressive therapy and closely monitored the patient's inflammatory markers.

4. Operative note: Cervical discography performed on a 55-year-old patient with severe torticollis and suspected inflammatory disc disease. Induced general anesthesia and carefully injected contrast dye into the suspected discs. Assessed for abnormal disc morphology and associated inflammatory changes. Initiated appropriate anti-inflammatory measures based on the findings.

5. Patient presented with severe bone pain and torticollis caused by an inflammatory reaction secondary to a recent trauma to the cervical spine. Urgently performed surgical intervention to address the inflammation and stabilize the injured area. Induced general anesthesia and meticulously debrided the inflamed tissues. Administered anti-inflammatory medications and closely monitored the patient's response.

6. Operative note: Cervical arthroscopy performed on a 40-year-old patient with severe torticollis and suspected inflammatory synovitis. Induced general anesthesia and carefully inserted the arthroscope into the affected joint. Visualized the joint space and identified inflammatory changes. Performed synovectomy and lavage to reduce inflammation. Administered targeted anti-inflammatory therapy postoperatively.

7. Patient diagnosed with severe bone pain and torticollis due to an inflammatory reaction in the cervical spine following recent surgery. Recommended surgical intervention in the form of revision surgery to address the underlying inflammation. Induced general anesthesia and carefully revised the surgical site, removing the inflamed tissues. Administered anti-inflammatory medications and closely monitored the patient's response.

8. Operative note: Cervical fusion surgery performed on a 45-year-old patient with severe torticollis and inflammatory spondylitis. Induced general anesthesia and carefully stabilized the affected vertebral levels. Administered disease-modifying antirheumatic drugs (DMARDs) and initiated postoperative anti-inflammatory measures.

9. Patient presented with severe bone pain and torticollis caused by an inflammatory process in the cervical spine associated with a known systemic inflammatory condition. Urgently performed surgical intervention to address the inflammation and provide pain relief. Induced general anesthesia and performed targeted corticosteroid injections to reduce local inflammation. Administered systemic anti-inflammatory medications postoperatively.

10. Operative note: Cervical synovial biopsy performed on a 60-year-old patient with severe torticollis and suspected inflammatory arthritis. Induced general anesthesia and carefully obtained a biopsy sample of the inflamed synovial tissue. Sent the sample for pathological analysis to determine the underlying cause of inflammation. Initiated appropriate anti-inflammatory therapy based on the results.

1. Patient presented with severe torticollis and a confirmed diagnosis of cervical spine malignancy. Extensive surgical intervention was performed, including tumor resection and spinal stabilization. Postoperative follow-up will include regular imaging, oncology consultations, and potential adjuvant therapies based on pathology results.

2. Operative note: Cervical discectomy performed on a 50-year-old patient with severe torticollis and a herniated disc causing nerve compression. Successful disc removal was achieved, and the patient's symptoms resolved. Follow-up will involve postoperative pain management, physiotherapy, and scheduled clinical evaluations to monitor the patient's recovery.

3. Patient diagnosed with severe bone pain and torticollis due to a rare congenital cervical spine anomaly. Surgical intervention was performed to address the anatomical abnormality and stabilize the spine. Follow-up will consist of regular clinical assessments, imaging studies, and close monitoring of the patient's neurological status.

4. Operative note: Cervical facet joint injection performed on a 55-year-old patient with severe torticollis and suspected facet joint syndrome. The patient experienced immediate pain relief post-procedure. Follow-up will involve assessing the duration of pain relief and determining the need for additional interventions, such as radiofrequency ablation or further diagnostic imaging.

5. Patient presented with severe bone pain and torticollis due to a traumatic cervical spine injury. Urgent surgical intervention was performed to stabilize the injured area and decompress the spinal cord. Follow-up will include close monitoring of neurological function, regular imaging, and physical rehabilitation to optimize the patient's recovery.

6. Operative note: Cervical arthroplasty performed on a 40-year-old patient with severe torticollis and symptomatic cervical disc degeneration. Successful disc replacement was achieved, providing relief from pain and restoring mobility. Follow-up will include regular clinical evaluations, radiographic assessments, and functional rehabilitation to ensure long-term success.

7. Patient diagnosed with severe bone pain and torticollis due to cervical spine infection. Urgent surgical intervention involved debridement and irrigation of the infected area. Follow-up will include antibiotic therapy, close monitoring of infection markers, and regular clinical evaluations to assess the effectiveness of treatment.

8. Operative note: Cervical laminoplasty performed on a 45-year-old patient with severe torticollis and cervical myelopathy. Decompression of the spinal cord was successfully achieved. Follow-up will consist of postoperative rehabilitation, close monitoring of neurological symptoms, and scheduled imaging to assess the stability of the cervical spine.

9. Patient presented with severe bone pain and torticollis caused by a degenerative cervical spine condition. Surgical intervention involved anterior cervical discectomy and fusion. Follow-up will include regular clinical assessments, imaging studies, and physical therapy to monitor fusion progress and optimize the patient's functional outcomes.

10. Operative note: Cervical osteotomy performed on a 60-year-old patient with severe torticollis and cervical kyphosis. Successful correction of the deformity was achieved. Follow-up will involve regular clinical evaluations, radiographic assessments, and physical rehabilitation to monitor the patient's alignment and overall recovery.

## M43.8 Other specified deforming dorsopathies

1. Operative Note: Patient underwent surgical intervention for other specified deforming dorsopathies. A posterior approach was employed, and a laminectomy was performed at the affected vertebral level. The deformed bony structures were carefully excised, and neurovascular structures were protected throughout the procedure. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well, and postoperative recovery was uneventful.

2. Operative Note: Surgical management was undertaken for other specified deforming dorsopathies. A midline incision was made, and a discectomy was performed at the affected disc level. The deformed disc material was meticulously removed, and the surrounding nerve roots were decompressed. The surgical site was thoroughly irrigated, and the wound was closed meticulously. The patient's vital signs remained stable, and they were transferred to the recovery area.

3. Operative Note: Patient underwent corrective surgery for other specified deforming dorsopathies. An anterior approach was utilized, and a vertebral osteotomy was performed to correct the deformity. The affected vertebral segment was realigned, and a stabilization device was implanted. Hemostasis was achieved, and the wound was meticulously closed. The patient tolerated the procedure well, and postoperative imaging confirmed the successful correction of the dorsopathy.

4. Operative Note: Surgical intervention was performed for other specified deforming dorsopathies. A lateral approach was employed, and a partial facetectomy was executed to alleviate the deformity. The affected facet joint was carefully excised, and the surrounding structures were preserved. Hemostasis was achieved, and the incision was closed meticulously. The patient's neurological status remained intact throughout the procedure, and they were transferred to the post-anesthesia care unit.

5. Operative Note: Patient underwent surgical correction for other specified deforming dorsopathies. A combination of anterior and posterior approaches was utilized. An interbody fusion was performed at the affected vertebral levels, followed by posterior instrumentation and fusion. The deformed structures were successfully corrected, and meticulous closure of the wounds was performed. The patient recovered well from anesthesia, and appropriate postoperative care instructions were provided.

6. Operative Note: Surgical management was undertaken for other specified deforming dorsopathies. A minimally invasive technique was employed, and a percutaneous vertebroplasty was performed. The deformed vertebral body was stabilized with bone cement, and the procedure was successfully completed. The patient experienced immediate pain relief, and they were discharged home with appropriate postoperative instructions.

7. Operative Note: Patient underwent surgical intervention for other specified deforming dorsopathies. A lateral transpsoas approach was utilized, and a discectomy and interbody fusion were performed at the affected disc level. The deformed disc material was meticulously removed, and a fusion cage was inserted. The surgical site was thoroughly irrigated, and the wound was closed meticulously. The patient's vital signs remained stable throughout the procedure.

8. Operative Note: Surgical correction was performed for other specified deforming dorsopathies. A posterior approach was employed, and a vertebral column resection was executed to address the deformity. The deformed vertebral segment was carefully removed, and a spinal osteotomy was performed to achieve realignment. The surgical site was meticulously irrigated, and the wounds were closed in layers. The patient was transferred to the intensive care unit for postoperative monitoring.

9. Operative Note: Patient underwent surgical intervention for other specified deforming dorsopathies. A posterior approach was utilized, and a deformity correction procedure was performed. The deformed vertebral elements were meticulously excised, and spinal instrumentation was applied to maintain alignment. Hemostasis was achieved, and the incision was closed meticulously. The patient remained stable throughout the procedure, and they were transferred to the postoperative recovery area.

10. Operative Note: Surgical management was undertaken for other specified deforming dorsopathies. An anterior approach was employed, and a corpectomy was performed to address the deformity. The affected vertebral body was meticulously removed, and a titanium mesh cage was inserted for stabilization. The surgical site was irrigated thoroughly, and the wound was closed meticulously. The patient's postoperative course was unremarkable, and they were discharged with appropriate follow-up instructions.

1. Operative Note: Patient underwent surgical correction for other specified deforming dorsopathies. A lateral approach was employed, and a foraminotomy was performed to decompress the affected nerve roots. The deformed bony structures were carefully removed, providing relief to the compressed neural elements. Hemostasis was achieved, and the wound was closed meticulously. The patient recovered well from anesthesia, and postoperative imaging confirmed successful decompression of the dorsopathy.

2. Operative Note: Surgical intervention was performed for other specified deforming dorsopathies. A minimally invasive approach was utilized, and a percutaneous endoscopic discectomy was performed at the affected disc level. The deformed disc material was meticulously removed under endoscopic visualization, relieving pressure on the neural structures. Hemostasis was achieved, and the incision was closed with steri-strips. The patient experienced immediate improvement in symptoms and was discharged home the same day.

3. Operative Note: Patient underwent surgical management for other specified deforming dorsopathies. An open approach was employed, and a vertebral osteotomy was performed to correct the deformity. The deformed vertebral segment was carefully repositioned, and spinal instrumentation was applied to maintain alignment. Hemostasis was achieved, and the wound was closed meticulously. The patient's vital signs remained stable throughout the procedure, and they were transferred to the post-anesthesia care unit for recovery.

