## M45 Ankylosing spondylitis

1. Patient presented with chronic lower back pain and stiffness. X-ray revealed bilateral sacroiliitis. Diagnosed with ankylosing spondylitis (AS). Initiated treatment with nonsteroidal anti-inflammatory drugs (NSAIDs) and physical therapy.

2. AS patient underwent sacroiliac joint injection for pain relief. Procedure performed under fluoroscopic guidance using a 22-gauge needle. Injected 1 ml of 0.25% bupivacaine and 40 mg of triamcinolone. Patient tolerated the procedure well and reported decreased pain post-injection.

3. A 45-year-old male with AS presented with worsening joint pain and limited mobility. Started on tumor necrosis factor (TNF) inhibitor therapy (adalimumab). Monitored for adverse effects and disease progression. Patient reported improved symptoms and increased functionality after 3 months of treatment.

4. AS patient underwent magnetic resonance imaging (MRI) of the spine to assess disease progression. MRI revealed evidence of spinal inflammation, vertebral fusion, and syndesmophyte formation. Altered treatment plan to include disease-modifying antirheumatic drugs (DMARDs) for better disease control.

5. Patient with AS underwent elective spinal fusion surgery to manage severe deformity and pain. Surgery involved posterior instrumentation and fusion of the affected vertebrae. Intraoperative complications were minimal. Patient experienced significant improvement in pain and increased spinal stability postoperatively.

6. AS patient presented with bilateral hip pain and limited range of motion. Diagnosed with bilateral hip joint involvement due to AS. Recommended hip replacement surgery to improve mobility and alleviate pain. Informed patient about the risks and benefits of the procedure. Patient agreed and scheduled for surgery.

7. Ankylosing spondylitis patient with active disease and elevated C-reactive protein (CRP) levels received intravenous infusion of infliximab, a TNF inhibitor. Monitored for infusion-related reactions and observed for clinical improvement. Patient responded well to treatment, with reduced CRP levels and improved symptoms.

8. AS patient with severe peripheral joint involvement underwent synovectomy of the affected joints. Procedure performed arthroscopically, targeting synovial tissue. Removed inflamed synovium and irrigated the joint. Patient experienced reduced joint pain and swelling postoperatively, improving overall joint function.

9. A 32-year-old female with AS presented with recurrent uveitis. Administered local corticosteroid injections into the affected eye. Patient instructed to monitor for any visual disturbances and promptly report any changes. Uveitis symptoms resolved after treatment, and patient scheduled for regular ophthalmological follow-ups.

10. AS patient enrolled in a physical therapy program to improve spinal flexibility and strengthen supporting muscles. Therapy included stretching exercises, range of motion exercises, and postural correction techniques. Patient demonstrated gradual improvement in flexibility, decreased pain, and enhanced functional abilities through the therapy sessions.

1. Patient with ankylosing spondylitis presented with peripheral joint involvement, specifically in the knees. Administered intra-articular corticosteroid injections to both knees. Patient reported reduced pain and improved mobility following the injections.

2. AS patient underwent a bone density scan (dual-energy X-ray absorptiometry) to evaluate for osteoporosis risk. Results indicated low bone mineral density. Initiated treatment with calcium and vitamin D supplementation, along with lifestyle modifications to reduce fracture risk.

3. A 50-year-old male with AS presented with worsening chest pain and shortness of breath. Diagnosed with restrictive lung disease associated with AS. Recommended pulmonary function testing and initiated treatment with pulmonary rehabilitation to improve lung function.

4. AS patient with active disease and inadequate response to NSAIDs started on a biologic therapy (etanercept). Monitored for clinical response and assessed for any adverse effects. Patient experienced significant reduction in disease activity and reported improved quality of life.

5. A 35-year-old female with AS underwent total hip replacement due to severe hip joint destruction. Surgery involved removal of the damaged joint surfaces and implantation of a prosthetic hip joint. Postoperatively, patient reported decreased pain and improved hip mobility.

6. AS patient presented with chronic eye inflammation (uveitis). Started on topical corticosteroid eye drops to manage the uveitis flare-up. Patient instructed on proper administration and advised to seek ophthalmological evaluation for regular monitoring.

7. A 40-year-old male with AS underwent electromyography (EMG) and nerve conduction studies to evaluate peripheral neuropathy symptoms. Results indicated mild sensory neuropathy. Implemented treatment plan to address neuropathic symptoms and provide pain relief.

8. AS patient enrolled in a structured exercise program tailored to their condition. Program included a combination of aerobic exercises, strength training, and flexibility exercises. Monitored patient's progress and observed improved overall fitness and reduced disease-related limitations.

9. Patient with AS presented with worsening symptoms of fatigue and malaise. Performed comprehensive blood workup, including testing for anemia, vitamin deficiencies, and thyroid function. Identified vitamin D deficiency and initiated appropriate supplementation.

10. AS patient underwent joint aspiration and synovial fluid analysis to evaluate for infection or crystal deposition. Analysis revealed no evidence of infection and absence of crystals. Continued monitoring for disease progression and optimization of treatment plan.

1. AS patient scheduled for sacroiliac joint injection under local anesthesia. Administered 2 ml of 1% lidocaine for anesthesia, followed by injection of 40 mg of triamcinolone into the joint. Patient experienced adequate pain relief and no complications during the procedure.

2. Ankylosing spondylitis patient underwent spinal fusion surgery with general anesthesia. Induction with propofol and maintenance with sevoflurane. Adequate muscle relaxation achieved using rocuronium. Monitored closely throughout the procedure, with stable hemodynamics and smooth extubation post-surgery.

3. AS patient with severe hip involvement underwent hip replacement surgery under spinal anesthesia. Administered hyperbaric bupivacaine 10 mg intrathecally. Patient remained comfortable throughout the procedure without the need for additional analgesics.

4. A 45-year-old male with AS underwent synovectomy of the knee joint under regional anesthesia. Administered femoral nerve block with 20 ml of 0.5% ropivacaine for postoperative pain control. Patient tolerated the procedure well and reported satisfactory pain relief postoperatively.

5. AS patient underwent electromyography (EMG) and nerve conduction studies under local anesthesia. Lidocaine 1% injected subcutaneously for anesthesia. Patient reported minimal discomfort during the procedure, allowing for accurate assessment of nerve function.

6. Ankylosing spondylitis patient undergoing total hip replacement surgery received general anesthesia with epidural analgesia. Induced with propofol and maintained with sevoflurane. Epidural catheter placed for postoperative pain management using a continuous infusion of bupivacaine and fentanyl.

7. AS patient scheduled for uveitis-related eye surgery under monitored anesthesia care (MAC). Administered intravenous midazolam and fentanyl for sedation and analgesia. Patient remained cooperative and comfortable throughout the procedure.

8. A 35-year-old female with AS underwent lumbar spine decompression surgery under general anesthesia. Induction with propofol and maintenance with a combination of sevoflurane and remifentanil. Close monitoring of neuromuscular function and adequate pain control achieved.

9. AS patient with significant peripheral joint involvement underwent arthroscopic synovectomy of the wrist joint under regional anesthesia. Administered wrist block with 15 ml of 0.25% bupivacaine. Patient reported minimal pain during the procedure and satisfactory relief afterward.

10. Ankylosing spondylitis patient undergoing elective cervical spine surgery received general anesthesia with endotracheal intubation. Induced with propofol and maintained with a combination of isoflurane and remifentanil. Patient remained hemodynamically stable throughout the procedure.

1. AS patient presented with progressive joint pain and radiographic evidence of bone erosion in the sacroiliac joints. Treatment initiated with a combination of disease-modifying antirheumatic drugs (DMARDs) and biologic therapy to halt disease progression and prevent further bone erosion.

2. A 40-year-old male with AS demonstrated bone erosion in the cervical spine on imaging studies. Started on a targeted therapy regimen to address active disease, including biologic agents and physical therapy to manage pain and improve function.

3. AS patient underwent magnetic resonance imaging (MRI) of the hands and wrists, revealing bone erosion and joint damage consistent with active inflammatory arthritis. Treatment plan modified to include combination therapy with DMARDs and biologic agents for comprehensive disease control.

4. Ankylosing spondylitis patient with advanced disease showed evidence of bone erosion in the hip joints on X-ray. Referred for consultation with an orthopedic surgeon to evaluate the need for hip replacement surgery to address the severe joint damage.

5. AS patient with bone erosion in the thoracic spine underwent minimally invasive vertebral augmentation procedure. Procedure involved injecting bone cement into the affected vertebrae to stabilize and relieve pain. Patient experienced significant pain reduction and improved vertebral integrity post-procedure.

6. A 50-year-old female with AS presented with foot pain and deformity. Imaging studies revealed bone erosion and joint destruction in the feet. Treatment plan included orthopedic consultation for potential joint reconstruction surgery and aggressive medical management to control disease activity.

7. AS patient with active disease and bone erosion in the hands underwent ultrasound-guided joint injections with corticosteroids. Injected small joints of the hands with triamcinolone to reduce inflammation, alleviate pain, and potentially slow down further bone erosion.

8. Ankylosing spondylitis patient showed progressive bone erosion and joint damage in the lumbar spine on computed tomography (CT) scan. Referred for consultation with a spine surgeon to assess the need for surgical intervention to stabilize the spine and prevent further complications.

9. AS patient presented with persistent foot pain and swelling. Imaging studies revealed severe bone erosion and joint destruction in the ankles. Treatment plan included a multidisciplinary approach involving rheumatology, orthopedics, and physical therapy for pain management and functional improvement.

10. A 45-year-old male with AS demonstrated bone erosion and joint space narrowing in the shoulders on X-ray. Initiated treatment with intra-articular corticosteroid injections to reduce inflammation and preserve joint function. Patient monitored for disease progression and offered additional treatment options as needed.

1. AS patient presented with severe bone pain in the spine and hips. Implemented a comprehensive pain management plan, including analgesic medications, physical therapy, and heat therapy, to alleviate pain and improve quality of life.

2. A 40-year-old female with AS reported excruciating bone pain in the knees. Initiated treatment with intra-articular corticosteroid injections for localized pain relief. Patient experienced significant reduction in knee pain and improved mobility.

3. AS patient with severe bone pain in the hands and wrists underwent hand splinting and occupational therapy to reduce pain and improve joint function. Patient educated on joint protection techniques and provided with assistive devices for daily activities.

4. Ankylosing spondylitis patient presented with severe bone pain in the feet, making walking difficult. Prescribed custom orthotic inserts to provide support and cushioning, along with appropriate footwear modifications, to alleviate foot pain and enhance mobility.

5. A 45-year-old male with AS experienced severe bone pain in the shoulders and elbows. Implemented a combination of physical therapy exercises, cold therapy, and nonsteroidal anti-inflammatory drugs (NSAIDs) to manage pain and reduce inflammation.

6. AS patient presented with debilitating bone pain in the hips and lower back. Initiated treatment with opioid analgesics under close monitoring to alleviate severe pain and improve functionality. Patient provided with comprehensive pain management support.

7. Ankylosing spondylitis patient reported severe bone pain in the thoracic spine. Initiated treatment with transcutaneous electrical nerve stimulation (TENS) therapy to provide localized pain relief and reduce discomfort.

8. AS patient presented with intense bone pain in the ankles and feet, limiting mobility. Recommended a combination of aquatic therapy and low-impact exercises to reduce pain, improve joint flexibility, and enhance weight-bearing abilities.

9. A 50-year-old female with AS experienced severe bone pain in the hands and wrists, affecting daily activities. Prescribed a short course of oral corticosteroids to alleviate acute pain and reduce inflammation. Long-term management plan established for disease control.

10. AS patient with severe bone pain throughout the body was referred to a specialized pain management clinic. Comprehensive evaluation conducted to identify appropriate interventions, including medication adjustments, nerve blocks, and alternative therapies, to address and alleviate the debilitating bone pain.

1. AS patient with severe bone pain in the cervical spine underwent anterior cervical discectomy and fusion (ACDF) surgery. Procedure involved removing the damaged intervertebral disc, decompressing the nerve roots, and stabilizing the spine with a bone graft and metal plate.

2. Ankylosing spondylitis patient with debilitating bone pain in the hips underwent total hip replacement surgery. Surgery involved removing the damaged joint surfaces and replacing them with artificial components to alleviate pain and improve joint function.

3. AS patient presented with severe bone pain in the knee joints. Recommended knee arthroscopy to address joint inflammation and assess the extent of joint damage. Procedure performed to remove inflamed tissue, repair any identified structural abnormalities, and provide pain relief.

4. A 45-year-old male with AS underwent corrective osteotomy surgery due to severe bone deformity and pain in the lower extremities. Procedure involved realigning the affected bones to improve joint function, alleviate pain, and restore proper biomechanics.

5. AS patient with recurrent bone pain and inflammation in the wrists underwent synovectomy surgery. Procedure performed to remove the inflamed synovial tissue, reducing pain and preventing further joint damage.

6. Ankylosing spondylitis patient with severe bone pain in the shoulders underwent shoulder arthroplasty surgery. Surgical intervention involved replacing the damaged shoulder joint with a prosthetic implant to relieve pain and restore range of motion.

7. AS patient presented with chronic bone pain in the feet and ankles. Recommended corrective foot and ankle surgery to address joint deformities, improve weight distribution, and alleviate pain. Surgical procedures tailored to the specific joint involvement and patient's functional goals.

8. A 50-year-old female with AS underwent spinal decompression surgery to relieve severe bone pain and nerve compression. Procedure involved removing bone spurs and decompressing the spinal cord and nerves, aiming to alleviate pain and improve neurological symptoms.

9. AS patient with debilitating bone pain in the elbows underwent arthroscopic surgery. Procedure performed to assess and address joint inflammation, remove loose bodies, and repair damaged structures within the elbow joint.

10. Ankylosing spondylitis patient with severe bone pain in the ankle joints underwent ankle fusion surgery. Surgical intervention involved permanently fusing the bones of the ankle joint to provide stability, relieve pain, and improve function.

1. AS patient with intractable bone pain in the thoracic spine underwent vertebroplasty surgery. Procedure involved injecting bone cement into the fractured vertebrae to stabilize the spine and provide immediate pain relief.

2. A 45-year-old male with AS presented with severe bone pain in the hands and wrists. Recommended hand and wrist joint replacement surgery to address joint destruction and alleviate chronic pain, improving hand function.

3. AS patient with debilitating bone pain in the sacroiliac joints underwent minimally invasive sacroiliac joint fusion surgery. Procedure involved stabilizing the joint with implants to alleviate pain and enhance stability.

4. Ankylosing spondylitis patient with severe bone pain in the hips and knees underwent total joint replacement surgery in both joints. Surgery aimed to replace the damaged joint surfaces with prosthetic components, providing pain relief and improved mobility.

5. AS patient presented with excruciating bone pain in the shoulder joints. Recommended shoulder resurfacing surgery to preserve joint function by replacing only the damaged portions of the joint, thereby reducing pain and improving range of motion.

6. A 50-year-old female with AS underwent spinal osteotomy surgery to correct severe spinal deformity and relieve bone pain. Surgical intervention involved realigning the spine to improve posture, alleviate pain, and enhance overall spinal balance.

7. AS patient with severe bone pain in the ankles and feet underwent ankle arthrodesis surgery. Procedure involved fusing the bones of the ankle joint to eliminate painful joint movement and provide long-term pain relief.

8. Ankylosing spondylitis patient with persistent bone pain in the hips underwent hip osteotomy surgery. Procedure performed to reposition the hip joint, improving alignment, reducing pain, and restoring proper joint mechanics.

9. AS patient presented with chronic bone pain in the elbow joints. Recommended elbow arthroplasty surgery to replace the damaged joint surfaces with prosthetic components, relieving pain and restoring function.

10. A 45-year-old male with AS underwent kyphoplasty surgery to address severe vertebral compression fractures and bone pain in the thoracic spine. Procedure involved using a balloon to restore vertebral height and injecting bone cement to stabilize the fractures and alleviate pain.

1. AS patient with severe infection in the knee joint underwent urgent surgical debridement and irrigation. Joint washout performed to remove infected tissue and fluid, followed by appropriate antibiotic therapy to treat the infection.

2. A 40-year-old male with AS presented with a severe infection in the shoulder joint. Emergent surgical intervention involved open joint debridement, extensive irrigation, and placement of antibiotic-impregnated beads to eradicate the infection.

3. AS patient with an extreme moving joint infection in the hip underwent hip joint aspiration and drainage. Surgical procedure performed to remove infected fluid and alleviate pain, followed by targeted antibiotic treatment to eradicate the infection.

4. Ankylosing spondylitis patient presented with a severe infection in the ankle joint. Urgent surgical intervention included joint debridement and irrigation, accompanied by a prolonged course of intravenous antibiotics to clear the infection.

5. AS patient with an infected wrist joint underwent urgent surgical washout and debridement. The joint was thoroughly irrigated, and infected tissues were removed to control the infection and prevent further joint damage.

6. A 50-year-old female with AS developed a severe infection in the elbow joint. Surgical intervention involved open joint debridement, irrigation, and placement of a temporary antibiotic-impregnated spacer to eradicate the infection and facilitate healing.

7. AS patient with a severe infection in the sacroiliac joint underwent surgical intervention, including joint debridement and irrigation. Drainage of abscesses and appropriate antibiotic therapy were administered to treat the infection.

8. Ankylosing spondylitis patient presented with a severe infection in the temporomandibular joint. Urgent surgical intervention involved joint debridement and irrigation, along with antibiotic therapy to clear the infection and preserve joint function.

9. AS patient with an infected ankle joint requiring surgical intervention underwent arthroscopic washout and debridement. The joint was thoroughly cleansed, and infected tissues were removed to control the infection and promote healing.

10. A 45-year-old male with AS developed a severe infection in the sternoclavicular joint. Immediate surgical debridement and irrigation were performed to clear the infection and prevent its spread to surrounding tissues. Intravenous antibiotics were administered to eradicate the infection completely.

1. AS patient presented with severe joint inflammation in the knees. Initiated treatment with intra-articular corticosteroid injections to reduce inflammation and provide symptomatic relief.

2. A 40-year-old male with AS demonstrated chronic inflammation in the spine, resulting in significant pain and stiffness. Started on a biologic therapy regimen to target and suppress the inflammatory response, aiming to alleviate symptoms and prevent further disease progression.

3. AS patient with acute inflammation in the shoulders underwent ultrasound-guided steroid injections for targeted anti-inflammatory treatment. Patient reported reduced pain and improved shoulder mobility following the procedure.

4. Ankylosing spondylitis patient presented with active inflammation in the sacroiliac joints. Prescribed a combination of nonsteroidal anti-inflammatory drugs (NSAIDs) and disease-modifying antirheumatic drugs (DMARDs) to control inflammation and manage symptoms.

5. AS patient with chronic inflammation in the ankles initiated treatment with a targeted DMARD to suppress inflammation and reduce pain. Close monitoring of disease activity and regular follow-ups to adjust the treatment plan as needed.

6. A 50-year-old female with AS experienced recurrent episodes of inflammation in the wrists and hands. Treatment plan involved a combination of oral corticosteroids and physical therapy exercises to manage acute inflammation and restore joint function.

7. AS patient with severe inflammation in the hip joints underwent ultrasound-guided hip joint injections with a long-acting corticosteroid for localized anti-inflammatory treatment. Patient reported decreased pain and improved mobility following the injections.

8. Ankylosing spondylitis patient presented with widespread inflammation throughout the spine and peripheral joints. Initiated treatment with a combination of systemic corticosteroids and biologic agents to control inflammation and prevent long-term joint damage.

9. AS patient with active inflammation in the temporomandibular joint received a referral to a maxillofacial specialist for evaluation and treatment. Treatment plan included targeted anti-inflammatory medications and jaw exercises to manage joint inflammation and improve jaw function.

10. A 45-year-old male with AS demonstrated severe inflammation in the sternoclavicular joints. Recommended a comprehensive treatment approach, including targeted anti-inflammatory medications, physical therapy, and joint protection techniques, to address inflammation and alleviate symptoms.

1. AS patient diagnosed with mild disease severity will have follow-up appointments every six months to monitor symptoms, adjust medications, and evaluate disease progression.

2. A 40-year-old male with moderate AS will have more frequent follow-ups, scheduled every three to four months, to closely monitor inflammation levels, assess treatment response, and make necessary modifications to the treatment plan.

3. AS patient with severe disease severity will require frequent follow-up visits, typically every one to two months, to closely monitor symptoms, evaluate medication effectiveness, and consider additional treatment options, such as biologic therapy or surgical interventions.

4. Ankylosing spondylitis patient with mild-to-moderate disease severity will have follow-up appointments every six to eight months to assess symptom progression, optimize pain management strategies, and provide education on self-care techniques.

5. AS patient with moderate-to-severe disease severity will have regular follow-up visits every three months to closely monitor disease activity, assess functional limitations, and consider more aggressive treatment options if needed, such as TNF inhibitors or physical therapy interventions.

6. A 50-year-old female with severe AS will require frequent follow-ups every one to two months to closely monitor disease activity, assess medication efficacy, and address any complications or side effects that may arise.

7. AS patient with mild disease severity and well-controlled symptoms will have annual follow-up visits to ensure ongoing disease management, review medication needs, and discuss strategies for maintaining a healthy lifestyle.

8. Ankylosing spondylitis patient with moderate disease severity will have follow-up appointments every four to six months to assess disease progression, monitor treatment response, and provide guidance on exercises and lifestyle modifications for symptom management.

9. AS patient with severe disease severity and high disease activity will require monthly follow-up visits to closely monitor response to treatment, adjust medication dosages, and discuss potential alternative therapies or clinical trials.

10. A 45-year-old male with moderate-to-severe AS will have regular follow-up visits every two to three months to assess disease activity, evaluate joint function, and discuss long-term management plans, including physical therapy, assistive devices, or surgical interventions if necessary.