4. Operative Note: Surgical correction was performed for other specified deforming dorsopathies. A posterior approach was utilized, and a spinal fusion procedure was performed at the affected levels. The deformed vertebral structures were meticulously prepared, and bone graft material was placed to facilitate fusion. Hemostasis was achieved, and the wounds were closed in layers. The patient tolerated the procedure well, and appropriate postoperative pain management was initiated.

5. Operative Note: Patient underwent surgical intervention for other specified deforming dorsopathies. A transforaminal lumbar interbody fusion (TLIF) was performed at the affected levels. The deformed disc material and bone spurs were meticulously removed, and a fusion cage was inserted to restore stability. Hemostasis was achieved, and the surgical site was thoroughly irrigated. The wounds were closed meticulously, and the patient was transferred to the recovery area in stable condition.

6. Operative Note: Surgical management was undertaken for other specified deforming dorsopathies. An anterior approach was employed, and a discectomy with artificial disc replacement was performed at the affected disc level. The deformed disc material was meticulously excised, and the artificial disc prosthesis was carefully inserted. Hemostasis was achieved, and the incision was closed meticulously. The patient recovered well from anesthesia and was started on a postoperative physical therapy regimen.

7. Operative Note: Patient underwent surgical intervention for other specified deforming dorsopathies. A posterior approach was utilized, and a laminoplasty was performed to address the deformity. The deformed laminae were carefully repositioned, and bone graft material was placed to promote fusion. Hemostasis was achieved, and the wound was closed meticulously. The patient's neurological status remained intact throughout the procedure, and they were transferred to the post-anesthesia care unit for monitoring.

8. Operative Note: Surgical correction was performed for other specified deforming dorsopathies. An oblique approach was employed, and a vertebral column resection was executed to address the deformity. The deformed vertebral segment was meticulously removed, and a spinal osteotomy was performed to achieve realignment. The surgical site was irrigated thoroughly, and the wounds were closed meticulously. The patient was transferred to the intensive care unit for postoperative monitoring.

9. Operative Note: Patient underwent surgical intervention for other specified deforming dorsopathies. A posterior approach was utilized, and a facet joint fusion was performed at the affected levels. The deformed facet joints were meticulously prepared, and bone graft material was placed to promote fusion. Hemostasis was achieved, and the wounds were closed meticulously. The patient tolerated the procedure well, and appropriate postoperative rehabilitation was initiated.

10. Operative Note: Surgical management was undertaken for other specified deforming dorsopathies. A combination of anterior and posterior approaches was utilized. An anterior discectomy and interbody fusion were performed, followed by posterior instrumentation and fusion. The deformed structures were successfully corrected, and the surgical site was thoroughly irrigated. The wounds were closed meticulously, and the patient's postoperative course was uneventful.

1. Operative Note: Patient underwent surgical correction for other specified deforming dorsopathies. A posterior approach was employed under general anesthesia, with an appropriate dosage tailored to the patient's weight and medical history. A vertebral osteotomy was performed to correct the deformity. Hemostasis was achieved, and the wound was closed meticulously. The patient's vital signs remained stable throughout the procedure, and they recovered smoothly from anesthesia.

2. Operative Note: Surgical intervention was performed for other specified deforming dorsopathies. A minimally invasive approach was utilized, with local anesthesia and conscious sedation administered to the patient. A percutaneous endoscopic discectomy was performed at the affected disc level. Hemostasis was achieved, and the incision was closed with steri-strips. The patient remained comfortable throughout the procedure and recovered quickly from the anesthesia.

3. Operative Note: Patient underwent surgical management for other specified deforming dorsopathies. An open approach was employed under regional anesthesia, with an appropriate dosage of local anesthetic administered. A vertebral osteotomy was performed to correct the deformity. Hemostasis was achieved, and the wound was closed meticulously. The patient remained hemodynamically stable throughout the procedure, and they recovered well from the regional anesthesia.

4. Operative Note: Surgical correction was performed for other specified deforming dorsopathies. A posterior approach was utilized under general anesthesia, with adjusted dosage considering the patient's age and comorbidities. A spinal fusion procedure was performed at the affected levels. Hemostasis was achieved, and the wounds were closed in layers. The patient tolerated the procedure well and had a smooth recovery from anesthesia.

5. Operative Note: Patient underwent surgical intervention for other specified deforming dorsopathies. A transforaminal lumbar interbody fusion (TLIF) was performed at the affected levels under general anesthesia, with appropriate dosages tailored to the patient's body weight and medical condition. The deformed disc material and bone spurs were meticulously removed, and a fusion cage was inserted. The patient's vital signs were stable throughout the procedure, and they had an uneventful recovery from anesthesia.

6. Operative Note: Surgical management was undertaken for other specified deforming dorsopathies. An anterior approach was employed under general anesthesia, with adjusted dosage based on the patient's age and weight. A discectomy with artificial disc replacement was performed at the affected disc level. Hemostasis was achieved, and the incision was closed meticulously. The patient recovered well from anesthesia and was closely monitored postoperatively.

7. Operative Note: Patient underwent surgical intervention for other specified deforming dorsopathies. A posterior approach was utilized under general anesthesia, with appropriate dosage based on the patient's weight and medical history. A laminoplasty was performed to address the deformity. Hemostasis was achieved, and the wound was closed meticulously. The patient's vital signs remained stable throughout the procedure, and they had a smooth recovery from anesthesia.

8. Operative Note: Surgical correction was performed for other specified deforming dorsopathies. An oblique approach was employed under regional anesthesia, with adjusted dosage considering the patient's age and comorbidities. A vertebral column resection was executed to address the deformity. Hemostasis was achieved, and the wounds were closed meticulously. The patient remained hemodynamically stable throughout the procedure and had a satisfactory recovery from anesthesia.

9. Operative Note: Patient underwent surgical intervention for other specified deforming dorsopathies. A combination of anterior and posterior approaches was utilized under general anesthesia, with customized dosage based on the patient's body weight and medical condition. An anterior discectomy and interbody fusion were performed, followed by posterior instrumentation and fusion. Hemostasis was achieved, and the surgical site was thoroughly irrigated. The wounds were closed meticulously, and the patient recovered smoothly from anesthesia.

10. Operative Note: Surgical management was undertaken for other specified deforming dorsopathies. A posterior approach was employed under monitored anesthesia care (MAC), with appropriate sedation dosage based on the patient's age and medical history. A facet joint fusion was performed at the affected levels. Hemostasis was achieved, and the wounds were closed meticulously. The patient remained comfortable and cooperative throughout the procedure, and they had a prompt recovery from the sedation.

1. Operative Note: Patient underwent surgical intervention for other specified deforming dorsopathies with significant bone erosion. A posterior approach was employed, and a vertebral corpectomy was performed to address the deformity and remove the eroded vertebral body. The adjacent vertebral segments were stabilized using spinal instrumentation and bone grafting. Hemostasis was achieved, and the wound was closed meticulously. The patient tolerated the procedure well and was transferred to the intensive care unit for postoperative monitoring.

2. Operative Note: Surgical correction was performed for other specified deforming dorsopathies associated with bone erosion. A combined anterior and posterior approach was utilized. The anterior procedure involved a discectomy with removal of the eroded disc material. Posteriorly, a laminectomy was performed, and spinal fusion with instrumentation was carried out to restore stability. Hemostasis was achieved, and the wounds were meticulously closed. The patient recovered well from anesthesia, and postoperative imaging confirmed successful correction of the dorsopathy and bone erosion.

3. Operative Note: Patient underwent surgical management for other specified deforming dorsopathies with severe bone erosion. An anterior approach was employed, and a vertebral corpectomy was performed to address the eroded vertebral body. The affected segment was stabilized with a mesh cage and bone grafting. A posterior instrumentation and fusion procedure were also performed for additional stability. Hemostasis was achieved, and the wounds were closed meticulously. The patient had an uneventful recovery from anesthesia.

4. Operative Note: Surgical intervention was performed for other specified deforming dorsopathies accompanied by bone erosion. A lateral approach was utilized, and a partial facetectomy was executed to decompress the affected nerve roots and address the eroded bony structures. The eroded bone was meticulously removed, and the nerve roots were decompressed. Hemostasis was achieved, and the incision was closed meticulously. The patient recovered well from anesthesia, and immediate relief from nerve compression was observed.

5. Operative Note: Patient underwent surgical correction for other specified deforming dorsopathies with bone erosion. A posterior approach was employed, and a laminoplasty was performed to address the eroded laminae and spinal canal stenosis. The eroded bone was carefully removed, and the spinal canal was decompressed. Hemostasis was achieved, and the wound was closed meticulously. The patient's neurological status improved postoperatively, and they were transferred to the recovery area.

6. Operative Note: Surgical management was undertaken for other specified deforming dorsopathies characterized by bone erosion. An anterior approach was employed, and a discectomy with extensive removal of the eroded disc material was performed. A fusion procedure with bone grafting and stabilization was carried out to address the instability caused by bone erosion. Hemostasis was achieved, and the incision was closed meticulously. The patient had a smooth recovery from anesthesia and reported improved symptoms postoperatively.

7. Operative Note: Patient underwent surgical intervention for other specified deforming dorsopathies with bone erosion. A transforaminal lumbar interbody fusion (TLIF) was performed at the affected levels. The eroded disc material and bone spurs were meticulously removed, and a fusion cage was inserted. Bone grafting was performed to address the eroded bone areas. Hemostasis was achieved, and the surgical site was thoroughly irrigated. The wounds were closed meticulously, and the patient's postoperative course was unremarkable.

8. Operative Note: Surgical correction was performed for other specified deforming dorsopathies accompanied by significant bone erosion. A posterior approach was utilized, and a multi-level laminectomy and facetectomy were performed to decompress the eroded bony structures and alleviate neural compression. Hemostasis was achieved, and the wounds were closed meticulously. The patient's neurological symptoms improved postoperatively, and they had an uncomplicated recovery from anesthesia.

9. Operative Note: Patient underwent surgical intervention for other specified deforming dorsopathies with bone erosion. An oblique approach was employed, and a vertebral column resection was executed to address the eroded vertebral segment. The eroded bone was meticulously removed, and spinal osteotomies were performed to achieve realignment. Hemostasis was achieved, and the wounds were closed meticulously. The patient's postoperative course was uneventful, with improvement in spinal alignment noted.

10. Operative Note: Surgical management was undertaken for other specified deforming dorsopathies associated with extensive bone erosion. A posterior approach was employed, and a vertebral augmentation procedure was performed using bone cement to stabilize the eroded vertebral bodies. The bone cement was carefully injected, and subsequent instrumentation and fusion were carried out to provide additional stability. Hemostasis was achieved, and the wounds were closed meticulously. The patient tolerated the procedure well and had a satisfactory recovery from anesthesia.

1. Operative Note: Patient underwent surgical intervention for other specified deforming dorsopathies with severe bone pain. A posterior approach was employed, and a laminectomy was performed to decompress the spinal canal and alleviate neural compression causing the pain. The deformed structures were meticulously removed, and spinal fusion with instrumentation was performed for stability. Hemostasis was achieved, and the wounds were closed meticulously. The patient experienced immediate relief from severe bone pain postoperatively.

2. Operative Note: Surgical correction was performed for other specified deforming dorsopathies accompanied by severe bone pain. An anterior approach was utilized, and a discectomy was performed to remove the affected disc material contributing to the pain. A fusion procedure with bone grafting was carried out to address the instability and provide relief. Hemostasis was achieved, and the incision was closed meticulously. The patient reported significant improvement in bone pain after the surgery.

3. Operative Note: Patient underwent surgical management for other specified deforming dorsopathies with severe bone pain. A lateral approach was employed, and a foraminotomy was performed to decompress the affected nerve roots, relieving the pain. The deformed bony structures were meticulously removed, restoring proper neural function. Hemostasis was achieved, and the incision was closed meticulously. The patient experienced immediate relief from severe bone pain and had an uneventful recovery from anesthesia.

4. Operative Note: Surgical intervention was performed for other specified deforming dorsopathies with severe bone pain. A posterior approach was utilized, and a laminoplasty was performed to address the pain caused by spinal canal stenosis. The deformed bone was meticulously removed, and the spinal canal was decompressed. Hemostasis was achieved, and the wound was closed meticulously. The patient reported significant improvement in severe bone pain postoperatively.

5. Operative Note: Patient underwent surgical correction for other specified deforming dorsopathies with severe bone pain. A posterior approach was employed, and a vertebral corpectomy was performed to address the deformed and painful vertebral body. The adjacent vertebral segments were stabilized using spinal instrumentation and bone grafting to alleviate pain and restore stability. Hemostasis was achieved, and the wound was closed meticulously. The patient reported immediate relief from severe bone pain after the surgery.

6. Operative Note: Surgical management was undertaken for other specified deforming dorsopathies associated with severe bone pain. An anterior approach was employed, and a corpectomy was performed to remove the deformed and painful vertebral body. The affected segment was stabilized with a mesh cage and bone grafting to address the pain and restore stability. Hemostasis was achieved, and the wounds were closed meticulously. The patient experienced significant relief from severe bone pain postoperatively.

7. Operative Note: Patient underwent surgical intervention for other specified deforming dorsopathies with severe bone pain. A transforaminal lumbar interbody fusion (TLIF) was performed at the affected levels. The deformed disc material and bone spurs were meticulously removed, and a fusion cage was inserted to alleviate pain and restore stability. Hemostasis was achieved, and the surgical site was thoroughly irrigated. The wounds were closed meticulously, and the patient reported marked improvement in severe bone pain after the surgery.

8. Operative Note: Surgical correction was performed for other specified deforming dorsopathies accompanied by severe bone pain. A posterior approach was utilized, and a laminectomy and facetectomy were performed to decompress the nerve roots and alleviate pain. The deformed bone and hypertrophic facet joints were meticulously removed. Hemostasis was achieved, and the wounds were closed meticulously. The patient experienced immediate relief from severe bone pain and had an uneventful recovery from anesthesia.

9. Operative Note: Patient underwent surgical management for other specified deforming dorsopathies with severe bone pain. An oblique approach was employed, and a vertebral column resection was executed to address the deformed and painful vertebral segment. The deformed bone was meticulously removed, and spinal osteotomies were performed to achieve realignment and alleviate pain. Hemostasis was achieved, and the wounds were closed meticulously. The patient reported significant improvement in severe bone pain after the surgery.

10. Operative Note: Surgical intervention was performed for other specified deforming dorsopathies associated with severe bone pain. A posterior approach was employed, and a vertebral augmentation procedure using bone cement was performed to stabilize the deformed and painful vertebral bodies. The bone cement was carefully injected, and subsequent instrumentation and fusion were carried out to provide additional stability and alleviate pain. Hemostasis was achieved, and the wounds were closed meticulously. The patient reported immediate relief from severe bone pain postoperatively.

1. Operative Note: Patient underwent a surgical intervention for other specified deforming dorsopathies. A posterior approach was employed, and a spinal fusion procedure was performed at the affected levels. The deformed structures were meticulously prepared, and bone graft material was placed to promote fusion. Hemostasis was achieved, and the wounds were closed meticulously. The patient tolerated the procedure well, and appropriate postoperative rehabilitation was initiated.

2. Operative Note: Surgical correction was performed for other specified deforming dorsopathies. An anterior approach was utilized, and a discectomy was performed to address the deformity. A fusion procedure with interbody cage placement was carried out to restore stability. Hemostasis was achieved, and the incision was closed meticulously. The patient had an uneventful recovery from anesthesia, and postoperative imaging confirmed successful correction of the dorsopathy.

3. Operative Note: Patient underwent a surgical intervention for other specified deforming dorsopathies. A posterior approach was employed, and a laminectomy and facetectomy were performed to decompress the affected nerve roots and spinal canal. The deformed bone and hypertrophic facet joints were meticulously removed. Hemostasis was achieved, and the wounds were closed meticulously. The patient experienced immediate relief from symptoms postoperatively.

4. Operative Note: Surgical management was undertaken for other specified deforming dorsopathies. An oblique approach was utilized, and a vertebral column resection was executed to address the deformity. The deformed bone was meticulously removed, and spinal osteotomies were performed to achieve realignment. Hemostasis was achieved, and the wounds were closed meticulously. The patient tolerated the surgical intervention well and was closely monitored postoperatively.

5. Operative Note: Patient underwent a surgical intervention for other specified deforming dorsopathies. A transforaminal lumbar interbody fusion (TLIF) was performed at the affected levels. The deformed disc material and bone spurs were meticulously removed, and a fusion cage was inserted. Hemostasis was achieved, and the surgical site was thoroughly irrigated. The wounds were closed meticulously, and the patient's postoperative course was unremarkable.

6. Operative Note: Surgical correction was performed for other specified deforming dorsopathies. A posterior approach was employed, and a vertebral corpectomy was performed to address the deformity. The affected segment was stabilized with a mesh cage and bone grafting. Hemostasis was achieved, and the wounds were closed meticulously. The patient recovered well from anesthesia, and appropriate postoperative care was provided.

7. Operative Note: Patient underwent a surgical intervention for other specified deforming dorsopathies. A lateral approach was employed, and a foraminotomy was performed to decompress the affected nerve roots. The deformed bony structures were meticulously removed, alleviating neural compression. Hemostasis was achieved, and the incision was closed meticulously. The patient experienced immediate relief from symptoms and had a smooth recovery from anesthesia.

8. Operative Note: Surgical management was undertaken for other specified deforming dorsopathies. An anterior approach was employed, and a vertebral corpectomy was performed to address the deformity. The affected vertebral body was meticulously removed, and the spinal stability was restored with instrumentation and fusion. Hemostasis was achieved, and the wounds were closed meticulously. The patient had an uneventful recovery from anesthesia and reported improved symptoms postoperatively.

9. Operative Note: Patient underwent a surgical intervention for other specified deforming dorsopathies. A combined anterior and posterior approach was utilized. The anterior procedure involved a discectomy and inter body fusion to address the deformity. Posteriorly, a laminectomy and fusion with instrumentation were performed for additional stability. Hemostasis was achieved, and the wounds were closed meticulously. The patient tolerated the surgical intervention well and had an uncomplicated recovery.

10. Operative Note: Surgical correction was performed for other specified deforming dorsopathies. A posterior approach was employed, and a multi-level laminectomy and facetectomy were performed to decompress the spinal canal. The deformed bone and hypertrophic facet joints were meticulously removed, alleviating neural compression. Hemostasis was achieved, and the wounds were closed meticulously. The patient experienced immediate relief from symptoms postoperatively.

1. Operative Note: Patient underwent a surgical intervention for other specified deforming dorsopathies. A posterior approach was employed, and a spinal decompression procedure was performed to alleviate neural compression. The deformed bony structures were meticulously removed, restoring proper nerve function. Hemostasis was achieved, and the wounds were closed meticulously. The patient reported immediate improvement in symptoms postoperatively.

2. Operative Note: Surgical correction was performed for other specified deforming dorsopathies. An anterior approach was utilized, and a corpectomy was performed to remove the deformed vertebral body. The affected segment was stabilized with a titanium mesh cage and bone grafting. Hemostasis was achieved, and the wounds were closed meticulously. The patient had an uneventful recovery from anesthesia and demonstrated improved spinal stability.

3. Operative Note: Patient underwent a surgical intervention for other specified deforming dorsopathies. A lateral approach was employed, and a lateral lumbar interbody fusion (LLIF) was performed to address the deformity. The deformed disc material and bony structures were meticulously removed, and a fusion cage was inserted. Hemostasis was achieved, and the wounds were closed meticulously. The patient experienced significant relief from symptoms postoperatively.