## M46.0 Spinal enthesopathy

1. Operative Note: Patient underwent a minimally invasive procedure for spinal enthesopathy. A small incision was made, and the affected ligamentous attachment was carefully dissected. Using fluoroscopic guidance, a needle was inserted, and corticosteroid medication was injected to alleviate inflammation. The wound was closed, and the patient tolerated the procedure well without any complications.

2. Operative Note: The patient with spinal enthesopathy underwent a decompressive laminectomy. After appropriate exposure, the lamina was removed to access the affected spinal ligament. The diseased tissue was excised, and meticulous hemostasis was achieved. The wound was closed in layers, and the patient was transferred to the recovery room in stable condition.

3. Operative Note: Surgical intervention was performed on the patient diagnosed with spinal enthesopathy. Under general anesthesia, a posterior approach was used to expose the affected vertebral segment. The damaged enthesis was carefully debrided, and a bone graft was placed to promote healing. The wound was closed, and the patient's postoperative course was uneventful.

4. Operative Note: Patient underwent an endoscopic procedure for spinal enthesopathy. A small incision was made, and an endoscope was inserted to visualize the affected area. The degenerated ligamentous attachment was identified and meticulously resected using specialized instruments. The procedure was completed without complications, and the patient was discharged in stable condition.

5. Operative Note: The patient with spinal enthesopathy underwent an arthroscopic procedure. Two small incisions were made, and arthroscopic instruments were inserted. The damaged ligament was visualized and debrided using specialized tools. The joint was irrigated thoroughly, and the wounds were closed. The patient tolerated the procedure well and was instructed on postoperative care.

6. Operative Note: Surgical intervention was performed on the patient presenting with spinal enthesopathy. A midline incision was made, and the affected vertebral level was exposed. The damaged ligamentous attachment was meticulously dissected and excised. The surgical site was thoroughly irrigated, and the wound was closed in layers. The patient recovered well postoperatively without any complications.

7. Operative Note: Patient underwent a percutaneous procedure for spinal enthesopathy. Under fluoroscopic guidance, a needle was advanced to the affected ligament. Radiofrequency ablation was performed to denervate the pain fibers and alleviate symptoms. The procedure was well-tolerated, and the patient experienced immediate relief. The patient was discharged with appropriate post-procedure instructions.

8. Operative Note: The patient diagnosed with spinal enthesopathy underwent a minimally invasive fusion procedure. Using a lateral approach, interbody fusion cages were inserted to stabilize the affected vertebral segment. Bone graft material was placed to promote fusion. Fluoroscopy confirmed proper cage placement. The wounds were closed, and the patient was transferred to the post-anesthesia care unit in stable condition.

9. Operative Note: Surgical intervention was performed on the patient with spinal enthesopathy. A transforaminal lumbar interbody fusion (TLIF) approach was utilized. The affected disc space was prepared, and a cage filled with bone graft was inserted. Pedicle screws were placed for additional stability. Intraoperative imaging confirmed satisfactory placement. The incision was closed, and the patient recovered well postoperatively.

10. Operative Note: Patient underwent an ultrasound-guided procedure for spinal enthesopathy. Under local anesthesia, the ultrasound probe was positioned over the affected enthesis. A needle was inserted, and a mixture of local anesthetic and corticosteroid medication was injected to provide pain relief and reduce inflammation. The patient tolerated the procedure well and reported immediate improvement in symptoms.

1. Operative Note: The patient underwent a minimally invasive laser ablation procedure for spinal enthesopathy. A small incision was made, and a laser fiber was inserted into the affected area. Controlled laser energy was delivered to target and ablate the degenerated ligament. Hemostasis was achieved, and the wound was closed. The patient experienced relief of symptoms and was discharged with postoperative instructions.

2. Operative Note: Surgical intervention was performed on the patient diagnosed with spinal enthesopathy. A posterior approach was utilized, and the affected ligamentous attachment was exposed. Using precision instruments, the degenerated tissue was meticulously excised. A biological scaffold was then placed to promote tissue regeneration. The wound was closed, and the patient's postoperative recovery was uneventful.

3. Operative Note: Patient underwent a radiofrequency neurotomy for spinal enthesopathy. Under fluoroscopic guidance, a radiofrequency probe was inserted near the affected enthesis. Controlled thermal energy was applied to interrupt the pain signals. The procedure was successful in alleviating the patient's symptoms. The patient was discharged with appropriate post-procedural care instructions.

4. Operative Note: The patient with spinal enthesopathy underwent a minimally invasive percutaneous discectomy. A small incision was made, and a specialized device was used to remove the damaged disc material and relieve pressure on the affected ligament. The procedure was completed without complications, and the patient experienced immediate pain relief.

5. Operative Note: Surgical intervention was performed on the patient presenting with spinal enthesopathy. A microdiscectomy approach was utilized to access the affected level. The degenerated ligamentous attachment was meticulously excised, and the surrounding area was thoroughly irrigated. A biological adhesive was applied to enhance healing. The wound was closed, and the patient had an uneventful recovery.

6. Operative Note: Patient underwent an epidural steroid injection for spinal enthesopathy. Under fluoroscopic guidance, a needle was advanced into the epidural space, and a corticosteroid medication was injected to reduce inflammation and alleviate pain. The procedure was well-tolerated, and the patient reported significant improvement in symptoms. Post-procedure instructions were provided before discharge.

7. Operative Note: The patient diagnosed with spinal enthesopathy underwent a percutaneous nucleoplasty procedure. Under fluoroscopic guidance, a needle was advanced into the affected disc space. The nucleoplasty device was used to ablate and remove a portion of the degenerated disc material, relieving pressure on the affected ligament. The procedure was successful, and the patient's symptoms improved postoperatively.

8. Operative Note: Surgical intervention was performed on the patient with spinal enthesopathy. A lateral transpsoas approach was utilized to access the affected vertebral segment. The damaged ligament was meticulously excised, and an interbody fusion device was inserted to restore stability. Bone graft material was placed to promote fusion. The wounds were closed, and the patient recovered well without complications.

9. Operative Note: Patient underwent a nucleoplasty procedure combined with a facet joint injection for spinal enthesopathy. Under fluoroscopic guidance, a needle was advanced into the affected disc space for nucleoplasty, and a separate needle was inserted into the facet joint for injection. The nucleoplasty device was used to remove disc material, and corticosteroid medication was injected into the facet joint to alleviate inflammation. The patient experienced relief and was discharged with instructions.

10. Operative Note: The patient with spinal enthesopathy underwent a dynamic stabilization procedure. A posterior approach was used to expose the affected vertebral segment. Pedicle screws were inserted, and a flexible rod was connected to provide stability while allowing controlled motion. The procedure was successful, and the patient's symptoms improved postoperatively. The wound was closed, and the patient was transferred to the recovery room in stable condition.

1. Operative Note: Patient underwent a spinal enthesopathy procedure under general anesthesia. A midline incision was made, and the affected vertebral level was exposed. The degenerated ligamentous attachment was meticulously dissected and excised. The surgical site was thoroughly irrigated, and the wound was closed in layers. The patient recovered well postoperatively without any complications.

2. Operative Note: The patient with spinal enthesopathy underwent a minimally invasive fusion procedure under moderate sedation. Using a lateral approach, interbody fusion cages were inserted to stabilize the affected vertebral segment. Bone graft material was placed to promote fusion. Fluoroscopy confirmed proper cage placement. The wounds were closed, and the patient was transferred to the post-anesthesia care unit in stable condition.

3. Operative Note: Surgical intervention was performed on the patient presenting with spinal enthesopathy under local anesthesia. A small incision was made, and the affected ligamentous attachment was exposed. The damaged tissue was carefully debrided, and meticulous hemostasis was achieved. The wound was closed, and the patient tolerated the procedure well without any complications.

4. Operative Note: Patient underwent an endoscopic procedure for spinal enthesopathy under regional anesthesia. Two small incisions were made, and endoscopic instruments were inserted. The damaged ligament was visualized and debrided using specialized tools. The joint was irrigated thoroughly, and the wounds were closed. The patient tolerated the procedure well and was instructed on postoperative care.

5. Operative Note: The patient diagnosed with spinal enthesopathy underwent a decompressive laminectomy under general anesthesia with reduced dosage. After appropriate exposure, the lamina was removed to access the affected spinal ligament. The diseased tissue was excised, and meticulous hemostasis was achieved. The wound was closed in layers, and the patient was transferred to the recovery room in stable condition.

6. Operative Note: Surgical intervention was performed on the patient with spinal enthesopathy under conscious sedation. A posterior approach was utilized, and the affected ligamentous attachment was exposed. Using precision instruments, the degenerated tissue was meticulously excised. A biological scaffold was then placed to promote tissue regeneration. The wound was closed, and the patient's postoperative recovery was uneventful.

7. Operative Note: Patient underwent a percutaneous procedure for spinal enthesopathy under monitored anesthesia care. Under fluoroscopic guidance, a needle was advanced to the affected ligament. Radiofrequency ablation was performed to denervate the pain fibers and alleviate symptoms. The procedure was well-tolerated, and the patient experienced immediate relief. The patient was discharged with appropriate post-procedure instructions.

8. Operative Note: The patient with spinal enthesopathy underwent an arthroscopic procedure under general anesthesia with adjusted dosage. Three small incisions were made, and arthroscopic instruments were inserted. The damaged ligament was visualized and debrided using specialized tools. The joint was irrigated thoroughly, and the wounds were closed. The patient tolerated the procedure well and was provided postoperative care instructions.

9. Operative Note: Surgical intervention was performed on the patient diagnosed with spinal enthesopathy under epidural anesthesia. A transforaminal lumbar interbody fusion (TLIF) approach was utilized. The affected disc space was prepared, and a cage filled with bone graft was inserted. Pedicle screws were placed for additional stability. Intraoperative imaging confirmed satisfactory placement. The incision was closed, and the patient recovered well postoperatively.

10. Operative Note: Patient underwent a minimally invasive laser ablation procedure for spinal enthesopathy under local anesthesia with reduced dosage. A small incision was made, and a laser fiber was inserted into the affected area. Controlled laser energy was delivered to target and ablate the degenerated ligament. Hemostasis was achieved, and the wound was closed. The patient experienced relief of symptoms and was discharged with postoperative instructions.

1. Operative Note: The patient with spinal enthesopathy and bone erosion underwent a posterior spinal fusion procedure under general anesthesia. The affected vertebral levels were exposed, revealing extensive bone erosion. After meticulous debridement of the eroded bone, a bone graft was placed to restore structural integrity. Pedicle screws and rods were utilized for stabilization. The wound was closed, and the patient recovered well postoperatively.

2. Operative Note: Surgical intervention was performed on the patient diagnosed with spinal enthesopathy and significant bone erosion. A transforaminal lumbar interbody fusion (TLIF) approach was utilized. The eroded bone was carefully excised, and a structural cage filled with bone graft was inserted to reconstruct the affected disc space. Additional fixation with pedicle screws was applied for stability. The incision was closed, and the patient had an uneventful recovery.

3. Operative Note: Patient underwent a minimally invasive decompression procedure for spinal enthesopathy with bone erosion. Under general anesthesia, a small incision was made, and the affected vertebral level was accessed. The eroded bone was meticulously removed, relieving pressure on the affected structures. The wound was closed, and the patient's postoperative course was uneventful.

4. Operative Note: The patient with spinal enthesopathy and bone erosion underwent a percutaneous vertebral augmentation procedure under monitored anesthesia care. Utilizing fluoroscopic guidance, bone cement was injected into the eroded vertebral body, stabilizing the affected segment. The procedure was successful in alleviating pain and restoring vertebral integrity. The patient tolerated the procedure well and was discharged with appropriate post-procedural care instructions.

5. Operative Note: Surgical intervention was performed on the patient presenting with spinal enthesopathy and severe bone erosion. A combined anterior and posterior approach was utilized. The anterior vertebral body was accessed, and a structural graft was placed to reconstruct the eroded area. Posteriorly, pedicle screws and rods were inserted to provide stabilization. The wounds were closed, and the patient recovered well without complications.

6. Operative Note: Patient underwent an endoscopic discectomy procedure for spinal enthesopathy with associated bone erosion. Two small incisions were made, and endoscopic instruments were inserted. The eroded disc material and affected bone were carefully excised, relieving pressure on neural structures. The wounds were closed, and the patient experienced immediate relief of symptoms.

7. Operative Note: The patient diagnosed with spinal enthesopathy and bone erosion underwent a minimally invasive posterior fusion procedure under general anesthesia. The eroded bone was meticulously debrided, and a bone graft was placed to restore stability and promote fusion. Pedicle screws and rods were utilized for additional support. The wound was closed, and the patient's postoperative recovery was uneventful.

8. Operative Note: Surgical intervention was performed on the patient with spinal enthesopathy and significant bone erosion under epidural anesthesia. A posterior approach was utilized, and extensive bone erosion was observed. After thorough debridement of the eroded bone, a bone graft was placed to reconstruct the affected area. The wounds were closed, and the patient tolerated the procedure well without any complications.

9. Operative Note: Patient underwent a minimally invasive percutaneous vertebroplasty procedure for spinal enthesopathy with bone erosion under local anesthesia. Fluoroscopy was used to guide the injection of bone cement into the eroded vertebral body, stabilizing the segment and reducing pain. The procedure was successful, and the patient reported significant improvement in symptoms. Post-procedure instructions were provided before discharge.

10. Operative Note: The patient with spinal enthesopathy and extensive bone erosion underwent a multilevel decompression and fusion procedure under general anesthesia. The eroded bone was meticulously removed, and structural grafts were placed to restore spinal alignment and stability. Pedicle screws and rods were utilized for additional support. The wounds were closed, and the patient's postoperative course was uneventful.

1. Operative Note: The patient with spinal enthesopathy and severe bone pain underwent a posterior lumbar fusion procedure under general anesthesia. Extensive bone erosion was noted, causing significant pain. The eroded bone was meticulously debrided, and bone grafts were placed to promote fusion and alleviate pain. Pedicle screws and rods were utilized for stabilization. The wound was closed, and the patient experienced relief of severe bone pain postoperatively.

2. Operative Note: Surgical intervention was performed on the patient diagnosed with spinal enthesopathy and severe bone pain. A transforaminal lumbar interbody fusion (TLIF) approach was utilized. The eroded bone and damaged disc material were meticulously removed, relieving pressure on neural structures and alleviating severe bone pain. Structural cages filled with bone graft were inserted for stabilization. The patient recovered well without complications.

3. Operative Note: Patient underwent a minimally invasive decompression procedure for spinal enthesopathy with severe bone pain. Under general anesthesia, a small incision was made, and the affected vertebral level was accessed. The eroded bone and hypertrophic ligament were meticulously removed, relieving pressure on the nerves and reducing severe bone pain. The wound was closed, and the patient's postoperative course was uneventful.

4. Operative Note: The patient with spinal enthesopathy and severe bone pain underwent a percutaneous vertebral augmentation procedure under monitored anesthesia care. Utilizing fluoroscopic guidance, bone cement was injected into the eroded vertebral body, stabilizing the affected segment and providing pain relief from severe bone pain. The patient tolerated the procedure well and reported immediate improvement in symptoms.

5. Operative Note: Surgical intervention was performed on the patient presenting with spinal enthesopathy and severe bone pain. A combined anterior and posterior approach was utilized. The anterior vertebral body was accessed, and the eroded bone was meticulously removed. Posteriorly, pedicle screws and rods were inserted to provide stabilization and alleviate severe bone pain. The patient's postoperative recovery was uneventful.

6. Operative Note: Patient underwent an endoscopic discectomy procedure for spinal enthesopathy with associated severe bone pain. Two small incisions were made, and endoscopic instruments were inserted. The eroded disc material and hypertrophic ligament were carefully excised, relieving pressure on the nerves and reducing severe bone pain. The wounds were closed, and the patient experienced immediate relief of symptoms.

7. Operative Note: The patient diagnosed with spinal enthesopathy and severe bone pain underwent a minimally invasive posterior fusion procedure under general anesthesia. The eroded bone and damaged ligamentous attachments were meticulously debrided, and bone grafts were placed to promote fusion and alleviate severe bone pain. Pedicle screws and rods were utilized for additional support. The patient's postoperative recovery was uneventful.

8. Operative Note: Surgical intervention was performed on the patient with spinal enthesopathy and severe bone pain under epidural anesthesia. A posterior approach was utilized, and extensive bone erosion was observed, causing severe pain. After thorough debridement of the eroded bone and hypertrophic ligament, a bone graft was placed to promote stability and alleviate severe bone pain. The wounds were closed, and the patient tolerated the procedure well without complications.

9. Operative Note: Patient underwent a minimally invasive percutaneous vertebroplasty procedure for spinal enthesopathy with severe bone pain under local anesthesia. Fluoroscopy was used to guide the injection of bone cement into the eroded vertebral body, stabilizing the segment and providing immediate relief from severe bone pain. The patient reported significant improvement in symptoms post-procedure.

10. Operative Note: The patient with spinal enthesopathy and severe bone pain underwent a multilevel decompression and fusion procedure under general anesthesia. The eroded bone and hypertrophic ligament were meticulously removed, relieving pressure on the nerves and reducing severe bone pain. Structural grafts were placed for stabilization. The patient experienced relief of severe bone pain and had an uneventful postoperative recovery.

1. Operative Note: The patient with spinal enthesopathy and persistent symptoms underwent a surgical intervention under general anesthesia. A posterior approach was used to access the affected area. The degenerated ligamentous attachment was meticulously excised, and the bony prominence was resected. The surgical site was thoroughly irrigated, and a bone graft was placed for stability. The wound was closed, and the patient tolerated the procedure well.

2. Operative Note: Surgical intervention was performed on the patient diagnosed with spinal enthesopathy and worsening symptoms. Under general anesthesia, a transforaminal approach was used to access the affected vertebral level. The diseased ligament was meticulously excised, and the bony irregularity was addressed. A structural cage filled with bone graft was inserted for stabilization. The incision was closed, and the patient had an uneventful recovery.

3. Operative Note: Patient underwent a surgical intervention for spinal enthesopathy under local anesthesia with sedation. A small incision was made, and the affected ligamentous attachment was exposed. The degenerated tissue was carefully excised, and meticulous hemostasis was achieved. The wound was closed in layers, and the patient tolerated the procedure well without any complications.

4. Operative Note: The patient with spinal enthesopathy and refractory pain underwent a surgical intervention under general anesthesia. A minimally invasive approach was utilized, and the degenerated ligament was visualized using endoscopic guidance. The tissue was meticulously excised, and a biological scaffold was placed to promote tissue regeneration. The wound was closed, and the patient's postoperative recovery was uneventful.

5. Operative Note: Surgical intervention was performed on the patient presenting with spinal enthesopathy and neurological deficits. Under general anesthesia, a posterior laminectomy and decompression were performed to relieve pressure on the neural elements. The diseased ligament was excised, and thorough hemostasis was achieved. The wound was closed, and the patient showed improvement in neurological function postoperatively.

6. Operative Note: Patient underwent a surgical intervention for spinal enthesopathy and recurrent symptoms. Under general anesthesia, an anterior approach was used to access the affected vertebral level. The degenerated ligamentous attachment was meticulously excised, and a bone graft was placed to restore stability. The incision was closed, and the patient tolerated the procedure well without complications.

7. Operative Note: The patient diagnosed with spinal enthesopathy and significant functional impairment underwent a surgical intervention under general anesthesia. A combined anterior and posterior approach was utilized to address the pathology. The degenerated ligament was excised, and bone grafts were placed to promote fusion and restore function. The patient's postoperative course was uneventful.

8. Operative Note: Surgical intervention was performed on the patient with spinal enthesopathy and persistent pain under epidural anesthesia. A posterior approach was used to access the affected area. The degenerated ligamentous attachment was meticulously excised, and the adjacent bony surfaces were prepared for fusion. Pedicle screws and rods were inserted for stabilization. The patient recovered well postoperatively without any complications.

9. Operative Note: Patient underwent a surgical intervention for spinal enthesopathy and worsening symptoms under general anesthesia. A minimally invasive technique was employed, and the diseased ligament was visualized using fluoroscopic guidance. The tissue was carefully excised, and a bone graft was placed to restore stability. The incision was closed, and the patient experienced relief of symptoms postoperatively.

10. Operative Note: The patient with spinal enthesopathy and persistent symptoms underwent a surgical intervention under monitored anesthesia care. A posterior approach was utilized to access the affected vertebral level. The degenerated ligamentous attachment was meticulously excised, and bone grafts were placed to promote fusion. The wound was closed, and the patient's postoperative recovery was satisfactory.

1. Operative Note: The patient with spinal enthesopathy and debilitating symptoms underwent a surgical intervention under general anesthesia. A posterior spinal fusion procedure was performed to address the pathology. The degenerated ligament was meticulously excised, and bone grafts were placed to promote fusion and restore stability. Pedicle screws and rods were utilized for additional support. The incision was closed, and the patient had a smooth postoperative course.

2. Operative Note: Surgical intervention was performed on the patient diagnosed with spinal enthesopathy and intractable pain. Under general anesthesia, a minimally invasive approach was utilized. The degenerated ligamentous attachment was carefully excised, and a biological scaffold was placed to enhance tissue regeneration. The wound was closed, and the patient showed significant improvement in pain symptoms postoperatively.

3. Operative Note: Patient underwent a surgical intervention for spinal enthesopathy and progressive neurological deficits. Under general anesthesia, a laminectomy and decompression procedure were performed to alleviate pressure on the spinal cord. The degenerated ligament was excised, and meticulous hemostasis was achieved. The wound was closed, and the patient's neurological function improved postoperatively.

4. Operative Note: The patient with spinal enthesopathy and chronic pain underwent a surgical intervention under general anesthesia. An anterior approach was used to access the affected vertebral level. The degenerated ligamentous attachment was meticulously excised, and a titanium cage filled with bone graft was inserted for stabilization. The incision was closed, and the patient experienced relief of chronic pain postoperatively.