4. Operative Note: Surgical management was undertaken for other specified deforming dorsopathies. A posterior approach was employed, and a spinal osteotomy was performed to correct the deformity. The deformed vertebral segments were meticulously realigned, and spinal fusion with instrumentation was carried out for stability. Hemostasis was achieved, and the wounds were closed meticulously. The patient had a smooth recovery from anesthesia, and postoperative imaging confirmed successful correction of the dorsopathy.

5. Operative Note: Patient underwent a surgical intervention for other specified deforming dorsopathies. A transpedicular approach was utilized, and a posterior vertebral column resection (PVCR) was performed to address the deformity. The deformed bone was meticulously removed, and spinal osteotomies were performed to achieve realignment. Hemostasis was achieved, and the wounds were closed meticulously. The patient's postoperative course was uneventful, with improvement in spinal alignment noted.

6. Operative Note: Surgical correction was performed for other specified deforming dorsopathies. An anterior approach was employed, and a discectomy and interbody fusion were performed to address the deformity. Posteriorly, a laminectomy and fusion with instrumentation were carried out for additional stability. Hemostasis was achieved, and the wounds were closed meticulously. The patient had a satisfactory recovery from anesthesia and reported improved symptoms postoperatively.

7. Operative Note: Patient underwent a surgical intervention for other specified deforming dorsopathies. A posterior approach was employed, and a laminoplasty was performed to address the deformity and spinal canal stenosis. The deformed bone was meticulously removed, and the spinal canal was decompressed. Hemostasis was achieved, and the wound was closed meticulously. The patient experienced immediate relief from symptoms and had an uneventful recovery from anesthesia.

8. Operative Note: Surgical management was undertaken for other specified deforming dorsopathies. An oblique approach was utilized, and a vertebral column resection with anterior and posterior fixation was executed to correct the deformity. The deformed bone was meticulously removed, and spinal osteotomies were performed to achieve realignment. Hemostasis was achieved, and the wounds were closed meticulously. The patient tolerated the surgical intervention well and was closely monitored postoperatively.

9. Operative Note: Patient underwent a surgical intervention for other specified deforming dorsopathies. A posterior approach was employed, and a laminectomy and facetectomy were performed to decompress the spinal canal and alleviate neural compression. The deformed bone and hypertrophic facet joints were meticulously removed. Hemostasis was achieved, and the wounds were closed meticulously. The patient experienced immediate relief from symptoms postoperatively.

10. Operative Note: Surgical correction was performed for other specified deforming dorsopathies. A posterior approach was utilized, and a multilevel fusion procedure was performed to address the deformity and provide spinal stability. The deformed structures were meticulously prepared, and bone graft material was placed to promote fusion. Hemostasis was achieved, and the wounds were closed meticulously. The patient had an uneventful recovery, and appropriate postoperative rehabilitation was initiated.

1. Operative Note: Patient underwent a surgical intervention for other specified deforming dorsopathies with a severe infection on the extreme moving joint. A posterior approach was employed, and extensive debridement of the infected joint was performed. The necrotic tissues were meticulously removed, and copious irrigation with antibiotic solution was carried out. Hemostasis was achieved, and the wounds were closed meticulously. Intravenous antibiotics were initiated postoperatively, and the patient was closely monitored for signs of infection resolution.

2. Operative Note: Surgical debridement and irrigation were performed for other specified deforming dorsopathies with a severe infection on the extreme moving joint. An anterior approach was utilized, and the infected joint was meticulously accessed. The infected tissues were thoroughly debrided, and the joint was irrigated with antibiotic solution. Hemostasis was achieved, and the incision was closed meticulously. Postoperatively, intravenous antibiotics were administered, and the patient's joint mobility and infection markers were closely monitored.

3. Operative Note: Patient underwent a surgical intervention for other specified deforming dorsopathies with a severe infection on the extreme moving joint. A combined anterior and posterior approach was employed. The infected joint was meticulously accessed, and extensive debridement was performed to remove all infected tissues. Copious irrigation with antibiotic solution was carried out. Hemostasis was achieved, and the wounds were closed meticulously. Postoperatively, appropriate antibiotic therapy was initiated, and the patient was closely monitored for infection control.

4. Operative Note: Surgical management was undertaken for other specified deforming dorsopathies with a severe infection on the extreme moving joint. A posterior approach was employed, and the infected joint was meticulously exposed. Debridement of the infected tissues was performed, and thorough irrigation with antibiotic solution was carried out. Hemostasis was achieved, and the wounds were closed meticulously. Postoperatively, intravenous antibiotics were administered, and the patient's joint function and infection markers were closely monitored.

5. Operative Note: Patient underwent a surgical intervention for other specified deforming dorsopathies with a severe infection on the extreme moving joint. An anterior approach was utilized, and the infected joint was meticulously addressed. Extensive debridement of infected tissues was performed, and the joint was thoroughly irrigated with antibiotic solution. Hemostasis was achieved, and the incision was closed meticulously. Postoperatively, appropriate antibiotic therapy was initiated, and the patient's joint mobility and infection parameters were closely monitored.

6. Operative Note: Surgical debridement and irrigation were performed for other specified deforming dorsopathies with a severe infection on the extreme moving joint. A posterior approach was employed, and the infected joint was meticulously accessed. The necrotic tissues were meticulously debrided, and the joint was thoroughly irrigated with antibiotic solution. Hemostasis was achieved, and the wounds were closed meticulously. Intravenous antibiotics were initiated postoperatively, and the patient's joint function and infection markers were closely monitored.

7. Operative Note: Patient underwent a surgical intervention for other specified deforming dorsopathies with a severe infection on the extreme moving joint. A combined anterior and posterior approach was employed. The infected joint was meticulously accessed, and extensive debridement was performed to remove all infected tissues. Copious irrigation with antibiotic solution was carried out. Hemostasis was achieved, and the wounds were closed meticulously. Postoperatively, appropriate antibiotic therapy was initiated, and the patient's joint mobility and infection control were closely monitored.

8. Operative Note: Surgical management was undertaken for other specified deforming dorsopathies with a severe infection on the extreme moving joint. A posterior approach was employed, and the infected joint was meticulously exposed. Debridement of the infected tissues was performed, and thorough irrigation with antibiotic solution was carried out. Hemostasis was achieved, and the wounds were closed meticulously. Postoperatively, intravenous antibiotics were administered, and the patient's joint function and infection markers were closely monitored.

9. Operative Note: Patient underwent a surgical intervention for other specified deforming dorsopathies with a severe infection on the extreme moving joint. An anterior approach was utilized, and the infected joint was meticulously addressed. Extensive debridement of infected tissues was performed, and the joint was thoroughly irrigated with antibiotic solution. Hemostasis was achieved, and the incision was closed meticulously. Postoperatively, appropriate antibiotic therapy was initiated, and the patient's joint mobility and infection parameters were closely monitored.

10. Operative Note: Surgical debridement and irrigation were performed for other specified deforming dorsopathies with a severe infection on the extreme moving joint. A posterior approach was employed, and the infected joint was meticulously accessed. The necrotic tissues were meticulously debrided, and the joint was thoroughly irrigated with antibiotic solution. Hemostasis was achieved, and the wounds were closed meticulously. Intravenous antibiotics were initiated postoperatively, and the patient's joint function and infection markers were closely monitored.

1. Operative Note: Patient underwent a surgical intervention for other specified deforming dorsopathies with severe inflammation. A posterior approach was employed, and extensive debridement of the inflamed tissues was performed. The affected structures were meticulously removed, and thorough irrigation with anti-inflammatory solution was carried out. Hemostasis was achieved, and the wounds were closed meticulously. The patient received postoperative anti-inflammatory medications, and appropriate follow-up was scheduled to monitor the resolution of inflammation.

2. Operative Note: Surgical correction was performed for other specified deforming dorsopathies with significant inflammation. An anterior approach was utilized, and the inflamed joint and surrounding tissues were meticulously addressed. Debridement of inflamed structures was performed, and the joint was thoroughly irrigated with anti-inflammatory solution. Hemostasis was achieved, and the incision was closed meticulously. The patient received postoperative anti-inflammatory treatment, and close monitoring was initiated to assess the reduction of inflammation.

3. Operative Note: Patient underwent a surgical intervention for other specified deforming dorsopathies with moderate inflammation. A combined anterior and posterior approach was employed. The inflamed structures were meticulously accessed, and debridement was performed to remove the affected tissues. Copious irrigation with anti-inflammatory solution was carried out. Hemostasis was achieved, and the wounds were closed meticulously. The patient received postoperative anti-inflammatory medications, and regular follow-up was scheduled to evaluate the resolution of inflammation.

4. Operative Note: Surgical management was undertaken for other specified deforming dorsopathies with mild inflammation. A posterior approach was employed, and the inflamed joint was meticulously accessed. Debridement of the inflamed tissues was performed, and thorough irrigation with anti-inflammatory solution was carried out. Hemostasis was achieved, and the wounds were closed meticulously. The patient received postoperative anti-inflammatory treatment, and close monitoring was initiated to assess the reduction of inflammation.

5. Operative Note: Patient underwent a surgical intervention for other specified deforming dorsopathies with severe inflammation. An anterior approach was utilized, and the inflamed joint was meticulously addressed. Extensive debridement of the inflamed tissues was performed, and the joint was thoroughly irrigated with anti-inflammatory solution. Hemostasis was achieved, and the incision was closed meticulously. The patient received postoperative anti-inflammatory medications, and regular follow-up was scheduled to evaluate the resolution of inflammation.

6. Operative Note: Surgical debridement and irrigation were performed for other specified deforming dorsopathies with moderate inflammation. A posterior approach was employed, and the inflamed joint was meticulously accessed. The inflamed tissues were thoroughly debrided, and the joint was irrigated with anti-inflammatory solution. Hemostasis was achieved, and the wounds were closed meticulously. The patient received postoperative anti-inflammatory treatment, and regular monitoring was initiated to assess the reduction of inflammation.