5. Operative Note: Surgical intervention was performed on the patient presenting with spinal enthesopathy and spinal instability. Under general anesthesia, a combination of posterior decompression and fusion was carried out. The degenerated ligament was excised, and bone grafts were placed to restore stability and promote fusion. The patient's postoperative recovery was uneventful.

6. Operative Note: Patient underwent a surgical intervention for spinal enthesopathy and persistent symptoms under general anesthesia. A minimally invasive approach was utilized, and the degenerated ligamentous attachment was meticulously excised. The surrounding bony prominences were addressed, and bone grafts were placed to restore stability. The wound was closed, and the patient had a satisfactory postoperative course.

7. Operative Note: The patient diagnosed with spinal enthesopathy and severe functional impairment underwent a surgical intervention under general anesthesia. A combined anterior and posterior approach was utilized to address the pathology comprehensively. The degenerated ligament was excised, and bone grafts were placed to promote fusion and restore function. The patient showed improvement in functional capacity postoperatively.

8. Operative Note: Surgical intervention was performed on the patient with spinal enthesopathy and persistent pain under epidural anesthesia. A posterior approach was utilized to access the affected area. The degenerated ligamentous attachment was meticulously excised, and the adjacent bony surfaces were prepared for fusion. Pedicle screws and rods were inserted for stabilization. The patient had a smooth recovery and reported reduced pain postoperatively.

9. Operative Note: Patient underwent a surgical intervention for spinal enthesopathy and worsening symptoms under general anesthesia. A posterior lumbar interbody fusion (PLIF) procedure was performed to address the pathology. The degenerated ligamentous attachment was excised, and interbody cages filled with bone graft were inserted for stabilization. The incision was closed, and the patient experienced improvement in symptoms postoperatively.

10. Operative Note: The patient with spinal enthesopathy and persistent symptoms underwent a surgical intervention under monitored anesthesia care. A posterior approach was utilized to access the affected vertebral level. The degenerated ligamentous attachment was meticulously excised, and bone grafts were placed to promote fusion. The wound was closed, and the patient had a satisfactory postoperative recovery without any complications.

1. Operative Note: The patient presented with spinal enthesopathy and a severe infection involving the extreme moving joint. Surgical intervention was performed under general anesthesia. A thorough debridement of the infected joint was carried out, removing necrotic tissue and purulent material. Irrigation with antimicrobial solution was performed, and a temporary joint spacer was inserted. The wound was closed, and the patient was started on appropriate antibiotic therapy.

2. Operative Note: Surgical intervention was performed on the patient with spinal enthesopathy and a severe infection affecting the extreme moving joint. Under general anesthesia, an open arthrotomy was performed, providing access to the infected joint. Debridement of necrotic tissue and aggressive irrigation were carried out. A temporary antibiotic-impregnated spacer was placed to maintain joint space and facilitate healing. The wound was closed, and the patient's postoperative recovery was closely monitored.

3. Operative Note: Patient underwent a surgical intervention for spinal enthesopathy with a severe infection involving the extreme moving joint. Under general anesthesia, a minimally invasive arthroscopic approach was used. The infected joint was thoroughly debrided, and multiple irrigation rounds were performed with antibiotic solution. A temporary joint spacer was inserted, and appropriate wound care was provided. The patient was started on intravenous antibiotics and scheduled for follow-up.

4. Operative Note: The patient with spinal enthesopathy and a severe infection of the extreme moving joint underwent surgical intervention under general anesthesia. A surgical incision was made, and the infected joint was exposed. Extensive debridement was performed, removing infected tissue and purulent material. Copious irrigation with antimicrobial solution was carried out. A temporary antibiotic-impregnated spacer was inserted, and the wound was closed with appropriate dressings.

5. Operative Note: Surgical intervention was performed on the patient presenting with spinal enthesopathy and a severe infection involving the extreme moving joint. Under general anesthesia, an open surgical approach was utilized. The infected joint was carefully debrided, removing infected tissue and pus. Thorough irrigation with antibiotic solution was performed. A temporary joint spacer was placed, and the wound was closed. Postoperatively, the patient was started on intravenous antibiotics.

6. Operative Note: Patient underwent a surgical intervention for spinal enthesopathy and a severe infection affecting the extreme moving joint. Under general anesthesia, an arthroscopic debridement procedure was performed. The infected joint was meticulously addressed, removing infected synovium and purulent material. Multiple rounds of irrigation with antimicrobial solution were carried out. A temporary joint spacer was inserted, and the patient was initiated on appropriate antibiotic therapy.

7. Operative Note: The patient diagnosed with spinal enthesopathy and a severe infection involving the extreme moving joint underwent surgical intervention under general anesthesia. A joint arthrotomy was performed, providing access to the infected joint. Extensive debridement of infected tissues was carried out, and thorough irrigation with antimicrobial solution was performed. A temporary antibiotic-impregnated spacer was placed, and the wound was closed with appropriate dressings.

8. Operative Note: Surgical intervention was performed on the patient with spinal enthesopathy and a severe infection of the extreme moving joint under general anesthesia. A comprehensive joint debridement was carried out, removing infected tissue and purulent material. The joint was thoroughly irrigated with antimicrobial solution. A temporary joint spacer was inserted, and appropriate wound care was provided. Intravenous antibiotic therapy was initiated postoperatively.

9. Operative Note: Patient underwent a surgical intervention for spinal enthesopathy and a severe infection involving the extreme moving joint. Under general anesthesia, an open surgical approach was employed. The infected joint was meticulously debrided, and copious irrigation with antibiotic solution was performed. A temporary joint spacer was placed, and the wound was closed. The patient was started on intravenous antibiotics and closely monitored for signs of infection.

10. Operative Note: The patient with spinal enthesopathy and a severe infection of the extreme moving joint underwent surgical intervention under general anesthesia. A joint arthrotomy was performed, and thorough debridement of the infected joint was carried out. Multiple rounds of irrigation with antimicrobial solution were performed. A temporary antibiotic-impregnated spacer was inserted, and appropriate wound closure was done. Postoperatively, the patient was initiated on intravenous antibiotics and monitored closely for response.

1. Operative Note: The patient with spinal enthesopathy and severe inflammation involving the extreme moving joint underwent surgical intervention under general anesthesia. A comprehensive joint debridement was performed, removing inflamed synovium and necrotic tissue. Thorough irrigation with anti-inflammatory solution was carried out. A temporary joint spacer was inserted, and the wound was closed. Postoperatively, the patient was started on appropriate anti-inflammatory medication and closely monitored for response.

2. Operative Note: Surgical intervention was performed on the patient presenting with spinal enthesopathy and significant inflammation of the extreme moving joint. Under general anesthesia, an arthroscopic approach was utilized. The inflamed joint was meticulously addressed, removing inflamed tissue and debris. Multiple rounds of irrigation with anti-inflammatory solution were performed. A temporary joint spacer was inserted, and the patient was initiated on systemic anti-inflammatory medication postoperatively.

3. Operative Note: Patient underwent a surgical intervention for spinal enthesopathy with severe inflammation affecting the extreme moving joint. Under general anesthesia, an open surgical approach was employed. The inflamed joint was carefully debrided, removing inflamed synovium and necrotic tissue. Thorough irrigation with anti-inflammatory solution was performed. A temporary joint spacer was placed, and appropriate wound closure was done. The patient was started on oral anti-inflammatory medication postoperatively.

4. Operative Note: The patient diagnosed with spinal enthesopathy and severe inflammation involving the extreme moving joint underwent surgical intervention under general anesthesia. A joint arthrotomy was performed, providing access to the inflamed joint. Extensive debridement of inflamed tissues was carried out, and thorough irrigation with anti-inflammatory solution was performed. A temporary joint spacer was inserted, and the wound was closed. The patient was started on systemic anti-inflammatory medication postoperatively.

5. Operative Note: Surgical intervention was performed on the patient with spinal enthesopathy and a severe inflammatory response in the extreme moving joint under general anesthesia. A comprehensive joint debridement was carried out, removing inflamed synovium and debris. Copious irrigation with anti-inflammatory solution was performed. A temporary joint spacer was placed, and the wound was closed with appropriate dressings. Postoperatively, the patient was initiated on systemic anti-inflammatory medication.

6. Operative Note: Patient underwent a surgical intervention for spinal enthesopathy and severe inflammation affecting the extreme moving joint. Under general anesthesia, an arthroscopic debridement procedure was performed. The inflamed joint was meticulously addressed, removing inflamed synovium and debris. Multiple rounds of irrigation with anti-inflammatory solution were carried out. A temporary joint spacer was inserted, and the patient was started on systemic anti-inflammatory medication postoperatively.

7. Operative Note: The patient with spinal enthesopathy and severe inflammation involving the extreme moving joint underwent surgical intervention under general anesthesia. A joint arthrotomy was performed, providing access to the inflamed joint. Extensive debridement of inflamed tissues was carried out, and thorough irrigation with anti-inflammatory solution was performed. A temporary joint spacer was placed, and the wound was closed with appropriate dressings. The patient was started on systemic anti-inflammatory medication postoperatively.

8. Operative Note: Surgical intervention was performed on the patient presenting with spinal enthesopathy and significant inflammation of the extreme moving joint under general anesthesia. A minimally invasive approach was utilized. The inflamed joint was meticulously addressed, removing inflamed tissue and debris. Thorough irrigation with anti-inflammatory solution was performed. A temporary joint spacer was inserted, and the patient was initiated on systemic anti-inflammatory medication postoperatively.

9. Operative Note: Patient underwent a surgical intervention for spinal enthesopathy with severe inflammation involving the extreme moving joint. Under general anesthesia, an open surgical approach was employed. The inflamed joint was meticulously debrided, and copious irrigation with anti-inflammatory solution was performed. A temporary joint spacer was inserted, and the wound was closed. The patient was started on systemic anti-inflammatory medication and closely monitored for response.

10. Operative Note: The patient with spinal enthesopathy and severe inflammation of the extreme moving joint underwent surgical intervention under general anesthesia. A joint arthrotomy was performed, and thorough debridement of the inflamed joint was carried out. Multiple rounds of irrigation with anti-inflammatory solution were performed. A temporary joint spacer was inserted, and the wound was closed. Postoperatively, the patient was started on systemic anti-inflammatory medication and closely monitored for response.

1. Operative Note: The patient with spinal enthesopathy and a moderate diagnosis underwent surgical intervention under general anesthesia. A thorough debridement of the affected area was performed, followed by irrigation and closure of the wound. Postoperative follow-up will include regular monitoring of symptoms and a review of imaging studies. Rehabilitation and physical therapy will be initiated based on the severity of the patient's condition.

2. Operative Note: Surgical intervention was performed on the patient diagnosed with severe spinal enthesopathy. Under general anesthesia, a comprehensive procedure was carried out, including debridement, stabilization, and fusion. Postoperatively, the patient will require close monitoring in the intensive care unit, followed by a long-term rehabilitation program tailored to the severity of the diagnosis.

3. Operative Note: Patient underwent a surgical intervention for spinal enthesopathy with a mild diagnosis. Under general anesthesia, a minimally invasive procedure was performed, targeting the affected area. Postoperatively, the patient will be scheduled for regular follow-up visits to assess pain levels and functional improvement. Further interventions or adjustments to the treatment plan will be determined based on the severity and progression of symptoms.

4. Operative Note: The patient with spinal enthesopathy and a severe diagnosis underwent surgical intervention under general anesthesia. A complex procedure was performed, including extensive debridement, reconstruction, and stabilization. Postoperatively, the patient will require intensive care management, followed by an extended hospital stay for close monitoring and appropriate interventions based on the severity of the diagnosis.

5. Operative Note: Surgical intervention was performed on the patient diagnosed with moderate spinal enthesopathy. Under general anesthesia, a comprehensive procedure was carried out to address the pathology. Postoperatively, the patient will be scheduled for regular follow-up appointments to evaluate the effectiveness of the surgery and adjust the treatment plan based on the severity of symptoms and functional improvement.

6. Operative Note: Patient underwent a surgical intervention for spinal enthesopathy with a mild diagnosis. Under general anesthesia, a minimally invasive procedure was performed to alleviate symptoms. Postoperatively, the patient will be instructed to follow up with the healthcare provider to assess the response to treatment and determine the need for further interventions based on the severity and progression of the diagnosis.

7. Operative Note: The patient with spinal enthesopathy and a severe diagnosis underwent surgical intervention under general anesthesia. A complex procedure was performed, involving extensive debridement, reconstruction, and fusion. Postoperatively, the patient will be closely monitored in the intensive care unit to manage pain, infection, and potential complications associated with the severity of the diagnosis.

8. Operative Note: Surgical intervention was performed on the patient diagnosed with moderate spinal enthesopathy. Under general anesthesia, a comprehensive procedure was carried out to address the pathology and stabilize the affected area. Postoperatively, the patient will be scheduled for regular follow-up visits to assess the progress, adjust medications, and recommend rehabilitation programs tailored to the severity of the diagnosis.

9. Operative Note: Patient underwent a surgical intervention for spinal enthesopathy with a mild diagnosis. Under general anesthesia, a minimally invasive procedure was performed, targeting the affected area. Postoperatively, the patient will be provided with appropriate pain management and instructed to follow up for regular check-ups to evaluate the response to treatment based on the severity of symptoms.

10. Operative Note: The patient with spinal enthesopathy and a severe diagnosis underwent surgical intervention under general anesthesia. A complex procedure was performed, including extensive debridement, reconstruction, and stabilization. Postoperatively, the patient will require an extended hospital stay for close monitoring, wound care, and appropriate interventions based on the severity of the diagnosis and progression of symptoms.

## M46.1 Sacroiliitis, not elsewhere classified

1. Operative Note: Sacroiliitis Resection Procedure: A surgical resection was performed to remove inflamed tissue and alleviate symptoms of sacroiliitis. A dorsal approach was used to access the sacroiliac joint. The joint space was carefully debrided, and any necrotic or damaged tissue was excised. Hemostasis was achieved, and the wound was closed in layers. Postoperative recovery was uneventful, with significant improvement in pain and mobility.

2. Operative Note: Sacroiliitis Radiofrequency Ablation Procedure: A radiofrequency ablation was performed to treat sacroiliitis. Under fluoroscopic guidance, a radiofrequency probe was inserted into the sacroiliac joint. The targeted nerves were identified and subjected to thermal energy to disrupt pain signals. Adequate sensory and motor responses were confirmed. The probe was removed, and the patient tolerated the procedure well. Follow-up evaluation will assess pain relief and functional improvement.

3. Operative Note: Sacroiliitis Arthrodesis Procedure: Arthrodesis of the sacroiliac joint was performed to address sacroiliitis-related pain and instability. An open approach was employed, and the joint surfaces were prepared for fusion. Autologous bone graft was obtained and placed across the joint. Internal fixation with screws and/or plates was applied to secure the graft. Postoperatively, the patient was placed in a brace for stabilization and encouraged to begin rehabilitation.

4. Operative Note: Sacroiliitis Steroid Injection Procedure: A fluoroscopy-guided steroid injection was performed to manage sacroiliitis. The patient was positioned appropriately, and the needle was inserted into the sacroiliac joint. A mixture of local anesthetic and corticosteroid was injected into the joint space. The patient tolerated the procedure well, and immediate pain relief was observed. Post-injection instructions were provided, including monitoring for potential complications.

5. Operative Note: Sacroiliitis Synovectomy Procedure: A synovectomy was performed to address synovial inflammation in sacroiliitis. The sacroiliac joint was accessed using a minimally invasive technique. The inflamed synovial tissue was carefully excised using arthroscopic instruments. Hemostasis was achieved, and the wound was closed with sutures. The patient's pain and mobility significantly improved following the procedure, and postoperative rehabilitation was initiated.

6. Operative Note: Sacroiliitis Sacroiliac Joint Denervation Procedure: A sacroiliac joint denervation procedure was performed to alleviate pain associated with sacroiliitis. The patient was positioned appropriately, and the target nerves were identified using fluoroscopic guidance. Radiofrequency energy was delivered to disrupt the nerve conduction. The patient tolerated the procedure well, and postoperative pain relief was observed. Follow-up evaluation will assess the duration and extent of pain relief.

7. Operative Note: Sacroiliitis Sacroiliac Joint Stabilization Procedure: Stabilization of the sacroiliac joint was performed to address sacroiliitis-related instability. An open surgical approach was employed, and the joint was anatomically reduced. Internal fixation with screws and/or plates was applied to achieve stability. The patient's pain and functional status significantly improved following the procedure, and rehabilitation was initiated to optimize outcomes and promote joint healing.

8. Operative Note: Sacroiliitis Sacroiliac Joint Distraction Procedure: Sacroiliac joint distraction was performed to alleviate pain and promote joint healing in sacroiliitis. A distraction device was placed across the joint, allowing controlled separation. The procedure was performed under fluoroscopic guidance. Distraction was achieved, and the joint was maintained in a distracted position for a predetermined period. Postoperatively, the patient was monitored for pain relief and functional improvement.

9. Operative Note: Sacroiliitis Sacroiliac Joint Arthrography Procedure: Sacroiliac joint arthrography was performed to aid in the diagnosis and treatment planning of sacroiliitis. Under fluoroscopic guidance, contrast material was injected into the joint space. The integrity of the joint and the presence of any abnormalities were assessed. The procedure was well-tolerated by the patient, and the obtained images provided valuable information for subsequent management decisions.

10. Operative Note: Sacroiliitis Sacroiliac Joint Fusion Procedure: Sacroiliac joint fusion was performed to address chronic sacroiliitis and associated pain. An open approach was utilized, and the joint surfaces were meticulously prepared. Bone graft material, along with appropriate biologic agents, was placed across the joint. Rigid internal fixation was achieved using screws and/or plates. The patient tolerated the procedure well, and postoperative recovery was initiated with appropriate pain management and rehabilitation.

1. Operative Note: Sacroiliitis Sacroiliac Joint Injection Procedure: A therapeutic injection was performed to alleviate pain and inflammation associated with sacroiliitis. Using fluoroscopic guidance, a mixture of local anesthetic and anti-inflammatory medication was injected into the sacroiliac joint. The patient experienced immediate pain relief, and post-injection instructions were provided. Follow-up evaluation will assess the duration and effectiveness of pain relief.

2. Operative Note: Sacroiliitis Sacroiliac Joint Resurfacing Procedure: Resurfacing of the sacroiliac joint was performed to address sacroiliitis-related cartilage damage and pain. A minimally invasive approach was utilized, and the joint surfaces were meticulously prepared. A biocompatible implant was precisely positioned and secured within the joint. Postoperatively, the patient showed improvement in pain and function, and rehabilitation was initiated for optimal recovery.

3. Operative Note: Sacroiliitis Sacroiliac Joint Capsulotomy Procedure: A capsulotomy of the sacroiliac joint was performed to address capsular restrictions and improve joint mobility in sacroiliitis. An arthroscopic approach was used, and the joint capsule was carefully incised to release adhesions. The procedure was well-tolerated by the patient, and postoperative physical therapy was initiated to optimize joint range of motion.

4. Operative Note: Sacroiliitis Sacroiliac Joint Exploration Procedure: A diagnostic exploration of the sacroiliac joint was performed to investigate the source of pain in sacroiliitis. An arthroscopic approach was utilized, allowing visualization of the joint structures. Thorough examination and evaluation were conducted, ruling out any associated pathologies. The findings provided valuable information for subsequent management decisions and treatment planning.

5. Operative Note: Sacroiliitis Sacroiliac Joint Decompression Procedure: A decompression procedure was performed to alleviate pressure on the sacroiliac joint and relieve pain in sacroiliitis. Using fluoroscopic guidance, a minimally invasive technique was employed to remove bony or soft tissue impinging on the joint. The procedure resulted in immediate pain relief, and postoperative rehabilitation was initiated to optimize outcomes.

6. Operative Note: Sacroiliitis Sacroiliac Joint Revision Procedure: A revision surgery was performed to address complications and optimize outcomes following a previous sacroiliac joint procedure in the context of sacroiliitis. An open approach was utilized, and the joint was carefully evaluated and revised as necessary. The patient tolerated the procedure well, and postoperative follow-up will monitor for improved pain relief and functional outcomes.

7. Operative Note: Sacroiliitis Sacroiliac Joint Neurectomy Procedure: A neurectomy of the sacroiliac joint was performed to address chronic pain in sacroiliitis. Under direct visualization, the targeted nerves were identified and excised to interrupt pain signals. The patient experienced immediate relief of pain, and postoperative recovery was initiated. Follow-up evaluation will assess the duration and extent of pain relief.

8. Operative Note: Sacroiliitis Sacroiliac Joint Synthesis Procedure: Synthesis of the sacroiliac joint was performed to address sacroiliitis-related instability and pain. An open surgical approach was employed, and the joint surfaces were meticulously prepared. Biological agents were applied to promote healing and fusion. Rigid internal fixation was achieved using screws and/or plates. The patient showed improvement in pain and stability postoperatively, and rehabilitation was initiated.

9. Operative Note: Sacroiliitis Sacroiliac Joint Debridement Procedure: A debridement of the sacroiliac joint was performed to remove infected or necrotic tissue and alleviate symptoms of sacroiliitis. Under arthroscopic visualization, the joint was carefully debrided using specialized instruments. Thorough irrigation was performed to ensure cleanliness. Postoperatively, the patient showed improvement in pain and functional status, and appropriate antibiotic therapy was initiated.

10. Operative Note: Sacroiliitis Sacroiliac Joint Osteotomy Procedure: An osteotomy of the sacroiliac joint was performed to address malalignment and improve joint mechanics in sacroiliitis. An open surgical approach was utilized, and precise bone cuts were made to correct the alignment. Internal fixation with screws and/or plates was applied to stabilize the joint. Postoperatively, the patient showed improved pain and function, and rehabilitation was initiated for optimal recovery.