7. Operative Note: Patient underwent a surgical intervention for other specified deforming dorsopathies with mild inflammation. A combined anterior and posterior approach was employed. The inflamed joint was meticulously accessed, and debridement of the inflamed tissues was performed. Copious irrigation with anti-inflammatory solution was carried out. Hemostasis was achieved, and the wounds were closed meticulously. The patient received postoperative anti-inflammatory medications, and regular follow-up was scheduled to evaluate the resolution of inflammation.

8. Operative Note: Surgical management was undertaken for other specified deforming dorsopathies with significant inflammation. A posterior approach was employed, and the inflamed joint was meticulously exposed. Debridement of the inflamed tissues was performed, and thorough irrigation with anti-inflammatory solution was carried out. Hemostasis was achieved, and the wounds were closed meticulously. The patient received postoperative anti-inflammatory treatment, and regular monitoring was initiated to assess the reduction of inflammation.

9. Operative Note: Patient underwent a surgical intervention for other specified deforming dorsopathies with mild inflammation. An anterior approach was utilized, and the inflamed joint was meticulously addressed. Debridement of the inflamed tissues was performed, and the joint was thoroughly irrigated with anti-inflammatory solution. Hemostasis was achieved, and the incision was closed meticulously. The patient received postoperative anti-inflammatory medications, and regular follow-up was scheduled to evaluate the resolution of inflammation.

10. Operative Note: Surgical debridement and irrigation were performed for other specified deforming dorsopathies with significant inflammation. A posterior approach was employed, and the inflamed joint was meticulously accessed. The inflamed tissues were thoroughly debrided, and the joint was irrigated with anti-inflammatory solution. Hemostasis was achieved, and the wounds were closed meticulously. The patient received postoperative anti-inflammatory treatment, and regular monitoring was initiated to assess the reduction of inflammation.

! Here are 10 synthetic operative notes pertaining to "Other specified deforming dorsopathies" with a surgical intervention, where the follow-up plans vary based on the severity of the diagnosis:

1. Operative Note: Patient underwent a surgical intervention for other specified deforming dorsopathies. A posterior approach was employed, and a corrective procedure was performed to address the deformity. Follow-up visits were scheduled at regular intervals for the first six months to closely monitor the patient's progress, while subsequent visits were scheduled on an as-needed basis depending on the severity of the diagnosis and the patient's response to treatment.

2. Operative Note: Surgical correction was performed for other specified deforming dorsopathies. An anterior approach was utilized, and a stabilization procedure was carried out to address the deformity. Follow-up plans were tailored based on the severity of the diagnosis. The patient was scheduled for frequent follow-up visits initially, with a gradual decrease in frequency as deemed appropriate by the medical team, to assess the progress and determine further interventions if necessary.

3. Operative Note: Patient underwent a surgical intervention for other specified deforming dorsopathies. A combined anterior and posterior approach was employed to address the deformity and provide stability. Postoperative follow-up plans were individualized based on the severity of the diagnosis. The patient was scheduled for regular visits initially, and subsequent appointments were adjusted according to the patient's progress and the need for ongoing monitoring or intervention.

4. Operative Note: Surgical management was undertaken for other specified deforming dorsopathies. A posterior approach was employed, and a decompression procedure was performed to alleviate neural compression. The follow-up schedule was determined based on the severity of the diagnosis. The patient was scheduled for frequent visits initially, with a gradual decrease in frequency as symptoms improved and the need for further intervention decreased.

5. Operative Note: Patient underwent a surgical intervention for other specified deforming dorsopathies. An anterior approach was utilized, and a corrective procedure was performed to address the deformity. The postoperative follow-up plan was tailored to the severity of the diagnosis. The patient was scheduled for regular visits initially, with the frequency adjusted based on the patient's response to treatment and the need for ongoing evaluation and intervention.

6. Operative Note: Surgical correction was performed for other specified deforming dorsopathies. A posterior approach was employed, and a fusion procedure was carried out to provide stability. The follow-up schedule was determined based on the severity of the diagnosis. The patient was initially scheduled for frequent visits to monitor the fusion process and assess the patient's recovery. Subsequent appointments were adjusted based on the patient's progress and the need for further intervention.

7. Operative Note: Patient underwent a surgical intervention for other specified deforming dorsopathies. A combined anterior and posterior approach was employed to address the deformity and provide stability. The follow-up plan was individualized based on the severity of the diagnosis. The patient was initially scheduled for regular visits to assess the surgical outcome and adjust postoperative care accordingly. Subsequent appointments were scheduled based on the patient's progress and the need for ongoing monitoring or intervention.

8. Operative Note: Surgical management was undertaken for other specified deforming dorsopathies. A posterior approach was employed, and a decompression procedure was performed to alleviate neural compression. The follow-up plan was customized based on the severity of the diagnosis. The patient was initially scheduled for frequent visits to assess the efficacy of the procedure and the patient's symptom improvement. Follow-up appointments were then adjusted based on the patient's progress and the need for ongoing evaluation or intervention.

9. Operative Note: Patient underwent a surgical intervention for other specified deforming dorsopathies. An anterior approach was utilized, and a stabilization procedure was performed to address the deformity. The follow-up schedule was determined based on the severity of the diagnosis. The patient was initially scheduled for regular visits to monitor the postoperative recovery and adjust the treatment plan as needed. Subsequent appointments were scheduled based on the patient's progress and the need for ongoing evaluation or intervention.

10. Operative Note: Surgical correction was performed for other specified deforming dorsopathies. A combined anterior and posterior approach was employed, and a fusion procedure was carried out to provide stability. The follow-up plan was tailored to the severity of the diagnosis. The patient was initially scheduled for frequent visits to monitor the fusion process, assess the patient's recovery, and manage any potential complications. Subsequent appointments were adjusted based on the patient's progress and the need for further intervention or monitoring.

## M43.9 Deforming dorsopathy, unspecified

1. Patient presented with severe deforming dorsopathy characterized by spinal malalignment and deformity. X-rays revealed multiple vertebral fractures and disc degeneration. Surgical intervention was performed to correct the deformity using spinal fusion and instrumentation. The procedure was successful, and the patient is recovering well.

2. Operative note for deforming dorsopathy: Patient underwent anterior vertebral column resection and reconstruction for severe spinal deformity. Multiple levels of the spine were addressed, and bone grafting with instrumentation was performed to restore alignment. Intraoperative monitoring ensured spinal cord safety. Postoperative imaging confirmed successful correction of the deformity.

3. Surgical procedure for deforming dorsopathy involved posterior spinal fusion with pedicle screw instrumentation. The patient had significant vertebral collapse and kyphotic deformity. The procedure successfully restored spinal alignment, and bone grafts were placed to promote fusion. Postoperative follow-up will monitor for proper healing and improved symptoms.

4. Operative intervention for deforming dorsopathy consisted of a posterior vertebral column resection. The patient had severe spinal deformity and compression of the spinal cord. A combination of osteotomies and spinal instrumentation was employed to correct the deformity. The procedure was completed without complications, and the patient's neurological function improved postoperatively.

5. Patient with deforming dorsopathy underwent a minimally invasive lateral lumbar interbody fusion procedure. The surgery addressed disc degeneration, vertebral misalignment, and spinal stenosis. Through a small incision, the disc was removed, and a cage with bone graft was inserted to restore height and stability. The patient experienced relief of symptoms and improved mobility postoperatively.

6. Surgical management of deforming dorsopathy involved a posterior decompression laminectomy and fusion. The patient presented with spinal canal stenosis and neurologic deficits. The procedure successfully decompressed the spinal cord, and instrumentation with bone grafting was performed for stabilization. Postoperative rehabilitation will focus on functional recovery and pain management.

7. Operative procedure for deforming dorsopathy included a posterior vertebral osteotomy and correction with pedicle screw instrumentation. The patient had severe kyphotic deformity and compromised lung function. The surgery achieved realignment of the spine and restored lung capacity. The patient is being closely monitored postoperatively for respiratory improvement and overall recovery.

8. Patient with deforming dorsopathy underwent a minimally invasive endoscopic discectomy and spinal fusion. The procedure addressed disc herniation, vertebral misalignment, and instability. A small incision was made, and the disc material was removed using an endoscope. A fusion cage was then inserted to restore stability. Postoperative imaging confirmed successful decompression and alignment.

9. Surgical intervention for deforming dorsopathy involved a posterior osteotomy and posterior spinal fusion. The patient presented with severe thoracolumbar kyphosis and compromised pulmonary function. The procedure corrected the deformity and improved lung capacity. Postoperative monitoring will focus on respiratory function, pain management, and rehabilitation.

10. Operative procedure for deforming dorsopathy included an anterior corpectomy and reconstruction. The patient had vertebral body collapse and spinal cord compression. The procedure successfully removed the affected vertebral body and replaced it with a cage and bone graft. Postoperative imaging confirmed decompression and stabilization of the spine. The patient is recovering well.

1. Patient underwent a posterior vertebral column resection and posterior fusion for severe deforming dorsopathy. The surgery addressed spinal malalignment and compression of neural elements. Intraoperative neuromonitoring was utilized to ensure the safety of the spinal cord. Postoperative imaging confirmed successful correction of the deformity and the patient's neurological function improved.

2. Surgical intervention for deforming dorsopathy consisted of a lateral lumbar interbody fusion with posterior instrumentation. The patient had significant disc degeneration and spinal instability. The procedure successfully restored disc height and alignment, providing stability to the affected segment. Postoperative follow-up will monitor fusion progress and symptom improvement.

3. Operative procedure for deforming dorsopathy included a minimally invasive decompression laminectomy and fusion. The patient presented with spinal canal stenosis and neurologic deficits. The surgery achieved decompression of the spinal cord and stabilization through instrumentation and fusion. The patient's neurologic function showed improvement postoperatively.

4. Patient with deforming dorsopathy underwent an anterior lumbar interbody fusion. The procedure addressed disc degeneration and instability in the lumbar spine. An interbody cage filled with bone graft was inserted to restore disc height and promote fusion. Postoperative recovery is progressing well with relief of symptoms and improved spinal stability.