1. Operative Note: Sacroiliitis Resection Procedure: A surgical resection was performed under general anesthesia to remove inflamed tissue and alleviate symptoms of sacroiliitis. An appropriate dosage of anesthesia was administered based on the patient's weight and medical condition. The procedure was carried out successfully, and the patient tolerated anesthesia well. Postoperative recovery was uneventful, with significant improvement in pain and mobility.

2. Operative Note: Sacroiliitis Radiofrequency Ablation Procedure: A radiofrequency ablation was performed under monitored anesthesia care (MAC) to treat sacroiliitis. The anesthesia dosage was carefully adjusted to maintain the patient in a comfortable sedated state. The procedure was carried out with precision, and the patient experienced pain relief. Post-procedure monitoring was conducted to ensure a smooth recovery.

3. Operative Note: Sacroiliitis Arthrodesis Procedure: Arthrodesis of the sacroiliac joint was performed under regional anesthesia to address sacroiliitis-related pain and instability. The anesthesia dosage was titrated to achieve adequate pain control and patient comfort. The surgical procedure proceeded smoothly, and the patient remained stable throughout. Postoperatively, pain management was continued, and rehabilitation was initiated.

4. Operative Note: Sacroiliitis Steroid Injection Procedure: A fluoroscopy-guided steroid injection was performed under local anesthesia to manage sacroiliitis. The anesthesia dosage was appropriately calculated to ensure patient comfort during the procedure. The injection was administered without complications, and immediate pain relief was observed. The patient was provided with post-injection instructions and monitored for potential adverse effects.

5. Operative Note: Sacroiliitis Synovectomy Procedure: A synovectomy was performed under general anesthesia to address synovial inflammation in sacroiliitis. The anesthesia dosage was adjusted to maintain the patient in a safe and comfortable state throughout the procedure. The surgical intervention was carried out successfully, and the patient showed improvement in pain and mobility. Postoperative pain management and monitoring were implemented.

6. Operative Note: Sacroiliitis Sacroiliac Joint Denervation Procedure: A sacroiliac joint denervation procedure was performed under conscious sedation to alleviate pain associated with sacroiliitis. The anesthesia dosage was carefully titrated to achieve optimal pain control and patient cooperation. The patient tolerated the procedure well, and postoperative pain relief was observed. Follow-up evaluation was scheduled to assess the duration and effectiveness of pain relief.

7. Operative Note: Sacroiliitis Sacroiliac Joint Stabilization Procedure: Stabilization of the sacroiliac joint was performed under general anesthesia to address sacroiliitis-related instability. The anesthesia dosage was adjusted to maintain the patient in a deep level of sedation throughout the procedure. The surgical intervention was successful, and the patient showed improvement in pain and functional status. Postoperatively, pain management and rehabilitation were initiated.

8. Operative Note: Sacroiliitis Sacroiliac Joint Distraction Procedure: Sacroiliac joint distraction was performed under spinal anesthesia to alleviate pain and promote joint healing in sacroiliitis. The anesthesia dosage was carefully calculated to achieve an appropriate level of sensory and motor block. The procedure was carried out successfully, and the patient experienced pain relief. Postoperatively, the patient was monitored for recovery and pain management.

9. Operative Note: Sacroiliitis Sacroiliac Joint Arthrography Procedure: Sacroiliac joint arthrography was performed under local anesthesia to aid in the diagnosis and treatment planning of sacroiliitis. The anesthesia dosage was adjusted to ensure patient comfort during the procedure. The patient tolerated the injection well, and the obtained images provided valuable information for subsequent management decisions. Post-procedure monitoring was conducted.

10. Operative Note: Sacroiliitis Sacroiliac Joint Fusion Procedure: Sacroiliac joint fusion was performed under general anesthesia to address chronic sacroiliitis and associated pain. The anesthesia dosage was carefully titrated to maintain the patient in a deep level of sedation throughout the procedure. The surgical intervention was successful, and the patient showed improvement in pain and stability postoperatively. Pain management and rehabilitation were initiated as part of the recovery plan.

1. Operative Note: Sacroiliitis Debridement with Bone Grafting Procedure: A debridement with bone grafting was performed to address sacroiliitis with significant bone erosion. An open surgical approach was utilized to access the affected sacroiliac joint. The eroded bone was meticulously debrided, and the joint surfaces were prepared. Autologous bone graft was harvested and applied to promote healing and restore joint integrity. Postoperatively, pain management and rehabilitation were initiated for optimal recovery.

2. Operative Note: Sacroiliitis Joint Reconstruction with Prosthesis Procedure: Joint reconstruction with a prosthesis was performed to address sacroiliitis-related bone erosion and joint dysfunction. An open surgical approach was employed, and the eroded sacroiliac joint was carefully resected. A prosthetic implant was meticulously positioned and secured to restore joint stability and function. The patient tolerated the procedure well, and postoperative rehabilitation was initiated to optimize outcomes.

3. Operative Note: Sacroiliitis Sacroiliac Joint Resurfacing with Allograft Procedure: Sacroiliac joint resurfacing with allograft was performed to address sacroiliitis-associated bone erosion and pain. A minimally invasive technique was utilized, and the eroded joint surfaces were meticulously prepared. Allograft material, with compatible articular surfaces, was precisely positioned to restore joint function. The patient showed improvement in pain and joint mobility postoperatively, and rehabilitation was initiated for optimal recovery.

4. Operative Note: Sacroiliitis Sacroiliac Joint Fusion with Structural Bone Graft Procedure: Sacroiliac joint fusion with structural bone graft was performed to address severe sacroiliitis with extensive bone erosion. An open surgical approach was utilized, and the eroded joint surfaces were meticulously prepared. Structural bone graft, obtained from the patient or a bone bank, was carefully placed to promote fusion and stabilize the joint. The patient showed improvement in pain and joint stability postoperatively.

5. Operative Note: Sacroiliitis Sacroiliac Joint Fixation with Expandable Implant Procedure: Sacroiliac joint fixation with an expandable implant was performed to address sacroiliitis-associated bone erosion and instability. An open surgical approach was employed, and the eroded joint surfaces were meticulously prepared. An expandable implant was precisely positioned and secured within the joint to provide stability and promote bone healing. The patient tolerated the procedure well, and postoperative rehabilitation was initiated for optimal recovery.

6. Operative Note: Sacroiliitis Sacroiliac Joint Fusion with Bone Substitute Procedure: Sacroiliac joint fusion with a bone substitute was performed to address sacroiliitis-related bone erosion and pain. An open surgical approach was employed, and the eroded joint surfaces were meticulously prepared. A bone substitute material, such as synthetic graft or bone morphogenetic protein, was precisely placed to facilitate fusion and restore joint stability. Postoperatively, the patient showed improvement in pain and functional status.

7. Operative Note: Sacroiliitis Sacroiliac Joint Arthrodesis with Bone Anchors Procedure: Sacroiliac joint arthrodesis with bone anchors was performed to address sacroiliitis-associated bone erosion and instability. An open surgical approach was utilized, and the eroded joint surfaces were meticulously prepared. Bone anchors were placed in strategic locations to stabilize the joint and promote fusion. The patient tolerated the procedure well, and postoperative pain management and rehabilitation were initiated.

8. Operative Note: Sacroiliitis Sacroiliac Joint Resection and Osteotomy Procedure: Sacroiliac joint resection and osteotomy were performed to address severe sacroiliitis with extensive bone erosion and joint deformity. An open surgical approach was employed, and the eroded joint surfaces were meticulously resected. Osteotomies were performed to correct deformities and restore proper alignment. Postoperatively, the patient showed improvement in pain and joint function, and rehabilitation was initiated for optimal recovery.

9. Operative Note: Sacroiliitis Sacroiliac Joint Reconstruction with Autograft and Plate Fixation Procedure: Sacroiliac joint reconstruction with autograft and plate fixation was performed to address sacroiliitis-associated bone erosion and instability. An open surgical approach was utilized, and the eroded joint surfaces were meticulously prepared. Autograft bone, harvested from the patient's own iliac crest, was precisely placed and secured with plate fixation to restore joint stability and promote fusion. The patient tolerated the procedure well, and postoperative rehabilitation was initiated.

10. Operative Note: Sacroiliitis Sacroiliac Joint Stabilization with Intramedullary Nail Procedure: Sacroiliac joint stabilization with an intramedullary nail was performed to address sacroiliitis-associated bone erosion and joint instability. An open surgical approach was employed, and the eroded joint surfaces were meticulously prepared. An intramedullary nail was precisely inserted to stabilize the joint and provide support for bone healing. The patient showed improvement in pain and joint stability postoperatively, and rehabilitation was initiated for optimal recovery.

1. Operative Note: Sacroiliitis Sacroiliac Joint Denervation Procedure: Sacroiliac joint denervation was performed under general anesthesia to alleviate severe bone pain associated with sacroiliitis. The procedure involved identifying and selectively ablating the sensory nerves supplying the joint. The patient tolerated the procedure well, and immediate relief from severe bone pain was observed. Postoperatively, pain management and physical therapy were initiated to optimize outcomes.

2. Operative Note: Sacroiliitis Sacroiliac Joint Fusion with Bone Grafting Procedure: Sacroiliac joint fusion with bone grafting was performed under general anesthesia to address severe bone pain in sacroiliitis. The procedure involved meticulously preparing the eroded joint surfaces and applying bone graft material to promote fusion. Internal fixation was achieved using screws and/or plates. The patient showed improvement in severe bone pain postoperatively, and rehabilitation was initiated for optimal recovery.

3. Operative Note: Sacroiliitis Sacroiliac Joint Resurfacing with Synthetic Cartilage Implant Procedure: Sacroiliac joint resurfacing with a synthetic cartilage implant was performed under general anesthesia to alleviate severe bone pain caused by sacroiliitis. The procedure involved replacing the eroded joint surfaces with the implant to restore smooth joint motion. The patient experienced significant relief from severe bone pain, and postoperative recovery was uneventful with improved functional outcomes.

4. Operative Note: Sacroiliitis Sacroiliac Joint Arthrodesis with RhBMP-2 Procedure: Sacroiliac joint arthrodesis with recombinant human bone morphogenetic protein-2 (rhBMP-2) was performed under general anesthesia to address severe bone pain in sacroiliitis. The procedure involved meticulously preparing the eroded joint surfaces and applying rhBMP-2 to stimulate bone fusion. The patient experienced relief from severe bone pain, and postoperative pain management and rehabilitation were initiated.

5. Operative Note: Sacroiliitis Sacroiliac Joint Fixation with Cannulated Screws Procedure: Sacroiliac joint fixation with cannulated screws was performed under general anesthesia to alleviate severe bone pain associated with sacroiliitis. The procedure involved stabilizing the joint by placing screws across the joint. The patient experienced significant relief from severe bone pain postoperatively, and rehabilitation was initiated for optimal recovery and functional improvement.

6. Operative Note: Sacroiliitis Sacroiliac Joint Resection and Osteotomy Procedure: Sacroiliac joint resection and osteotomy were performed under general anesthesia to address severe bone pain and joint deformity in sacroiliitis. The procedure involved meticulously resecting the eroded joint surfaces and performing osteotomies to correct deformities. The patient experienced relief from severe bone pain, and postoperative pain management and rehabilitation were implemented.

7. Operative Note: Sacroiliitis Sacroiliac Joint Decompression with Foraminotomy Procedure: Sacroiliac joint decompression with foraminotomy was performed under general anesthesia to alleviate severe bone pain caused by nerve compression in sacroiliitis. The procedure involved removing bony or soft tissue impinging on the nerve roots. The patient experienced significant relief from severe bone pain, and postoperative recovery was uneventful with improved neurological symptoms.

8. Operative Note: Sacroiliitis Sacroiliac Joint Synovectomy with Capsular Release Procedure: Sacroiliac joint synovectomy with capsular release was performed under general anesthesia to address severe bone pain and inflammation in sacroiliitis. The procedure involved removing the inflamed synovium and releasing tight joint capsules. The patient experienced relief from severe bone pain, and postoperative pain management and physical therapy were initiated.

9. Operative Note: Sacroiliitis Radiofrequency Ablation of Sacral Nerves Procedure: Radiofrequency ablation of sacral nerves was performed under sedation to alleviate severe bone pain associated with sacroiliitis. The procedure involved selectively ablating the nerve fibers transmitting pain signals from the sacroiliac joint. The patient experienced significant relief from severe bone pain, and postoperative pain management and rehabilitation were implemented.

10. Operative Note: Sacroiliitis Sacroiliac Joint Fusion with Pedicle Screw Fixation Procedure: Sacroiliac joint fusion with pedicle screw fixation was performed under general anesthesia to address severe bone pain and joint instability in sacroiliitis. The procedure involved meticulously preparing the eroded joint surfaces, placing pedicle screws, and applying bone graft material for fusion. The patient experienced relief from severe bone pain, and postoperative rehabilitation was initiated for optimal recovery.

1. Operative Note: Sacroiliitis Sacroiliac Joint Arthroscopy Procedure: Sacroiliac joint arthroscopy was performed under general anesthesia to diagnose and treat sacroiliitis. The procedure involved inserting a small camera and specialized instruments into the joint to visualize and address the pathology. The surgical intervention was successful in removing inflamed tissue and improving joint function. Postoperatively, pain management and rehabilitation were initiated.

2. Operative Note: Sacroiliitis Sacroiliac Joint Stabilization with Screw Fixation Procedure: Sacroiliac joint stabilization with screw fixation was performed under general anesthesia to address severe pain and instability in sacroiliitis. The procedure involved meticulously preparing the eroded joint surfaces and placing screws to stabilize the joint. The surgical intervention was successful in reducing pain and restoring joint stability. Postoperatively, pain management and rehabilitation were initiated for optimal recovery.

3. Operative Note: Sacroiliitis Sacroiliac Joint Resection and Fusion Procedure: Sacroiliac joint resection and fusion were performed under general anesthesia to address severe pain and joint dysfunction in sacroiliitis. The procedure involved meticulously resecting the eroded joint surfaces and fusing the adjacent bones using bone graft material and fixation hardware. The surgical intervention resulted in pain relief and improved joint function. Postoperatively, pain management and rehabilitation were implemented.

4. Operative Note: Sacroiliitis Sacroiliac Joint Denervation and Capsular Release Procedure: Sacroiliac joint denervation and capsular release were performed under general anesthesia to address severe pain and inflammation in sacroiliitis. The procedure involved selectively ablating the sensory nerves supplying the joint and releasing tight joint capsules. The surgical intervention was successful in reducing pain and improving joint mobility. Postoperatively, pain management and physical therapy were initiated.

5. Operative Note: Sacroiliitis Sacroiliac Joint Microdiscectomy Procedure: Sacroiliac joint microdiscectomy was performed under general anesthesia to alleviate severe pain and nerve compression in sacroiliitis. The procedure involved removing the herniated disc material pressing on the nerve roots. The surgical intervention resulted in pain relief and improved neurological symptoms. Postoperatively, pain management and rehabilitation were implemented.

6. Operative Note: Sacroiliitis Sacroiliac Joint Osteoplasty Procedure: Sacroiliac joint osteoplasty was performed under general anesthesia to address severe pain and joint deformity in sacroiliitis. The procedure involved meticulously reshaping the eroded joint surfaces to restore proper alignment. The surgical intervention resulted in pain reduction and improved joint function. Postoperatively, pain management and rehabilitation were initiated for optimal recovery.

7. Operative Note: Sacroiliitis Sacroiliac Joint Arthrodesis with Rod and Screw Fixation Procedure: Sacroiliac joint arthrodesis with rod and screw fixation was performed under general anesthesia to address severe pain and joint instability in sacroiliitis. The procedure involved meticulously preparing the eroded joint surfaces, inserting a rod, and securing it with screws to promote fusion and stability. The surgical intervention resulted in pain relief and improved joint stability. Postoperatively, pain management and rehabilitation were implemented.

8. Operative Note: Sacroiliitis Sacroiliac Joint Synovectomy and Debridement Procedure: Sacroiliac joint synovectomy and debridement were performed under general anesthesia to address severe pain and inflammation in sacroiliitis. The procedure involved removing the inflamed synovium and clearing out any necrotic or damaged tissue. The surgical intervention resulted in pain reduction and improved joint function. Postoperatively, pain management and physical therapy were initiated.

9. Operative Note: Sacroiliitis Sacroiliac Joint Fusion with Bone Allograft Procedure: Sacroiliac joint fusion with bone allograft was performed under general anesthesia to address severe pain and joint instability in sacroiliitis. The procedure involved meticulously preparing the eroded joint surfaces and placing bone allograft material to promote fusion and stability. The surgical intervention resulted in pain relief and improved joint function. Postoperatively, pain management and rehabilitation were initiated.

10. Operative Note: Sacroiliitis Sacroiliac Joint Resurfacing with Metal Implant Procedure: Sacroiliac joint resurfacing with a metal implant was performed under general anesthesia to address severe pain and joint dysfunction in sacroiliitis. The procedure involved replacing the eroded joint surfaces with a metal implant to restore smooth joint motion. The surgical intervention resulted in pain reduction and improved joint function. Postoperatively, pain management and rehabilitation were implemented.

1. Operative Note: Sacroiliitis Sacroiliac Joint Radiofrequency Ablation Procedure: Sacroiliac joint radiofrequency ablation was performed under local anesthesia to alleviate pain and inflammation in sacroiliitis. The procedure involved using a specialized needle to deliver radiofrequency energy to the affected nerves, disrupting their ability to transmit pain signals. The surgical intervention resulted in pain reduction and improved quality of life. Postoperatively, pain management and physical therapy were initiated.

2. Operative Note: Sacroiliitis Sacroiliac Joint Arthrodesis with Bone Dowels Procedure: Sacroiliac joint arthrodesis with bone dowels was performed under general anesthesia to address severe pain and joint instability in sacroiliitis. The procedure involved meticulously preparing the eroded joint surfaces and inserting bone dowels to promote fusion and stability. The surgical intervention resulted in pain relief and improved joint function. Postoperatively, pain management and rehabilitation were initiated.

3. Operative Note: Sacroiliitis Sacroiliac Joint Endoscopic Fusion Procedure: Sacroiliac joint endoscopic fusion was performed under general anesthesia to address severe pain and joint dysfunction in sacroiliitis. The procedure involved inserting specialized instruments and a fusion device through small incisions to achieve fusion of the joint. The surgical intervention resulted in pain reduction and improved joint stability. Postoperatively, pain management and rehabilitation were implemented.

4. Operative Note: Sacroiliitis Sacroiliac Joint Distraction Procedure: Sacroiliac joint distraction was performed under general anesthesia to alleviate pain and improve joint mobility in sacroiliitis. The procedure involved applying external distractors to the joint, gently pulling it apart to create space and relieve pressure. The surgical intervention resulted in pain reduction and improved joint function. Postoperatively, pain management and physical therapy were initiated.

5. Operative Note: Sacroiliitis Sacroiliac Joint Revision Surgery Procedure: Sacroiliac joint revision surgery was performed under general anesthesia to address persistent pain and complications following a previous surgical intervention for sacroiliitis. The procedure involved identifying and addressing the underlying cause of the issues, such as hardware malposition or infection. The surgical intervention aimed to improve pain relief and optimize joint function. Postoperatively, pain management and rehabilitation were implemented.

6. Operative Note: Sacroiliitis Sacroiliac Joint Arthroplasty Procedure: Sacroiliac joint arthroplasty was performed under general anesthesia to address severe pain and joint degeneration in sacroiliitis. The procedure involved removing the damaged joint surfaces and replacing them with an artificial joint implant. The surgical intervention resulted in pain reduction and improved joint function. Postoperatively, pain management and rehabilitation were initiated.

7. Operative Note: Sacroiliitis Sacroiliac Joint Capsular Repair Procedure: Sacroiliac joint capsular repair was performed under local anesthesia to address pain and instability in sacroiliitis. The procedure involved meticulously repairing the damaged joint capsule to restore stability and limit excessive joint motion. The surgical intervention resulted in pain reduction and improved joint function. Postoperatively, pain management and physical therapy were initiated.

8. Operative Note: Sacroiliitis Sacroiliac Joint Neurolysis Procedure: Sacroiliac joint neurolysis was performed under local anesthesia to alleviate pain and inflammation in sacroiliitis. The procedure involved injecting a medication or chemical agent to disrupt the nerve conduction and provide pain relief. The surgical intervention resulted in pain reduction and improved quality of life. Postoperatively, pain management and physical therapy were implemented.

9. Operative Note: Sacroiliitis Sacroiliac Joint Resection and Decortication Procedure: Sacroiliac joint resection and decortication were performed under general anesthesia to address severe pain and joint deformity in sacroiliitis. The procedure involved meticulously resecting the eroded joint surfaces and removing the outer layer of the adjacent bones to stimulate fusion. The surgical intervention resulted in pain relief and improved joint function. Postoperatively, pain management and rehabilitation were initiated.

10. Operative Note: Sacroiliitis Sacroiliac Joint Injection with Corticosteroids Procedure: Sacroiliac joint injection with corticosteroids was performed under local anesthesia to alleviate pain and inflammation in sacroiliitis. The procedure involved injecting a mixture of corticosteroids and a local anesthetic directly into the joint to reduce pain and swelling. The surgical intervention resulted in pain reduction and improved quality of life. Postoperatively, pain management and physical therapy were implemented.

1. Operative Note: Sacroiliitis Sacroiliac Joint Debridement and Drainage for Severe Infection Procedure: Sacroiliac joint debridement and drainage were performed under general anesthesia to address a severe infection in sacroiliitis. The procedure involved meticulously removing infected tissue and draining the abscesses to control the infection. The surgical intervention aimed to eradicate the infection and promote healing. Postoperatively, appropriate antibiotic therapy and close monitoring were initiated.

2. Operative Note: Sacroiliitis Sacroiliac Joint Resection and Antibiotic Spacer Placement Procedure: Sacroiliac joint resection and antibiotic spacer placement were performed under general anesthesia to treat a severe infection in sacroiliitis. The procedure involved meticulously resecting the infected joint surfaces and placing an antibiotic-loaded spacer to deliver targeted therapy. The surgical intervention aimed to eradicate the infection and provide a temporary joint replacement. Postoperatively, appropriate antibiotic therapy and rehabilitation were initiated.

3. Operative Note: Sacroiliitis Sacroiliac Joint Arthrodesis with Antibiotic-Impregnated Graft Procedure: Sacroiliac joint arthrodesis with antibiotic-impregnated graft was performed under general anesthesia to address a severe infection and joint instability in sacroiliitis. The procedure involved meticulously preparing the eroded joint surfaces, applying antibiotic-impregnated graft material, and using internal fixation. The surgical intervention aimed to eradicate the infection and promote fusion. Postoperatively, appropriate antibiotic therapy and rehabilitation were initiated.

4. Operative Note: Sacroiliitis Sacroiliac Joint Lavage and Continuous Antibiotic Irrigation Procedure: Sacroiliac joint lavage and continuous antibiotic irrigation were performed under general anesthesia to treat a severe infection in sacroiliitis. The procedure involved meticulously flushing the joint with a sterile solution and continuously irrigating with antibiotics to control the infection. The surgical intervention aimed to eradicate the infection and promote healing. Postoperatively, appropriate antibiotic therapy and close monitoring were initiated.

5. Operative Note: Sacroiliitis Sacroiliac Joint Explantation and Antibiotic Bead Placement Procedure: Sacroiliac joint explantation and antibiotic bead placement were performed under general anesthesia to treat a severe infection in sacroiliitis. The procedure involved meticulously removing the infected joint components and placing antibiotic-impregnated beads in the joint space for targeted therapy. The surgical intervention aimed to eradicate the infection and provide local antibiotic delivery. Postoperatively, appropriate antibiotic therapy and rehabilitation were initiated.

6. Operative Note: Sacroiliitis Sacroiliac Joint Synovectomy and Antibiotic Spacer Placement Procedure: Sacroiliac joint synovectomy and antibiotic spacer placement were performed under general anesthesia to address a severe infection in sacroiliitis. The procedure involved meticulously removing the inflamed synovium and placing an antibiotic-loaded spacer to provide targeted therapy. The surgical intervention aimed to eradicate the infection and restore joint stability. Postoperatively, appropriate antibiotic therapy and rehabilitation were initiated.

7. Operative Note: Sacroiliitis Sacroiliac Joint Arthroscopy with Debridement and Irrigation Procedure: Sacroiliac joint arthroscopy with debridement and irrigation was performed under general anesthesia to treat a severe infection in sacroiliitis. The procedure involved inserting a small camera and specialized instruments into the joint to visualize and remove infected tissue, followed by thorough joint irrigation. The surgical intervention aimed to eradicate the infection and promote healing. Postoperatively, appropriate antibiotic therapy and rehabilitation were initiated.

8. Operative Note: Sacroiliitis Sacroiliac Joint Fusion Revision with Intravenous Antibiotic Therapy Procedure: Sacroiliac joint fusion revision with intravenous antibiotic therapy was performed under general anesthesia to address a severe infection and implant failure in sacroiliitis. The procedure involved meticulously removing the infected implant, debriding the area, and placing a new implant with supplemental antibiotics. The surgical intervention aimed to eradicate the infection and promote fusion. Postoperatively, appropriate antibiotic therapy and rehabilitation were initiated.

9. Operative Note: Sacroiliitis Sacroiliac Joint Resection and Vacuum-Assisted Closure for Severe Infection Procedure: Sacroiliac joint resection and vacuum-assisted closure (VAC) were performed under general anesthesia to address a severe infection in sacroiliitis. The procedure involved meticulously resecting the infected joint surfaces and applying a VAC dressing to promote wound healing and control the infection. The surgical intervention aimed to eradicate the infection and facilitate wound closure. Postoperatively, appropriate antibiotic therapy and close monitoring were initiated.

10. Operative Note: Sacroiliitis Sacroiliac Joint Explantation and Temporary Joint Stabilization for Severe Infection Procedure: Sacroiliac joint explantation and temporary joint stabilization were performed under general anesthesia to treat a severe infection in sacroiliitis. The procedure involved meticulously removing the infected joint components and stabilizing the joint temporarily to control the infection. The surgical intervention aimed to eradicate the infection and provide stability for subsequent reconstruction. Postoperatively, appropriate antibiotic therapy and rehabilitation were initiated.

1. Operative Note: Sacroiliitis Sacroiliac Joint Arthrocentesis for Acute Inflammatory Flare Procedure: Sacroiliac joint arthrocentesis was performed under local anesthesia to address an acute inflammatory flare in sacroiliitis. The procedure involved aspirating synovial fluid from the joint for diagnostic evaluation and providing immediate pain relief. The surgical intervention aimed to alleviate inflammation and improve symptoms. Postoperatively, pain management and anti-inflammatory medications were initiated.

2. Operative Note: Sacroiliitis Sacroiliac Joint Corticosteroid Injection for Moderate InflammationProcedure: Sacroiliac joint corticosteroid injection was performed under local anesthesia to address moderate inflammation in sacroiliitis. The procedure involved injecting a corticosteroid medication directly into the joint to reduce inflammation and alleviate pain. The surgical intervention aimed to provide targeted anti-inflammatory therapy and improve symptom control. Postoperatively, pain management and physical therapy were initiated.

3. Operative Note: Sacroiliitis Sacroiliac Joint Biopsy for Chronic Inflammatory Process Procedure: Sacroiliac joint biopsy was performed under local anesthesia to investigate the underlying cause of a chronic inflammatory process in sacroiliitis. The procedure involved obtaining tissue samples from the joint for pathological examination. The surgical intervention aimed to identify specific inflammatory markers and guide further treatment decisions. Postoperatively, appropriate anti-inflammatory medications and management strategies were implemented.

4. Operative Note: Sacroiliitis Sacroiliac Joint Bursectomy for Bursal Inflammation Procedure: Sacroiliac joint bursectomy was performed under general anesthesia to address bursal inflammation in sacroiliitis. The procedure involved meticulously removing the inflamed bursa surrounding the joint to alleviate pain and reduce inflammation. The surgical intervention aimed to improve symptoms and promote healing. Postoperatively, pain management and physical therapy were initiated.

5. Operative Note: Sacroiliitis Sacroiliac Joint Synovial Biopsy for Synovitis Evaluation Procedure: Sacroiliac joint synovial biopsy was performed under local anesthesia to evaluate synovitis in sacroiliitis. The procedure involved obtaining synovial tissue samples for histopathological examination. The surgical intervention aimed to assess the severity of inflammation and guide further treatment decisions. Postoperatively, appropriate anti-inflammatory medications and management strategies were implemented.

6. Operative Note: Sacroiliitis Sacroiliac Joint Arthroscopy with Synovectomy for Diffuse Inflammation Procedure: Sacroiliac joint arthroscopy with synovectomy was performed under general anesthesia to address diffuse inflammation in sacroiliitis. The procedure involved inserting a small camera and specialized instruments into the joint to visualize and remove inflamed synovial tissue. The surgical intervention aimed to reduce inflammation and improve joint function. Postoperatively, pain management and physical therapy were initiated.

7. Operative Note: Sacroiliitis Sacroiliac Joint Radiofrequency Ablation for Inflammatory Pain Management Procedure: Sacroiliac joint radiofrequency ablation was performed under local anesthesia to manage inflammatory pain in sacroiliitis. The procedure involved using radiofrequency energy to selectively ablate the sensory nerves supplying the joint, reducing pain signals. The surgical intervention aimed to provide targeted pain relief and improve quality of life. Postoperatively, pain management and rehabilitation were initiated.

8. Operative Note: Sacroiliitis Sacroiliac Joint Arthrodesis for Chronic Inflammatory Erosion Procedure: Sacroiliac joint arthrodesis was performed under general anesthesia to address chronic inflammatory erosion in sacroiliitis. The procedure involved meticulously preparing the eroded joint surfaces and using internal fixation to promote fusion and stability. The surgical intervention aimed to alleviate inflammation, restore joint function, and prevent further damage. Postoperatively, appropriate anti-inflammatory medications and rehabilitation were initiated.

9. Operative Note: Sacroiliitis Sacroiliac Joint Lavage for Inflammatory Flare Procedure: Sacroiliac joint lavage was performed under local anesthesia to address an inflammatory flare in sacroiliitis. The procedure involved irrigating the joint with a sterile solution to remove inflammatory debris and reduce inflammation. The surgical intervention aimed to provide immediate relief and improve symptom control. Postoperatively, pain management and physical therapy were initiated.

10. Operative Note: Sacroiliitis Sacroiliac Joint Denervation for Refractory Inflammatory Pain Procedure: Sacroiliac joint denervation was performed under local anesthesia to manage refractory inflammatory pain in sacroiliitis. The procedure involved using specialized needles to disrupt the sensory nerves supplying the joint, providing long-lasting pain relief. The surgical intervention aimed to alleviate inflammation, improve function, and enhance quality of life. Postoperatively, pain management and rehabilitation were initiated.

1. Operative Note: Sacroiliitis Sacroiliac Joint Arthrocentesis for Diagnostic Purposes Procedure: Sacroiliac joint arthrocentesis was performed under local anesthesia to obtain synovial fluid for diagnostic purposes in a suspected case of sacroiliitis. Further management and follow-up will be based on the findings of the synovial fluid analysis. Postoperatively, the patient was instructed to schedule a follow-up appointment for discussion of the results and formulation of an appropriate treatment plan.

2. Operative Note: Sacroiliitis Sacroiliac Joint Corticosteroid Injection for Mild Inflammation Procedure: Sacroiliac joint corticosteroid injection was performed under local anesthesia to manage mild inflammation in sacroiliitis. The patient was advised to monitor their symptoms and report any changes or worsening of pain. A follow-up appointment was scheduled in two weeks to evaluate the response to the injection and discuss further treatment options, including additional injections or physical therapy.

3. Operative Note: Sacroiliitis Sacroiliac Joint Arthroscopy with Synovectomy for Moderate Inflammation Procedure: Sacroiliac joint arthroscopy with synovectomy was performed under general anesthesia to address moderate inflammation in sacroiliitis. The patient was informed about the importance of postoperative rehabilitation and pain management. A follow-up appointment was scheduled in four weeks to assess the patient's progress, monitor pain levels, and determine the need for further interventions or adjustments in the treatment plan.

4. Operative Note: Sacroiliitis Sacroiliac Joint Arthrodesis for Severe Joint Erosion Procedure: Sacroiliac joint arthrodesis was performed under general anesthesia to address severe joint erosion in sacroiliitis. The patient was informed about the expected duration of recovery and the importance of adhering to postoperative instructions. A follow-up appointment was scheduled in six weeks for a comprehensive evaluation of the surgical outcome, assessment of pain levels, and consideration of further rehabilitation and management strategies.

5. Operative Note: Sacroiliitis Sacroiliac Joint Resection and Antibiotic Spacer Placement for Severe Infection Procedure: Sacroiliac joint resection and antibiotic spacer placement were performed under general anesthesia to treat a severe infection in sacroiliitis. The patient was started on appropriate antibiotic therapy and closely monitored for signs of infection resolution. A follow-up appointment was scheduled in two weeks to assess the response to treatment, monitor wound healing, and discuss the possibility of spacer removal and joint reconstruction.

6. Operative Note: Sacroiliitis Sacroiliac Joint Radiofrequency Ablation for Chronic Pain Management Procedure: Sacroiliac joint radiofrequency ablation was performed under local anesthesia to manage chronic pain in sacroiliitis. The patient was advised to keep a pain diary and report any changes or improvements in symptoms. A follow-up appointment was scheduled in four weeks to assess the efficacy of the procedure, evaluate pain levels, and determine the need for additional interventions or adjustments in pain management strategies.

7. Operative Note: Sacroiliitis Sacroiliac Joint Arthroscopy with Debridement for Recurrent Flares Procedure: Sacroiliac joint arthroscopy with debridement was performed under general anesthesia to address recurrent inflammatory flares in sacroiliitis. The patient was educated about triggers and preventive measures to minimize future flares. A follow-up appointment was scheduled in six weeks to evaluate the response to the procedure, discuss the effectiveness of preventive strategies, and consider long-term management options.

8. Operative Note: Sacroiliitis Sacroiliac Joint Fusion Revision for Failed Previous Surgery Procedure: Sacroiliac joint fusion revision was performed under general anesthesia to address a failed previous surgery in sacroiliitis. The patient was informed about the need for extensive rehabilitation and the potential challenges associated with revision surgery. A follow-up appointment was scheduled in eight weeks to assess the fusion progress, monitor pain levels, and discuss further rehabilitation and management options.

9. Operative Note: Sacroiliitis Sacroiliac Joint Denervation for Refractory Pain Procedure: Sacroiliac joint denervation was performed under local anesthesia to manage refractory pain in sacroiliitis. The patient was advised to maintain a pain diary and document changes in symptoms. A follow-up appointment was scheduled in four weeks to evaluate the effectiveness of the procedure, assess pain levels, and discuss additional pain management strategies if necessary.

10. Operative Note: Sacroiliitis Sacroiliac Joint Explantation and Temporary Joint Stabilization for Severe Instability Procedure: Sacroiliac joint explantation and temporary joint stabilization were performed under general anesthesia to address severe joint instability in sacroiliitis. The patient was instructed on the importance of postoperative immobilization and adherence to physical therapy protocols. A follow-up appointment was scheduled in six weeks to assess the stability of the joint, monitor pain levels, and discuss the need for further surgical interventions or long-term joint reconstruction options.

## M46.2 Osteomyelitis of vertebra

1. Operative Note: A laminectomy was performed at L4-L5 to expose the infected vertebrae. Debridement of necrotic bone and abscess drainage were carried out. The affected area was thoroughly irrigated with saline solution. A bone graft was placed to promote healing. Hemostasis was achieved, and the wound was closed in layers. The patient tolerated the procedure well, and postoperative antibiotics were initiated.

2. Operative Note: A posterior approach was utilized to access the infected vertebrae. A laminectomy was performed at T12-L1, exposing the affected area. Necrotic bone and purulent material were meticulously debrided. Copious irrigation with antibiotic solution was performed. A pedicle screw fixation system was utilized for stabilization. Closure was completed without complications, and appropriate postoperative care was initiated.

3. Operative Note: A thoracotomy was performed to access the affected vertebrae. Debridement of necrotic bone and abscess evacuation were carried out. Thorough irrigation with saline solution and antibiotic wash was performed. An anterior cage was placed for structural support. Hemostasis was achieved, and the incision was closed in layers. The patient was transferred to the recovery unit in stable condition.

4. Operative Note: An anterior approach was utilized to access the infected vertebrae. A laparotomy was performed, and the affected area was exposed. Debridement of necrotic bone and abscess drainage were performed meticulously. Irrigation with antibiotic solution was carried out. An interbody cage was inserted for stabilization. Hemostasis was achieved, and the incision was closed. The patient tolerated the procedure well, and postoperative antibiotics were administered.

5. Operative Note: A minimally invasive procedure was performed to address the osteomyelitis of the vertebrae. Using fluoroscopic guidance, percutaneous access was gained to the affected area. Curettage of necrotic bone and abscess evacuation were carried out. The region was irrigated with antibiotic solution. A bone cement mixture was injected for stabilization. The incision site was closed, and appropriate postoperative care was provided.

6. Operative Note: A transforaminal approach was utilized to access the infected vertebrae. Under fluoroscopic guidance, the affected area was identified. Debridement of necrotic bone and abscess drainage were meticulously performed. Copious irrigation with antibiotic solution was carried out. Bone morphogenetic protein was applied for enhanced healing. Hemostasis was achieved, and the incision was closed. The patient's vital signs remained stable throughout the procedure.

7. Operative Note: A posterior midline approach was employed to access the infected vertebrae. Laminectomy was performed at the affected levels, exposing the site. Debridement of necrotic bone and abscess evacuation were carried out. Thorough irrigation with antibiotic solution was performed. Pedicle screw fixation was utilized for stabilization. The wound was closed in layers without any complications. Postoperative pain control and antibiotic therapy were initiated.

8. Operative Note: A lateral extracavitary approach was utilized to access the infected vertebrae. The affected levels were exposed, and meticulous debridement of necrotic bone and abscess evacuation were performed. Irrigation with antibiotic solution was carried out. An expandable titanium cage was placed for structural support. Hemostasis was achieved, and the wound was closed. The patient tolerated the procedure well, and appropriate postoperative precautions were implemented.

9. Operative Note: A combined anterior and posterior approach was employed to address the osteomyelitis of the vertebrae. An anterior thoracotomy was performed to access the affected area and debride necrotic bone. A posterior laminectomy was then carried out for further debridement and abscess evacuation. Thorough irrigation with antibiotic solution was performed. Stabilization was achieved using pedicle screw fixation. The patient was transferred to the intensive care unit postoperatively.

10. Operative Note: A percutaneous minimally invasive approach was employed to address the osteomyelitis of the vertebrae. Under fluoroscopic guidance, access to the affected area was gained. Necrotic bone and abscess evacuation were meticulously performed. The region was irrigated with antibiotic solution. Injectable bone graft material was utilized for stabilization. The procedure was uneventful, and the patient's postoperative recovery was satisfactory.

1. Operative Note: A transpedicular approach was utilized to access the infected vertebrae. Bilateral pedicle screws were inserted, and the lamina was partially removed to expose the affected area. Debridement of necrotic bone and abscess drainage were meticulously performed. Thorough irrigation with antibiotic solution was carried out. A titanium mesh cage was placed for structural support. Hemostasis was achieved, and the wound was closed in layers.

2. Operative Note: A posterior midline approach was employed to access the infected vertebrae. Laminectomy was performed, and the affected levels were exposed. Debridement of necrotic bone and abscess evacuation were meticulously carried out. Copious irrigation with antibiotic solution was performed. Autologous bone graft was harvested and placed for fusion. Closure was completed without complications, and the patient was transferred to the post-anesthesia care unit.

3. Operative Note: An open anterior approach was utilized to address the osteomyelitis of the vertebrae. A transverse incision was made, and the affected levels were exposed. Debridement of necrotic bone and abscess evacuation were meticulously performed. The area was irrigated with antibiotic solution. An interbody fusion cage was inserted, followed by anterior plating for stabilization. The incision was closed, and the patient's vitals remained stable throughout the procedure.

4. Operative Note: A minimally invasive lateral approach was employed to access the infected vertebrae. Using fluoroscopic guidance, a small incision was made, and access to the affected area was achieved. Debridement of necrotic bone and abscess drainage were performed meticulously. Irrigation with antibiotic solution was carried out. An expandable vertebral body replacement device was inserted for stabilization. The incision was closed, and the patient was moved to the recovery area.

5. Operative Note: A combined posterior-anterior approach was utilized to address the osteomyelitis of the vertebrae. Posteriorly, a midline incision was made, and laminectomy was performed to expose the affected levels. Debridement of necrotic bone and abscess evacuation were meticulously carried out. Anteriorly, a retroperitoneal approach was used to access the vertebral body for further debridement and irrigation. An anterior cage was inserted, followed by posterior pedicle screw fixation. Closure was completed without complications.

6. Operative Note: A percutaneous endoscopic approach was employed to address the osteomyelitis of the vertebrae. Under fluoroscopic guidance, access to the affected levels was achieved using small incisions. Necrotic bone and abscess evacuation were meticulously performed using endoscopic instruments. Thorough irrigation with antibiotic solution was carried out. No complications were encountered, and the patient's pain was well-controlled postoperatively.

7. Operative Note: A posterolateral approach was utilized to access the infected vertebrae. A small incision was made, and the affected levels were exposed. Debridement of necrotic bone and abscess evacuation were meticulously performed. The area was thoroughly irrigated with antibiotic solution. A local muscle flap was used for soft tissue coverage. Hemostasis was achieved, and the wound was closed in layers. The patient was transferred to the surgical intensive care unit for monitoring.

8. Operative Note: A percutaneous image-guided approach was employed to address the osteomyelitis of the vertebrae. Under computed tomography guidance, access to the affected area was gained using needle punctures. Debridement of necrotic bone and abscess drainage were meticulously performed. Irrigation with antibiotic solution was carried out. No intraoperative complications occurred, and the patient was transferred to the post-anesthesia care unit in stable condition.

9. Operative Note: A lateral retropleural approach was utilized to access the infected vertebrae. The ribs were sequentially removed, and the affected levels were exposed. Debridement of necrotic bone and abscess evacuation were meticulously performed. Thorough irrigation with antibiotic solution was carried out. An allograft bone strut was placed for structural support. Hemostasis was achieved, and the incision was closed. The patient tolerated the procedure well and was transferred to the ward for further care.

10. Operative Note: A transoral approach was employed to address the osteomyelitis of the vertebrae. An incision was made in the oral cavity, and the affected levels were accessed. Debridement of necrotic bone and abscess evacuation were meticulously performed. Copious irrigation with antibiotic solution was carried out. An anterior cage was placed for stabilization. The incision was closed, and the patient was monitored closely postoperatively for any signs of airway compromise.

1. Operative Note: A posterior approach was utilized to access the infected vertebrae. General anesthesia was induced with intravenous propofol (150 mg) and maintained with sevoflurane in oxygen and nitrous oxide. A laminectomy was performed, exposing the affected area. Debridement of necrotic bone and abscess evacuation were meticulously carried out. Copious irrigation with antibiotic solution was performed. Pedicle screw fixation was used for stabilization. The patient's vitals remained stable throughout the procedure.

2. Operative Note: A minimally invasive lateral approach was employed to address the osteomyelitis of the vertebrae. The patient received spinal anesthesia with 10 mg of hyperbaric bupivacaine at the L3-L4 level. A small incision was made, and access to the affected area was achieved. Debridement of necrotic bone and abscess drainage were meticulously performed. Thorough irrigation with antibiotic solution was carried out. An expandable vertebral body replacement device was inserted for stabilization. The incision was closed without complications.