5. Surgical management of deforming dorsopathy involved a posterior osteotomy and correction with posterior instrumentation. The patient presented with severe kyphotic deformity and spinal cord compression. The surgery successfully corrected the deformity, decompressed the spinal cord, and restored spinal alignment. The patient is showing signs of neurological improvement.

6. Operative procedure for deforming dorsopathy included an anterior vertebral column resection and reconstruction. The patient had severe spinal deformity with vertebral collapse. The procedure involved removing the affected vertebra and reconstructing the spine using instrumentation and bone graft. Postoperative imaging confirmed successful correction of the deformity.

7. Patient underwent a minimally invasive lateral lumbar fusion for deforming dorsopathy. The surgery addressed disc degeneration and spinal instability. Through a small incision, the affected disc was removed, and a fusion cage with bone graft was inserted. Postoperative recovery is progressing well with reduced pain and improved function.

8. Surgical intervention for deforming dorsopathy consisted of a posterior decompression laminectomy and fusion. The patient presented with spinal canal stenosis and radiculopathy. The procedure successfully decompressed the spinal canal, stabilized the affected segment, and relieved pressure on the nerves. Postoperative rehabilitation is focusing on pain management and functional restoration.

9. Operative procedure for deforming dorsopathy included a posterior vertebral column resection and reconstruction. The patient had severe kyphotic deformity and neurological deficits. The surgery involved removing the affected vertebral segments and reconstructing the spine using instrumentation and bone graft. The patient's neurological function improved postoperatively.

10. Patient with deforming dorsopathy underwent an anterior corpectomy and fusion. The procedure addressed vertebral body collapse and spinal cord compression. The affected vertebral body was removed, and a cage with bone graft was inserted to restore stability. Postoperative imaging confirmed successful decompression and stabilization of the spine. The patient is experiencing symptomatic relief and improved mobility.

1. Patient underwent a posterior vertebral column resection and posterior fusion for severe deforming dorsopathy under general anesthesia with moderate sedation. The surgery addressed spinal malalignment and compression of neural elements. Intraoperative neuromonitoring was utilized to ensure the safety of the spinal cord. Postoperative imaging confirmed successful correction of the deformity and the patient's neurological function improved.

2. Surgical intervention for deforming dorsopathy consisted of a lateral lumbar interbody fusion with posterior instrumentation under general anesthesia. The patient had significant disc degeneration and spinal instability. The procedure successfully restored disc height and alignment, providing stability to the affected segment. Postoperative follow-up will monitor fusion progress and symptom improvement.

3. Operative procedure for deforming dorsopathy included a minimally invasive decompression laminectomy and fusion under spinal anesthesia. The patient presented with spinal canal stenosis and neurologic deficits. The surgery achieved decompression of the spinal cord and stabilization through instrumentation and fusion. The patient's neurologic function showed improvement postoperatively.

4. Patient with deforming dorsopathy underwent an anterior lumbar interbody fusion under general anesthesia with low-dose opioids. The procedure addressed disc degeneration and instability in the lumbar spine. An interbody cage filled with bone graft was inserted to restore disc height and promote fusion. Postoperative recovery is progressing well with relief of symptoms and improved spinal stability.

5. Surgical management of deforming dorsopathy involved a posterior osteotomy and correction with posterior instrumentation under regional anesthesia. The patient presented with severe kyphotic deformity and spinal cord compression. The surgery successfully corrected the deformity, decompressed the spinal cord, and restored spinal alignment. The patient is showing signs of neurological improvement.

6. Operative procedure for deforming dorsopathy included an anterior vertebral column resection and reconstruction under general anesthesia with higher sedation levels. The patient had severe spinal deformity with vertebral collapse. The procedure involved removing the affected vertebra and reconstructing the spine using instrumentation and bone graft. Postoperative imaging confirmed successful correction of the deformity.

7. Patient underwent a minimally invasive lateral lumbar fusion for deforming dorsopathy under local anesthesia with conscious sedation. The surgery addressed disc degeneration and spinal instability. Through a small incision, the affected disc was removed, and a fusion cage with bone graft was inserted. Postoperative recovery is progressing well with reduced pain and improved function.

8. Surgical intervention for deforming dorsopathy consisted of a posterior decompression laminectomy and fusion under general anesthesia with epidural analgesia. The patient presented with spinal canal stenosis and radiculopathy. The procedure successfully decompressed the spinal canal, stabilized the affected segment, and relieved pressure on the nerves. Postoperative rehabilitation is focusing on pain management and functional restoration.

9. Operative procedure for deforming dorsopathy included a posterior vertebral column resection and reconstruction under general anesthesia with lower sedation levels. The patient had severe kyphotic deformity and neurological deficits. The surgery involved removing the affected vertebral segments and reconstructing the spine using instrumentation and bone graft. The patient's neurological function improved postoperatively.

10. Patient with deforming dorsopathy underwent an anterior corpectomy and fusion under general anesthesia with balanced anesthesia techniques. The procedure addressed vertebral body collapse and spinal cord compression. The affected vertebral body was removed, and a cage with bone graft was inserted to restore stability. Postoperative imaging confirmed successful decompression and stabilization of the spine. The patient is experiencing symptomatic relief and improved mobility.

1. Patient with deforming dorsopathy and severe bone erosion underwent a posterior vertebral column resection and posterior fusion. The surgery addressed spinal malalignment, compression of neural elements, and erosion of vertebral bodies. Intraoperative neuromonitoring was utilized to ensure the safety of the spinal cord. Postoperative imaging confirmed successful correction of the deformity, stabilization, and restoration of vertebral height.

2. Surgical intervention for deforming dorsopathy with extensive bone erosion included a lateral lumbar interbody fusion with posterior instrumentation. The procedure addressed disc degeneration, spinal instability, and erosion of adjacent vertebral bodies. The surgery successfully restored disc height, alignment, and stability, providing relief of symptoms. Postoperative follow-up will monitor fusion progress and assess the extent of bone erosion repair.

3. Operative procedure for deforming dorsopathy and significant bone erosion involved a minimally invasive decompression laminectomy and fusion. The patient presented with spinal canal stenosis, neurologic deficits, and erosion of vertebral bodies. The surgery achieved decompression of the spinal cord, stabilization, and grafting to restore vertebral integrity. The patient's neurologic function showed improvement postoperatively, and bone erosion repair will be monitored.

4. Patient with deforming dorsopathy and severe bone erosion underwent an anterior lumbar interbody fusion. The procedure addressed disc degeneration, spinal instability, and erosion of adjacent vertebral bodies. An interbody cage filled with bone graft was inserted to restore disc height, alignment, and provide stability. Postoperative recovery is progressing well, and bone erosion repair will be assessed in follow-up.

5. Surgical management of deforming dorsopathy and extensive bone erosion involved a posterior osteotomy, correction with posterior instrumentation, and bone grafting. The patient presented with severe kyphotic deformity, spinal cord compression, and significant bone erosion. The surgery successfully corrected the deformity, decompressed the spinal cord, and addressed vertebral body erosion. The patient is showing signs of neurological improvement, and bone erosion repair will be monitored.

6. Operative procedure for deforming dorsopathy and advanced bone erosion included an anterior vertebral column resection and reconstruction. The patient had severe spinal deformity, vertebral collapse, and erosion. The procedure involved removing the affected vertebra, addressing erosion, and reconstructing the spine using instrumentation and bone graft. Postoperative imaging confirmed successful correction of the deformity, stabilization, and bone erosion repair.

7. Patient with deforming dorsopathy and extensive bone erosion underwent a minimally invasive lateral lumbar fusion. The surgery addressed disc degeneration, spinal instability, erosion of adjacent vertebral bodies, and facet joint erosion. Through a small incision, the affected disc was removed, and a fusion cage with bone graft was inserted. Postoperative recovery is progressing well, and bone erosion repair will be assessed in follow-up.

8. Surgical intervention for deforming dorsopathy and significant bone erosion consisted of a posterior decompression laminectomy and fusion. The patient presented with spinal canal stenosis, radiculopathy, and erosion of vertebral bodies. The surgery successfully decompressed the spinal canal, stabilized the affected segment, and addressed bone erosion. Postoperative rehabilitation is focusing on pain management, functional restoration, and bone erosion repair.

9. Operative procedure for deforming dorsopathy and extensive bone erosion included a posterior vertebral column resection and reconstruction with bone grafting. The patient had severe kyphotic deformity, neurological deficits, and erosion of vertebral bodies. The surgery involved removing the affected vertebral segments, addressing erosion, and reconstructing the spine using instrumentation and bone graft. The patient's neurological function improved postoperatively, and bone erosion repair will be monitored.

10. Patient with deforming dorsopathy and advanced bone erosion underwent an anterior corpectomy and fusion. The procedure addressed vertebral body collapse, spinal cord compression, and erosion of vertebral bodies. The affected vertebral body was removed, and a cage with bone graft was inserted to restore stability and address bone erosion. Postoperative imaging confirmed successful decompression, stabilization, and bone erosion repair. The patient is experiencing symptomatic relief and improved mobility, and bone erosion repair will be monitored in follow-up.

1. Patient with deforming dorsopathy and severe bone pain underwent a posterior vertebral column resection and posterior fusion. The surgery addressed spinal malalignment, compression of neural elements, and severe bone pain. Intraoperative neuromonitoring was utilized to ensure the safety of the spinal cord. Postoperative imaging confirmed successful correction of the deformity, stabilization, and significant reduction in bone pain.

2. Surgical intervention for deforming dorsopathy with severe bone pain included a lateral lumbar interbody fusion with posterior instrumentation. The procedure addressed disc degeneration, spinal instability, and debilitating bone pain. The surgery successfully restored disc height, alignment, and stability, providing significant relief of bone pain. Postoperative follow-up will monitor fusion progress and continued improvement in pain symptoms.

3. Operative procedure for deforming dorsopathy included a minimally invasive decompression laminectomy and fusion to alleviate severe bone pain. The patient presented with spinal canal stenosis, neurologic deficits, and debilitating bone pain. The surgery achieved decompression of the spinal cord, stabilization, and bone grafting to address the underlying cause of bone pain. The patient's neurologic function showed improvement postoperatively, with a notable reduction in bone pain.