3. Operative Note: A combined anterior and posterior approach was utilized to address the osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (150 mcg) and sevoflurane inhalation. An anterior thoracotomy was performed for debridement of necrotic bone and abscess evacuation. A posterior laminectomy was then carried out. Thorough irrigation with antibiotic solution was performed. Anterior interbody cage placement and posterior pedicle screw fixation were performed. The patient remained stable throughout the procedure.

4. Operative Note: A percutaneous endoscopic approach was employed to address the osteomyelitis of the vertebrae. The patient received monitored anesthesia care with intravenous midazolam (2 mg) and remifentanil infusion (0.1 mcg/kg/min). Under fluoroscopic guidance, access to the affected levels was achieved using small incisions. Debridement of necrotic bone and abscess evacuation were meticulously performed using endoscopic instruments. Thorough irrigation with antibiotic solution was carried out. No complications were encountered.

5. Operative Note: A transpedicular approach was utilized to access the infected vertebrae. The patient received combined spinal-epidural anesthesia with intrathecal injection of 0.5% hyperbaric bupivacaine (10 mg) and epidural infusion of 0.125% bupivacaine with fentanyl (2 mcg/mL). Bilateral pedicle screws were inserted, and the lamina was partially removed to expose the affected area. Debridement of necrotic bone and abscess drainage were meticulously performed. Thorough irrigation with antibiotic solution was carried out. A titanium mesh cage was placed for stabilization.

6. Operative Note: A lateral retropleural approach was employed to access the infected vertebrae. The patient received general anesthesia with endotracheal intubation using propofol (200 mg) and rocuronium (50 mg). The ribs were sequentially removed, and the affected levels were exposed. Debridement of necrotic bone and abscess evacuation were meticulously performed. Thorough irrigation with antibiotic solution was carried out. An allograft bone strut was placed for structural support. Hemostasis was achieved, and the incision was closed.

7. Operative Note: A combined posterior-anterior approach was utilized to address the osteomyelitis of the vertebrae. The patient received regional anesthesia with thoracic epidural catheter placement and infusion of bupivacaine (0.25%, 10 mL). Posteriorly, a midline incision was made, and laminectomy was performed to expose the affected levels. Debridement of necrotic bone and abscess evacuation were meticulously carried out. Anteriorly, a retroperitoneal approach was used for further debridement and irrigation. An anterior cage was inserted, followed by posterior pedicle screw fixation. The patient remained stable throughout the procedure.

8. Operative Note: A transoral approach was employed to address the osteomyelitis of the vertebrae. The patient received general anesthesia with endotracheal intubation using propofol (150 mg) and fentanyl (100 mcg). An incision was made in the oral cavity, and the affected levels were accessed. Debridement of necrotic bone and abscess evacuation were meticulously performed. Copious irrigation with antibiotic solution was carried out. An anterior cage was placed for stabilization. The incision was closed, and the patient's vitals remained stable throughout the procedure.

9. Operative Note: A posterior approach was utilized to access the infected vertebrae. The patient received regional anesthesia with thoracic epidural catheter placement and infusion of ropivacaine (0.2%, 10 mL/h) and sufentanil (2 mcg/h). A laminectomy was performed, exposing the affected area. Debridement of necrotic bone and abscess evacuation were meticulously carried out. Copious irrigation with antibiotic solution was performed. Pedicle screw fixation was used for stabilization. The patient's vitals remained stable throughout the procedure.

10. Operative Note: A minimally invasive lateral approach was employed to address the osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous remifentanil infusion (0.1 mcg/kg/min) and sevoflurane inhalation. Spinal anesthesia was also administered with hyperbaric bupivacaine (10 mg). A small incision was made, and access to the affected area was achieved. Debridement of necrotic bone and abscess drainage were meticulously performed. Thorough irrigation with antibiotic solution was carried out. An expandable vertebral body replacement device was inserted for stabilization.

1. Operative Note: A posterior approach was utilized to access the infected vertebrae with extensive bone erosion. General anesthesia was induced with intravenous propofol (150 mg) and maintained with sevoflurane in oxygen and nitrous oxide. A laminectomy was performed, exposing the eroded vertebra. Debridement of necrotic bone and abscess evacuation were meticulously carried out. Copious irrigation with antibiotic solution was performed. Pedicle screw fixation was used for stabilization. The patient's vitals remained stable throughout the procedure.

2. Operative Note: A minimally invasive lateral approach was employed to address the osteomyelitis of the vertebrae with significant bone erosion. The patient received spinal anesthesia with 10 mg of hyperbaric bupivacaine at the L3-L4 level. A small incision was made, and access to the eroded area was achieved. Debridement of necrotic bone and abscess drainage were meticulously performed. Thorough irrigation with antibiotic solution was carried out. An expandable vertebral body replacement device was inserted for stabilization. The incision was closed without complications.

3. Operative Note: A combined anterior and posterior approach was utilized to address the osteomyelitis of the vertebrae with extensive bone erosion. The patient received general anesthesia with intravenous fentanyl (150 mcg) and sevoflurane inhalation. An anterior thoracotomy was performed for debridement of necrotic bone and abscess evacuation. A posterior laminectomy was then carried out. Thorough irrigation with antibiotic solution was performed. Anterior interbody cage placement and posterior pedicle screw fixation were performed. The patient remained stable throughout the procedure.

4. Operative Note: A percutaneous endoscopic approach was employed to address the osteomyelitis of the vertebrae with bone erosion. The patient received monitored anesthesia care with intravenous midazolam (2 mg) and remifentanil infusion (0.1 mcg/kg/min). Under fluoroscopic guidance, access to the eroded levels was achieved using small incisions. Debridement of necrotic bone and abscess evacuation were meticulously performed using endoscopic instruments. Thorough irrigation with antibiotic solution was carried out. No complications were encountered.

5. Operative Note: A transpedicular approach was utilized to access the infected vertebrae with significant bone erosion. The patient received combined spinal-epidural anesthesia with intrathecal injection of 0.5% hyperbaric bupivacaine (10 mg) and epidural infusion of 0.125% bupivacaine with fentanyl (2 mcg/mL). Bilateral pedicle screws were inserted, and the lamina was partially removed to expose the eroded area. Debridement of necrotic bone and abscess drainage were meticulously performed. Thorough irrigation with antibiotic solution was carried out. A titanium mesh cage was placed for stabilization.

6. Operative Note: A lateral retropleural approach was employed to access the infected vertebrae with extensive bone erosion. The patient received general anesthesia with endotracheal intubation using propofol (200 mg) and rocuronium (50 mg). The ribs were sequentially removed, and the eroded levels were exposed. Debridement of necrotic bone and abscess evacuation were meticulously performed. Thorough irrigation with antibiotic solution was carried out. An allograft bone strut was placed for structural support. Hemostasis was achieved, and the incision was closed.

7. Operative Note: A combined posterior-anterior approach was utilized to address the osteomyelitis of the vertebrae with significant bone erosion. The patient received regional anesthesia with thoracic epidural catheter placement and infusion of bupivacaine (0.25%, 10 mL). Posteriorly, a midline incision was made, and laminectomy was performed to expose the eroded levels. Debridement of necrotic bone and abscess evacuation were meticulously carried out. Anteriorly, a retroperitoneal approach was used for further debridement and irrigation. An anterior cage was inserted, followed by posterior pedicle screw fixation. The patient remained stable throughout the procedure.

8. Operative Note: A transoral approach was employed to address the osteomyelitis of the vertebrae with bone erosion. The patient received general anesthesia with endotracheal intubation using propofol (150 mg) and fentanyl (100 mcg). An incision was made in the oral cavity, and the eroded levels were accessed. Debridement of necrotic bone and abscess evacuation were meticulously performed. Copious irrigation with antibiotic solution was carried out. An anterior cage was placed for stabilization. The incision was closed, and the patient's vitals remained stable throughout the procedure.

9. Operative Note: A posterior approach was utilized to access the infected vertebrae with extensive bone erosion. The patient received regional anesthesia with thoracic epidural catheter placement and infusion of ropivacaine (0.2%, 10 mL/h) and sufentanil (2 mcg/h). A laminectomy was performed, exposing the eroded area. Debridement of necrotic bone and abscess evacuation were meticulously carried out. Copious irrigation with antibiotic solution was performed. Pedicle screw fixation was used for stabilization. The patient's vitals remained stable throughout the procedure.

10. Operative Note: A minimally invasive lateral approach was employed to address the osteomyelitis of the vertebrae with significant bone erosion. The patient received general anesthesia with intravenous remifentanil infusion (0.1 mcg/kg/min) and sevoflurane inhalation. Spinal anesthesia was also administered with hyperbaric bupivacaine (10 mg). A small incision was made, and access to the eroded area was achieved. Debridement of necrotic bone and abscess drainage were meticulously performed. Thorough irrigation with antibiotic solution was carried out. An expandable vertebral body replacement device was inserted for stabilization.

1. Operative Note: A posterior approach was utilized to address the severe bone pain caused by osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (150 mcg) and sevoflurane inhalation. A laminectomy was performed, exposing the affected levels. Debridement of necrotic bone and abscess evacuation were meticulously carried out. Copious irrigation with antibiotic solution was performed to alleviate the source of severe pain. Pedicle screw fixation was used for stabilization. The patient's vitals remained stable throughout the procedure.

2. Operative Note: A minimally invasive lateral approach was employed to alleviate the severe bone pain caused by osteomyelitis of the vertebrae. The patient received spinal anesthesia with 10 mg of hyperbaric bupivacaine at the L3-L4 level. A small incision was made, and access to the affected area was achieved. Debridement of necrotic bone and abscess drainage were meticulously performed to relieve the severe pain. Thorough irrigation with antibiotic solution was carried out. An expandable vertebral body replacement device was inserted for stabilization. The incision was closed without complications.

3. Operative Note: A combined anterior and posterior approach was utilized to address the severe bone pain associated with osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (150 mcg) and sevoflurane inhalation. An anterior thoracotomy was performed for debridement of necrotic bone and abscess evacuation to alleviate the severe pain. A posterior laminectomy was then carried out. Thorough irrigation with antibiotic solution was performed. Anterior interbody cage placement and posterior pedicle screw fixation were performed. The patient remained stable throughout the procedure.

4. Operative Note: A percutaneous endoscopic approach was employed to alleviate the severe bone pain caused by osteomyelitis of the vertebrae. The patient received monitored anesthesia care with intravenous midazolam (2 mg) and remifentanil infusion (0.1 mcg/kg/min). Under fluoroscopic guidance, access to the affected levels was achieved using small incisions. Debridement of necrotic bone and abscess evacuation were meticulously performed using endoscopic instruments to relieve the severe pain. Thorough irrigation with antibiotic solution was carried out. No complications were encountered.

5. Operative Note: A transpedicular approach was utilized to address the severe bone pain associated with osteomyelitis of the vertebrae. The patient received combined spinal-epidural anesthesia with intrathecal injection of 0.5% hyperbaric bupivacaine (10 mg) and epidural infusion of 0.125% bupivacaine with fentanyl (2 mcg/mL). Bilateral pedicle screws were inserted, and the lamina was partially removed to expose the affected area and alleviate the severe pain. Debridement of necrotic bone and abscess drainage were meticulously performed. Thorough irrigation with antibiotic solution was carried out. A titanium mesh cage was placed for stabilization.

6. Operative Note: A lateral retropleural approach was employed to address the severe bone pain caused by osteomyelitis of the vertebrae. The patient received general anesthesia with endotracheal intubation using propofol (200 mg) and rocuronium (50 mg). The ribs were sequentially removed, and the affected levels were exposed. Debridement of necrotic bone and abscess evacuation were meticulously performed to relieve the severe pain. Thorough irrigation with antibiotic solution was carried out. An allograft bone strut was placed for structural support. Hemostasis was achieved, and the incision was closed.

7. Operative Note: A combined posterior-anterior approach was utilized to address the severe bone pain associated with osteomyelitis of the vertebrae. The patient received regional anesthesia with thoracic epidural catheter placement and infusion of bupivacaine (0.25%, 10 mL). Posteriorly, a midline incision was made, and laminectomy was performed to expose the affected levels and alleviate the severe pain. Debridement of necrotic bone and abscess evacuation were meticulously carried out. Anteriorly, a retroperitoneal approach was used for further debridement and irrigation. An anterior cage was inserted, followed by posterior pedicle screw fixation. The patient remained stable throughout the procedure.

8. Operative Note: A transoral approach was employed to address the severe bone pain caused by osteomyelitis of the vertebrae. The patient received general anesthesia with endotracheal intubation using propofol (150 mg) and fentanyl (100 mcg). An incision was made in the oral cavity, and the affected levels were accessed to alleviate the severe pain. Debridement of necrotic bone and abscess evacuation were meticulously performed. Copious irrigation with antibiotic solution was carried out. An anterior cage was placed for stabilization. The incision was closed, and the patient's vitals remained stable throughout the procedure.

9. Operative Note: A posterior approach was utilized to address the severe bone pain associated with osteomyelitis of the vertebrae. The patient received regional anesthesia with thoracic epidural catheter placement and infusion of ropivacaine (0.2%, 10 mL/h) and sufentanil (2 mcg/h). A laminectomy was performed, exposing the affected area to alleviate the severe pain. Debridement of necrotic bone and abscess evacuation were meticulously carried out. Copious irrigation with antibiotic solution was performed. Pedicle screw fixation was used for stabilization. The patient's vitals remained stable throughout the procedure.

10. Operative Note: A minimally invasive lateral approach was employed to address the severe bone pain caused by osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous remifentanil infusion (0.1 mcg/kg/min) and sevoflurane inhalation. Spinal anesthesia was also administered with hyperbaric bupivacaine (10 mg). A small incision was made, and access to the affected area was achieved to alleviate the severe pain. Debridement of necrotic bone and abscess drainage were meticulously performed. Thorough irrigation with antibiotic solution was carried out. An expandable vertebral body replacement device was inserted for stabilization.

1. Operative Note: A posterior approach with surgical intervention was utilized to address the severe bone pain caused by osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (150 mcg) and sevoflurane inhalation. A laminectomy was performed, exposing the affected levels. Surgical debridement of necrotic bone and abscess evacuation were meticulously carried out. Copious irrigation with antibiotic solution was performed. Pedicle screw fixation and bone grafting were performed to restore stability and promote healing. The patient's vitals remained stable throughout the procedure.

2. Operative Note: A combined anterior and posterior approach with surgical intervention was employed to address the severe bone pain associated with osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (150 mcg) and sevoflurane inhalation. An anterior thoracotomy was performed for surgical debridement of necrotic bone and abscess evacuation. Posteriorly, a laminectomy was carried out. Thorough irrigation with antibiotic solution was performed. Anterior interbody cage placement, posterior pedicle screw fixation, and bone grafting were performed to stabilize the spine. The patient remained stable throughout the procedure.

3. Operative Note: A percutaneous endoscopic approach with surgical intervention was employed to alleviate the severe bone pain caused by osteomyelitis of the vertebrae. The patient received monitored anesthesia care with intravenous midazolam (2 mg) and remifentanil infusion (0.1 mcg/kg/min). Under fluoroscopic guidance, access to the affected levels was achieved using small incisions. Surgical debridement of necrotic bone and abscess evacuation were meticulously performed using endoscopic instruments. Thorough irrigation with antibiotic solution was carried out. Additional surgical intervention included placement of antibiotic-impregnated bone cement and local bone grafting for enhanced healing.

4. Operative Note: A transpedicular approach with surgical intervention was utilized to address the severe bone pain associated with osteomyelitis of the vertebrae. The patient received combined spinal-epidural anesthesia with intrathecal injection of 0.5% hyperbaric bupivacaine (10 mg) and epidural infusion of 0.125% bupivacaine with fentanyl (2 mcg/mL). Bilateral pedicle screws were inserted, and the lamina was partially removed to expose the affected area. Surgical debridement of necrotic bone and abscess drainage were meticulously performed. Thorough irrigation with antibiotic solution was carried out. Placement of an intervertebral cage and local bone grafting were performed for structural support and fusion.

5. Operative Note: A lateral retropleural approach with surgical intervention was employed to address the severe bone pain caused by osteomyelitis of the vertebrae. The patient received general anesthesia with endotracheal intubation using propofol (200 mg) and rocuronium (50 mg). The ribs were sequentially removed, and the affected levels were exposed. Surgical debridement of necrotic bone and abscess evacuation were meticulously performed. Thorough irrigation with antibiotic solution was carried out. Additional surgical intervention included the use of an allograft bone strut and posterior instrumentation for stabilization and fusion. Hemostasis was achieved, and the incision was closed.

6. Operative Note: A combined posterior-anterior approach with surgical intervention was utilized to address the severe bone pain associated with osteomyelitis of the vertebrae. The patient received regional anesthesia with thoracic epidural catheter placement and infusion of bupivacaine (0.25%, 10 mL). Posteriorly, a midline incision was made, and laminectomy was performed to expose the affected levels. Surgical debridement of necrotic bone and abscess evacuation were meticulously carried out. Anteriorly, a retroperitoneal approach was used for further surgical debridement and irrigation. An anterior cage was inserted, followed by posterior pedicle screw fixation and bone grafting. The patient remained stable throughout the procedure.

7. Operative Note: A transoral approach with surgical intervention was employed to address the severe bone pain caused by osteomyelitis of the vertebrae. The patient received general anesthesia with endotracheal intubation using propofol (150 mg) and fentanyl (100 mcg). An incision was made in the oral cavity, and the affected levels were accessed. Surgical debridement of necrotic bone and abscess evacuation were meticulously performed. Copious irrigation with antibiotic solution was carried out. An anterior cage was placed, followed by posterior instrumentation and bone grafting to stabilize the spine. The incision was closed, and the patient's vitals remained stable throughout the procedure.

8. Operative Note: A posterior approach with surgical intervention was utilized to address the severe bone pain associated with osteomyelitis of the vertebrae. The patient received regional anesthesia with thoracic epidural catheter placement and infusion of ropivacaine (0.2%, 10 mL/h) and sufentanil (2 mcg/h). A laminectomy was performed, exposing the affected area. Surgical debridement of necrotic bone and abscess evacuation were meticulously carried out. Copious irrigation with antibiotic solution was performed. Additional surgical intervention included posterior pedicle screw fixation, bone grafting, and the application of a local antibiotic carrier to enhance infection control. The patient's vitals remained stable throughout the procedure.

9. Operative Note: A minimally invasive lateral approach with surgical intervention was employed to address the severe bone pain caused by osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous remifentanil infusion (0.1 mcg/kg/min) and sevoflurane inhalation. Spinal anesthesia was also administered with hyperbaric bupivacaine (10 mg). A small incision was made, and access to the affected area was achieved. Surgical debridement of necrotic bone and abscess drainage were meticulously performed. Thorough irrigation with antibiotic solution was carried out. An expandable vertebral body replacement device was inserted, followed by posterior instrumentation and bone grafting. The incision was closed, and the patient's vitals remained stable throughout the procedure.

10. Operative Note: A posterior approach with surgical intervention was utilized to address the severe bone pain associated with osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (150 mcg) and sevoflurane inhalation. A laminectomy was performed, exposing the affected levels. Surgical debridement of necrotic bone and abscess evacuation were meticulously carried out. Copious irrigation with antibiotic solution was performed. Additional surgical intervention included posterior pedicle screw fixation, bone grafting, and the placement of a titanium mesh cage to restore stability and facilitate fusion. The patient's vitals remained stable throughout the procedure.

1. Operative Note: A transforaminal approach with surgical intervention was employed to address the severe bone pain caused by osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (100 mcg) and sevoflurane inhalation. Under fluoroscopic guidance, access to the affected levels was achieved through a small incision. Surgical debridement of necrotic bone and abscess evacuation were meticulously performed. Thorough irrigation with antibiotic solution was carried out. Additional surgical intervention included the insertion of bone cement and posterior instrumentation for stabilization. The patient tolerated the procedure well without any complications.

2. Operative Note: A posterior midline approach with surgical intervention was utilized to address the severe bone pain associated with osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (150 mcg) and sevoflurane inhalation. A laminectomy was performed, exposing the affected levels. Surgical debridement of necrotic bone and abscess evacuation were meticulously carried out. Copious irrigation with antibiotic solution was performed. Additional surgical intervention included the insertion of an expandable titanium cage and posterior pedicle screw fixation for stabilization. The patient remained hemodynamically stable throughout the procedure.

3. Operative Note: A lateral transpsoas approach with surgical intervention was employed to address the severe bone pain caused by osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (100 mcg) and sevoflurane inhalation. Through a small incision, access to the affected levels was achieved. Surgical debridement of necrotic bone and abscess evacuation were meticulously performed. Thorough irrigation with antibiotic solution was carried out. Additional surgical intervention included interbody fusion with an allograft bone and posterior instrumentation for stabilization. The patient tolerated the procedure well without any perioperative complications.

4. Operative Note: A combined anterior-posterior approach with surgical intervention was utilized to address the severe bone pain associated with osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (150 mcg) and sevoflurane inhalation. Anteriorly, an open thoracotomy was performed for surgical debridement of necrotic bone and abscess evacuation. Posteriorly, a midline incision was made, and laminectomy was performed to expose the affected levels. Thorough irrigation with antibiotic solution was performed. Additional surgical intervention included the placement of an anterior cage, posterior pedicle screw fixation, and bone grafting for stabilization. The patient's vitals remained stable throughout the procedure.

5. Operative Note: A percutaneous transpedicular approach with surgical intervention was employed to alleviate the severe bone pain caused by osteomyelitis of the vertebrae. The patient received monitored anesthesia care with intravenous midazolam (2 mg) and remifentanil infusion (0.05 mcg/kg/min). Under fluoroscopic guidance, access to the affected levels was achieved using percutaneous incisions. Surgical debridement of necrotic bone and abscess evacuation were meticulously performed with the assistance of endoscopic instruments. Thorough irrigation with antibiotic solution was carried out. Additional surgical intervention included the placement of bone cement and percutaneous pedicle screw fixation for stabilization. The patient tolerated the procedure well with minimal intraoperative complications.

6. Operative Note: A minimally invasive lateral retropleural approach with surgical intervention was utilized to address the severe bone pain associated with osteomyelitis of the vertebrae. The patient received general anesthesia with endotracheal intubation using propofol (150 mg) and fentanyl (100 mcg). The affected levels were accessed through a small incision, and surgical debridement of necrotic bone and abscess evacuation were meticulously performed. Thorough irrigation with antibiotic solution was carried out. Additional surgical intervention included the placement of a lateral interbody cage and posterior pedicle screw fixation for stabilization. The patient's vitals remained stable throughout the procedure.

7. Operative Note: A posterior approach with surgical intervention was employed to address the severe bone pain caused by osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (100 mcg) and sevoflurane inhalation. A laminectomy was performed, exposing the affected levels. Surgical debridement of necrotic bone and abscess evacuation were meticulously carried out. Copious irrigation with antibiotic solution was performed. Additional surgical intervention included posterior pedicle screw fixation, bone grafting, and the application of local vancomycin powder to enhance infection control. The patient tolerated the procedure well without any significant complications.

8. Operative Note: A combined anterior and posterior approach with surgical intervention was utilized to address the severe bone pain associated with osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (150 mcg) and sevoflurane inhalation. An anterior thoracotomy was performed for surgical debridement of necrotic bone and abscess evacuation. Posteriorly, a midline incision was made, and laminectomy was performed to expose the affected levels. Thorough irrigation with antibiotic solution was performed. Additional surgical intervention included the placement of an anterior interbody cage, posterior pedicle screw fixation, and bone grafting for stabilization. The patient's vitals remained stable throughout the procedure.

9. Operative Note: A lateral transpsoas approach with surgical intervention was employed to address the severe bone pain caused by osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (100 mcg) and sevoflurane inhalation. Through a small incision, access to the affected levels was achieved. Surgical debridement of necrotic bone and abscess evacuation were meticulously performed. Thorough irrigation with antibiotic solution was carried out. Additional surgical intervention included interbody fusion with an expandable cage and posterior pedicle screw fixation for stabilization. The patient tolerated the procedure well without any perioperative complications.

10. Operative Note: A posterior midline approach with surgical intervention was utilized to address the severe bone pain associated with osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (150 mcg) and sevoflurane inhalation. A laminectomy was performed, exposing the affected levels. Surgical debridement of necrotic bone and abscess evacuation were meticulously carried out. Copious irrigation with antibiotic solution was performed. Additional surgical intervention included posterior pedicle screw fixation, bone grafting, and the application of local antibiotic-impregnated collagen sponges. The patient's vitals remained stable throughout the procedure.

1. Operative Note: A surgical intervention was performed to address the severe infection on the extreme moving joint caused by osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (150 mcg) and sevoflurane inhalation. An arthrotomy was performed, exposing the infected joint. Thorough debridement of necrotic bone and abscess evacuation were meticulously carried out. Copious irrigation with antibiotic solution was performed. Additional surgical intervention included the removal of infected joint components and the placement of antibiotic-impregnated cement spacers. The wound was closed, and the patient's vitals remained stable throughout the procedure.

2. Operative Note: A joint debridement procedure with surgical intervention was employed to address the severe infection on the extreme moving joint caused by osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (100 mcg) and sevoflurane inhalation. A surgical incision was made, providing access to the infected joint. Thorough debridement of necrotic bone and abscess evacuation were meticulously performed. Copious irrigation with antibiotic solution was carried out. Additional surgical intervention included the application of negative pressure wound therapy and the administration of intra-articular antibiotics. The patient tolerated the procedure well with minimal complications.

3. Operative Note: A joint exploration and irrigation procedure with surgical intervention was performed to address the severe infection on the extreme moving joint caused by osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (100 mcg) and sevoflurane inhalation. An arthrotomy was performed, providing direct access to the infected joint. Thorough debridement of necrotic bone and abscess evacuation were meticulously carried out. Copious irrigation with antibiotic solution was performed. Additional surgical intervention included the insertion of antibiotic-impregnated beads and the placement of a temporary external fixator for joint stability. The patient's vitals remained stable throughout the procedure.

4. Operative Note: A joint arthroscopy with surgical intervention was employed to address the severe infection on the extreme moving joint caused by osteomyelitis of the vertebrae. The patient received regional anesthesia with a femoral nerve block and intravenous sedation using midazolam (2 mg). Arthroscopic portals were established, allowing visualization of the infected joint. Thorough debridement of necrotic bone and abscess evacuation were meticulously performed. Copious irrigation with antibiotic solution was carried out. Additional surgical intervention included the insertion of antibiotic-impregnated collagen sponges and the application of intra-articular antibiotics. The patient tolerated the procedure well with minimal postoperative pain.

5. Operative Note: A joint fusion procedure with surgical intervention was utilized to address the severe infection on the extreme moving joint caused by osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (150 mcg) and sevoflurane inhalation. An arthrotomy was performed, exposing the infected joint surfaces. Thorough debridement of necrotic bone and abscess evacuation were meticulously carried out. Copious irrigation with antibiotic solution was performed. Additional surgical intervention included the placement of bone grafts and internal fixation with plates and screws for joint stabilization. The patient's vitals remained stable throughout the procedure.

6. Operative Note: A joint resurfacing procedure with surgical intervention was employed to address the severe infection on the extreme moving joint caused by osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (100 mcg) and sevoflurane inhalation. An arthrotomy was performed, exposing the infected joint surfaces. Thorough debridement of necrotic bone and abscess evacuation were meticulously performed. Copious irrigation with antibiotic solution was carried out. Additional surgical intervention included the placement of a metal-on-metal joint implant and the administration of systemic antibiotics. The patient tolerated the procedure well with satisfactory joint mobility.

7. Operative Note: A joint salvage procedure with surgical intervention was performed to address the severe infection on the extreme moving joint caused by osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (150 mcg) and sevoflurane inhalation. An arthrotomy was performed, providing direct access to the infected joint. Thorough debridement of necrotic bone and abscess evacuation were meticulously carried out. Copious irrigation with antibiotic solution was performed. Additional surgical intervention included the placement of an antibiotic-impregnated spacer and the application of negative pressure wound therapy. The patient's vitals remained stable throughout the procedure.

8. Operative Note: A joint resection and reconstruction procedure with surgical intervention was employed to address the severe infection on the extreme moving joint caused by osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (100 mcg) and sevoflurane inhalation. An arthrotomy was performed, providing access to the infected joint. Thorough debridement of necrotic bone and abscess evacuation were meticulously carried out. Copious irrigation with antibiotic solution was performed. Additional surgical intervention included the excision of infected joint components and the reconstruction with a custom-made prosthesis. The patient tolerated the procedure well with improved joint functionality.

9. Operative Note: A joint amputation procedure with surgical intervention was utilized to address the severe infection on the extreme moving joint caused by osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (150 mcg) and sevoflurane inhalation. An amputation incision was made, providing adequate exposure of the infected joint. Thorough debridement of necrotic bone and abscess evacuation were meticulously performed. Copious irrigation with antibiotic solution was carried out. Additional surgical intervention included the placement of a temporary antibiotic-impregnated cement spacer. The wound was closed, and the patient's vitals remained stable throughout the procedure.

10. Operative Note: A joint debridement and external fixation procedure with surgical intervention was employed to address the severe infection on the extreme moving joint caused by osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (100 mcg) and sevoflurane inhalation. An arthrotomy was performed, providing direct access to the infected joint. Thorough debridement of necrotic bone and abscess evacuation were meticulously performed. Copious irrigation with antibiotic solution was performed. Additional surgical intervention included the placement of an external fixator for joint stabilization and the administration of intravenous antibiotics. The patient tolerated the procedure well with satisfactory wound healing.

1. Operative Note: A surgical intervention was performed to address the severe inflammation and infection on the extreme moving joint caused by osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (150 mcg) and sevoflurane inhalation. An arthrotomy was performed, exposing the inflamed joint. Thorough debridement of necrotic bone and abscess evacuation were meticulously carried out. Copious irrigation with antibiotic solution was performed. Additional surgical intervention included the placement of antibiotic-impregnated beads and the application of anti-inflammatory agents intraoperatively. The wound was closed, and the patient's vitals remained stable throughout the procedure.

2. Operative Note: A joint debridement procedure with surgical intervention was employed to address the severe inflammation and infection on the extreme moving joint caused by osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (100 mcg) and sevoflurane inhalation. A surgical incision was made, providing access to the inflamed joint. Thorough debridement of necrotic bone and abscess evacuation were meticulously carried out. Copious irrigation with antibiotic solution was performed. Additional surgical intervention included the application of anti-inflammatory agents and the administration of intra-articular steroids to reduce inflammation. The patient tolerated the procedure well with minimal complications.

3. Operative Note: A joint exploration and irrigation procedure with surgical intervention was performed to address the severe inflammation and infection on the extreme moving joint caused by osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (100 mcg) and sevoflurane inhalation. An arthrotomy was performed, providing direct access to the inflamed joint. Thorough debridement of necrotic bone and abscess evacuation were meticulously carried out. Copious irrigation with antibiotic solution was performed. Additional surgical intervention included the insertion of anti-inflammatory agents and the application of local corticosteroid injections to reduce inflammation. The patient's vitals remained stable throughout the procedure.

4. Operative Note: A joint arthroscopy with surgical intervention was employed to address the severe inflammation and infection on the extreme moving joint caused by osteomyelitis of the vertebrae. The patient received regional anesthesia with a femoral nerve block and intravenous sedation using midazolam (2 mg). Arthroscopic portals were established, allowing visualization of the inflamed joint. Thorough debridement of necrotic bone and abscess evacuation were meticulously performed. Copious irrigation with antibiotic solution was carried out. Additional surgical intervention included the insertion of anti-inflammatory agents and the application of intra-articular corticosteroids to reduce inflammation. The patient tolerated the procedure well with minimal postoperative pain.

5. Operative Note: A joint fusion procedure with surgical intervention was utilized to address the severe inflammation and infection on the extreme moving joint caused by osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (150 mcg) and sevoflurane inhalation. An arthrotomy was performed, exposing the inflamed joint surfaces. Thorough debridement of necrotic bone and abscess evacuation were meticulously carried out. Copious irrigation with antibiotic solution was performed. Additional surgical intervention included the placement of bone grafts and internal fixation with plates and screws for joint stabilization. The patient's vitals remained stable throughout the procedure.

6. Operative Note: A joint resurfacing procedure with surgical intervention was employed to address the severe inflammation and infection on the extreme moving joint caused by osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (100 mcg) and sevoflurane inhalation. An arthrotomy was performed, exposing the inflamed joint surfaces. Thorough debridement of necrotic bone and abscess evacuation were meticulously performed. Copious irrigation with antibiotic solution was carried out. Additional surgical intervention included the placement of a metal-on-metal joint implant and the administration of anti-inflammatory agents to reduce inflammation. The patient tolerated the procedure well with improved joint functionality.

7. Operative Note: A joint salvage procedure with surgical intervention was performed to address the severe inflammation and infection on the extreme moving joint caused by osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (150 mcg) and sevoflurane inhalation. An arthrotomy was performed, providing direct access to the inflamed joint. Thorough debridement of necrotic bone and abscess evacuation were meticulously carried out. Copious irrigation with antibiotic solution was performed. Additional surgical intervention included the placement of an antibiotic-impregnated spacer and the application of anti-inflammatory agents intraoperatively. The patient's vitals remained stable throughout the procedure.

8. Operative Note: A joint resection and reconstruction procedure with surgical intervention was employed to address the severe inflammation and infection on the extreme moving joint caused by osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (100 mcg) and sevoflurane inhalation. An arthrotomy was performed, providing access to the inflamed joint. Thorough debridement of necrotic bone and abscess evacuation were meticulously carried out. Copious irrigation with antibiotic solution was performed. Additional surgical intervention included the excision of inflamed joint components and the reconstruction with a custom-made prosthesis. The patient tolerated the procedure well with improved joint functionality.

9. Operative Note: A joint amputation procedure with surgical intervention was utilized to address the severe inflammation and infection on the extreme moving joint caused by osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (150 mcg) and sevoflurane inhalation. An amputation incision was made, providing adequate exposure of the inflamed joint. Thorough debridement of necrotic bone and abscess evacuation were meticulously performed. Copious irrigation with antibiotic solution was carried out. Additional surgical intervention included the placement of a temporary antibiotic-impregnated cement spacer and the application of anti-inflammatory agents. The wound was closed, and the patient's vitals remained stable throughout the procedure.

10. Operative Note: A joint debridement and external fixation procedure with surgical intervention was employed to address the severe inflammation and infection on the extreme moving joint caused by osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (100 mcg) and sevoflurane inhalation. An arthrotomy was performed, providing direct access to the inflamed joint. Thorough debridement of necrotic bone and abscess evacuation were meticulously performed. Copious irrigation with antibiotic solution was carried out. Additional surgical intervention included the placement of an external fixator for joint stabilization and the administration of anti-inflammatory agents. The patient tolerated the procedure well with satisfactory wound healing.

1. Operative Note: A surgical intervention was performed to address the severe diagnosis of osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (150 mcg) and sevoflurane inhalation. An extensive laminectomy was performed to expose the affected vertebrae. Thorough debridement of necrotic bone and abscess evacuation were meticulously carried out. Copious irrigation with antibiotic solution was performed. Postoperatively, the patient will require long-term intravenous antibiotic therapy and close monitoring for signs of recurrent infection.

2. Operative Note: A surgical intervention was performed to address the moderate diagnosis of osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (100 mcg) and sevoflurane inhalation. An incision was made over the affected area, providing access to the infected vertebrae. Thorough debridement of necrotic bone and abscess evacuation were meticulously performed. Copious irrigation with antibiotic solution was carried out. Postoperatively, the patient will require a course of oral antibiotics and regular follow-up appointments for clinical assessment and imaging to monitor the resolution of infection.

3. Operative Note: A surgical intervention was performed to address the mild diagnosis of osteomyelitis of the vertebrae. The patient received local anesthesia with intravenous sedation using midazolam (2 mg). A small incision was made to access the infected vertebrae. Limited debridement of necrotic bone and abscess evacuation were performed. Copious irrigation with antibiotic solution was carried out. Postoperatively, the patient will be prescribed a short course of oral antibiotics and advised to follow up with their primary care physician for further evaluation and monitoring.

4. Operative Note: A surgical intervention was performed to address the critical diagnosis of osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (150 mcg) and sevoflurane inhalation. A comprehensive spinal decompression and stabilization procedure were performed to alleviate spinal cord compression caused by the infected vertebrae. Thorough debridement of necrotic bone and abscess evacuation were meticulously carried out. Copious irrigation with antibiotic solution was performed. Postoperatively, the patient will require intensive care unit monitoring, intravenous broad-spectrum antibiotics, and further imaging studies to assess treatment response and guide further management.

5. Operative Note: A surgical intervention was performed to address the severe diagnosis of osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (100 mcg) and sevoflurane inhalation. An incision was made over the affected area, providing access to the infected vertebrae. Extensive debridement of necrotic bone and abscess evacuation were meticulously performed. Copious irrigation with antibiotic solution was carried out. Postoperatively, the patient will require an extended course of intravenous antibiotics, close clinical monitoring, and regular follow-up imaging studies to ensure adequate healing and resolution of infection.

6. Operative Note: A surgical intervention was performed to address the moderate diagnosis of osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (150 mcg) and sevoflurane inhalation. An incision was made over the affected area, providing access to the infected vertebrae. Thorough debridement of necrotic bone and abscess evacuation were performed. Copious irrigation with antibiotic solution was carried out. Postoperatively, the patient will be prescribed a course of oral or intravenous antibiotics depending on the severity of infection and closely monitored for clinical response and potential complications.

7. Operative Note: A surgical intervention was performed to address the mild diagnosis of osteomyelitis of the vertebrae. The patient received local anesthesia with intravenous sedation using midazolam (2 mg). A small incision was made to access the infected vertebrae. Limited debridement of necrotic bone and abscess evacuation were performed. Copious irrigation with antibiotic solution was carried out. Postoperatively, the patient will be prescribed a short course of oral antibiotics and instructed to follow up with their primary care physician for further evaluation and monitoring.

8. Operative Note: A surgical intervention was performed to address the critical diagnosis of osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (150 mcg) and sevoflurane inhalation. An extensive laminectomy and debridement procedure were performed to remove the infected vertebrae. Copious irrigation with antibiotic solution was carried out. Postoperatively, the patient will require a prolonged course of intravenous antibiotics, close monitoring for any signs of neurological deficits, and a comprehensive rehabilitation program for functional recovery.

9. Operative Note: A surgical intervention was performed to address the severe diagnosis of osteomyelitis of the vertebrae. The patient received general anesthesia with intravenous fentanyl (100 mcg) and sevoflurane inhalation. An incision was made over the affected area, providing access to the infected vertebrae. Thorough debridement of necrotic bone and abscess evacuation were meticulously performed. Copious irrigation with antibiotic solution was carried out. Postoperatively, the patient will be placed on a tailored antibiotic regimen, closely monitored for any signs of recurrence, and scheduled for regular follow-up appointments to evaluate treatment response and assess the need for further interventions.

10. Operative Note: A surgical intervention was performed to address the mild diagnosis of osteomyelitis of the vertebrae. The patient received local anesthesia with intravenous sedation using midazolam (2 mg). A small incision was made to access the infected vertebrae. Limited debridement of necrotic bone and abscess evacuation were performed. Copious irrigation with antibiotic solution was carried out. Postoperatively, the patient will be prescribed a short course of oral antibiotics and advised to follow up with their primary care physician for further evaluation and monitoring of symptoms and infection resolution.

## M46.3 Infection of intervertebral disc (pyogenic)

1. Patient presented with symptoms of fever, severe back pain, and limited mobility. MRI revealed pyogenic infection of the intervertebral disc at L4-L5. Surgical intervention performed with discectomy and debridement. Infected disc material sent for culture and sensitivity testing. Postoperative antibiotics initiated. Patient advised bed rest and regular follow-ups for monitoring.

2. Operative intervention conducted for pyogenic infection of the intervertebral disc at C6-C7. Decompression and discectomy performed to remove infected tissue. Intraoperative cultures obtained for microbiological analysis. Wound closed in layers. Postoperative antibiotics initiated. Patient instructed to maintain strict activity restrictions and scheduled for a follow-up visit.

3. Infection of the intervertebral disc at T11-T12 identified in the patient. Surgical intervention involved discectomy and thorough irrigation of the affected area. Infected tissue sent for analysis. Closure performed using layered sutures. Appropriate antibiotics initiated postoperatively. Patient advised to adhere to strict bed rest and attend regular follow-up appointments.

4. A case of pyogenic infection in the intervertebral disc at L2-L3 was surgically treated. Discectomy and extensive debridement performed to remove infected material. Intraoperative samples collected for culture and sensitivity testing. Wound closed meticulously. Postoperative antibiotics administered. Patient instructed to observe strict immobilization and scheduled for follow-up examination.

5. Patient presented with symptoms of intervertebral disc infection at C4-C5. Surgical intervention involved discectomy and thorough debridement. Samples collected for microbial analysis. Closure performed using layered sutures. Postoperative antibiotics initiated. Patient advised strict immobilization and regular monitoring.

6. Operative intervention carried out for pyogenic infection of the intervertebral disc at T7-T8. Discectomy and extensive debridement conducted to remove infected tissue. Intraoperative cultures obtained for analysis. Closure performed meticulously. Postoperative antibiotics initiated. Patient instructed to adhere to strict bed rest and follow-up visits scheduled.

7. A case of intervertebral disc infection at L3-L4 was treated surgically. Discectomy and thorough debridement performed to eliminate the infected material. Intraoperative cultures collected for microbiological analysis. Wound closed meticulously. Postoperative antibiotics administered. Patient advised strict immobilization and regular follow-up examinations.

8. Patient presented with pyogenic infection of the intervertebral disc at C2-C3. Surgical intervention involved discectomy and meticulous debridement. Intraoperative samples obtained for culture and sensitivity testing. Wound closed meticulously in layers. Postoperative antibiotics initiated. Patient instructed to observe strict immobilization and scheduled for follow-up evaluation.

9. Operative intervention conducted for pyogenic infection of the intervertebral disc at T9-T10. Discectomy and thorough debridement performed to remove infected tissue. Intraoperative cultures obtained for analysis. Closure performed meticulously. Postoperative antibiotics initiated. Patient advised strict bed rest and regular follow-up appointments.

10. A case of intervertebral disc infection at L5-S1 was surgically managed. Discectomy and extensive debridement performed to remove infected material. Intraoperative samples collected for microbial analysis. Closure performed meticulously. Postoperative antibiotics initiated. Patient instructed to adhere to strict immobilization and scheduled for regular follow-up examinations.

1. Surgical intervention conducted for pyogenic infection of the intervertebral disc at T4-T5. Discectomy and meticulous debridement performed to remove infected tissue. Intraoperative cultures obtained for analysis. Closure achieved with layered sutures. Postoperative antibiotics initiated. Patient instructed to maintain strict immobilization and scheduled for regular follow-up visits.

2. Patient presented with symptoms of intervertebral disc infection at L1-L2. Surgical intervention involved discectomy and thorough debridement. Intraoperative samples collected for microbiological analysis. Closure performed meticulously. Postoperative antibiotics initiated. Patient advised strict immobilization and regular monitoring.

3. Operative intervention carried out for pyogenic infection of the intervertebral disc at C7-T1. Discectomy and extensive debridement conducted to remove infected tissue. Intraoperative cultures obtained for analysis. Closure performed meticulously. Postoperative antibiotics initiated. Patient instructed to adhere to strict bed rest and follow-up visits scheduled.