4. Patient with deforming dorsopathy and severe bone pain underwent an anterior lumbar interbody fusion. The procedure addressed disc degeneration, spinal instability, and excruciating bone pain. An interbody cage filled with bone graft was inserted to restore disc height, alignment, stability, and alleviate bone pain. Postoperative recovery is progressing well, with a significant reduction in bone pain symptoms.

5. Surgical management of deforming dorsopathy and severe bone pain involved a posterior osteotomy, correction with posterior instrumentation, and bone grafting. The patient presented with severe kyphotic deformity, spinal cord compression, and excruciating bone pain. The surgery successfully corrected the deformity, decompressed the spinal cord, and addressed the underlying cause of bone pain. The patient reported significant improvement in pain symptoms postoperatively.

6. Operative procedure for deforming dorsopathy included an anterior vertebral column resection and reconstruction to alleviate severe bone pain. The patient had severe spinal deformity, vertebral collapse, and debilitating bone pain. The procedure involved removing the affected vertebra, addressing the underlying cause of bone pain, and reconstructing the spine using instrumentation and bone graft. Postoperative imaging confirmed successful correction of the deformity, stabilization, and significant reduction in bone pain.

7. Patient with deforming dorsopathy and severe bone pain underwent a minimally invasive lateral lumbar fusion. The surgery addressed disc degeneration, spinal instability, debilitating bone pain, and restoration of function. Through a small incision, the affected disc was removed, and a fusion cage with bone graft was inserted to restore disc height, alignment, stability, and alleviate bone pain. Postoperative recovery is progressing well, with a substantial reduction in bone pain symptoms.

8. Surgical intervention for deforming dorsopathy and severe bone pain consisted of a posterior decompression laminectomy and fusion. The patient presented with spinal canal stenosis, radiculopathy, and excruciating bone pain. The surgery successfully decompressed the spinal canal, stabilized the affected segment, and addressed the underlying cause of bone pain. Postoperative rehabilitation is focusing on pain management, functional restoration, and continued improvement in bone pain symptoms.

9. Operative procedure for deforming dorsopathy included a posterior vertebral column resection and reconstruction with bone grafting to alleviate severe bone pain. The patient had severe kyphotic deformity, neurological deficits, and debilitating bone pain. The surgery involved removing the affected vertebral segments, addressing the underlying cause of bone pain, and reconstructing the spine using instrumentation and bone graft. The patient reported significant reduction in bone pain postoperatively, along with improved neurologic function.

10. Patient with deforming dorsopathy and severe bone pain underwent an anterior corpectomy and fusion. The procedure addressed vertebral body collapse, spinal cord compression, and excruciating bone pain. The affected vertebral body was removed, and a cage with bone graft was inserted to restore stability, alleviate bone pain, and promote fusion. Postoperative imaging confirmed successful decompression, stabilization, and significant reduction in bone pain. The patient is experiencing symptomatic relief and improved mobility, with continued monitoring of bone pain symptoms.

1. Surgical intervention for deforming dorsopathy included a posterior vertebral column resection and fusion. The patient presented with severe spinal deformity and compression of neural elements. The surgery successfully corrected the deformity, decompressed the spinal cord, and achieved spinal stabilization through instrumentation and fusion. Postoperative imaging confirmed the restoration of spinal alignment and the patient's improved neurological function.

2. Patient with deforming dorsopathy underwent a minimally invasive lateral lumbar fusion. The surgery addressed spinal instability and disc degeneration. Through a small incision, the affected disc was removed, and a fusion cage with bone graft was inserted to restore disc height and provide stability. The patient experienced significant improvement in symptoms and restored spinal function postoperatively.

3. Operative procedure for deforming dorsopathy included an anterior corpectomy and fusion. The patient had severe vertebral body collapse and spinal cord compression. The surgery involved removing the affected vertebral body, restoring stability with a cage and bone graft, and decompressing the spinal cord. Postoperative imaging confirmed successful restoration of vertebral height and decompression of neural structures.

4. Surgical management of deforming dorsopathy involved a posterior decompression laminectomy and fusion. The patient presented with spinal canal stenosis and radiculopathy. The surgery successfully decompressed the spinal canal, stabilized the affected segment, and relieved pressure on the nerves. Postoperative rehabilitation focused on pain management and functional restoration.

5. Patient with deforming dorsopathy underwent an anterior lumbar interbody fusion. The surgery addressed disc degeneration and spinal instability. An interbody cage filled with bone graft was inserted to restore disc height and promote fusion. The patient experienced relief of symptoms and improved spinal stability postoperatively.

6. Operative procedure for deforming dorsopathy included a posterior osteotomy, correction with posterior instrumentation, and fusion. The patient had severe kyphotic deformity and spinal cord compression. The surgery successfully corrected the deformity, decompressed the spinal cord, and achieved spinal stabilization. Postoperative follow-up will monitor fusion progress and assess the patient's neurological improvement.

7. Surgical intervention for deforming dorsopathy consisted of a minimally invasive decompression laminectomy and fusion. The patient presented with spinal canal stenosis and neurologic deficits. The surgery achieved decompression of the spinal cord and stabilization through instrumentation and fusion. The patient's neurologic function showed improvement postoperatively.

8. Patient with deforming dorsopathy underwent an anterior vertebral column resection and reconstruction. The surgery addressed severe spinal deformity and compression of neural elements. The affected vertebra was removed, and the spine was reconstructed using instrumentation and bone graft. Postoperative imaging confirmed successful correction of the deformity and the patient's improved neurological function.

9. Operative procedure for deforming dorsopathy included a lateral lumbar interbody fusion with posterior instrumentation. The surgery addressed disc degeneration, spinal instability, and compression of neural elements. The procedure successfully restored disc height, alignment, and stability, resulting in improved symptomatology and spinal function.

10. Patient with deforming dorsopathy underwent a posterior decompression laminectomy and fusion. The surgery addressed spinal canal stenosis and radiculopathy. The surgery successfully decompressed the spinal canal, stabilized the affected segment, and alleviated pressure on the nerves. Postoperative rehabilitation focused on pain management and functional recovery.

1. Surgical intervention for deforming dorsopathy included a posterior vertebral column resection and fusion with supplemental bone grafting. The patient presented with severe spinal deformity and compression of neural elements. The surgery successfully corrected the deformity, decompressed the spinal cord, achieved spinal stabilization, and promoted fusion for long-term stability and functional improvement.

2. Patient with deforming dorsopathy underwent a minimally invasive transforaminal lumbar interbody fusion. The surgery addressed disc degeneration, spinal instability, and foraminal stenosis. Through small incisions, the affected discs were removed, and interbody cages with bone graft were inserted to restore disc height, decompress neural elements, and stabilize the spine. The patient experienced significant relief of symptoms and improved functional outcomes.

3. Operative procedure for deforming dorsopathy included an anterior lumbar corpectomy and fusion. The patient presented with severe vertebral body collapse and spinal cord compression. The surgery involved removing the affected vertebral bodies, restoring stability with cages and bone grafts, and decompressing the spinal cord. Postoperative imaging confirmed successful restoration of vertebral height, decompression of neural structures, and improved patient's neurological function.

4. Surgical management of deforming dorsopathy involved a posterior decompression laminectomy with instrumented fusion. The patient presented with spinal canal stenosis and neurologic deficits. The surgery successfully decompressed the spinal canal, stabilized the affected segment using instrumentation, and promoted fusion for long-term stability and improved neurological function.

5. Patient with deforming dorsopathy underwent an anterior cervical discectomy and fusion. The surgery addressed cervical disc degeneration and spinal instability. The affected disc was removed, and a bone graft was inserted to restore disc height and promote fusion. The patient experienced relief of symptoms and improved cervical spine stability postoperatively.

6. Operative procedure for deforming dorsopathy included a posterior osteotomy, correction with pedicle screw instrumentation, and fusion. The patient had severe kyphotic deformity and spinal cord compression. The surgery successfully corrected the deformity, decompressed the spinal cord, and achieved spinal stabilization. Postoperative follow-up will monitor fusion progress and assess the patient's neurological improvement.

7. Surgical intervention for deforming dorsopathy consisted of a minimally invasive lateral lumbar interbody fusion with percutaneous pedicle screw fixation. The surgery addressed disc degeneration, spinal instability, and foraminal stenosis. The procedure successfully restored disc height, decompressed neural elements, and provided segmental stability. The patient experienced significant improvement in symptoms and restored spinal function postoperatively.

8. Patient with deforming dorsopathy underwent a posterior decompression laminectomy and posterolateral fusion. The surgery addressed spinal canal stenosis and radiculopathy. The surgery successfully decompressed the spinal canal, stabilized the affected segment using bone grafts and instrumentation, and alleviated pressure on the nerves. Postoperative rehabilitation focused on pain management and functional recovery.

9. Operative procedure for deforming dorsopathy included an anterior lumbar interbody fusion with posterior pedicle screw fixation. The surgery addressed disc degeneration, spinal instability, and foraminal stenosis. The procedure successfully restored disc height, decompressed neural elements, and provided long-term stabilization. The patient experienced significant relief of symptoms and improved spinal stability postoperatively.

10. Patient with deforming dorsopathy underwent a posterior vertebral column resection and reconstruction with expandable cage placement. The surgery addressed severe spinal deformity and compression of neural elements. The affected vertebrae were removed, and the spine was reconstructed using expandable cages and bone grafts to restore alignment, decompress the spinal cord, and achieve stability. Postoperative imaging confirmed successful correction of the deformity and decompression of neural structures.

1. Surgical intervention for deforming dorsopathy and severe infection on the extreme moving joint included a two-stage procedure. The initial surgery involved debridement of the infected joint, removal of necrotic tissue, and placement of antibiotic-impregnated spacers. The second stage, performed after infection control, involved joint reconstruction and stabilization to restore function and alleviate deformity. Postoperative management included intravenous antibiotics and close monitoring of infection markers.

2. Patient with deforming dorsopathy and severe infection on the extreme moving joint underwent a radical debridement and joint arthrodesis. The surgery involved excision of infected tissue, thorough irrigation, and fusion of the affected joint to eliminate the infection source and provide stability. Postoperative antibiotic therapy was initiated, and the patient was closely monitored for signs of infection recurrence.

3. Operative procedure for deforming dorsopathy with severe infection on the extreme moving joint included a joint resection and arthroplasty. The infected joint was removed, and a prosthetic joint was implanted to restore joint function and alleviate deformity. Aggressive antibiotic therapy was administered postoperatively to address the infection, and regular follow-up was scheduled to monitor the joint's healing and infection control.

4. Surgical management of deforming dorsopathy and severe infection on the extreme moving joint involved a joint irrigation and debridement. The procedure included thorough cleaning and removal of infected tissue, followed by antibiotic irrigation. The joint was then stabilized to promote healing and restore functionality. Postoperatively, intravenous antibiotics were administered, and close monitoring of infection markers was performed.

5. Patient with deforming dorsopathy and severe infection on the extreme moving joint underwent a joint fusion and debridement. The surgery involved removing the infected joint surfaces, thorough debridement, and subsequent fusion to eradicate the infection and provide stability. Postoperative antibiotic therapy was initiated, and the patient's response to treatment was closely monitored.

6. Operative procedure for deforming dorsopathy included a joint excision and antibiotic cement spacer placement due to severe infection on the extreme moving joint. The infected joint was removed, and an antibiotic-loaded cement spacer was implanted to fill the void. The patient received intravenous antibiotics and was closely monitored for infection control and subsequent joint reconstruction.

7. Surgical intervention for deforming dorsopathy and severe infection on the extreme moving joint consisted of a joint irrigation, debridement, and external fixation. The infected joint was thoroughly irrigated, necrotic tissue was debrided, and an external fixator was applied to provide stability and support during the healing process. Postoperatively, aggressive antibiotic therapy was initiated, and regular wound care was performed.

8. Patient with deforming dorsopathy and severe infection on the extreme moving joint underwent a joint arthrodesis and debridement. The surgery involved removing the infected joint surfaces, thorough debridement, and fusion to eliminate the infection source and restore stability. Intravenous antibiotics were administered postoperatively, and the patient's progress was closely monitored.

9. Operative procedure for deforming dorsopathy included a joint irrigation, debridement, and antibiotic bead placement. The infected joint was thoroughly irrigated, necrotic tissue was debrided, and antibiotic-loaded beads were implanted to provide localized antibiotic therapy. The patient received systemic antibiotics, and close monitoring was performed to ensure infection control and joint stability.

10. Surgical management of deforming dorsopathy and severe infection on the extreme moving joint involved a joint resection and antibiotic-impregnated cement spacer placement. The infected joint was excised, and a cement spacer containing antibiotics was inserted to eradicate the infection and provide temporary stability. The patient received intravenous antibiotics, and plans for subsequent joint reconstruction were made after infection control was achieved.

1. Surgical intervention for deforming dorsopathy and severe inflammation included a posterior decompression laminectomy and fusion. The procedure addressed spinal canal stenosis and inflammation. The surgery successfully decompressed the spinal cord, stabilized the affected segment, and alleviated symptoms associated with inflammation. Postoperative management included anti-inflammatory medications and close monitoring of inflammatory markers.

2. Patient with deforming dorsopathy and severe inflammatory response underwent a minimally invasive lateral lumbar fusion. The surgery addressed spinal instability and inflammation. Through a small incision, the affected discs were removed, and a fusion cage with bone graft was inserted to restore stability and reduce inflammation. The patient experienced significant improvement in symptoms and reduced inflammatory markers postoperatively.

3. Operative procedure for deforming dorsopathy and severe inflammation included an anterior corpectomy and fusion. The patient had severe vertebral body collapse and inflammatory changes. The surgery involved removing the affected vertebral body, restoring stability with a cage and bone graft, and addressing the inflammatory response. Postoperative imaging confirmed successful restoration of vertebral height and reduction in inflammation.

4. Surgical management of deforming dorsopathy and severe inflammation involved a posterior decompression laminectomy and anti-inflammatory treatment. The patient presented with spinal canal stenosis and inflammatory symptoms. The surgery successfully decompressed the spinal canal and alleviated symptoms associated with inflammation. Postoperatively, the patient received anti-inflammatory medications and close monitoring of inflammatory markers.

5. Patient with deforming dorsopathy and severe inflammation underwent an anterior lumbar interbody fusion with anti-inflammatory adjuncts. The surgery addressed disc degeneration, spinal instability, and inflammatory response. An interbody cage filled with bone graft was inserted to restore disc height, provide stability, and mitigate inflammation. The patient experienced relief of symptoms and reduced inflammatory markers postoperatively.

6. Operative procedure for deforming dorsopathy and severe inflammation included a posterior osteotomy, correction with posterior instrumentation, and anti-inflammatory management. The surgery corrected the deformity, addressed spinal cord compression, and managed the inflammatory response. Postoperative follow-up included anti-inflammatory medications and close monitoring of inflammatory markers.

7. Surgical intervention for deforming dorsopathy and severe inflammation consisted of a minimally invasive decompression laminectomy, fusion, and anti-inflammatory therapy. The surgery addressed spinal canal stenosis, instability, and inflammatory changes. The procedure successfully decompressed the spinal canal, stabilized the affected segment, and mitigated the inflammatory response. Postoperatively, the patient received anti-inflammatory medications and regular monitoring of inflammatory markers.

8. Patient with deforming dorsopathy and severe inflammation underwent an anterior cervical discectomy and fusion with anti-inflammatory adjuncts. The surgery addressed cervical disc degeneration, instability, and inflammation. The affected disc was removed, and a bone graft was inserted to restore disc height, provide stability, and reduce inflammation. The patient experienced symptom relief and decreased inflammatory markers postoperatively.

9. Operative procedure for deforming dorsopathy and severe inflammation included a lateral lumbar interbody fusion with anti-inflammatory management. The surgery addressed disc degeneration, spinal instability, and inflammatory response. The procedure successfully restored disc height, provided stability, and reduced inflammation. Postoperatively, the patient received anti-inflammatory medications and close monitoring of inflammatory markers.

10. Patient with deforming dorsopathy and severe inflammation underwent a posterior vertebral column resection and fusion with anti-inflammatory adjuncts. The surgery addressed severe spinal deformity, spinal cord compression, and inflammation. The procedure corrected the deformity, decompressed the spinal cord, and mitigated the inflammatory response. Postoperatively, the patient received anti-inflammatory medications and regular monitoring of inflammatory markers.

1. Surgical intervention for severe deforming dorsopathy included a multi-level spinal fusion with extensive instrumentation. The patient presented with significant spinal deformity and neurologic deficits. Postoperatively, the patient will require close follow-up visits and imaging studies to monitor the fusion progress, assess neurological improvement, and determine the need for additional rehabilitation or interventions.

2. Patient with moderate deforming dorsopathy underwent a minimally invasive posterior decompression laminectomy and fusion. The surgery addressed spinal stenosis and instability. The patient will be scheduled for regular postoperative check-ups to evaluate pain levels, monitor fusion progress, and assess functional recovery. Additional interventions or physical therapy may be recommended based on the patient's individual progress.

3. Operative procedure for mild deforming dorsopathy included a single-level anterior cervical discectomy and fusion. The patient had disc degeneration and radiculopathy. Postoperatively, the patient will undergo regular follow-up appointments to evaluate pain relief, monitor fusion success, and assess the need for physical therapy or further interventions based on clinical progress.

4. Surgical management of severe deforming dorsopathy included a multi-stage procedure involving anterior corpectomy, posterior decompression laminectomy, and fusion. The patient had severe spinal deformity and spinal cord compression. Postoperatively, the patient will require intensive follow-up visits, neurological examinations, and imaging studies to assess fusion progression, monitor neurologic recovery, and determine the need for rehabilitation or potential revision surgeries.

5. Patient with moderate deforming dorsopathy underwent a posterior decompression laminectomy and fusion with instrumentation. The surgery addressed spinal instability and radiculopathy. The patient's follow-up plan includes regular visits to evaluate pain levels, monitor fusion progress, and assess functional improvement. Physical therapy or further interventions may be recommended based on the patient's specific needs.

6. Operative procedure for mild deforming dorsopathy included a minimally invasive lateral lumbar fusion. The surgery addressed disc degeneration and instability. Postoperatively, the patient will have scheduled follow-up appointments to assess pain levels, monitor fusion success, and determine the need for rehabilitation or additional interventions based on the individual's progress.

7. Surgical intervention for severe deforming dorsopathy consisted of a posterior osteotomy, correction with instrumentation, and fusion. The patient had significant spinal deformity and compression of neural structures. Postoperatively, the patient will undergo frequent follow-up visits, imaging studies, and neurological evaluations to monitor fusion progress, assess neurologic recovery, and guide rehabilitation plans accordingly.

8. Patient with moderate deforming dorsopathy underwent a minimally invasive decompression laminectomy and fusion. The surgery addressed spinal canal stenosis and radiculopathy. Postoperatively, the patient will have regular check-ups to evaluate pain levels, monitor fusion progress, and determine the need for physical therapy or further interventions based on individual progress and symptomatology.

9. Operative procedure for mild deforming dorsopathy included a single-level posterior lumbar interbody fusion. The surgery addressed disc degeneration and instability. Postoperatively, the patient will have periodic follow-up appointments to assess pain relief, monitor fusion success, and evaluate the need for physical therapy or additional interventions based on clinical progress.

10. Surgical management of severe deforming dorsopathy involved a multi-level spinal fusion with extensive instrumentation. The patient had severe spinal deformity and significant neurologic deficits. Postoperatively, the patient will undergo frequent follow-up visits, imaging studies, and neurologic assessments to monitor fusion progress, evaluate neurologic recovery, and determine the need for rehabilitation or potential revision surgeries based on individual response to treatment.