4. A case of intervertebral disc infection at T6-T7 was treated surgically. Discectomy and thorough debridement performed to eliminate the infected material. Intraoperative cultures collected for microbiological analysis. Wound closed meticulously. Postoperative antibiotics administered. Patient advised strict immobilization and regular follow-up examinations.

5. Patient presented with pyogenic infection of the intervertebral disc at C3-C4. Surgical intervention involved discectomy and meticulous debridement. Intraoperative samples obtained for culture and sensitivity testing. Wound closed meticulously in layers. Postoperative antibiotics initiated. Patient instructed to observe strict immobilization and scheduled for follow-up evaluation.

6. Operative intervention conducted for pyogenic infection of the intervertebral disc at T12-L1. Discectomy and thorough debridement performed to remove infected tissue. Intraoperative cultures obtained for analysis. Closure achieved with layered sutures. Postoperative antibiotics initiated. Patient advised strict bed rest and regular follow-up appointments.

7. A case of intervertebral disc infection at L4-L5 was surgically managed. Discectomy and extensive debridement performed to remove infected material. Intraoperative samples collected for microbial analysis. Closure achieved with meticulous technique. Postoperative antibiotics initiated. Patient instructed to adhere to strict immobilization and scheduled for regular follow-up examinations.

8. Patient presented with symptoms of intervertebral disc infection at C1-C2. Surgical intervention involved discectomy and thorough debridement. Intraoperative cultures obtained for microbiological analysis. Closure achieved meticulously. Postoperative antibiotics initiated. Patient advised strict immobilization and regular monitoring.

9. Operative intervention carried out for pyogenic infection of the intervertebral disc at T5-T6. Discectomy and extensive debridement conducted to remove infected tissue. Intraoperative samples obtained for analysis. Closure achieved meticulously. Postoperative antibiotics initiated. Patient instructed to adhere to strict bed rest and follow-up visits scheduled.

10. A case of pyogenic infection in the intervertebral disc at L3-L4 was surgically treated. Discectomy and thorough debridement performed to remove infected material. Intraoperative samples collected for culture and sensitivity testing. Wound closed meticulously. Postoperative antibiotics administered. Patient advised strict immobilization and regular monitoring.

1. Surgical intervention conducted for pyogenic infection of the intervertebral disc at T4-T5. Discectomy and meticulous debridement performed under general anesthesia with appropriate dosage. Intraoperative cultures obtained for analysis. Closure achieved with layered sutures. Postoperative antibiotics initiated. Patient instructed to maintain strict immobilization and scheduled for regular follow-up visits.

2. Patient presented with symptoms of intervertebral disc infection at L1-L2. Surgical intervention involved discectomy and thorough debridement performed under regional anesthesia with adjusted dosage. Intraoperative samples collected for microbiological analysis. Closure performed meticulously. Postoperative antibiotics initiated. Patient advised strict immobilization and regular monitoring.

3. Operative intervention carried out for pyogenic infection of the intervertebral disc at C7-T1. Discectomy and extensive debridement conducted under general anesthesia with modified dosage. Intraoperative cultures obtained for analysis. Closure performed meticulously. Postoperative antibiotics initiated. Patient instructed to adhere to strict bed rest and follow-up visits scheduled.

4. A case of intervertebral disc infection at T6-T7 was treated surgically. Discectomy and thorough debridement performed under local anesthesia with appropriate dosage to remove the infected material. Intraoperative cultures collected for microbiological analysis. Wound closed meticulously. Postoperative antibiotics administered. Patient advised strict immobilization and regular follow-up examinations.

5. Patient presented with pyogenic infection of the intervertebral disc at C3-C4. Surgical intervention involved discectomy and meticulous debridement performed under general anesthesia with adjusted dosage. Intraoperative samples obtained for culture and sensitivity testing. Wound closed meticulously in layers. Postoperative antibiotics initiated. Patient instructed to observe strict immobilization and scheduled for follow-up evaluation.

6. Operative intervention conducted for pyogenic infection of the intervertebral disc at T12-L1. Discectomy and thorough debridement performed under regional anesthesia with modified dosage. Intraoperative cultures obtained for analysis. Closure achieved with layered sutures. Postoperative antibiotics initiated. Patient advised strict bed rest and regular follow-up appointments.

7. A case of intervertebral disc infection at L4-L5 was surgically managed. Discectomy and extensive debridement performed under general anesthesia with appropriate dosage to remove infected material. Intraoperative samples collected for microbial analysis. Closure achieved with meticulous technique. Postoperative antibiotics initiated. Patient instructed to adhere to strict immobilization and scheduled for regular follow-up examinations.

8. Patient presented with symptoms of intervertebral disc infection at C1-C2. Surgical intervention involved discectomy and thorough debridement performed under local anesthesia with adjusted dosage. Intraoperative cultures obtained for microbiological analysis. Closure achieved meticulously. Postoperative antibiotics initiated. Patient advised strict immobilization and regular monitoring.

9. Operative intervention carried out for pyogenic infection of the intervertebral disc at T5-T6. Discectomy and extensive debridement conducted under general anesthesia with modified dosage. Intraoperative samples obtained for analysis. Closure achieved meticulously. Postoperative antibiotics initiated. Patient instructed to adhere to strict bed rest and follow-up visits scheduled.

10. A case of pyogenic infection in the intervertebral disc at L3-L4 was surgically treated. Discectomy and thorough debridement performed under regional anesthesia with appropriate dosage to remove infected material. Intraoperative samples collected for culture and sensitivity testing. Wound closed meticulously. Postoperative antibiotics administered. Patient advised strict immobilization and regular monitoring.

1. Surgical intervention conducted for pyogenic infection of the intervertebral disc at T4-T5 with associated bone erosion. Discectomy, extensive debridement, and bone curettage performed to remove infected tissue and eroded bone fragments. Intraoperative cultures obtained for analysis. Closure achieved with layered sutures. Postoperative antibiotics initiated. Patient instructed to maintain strict immobilization and scheduled for regular follow-up visits.

2. Patient presented with symptoms of intervertebral disc infection at L1-L2 with significant bone erosion. Surgical intervention involved discectomy, thorough debridement, and bone grafting to restore stability and promote bone healing. Intraoperative samples collected for microbiological analysis. Closure performed meticulously. Postoperative antibiotics initiated. Patient advised strict immobilization and regular monitoring.

3. Operative intervention carried out for pyogenic infection of the intervertebral disc at C7-T1 with evident bone erosion. Discectomy, extensive debridement, and bone augmentation performed to address infected tissue and restore structural integrity. Intraoperative cultures obtained for analysis. Closure achieved meticulously. Postoperative antibiotics initiated. Patient instructed to adhere to strict bed rest and follow-up visits scheduled.

4. A case of intervertebral disc infection at T6-T7 with severe bone erosion necessitating surgical intervention. Discectomy, thorough debridement, and bone grafting performed to address infected tissue and restore vertebral stability. Intraoperative cultures collected for microbiological analysis. Wound closed meticulously. Postoperative antibiotics administered. Patient advised strict immobilization and regular follow-up examinations.

5. Patient presented with pyogenic infection of the intervertebral disc at C3-C4 with significant bone erosion. Surgical intervention involved discectomy, meticulous debridement, bone resection, and stabilization using instrumentation. Intraoperative samples obtained for culture and sensitivity testing. Wound closed meticulously in layers. Postoperative antibiotics initiated. Patient instructed to observe strict immobilization and scheduled for follow-up evaluation.

6. Operative intervention conducted for pyogenic infection of the intervertebral disc at T12-L1 with associated bone erosion. Discectomy, thorough debridement, and bone grafting performed to address infected tissue and restore vertebral stability. Intraoperative cultures obtained for analysis. Closure achieved with layered sutures. Postoperative antibiotics initiated. Patient advised strict bed rest and regular follow-up appointments.

7. A case of intervertebral disc infection at L4-L5 with bone erosion was surgically managed. Discectomy, extensive debridement, bone curettage, and spinal fusion performed to address infected tissue, eradicate erosive bone, and restore spinal stability. Intraoperative samples collected for microbial analysis. Closure achieved with meticulous technique. Postoperative antibiotics initiated. Patient instructed to adhere to strict immobilization and scheduled for regular follow-up examinations.

8. Patient presented with symptoms of intervertebral disc infection at C1-C2 with evident bone erosion. Surgical intervention involved discectomy, thorough debridement, bone grafting, and stabilization using specialized implants. Intraoperative cultures obtained for microbiological analysis. Closure achieved meticulously. Postoperative antibiotics initiated. Patient advised strict immobilization and regular monitoring.

9. Operative intervention carried out for pyogenic infection of the intervertebral disc at T5-T6 with significant bone erosion. Discectomy, extensive debridement, bone grafting, and spinal fusion performed to address infected tissue, remove eroded bone, and restore spinal stability. Intraoperative samples obtained for analysis. Closure achieved meticulously. Postoperative antibiotics initiated. Patient instructed to adhere to strict bed rest and follow-up visits scheduled.

10. A case of pyogenic infection in the intervertebral disc at L3-L4 with associated bone erosion was surgically treated. Discectomy, thorough debridement, bone resection, and spinal instrumentation performed to address infected tissue, eradicate erosive bone, and stabilize the vertebral segment. Intraoperative samples collected for culture and sensitivity testing. Wound closed meticulously. Postoperative antibiotics administered. Patient advised strict immobilization and regular monitoring.

1. Surgical intervention conducted for pyogenic infection of the intervertebral disc at T4-T5 with severe bone pain. Discectomy and extensive debridement performed to remove infected tissue and alleviate pain. Intraoperative cultures obtained for analysis. Closure achieved with layered sutures. Postoperative pain management initiated. Patient instructed to maintain strict immobilization and scheduled for regular follow-up visits.

2. Patient presented with symptoms of intervertebral disc infection at L1-L2 with severe bone pain. Surgical intervention involved discectomy and thorough debridement performed to address infected tissue and alleviate pain. Intraoperative samples collected for microbiological analysis. Closure performed meticulously. Postoperative pain management initiated. Patient advised strict immobilization and regular monitoring.

3. Operative intervention carried out for pyogenic infection of the intervertebral disc at C7-T1 with severe bone pain. Discectomy and extensive debridement conducted to remove infected tissue and alleviate pain. Intraoperative cultures obtained for analysis. Closure achieved meticulously. Postoperative pain management initiated. Patient instructed to adhere to strict bed rest and follow-up visits scheduled.

4. A case of intervertebral disc infection at T6-T7 with severe bone pain necessitating surgical intervention. Discectomy, thorough debridement, and bone grafting performed to address infected tissue, relieve pain, and promote bone healing. Intraoperative cultures collected for microbiological analysis. Wound closed meticulously. Postoperative pain management initiated. Patient advised strict immobilization and regular follow-up examinations.

5. Patient presented with pyogenic infection of the intervertebral disc at C3-C4 with severe bone pain. Surgical intervention involved discectomy, meticulous debridement, and bone resection to address infected tissue and alleviate pain. Intraoperative samples obtained for culture and sensitivity testing. Wound closed meticulously in layers. Postoperative pain management initiated. Patient instructed to observe strict immobilization and scheduled for follow-up evaluation.

6. Operative intervention conducted for pyogenic infection of the intervertebral disc at T12-L1 with severe bone pain. Discectomy and thorough debridement performed to remove infected tissue and alleviate pain. Intraoperative cultures obtained for analysis. Closure achieved with layered sutures. Postoperative pain management initiated. Patient advised strict bed rest and regular follow-up appointments.

7. A case of intervertebral disc infection at L4-L5 with severe bone pain was surgically managed. Discectomy, extensive debridement, and bone curettage performed to address infected tissue, alleviate pain, and remove eroded bone fragments. Intraoperative samples collected for microbial analysis. Closure achieved with meticulous technique. Postoperative pain management initiated. Patient instructed to adhere to strict immobilization and scheduled for regular follow-up examinations.

8. Patient presented with symptoms of intervertebral disc infection at C1-C2 with severe bone pain. Surgical intervention involved discectomy, thorough debridement, and bone grafting performed to address infected tissue, relieve pain, and promote bone healing. Intraoperative cultures obtained for microbiological analysis. Closure achieved meticulously. Postoperative pain management initiated. Patient advised strict immobilization and regular monitoring.

9. Operative intervention carried out for pyogenic infection of the intervertebral disc at T5-T6 with severe bone pain. Discectomy, extensive debridement, and bone grafting performed to remove infected tissue, alleviate pain, and promote bone stability. Intraoperative samples obtained for analysis. Closure achieved meticulously. Postoperative pain management initiated. Patient instructed to adhere to strict bed rest and follow-up visits scheduled.

10. A case of pyogenic infection in the intervertebral disc at L3-L4 with severe bone pain was surgically treated. Discectomy, thorough debridement, bone resection, and spinal fusion performed to address infected tissue, alleviate pain, and stabilize the vertebral segment. Intraoperative samples collected for culture and sensitivity testing. Wound closed meticulously. Postoperative pain management administered. Patient advised strict immobilization and regular monitoring.

1. Surgical intervention conducted for pyogenic infection of the intervertebral disc at T4-T5. Discectomy and thorough debridement performed to remove infected tissue and restore spinal stability. Intraoperative cultures obtained for analysis. Closure achieved with layered sutures. Postoperative antibiotics initiated. Patient instructed to maintain strict immobilization and scheduled for regular follow-up visits.

2. Patient presented with symptoms of intervertebral disc infection at L1-L2. Surgical intervention involved discectomy and extensive debridement performed to address infected tissue and promote healing. Intraoperative samples collected for microbiological analysis. Closure performed meticulously. Postoperative antibiotics initiated. Patient advised strict immobilization and regular monitoring.

3. Operative intervention carried out for pyogenic infection of the intervertebral disc at C7-T1. Discectomy, thorough debridement, and bone curettage performed to remove infected tissue and address bone erosion. Intraoperative cultures obtained for analysis. Closure achieved meticulously. Postoperative antibiotics initiated. Patient instructed to adhere to strict bed rest and follow-up visits scheduled.

4. A case of intervertebral disc infection at T6-T7 was surgically managed. Discectomy, extensive debridement, and bone grafting performed to address infected tissue, restore spinal stability, and promote bone healing. Intraoperative cultures collected for microbiological analysis. Wound closed meticulously. Postoperative antibiotics administered. Patient advised strict immobilization and regular follow-up examinations.

5. Patient presented with pyogenic infection of the intervertebral disc at C3-C4. Surgical intervention involved discectomy, meticulous debridement, and bone resection performed to remove infected tissue and address bone erosion. Intraoperative samples obtained for culture and sensitivity testing. Wound closed meticulously in layers. Postoperative antibiotics initiated. Patient instructed to observe strict immobilization and scheduled for follow-up evaluation.

6. Operative intervention conducted for pyogenic infection of the intervertebral disc at T12-L1. Discectomy, thorough debridement, and bone grafting performed to remove infected tissue, restore spinal stability, and promote bone fusion. Intraoperative cultures obtained for analysis. Closure achieved with layered sutures. Postoperative antibiotics initiated. Patient advised strict bed rest and regular follow-up appointments.

7. A case of intervertebral disc infection at L4-L5 was surgically treated. Discectomy, extensive debridement, and bone curettage performed to remove infected tissue, address bone erosion, and promote healing. Intraoperative samples collected for microbial analysis. Closure achieved with meticulous technique. Postoperative antibiotics initiated. Patient instructed to adhere to strict immobilization and scheduled for regular follow-up examinations.

8. Patient presented with symptoms of intervertebral disc infection at C1-C2. Surgical intervention involved discectomy, thorough debridement, and bone grafting performed to remove infected tissue, restore spinal stability, and promote bone fusion. Intraoperative cultures obtained for microbiological analysis. Closure achieved meticulously. Postoperative antibiotics initiated. Patient advised strict immobilization and regular monitoring.

9. Operative intervention carried out for pyogenic infection of the intervertebral disc at T5-T6. Discectomy, extensive debridement, and bone grafting performed to remove infected tissue, restore spinal stability, and promote bone fusion. Intraoperative samples obtained for analysis. Closure achieved meticulously. Postoperative antibiotics initiated. Patient instructed to adhere to strict bed rest and follow-up visits scheduled.

10. A case of pyogenic infection in the intervertebral disc at L3-L4 was surgically treated. Discectomy, thorough debridement, bone resection, and spinal fusion performed to remove infected tissue, address bone erosion, and restore spinal stability. Intraoperative samples collected for culture and sensitivity testing. Wound closed meticulously. Postoperative antibiotics administered. Patient advised strict immobilization and regular monitoring.

1. Surgical intervention conducted for pyogenic infection of the intervertebral disc at T4-T5. Discectomy, extensive debridement, and bone grafting performed to remove infected tissue, address bone erosion, and promote spinal stability. Intraoperative cultures obtained for analysis. Closure achieved with layered sutures. Postoperative antibiotics initiated. Patient instructed to maintain strict immobilization and scheduled for regular follow-up visits.

2. Patient presented with symptoms of intervertebral disc infection at L1-L2. Surgical intervention involved discectomy, thorough debridement, and spinal fusion performed to address infected tissue, restore vertebral stability, and promote healing. Intraoperative samples collected for microbiological analysis. Closure performed meticulously. Postoperative antibiotics initiated. Patient advised strict immobilization and regular monitoring.

3. Operative intervention carried out for pyogenic infection of the intervertebral disc at C7-T1 with bone erosion. Discectomy, thorough debridement, and bone curettage performed to remove infected tissue and address erosive bone fragments. Intraoperative cultures obtained for analysis. Closure achieved meticulously. Postoperative antibiotics initiated. Patient instructed to adhere to strict bed rest and follow-up visits scheduled.

4. A case of intervertebral disc infection at T6-T7 with severe bone pain was surgically managed. Discectomy, extensive debridement, bone grafting, and spinal instrumentation performed to remove infected tissue, alleviate pain, and restore spinal stability. Intraoperative cultures collected for microbiological analysis. Wound closed meticulously. Postoperative pain management initiated. Patient advised strict immobilization and regular follow-up examinations.

5. Patient presented with pyogenic infection of the intervertebral disc at C3-C4 with bone erosion. Surgical intervention involved discectomy, meticulous debridement, bone resection, and stabilization using specialized implants to address infected tissue and restore vertebral stability. Intraoperative samples obtained for culture and sensitivity testing. Wound closed meticulously in layers. Postoperative antibiotics initiated. Patient instructed to observe strict immobilization and scheduled for follow-up evaluation.

6. Operative intervention conducted for pyogenic infection of the intervertebral disc at T12-L1. Discectomy, extensive debridement, and bone grafting performed to remove infected tissue, address bone erosion, and promote spinal stability. Intraoperative cultures obtained for analysis. Closure achieved with layered sutures. Postoperative antibiotics initiated. Patient advised strict bed rest and regular follow-up appointments.

7. A case of intervertebral disc infection at L4-L5 with bone erosion was surgically treated. Discectomy, thorough debridement, bone curettage, and spinal fusion performed to remove infected tissue, address erosive bone fragments, and restore spinal stability. Intraoperative samples collected for microbial analysis. Closure achieved with meticulous technique. Postoperative antibiotics initiated. Patient instructed to adhere to strict immobilization and scheduled for regular follow-up examinations.

8. Patient presented with symptoms of intervertebral disc infection at C1-C2. Surgical intervention involved discectomy, thorough debridement, bone grafting, and stabilization using specialized implants to remove infected tissue, restore spinal stability, and promote bone fusion. Intraoperative cultures obtained for microbiological analysis. Closure achieved meticulously. Postoperative antibiotics initiated. Patient advised strict immobilization and regular monitoring.

9. Operative intervention carried out for pyogenic infection of the intervertebral disc at T5-T6 with bone erosion. Discectomy, extensive debridement, bone grafting, and spinal fusion performed to remove infected tissue, address bone erosion, and promote spinal stability. Intraoperative samples obtained for analysis. Closure achieved meticulously. Postoperative antibiotics initiated. Patient instructed to adhere to strict bed rest and follow-up visits scheduled.

10. A case of pyogenic infection in the intervertebral disc at L3-L4 with bone erosion was surgically treated. Discectomy, thorough debridement, bone resection, and spinal fusion performed to address infected tissue, remove erosive bone fragments, and restore spinal stability. Intraoperative samples collected for culture and sensitivity testing. Wound closed meticulously. Postoperative antibiotics administered. Patient advised strict immobilization and regular monitoring.

1. Surgical intervention conducted for severe pyogenic infection of the intervertebral disc at T4-T5, affecting the extreme moving joint. Discectomy, thorough debridement, and joint stabilization performed to remove infected tissue and restore joint functionality. Intraoperative cultures obtained for analysis. Closure achieved with layered sutures. Postoperative antibiotics initiated. Patient instructed to maintain strict immobilization and scheduled for regular follow-up visits.

2. Patient presented with symptoms of severe intervertebral disc infection at L1-L2, involving the extreme moving joint. Surgical intervention involved discectomy, extensive debridement, and joint fusion performed to address infected tissue and restore joint stability. Intraoperative samples collected for microbiological analysis. Closure performed meticulously. Postoperative antibiotics initiated. Patient advised strict immobilization and regular monitoring.

3. Operative intervention carried out for severe pyogenic infection of the intervertebral disc at C7-T1, affecting the extreme moving joint. Discectomy, thorough debridement, joint debridement, and stabilization performed to remove infected tissue and address joint erosion. Intraoperative cultures obtained for analysis. Closure achieved meticulously. Postoperative antibiotics initiated. Patient instructed to adhere to strict bed rest and follow-up visits scheduled.

4. A case of severe intervertebral disc infection at T6-T7, involving the extreme moving joint, was surgically managed. Discectomy, extensive debridement, joint resection, and stabilization performed to remove infected tissue, alleviate pain, and restore joint functionality. Intraoperative cultures collected for microbiological analysis. Wound closed meticulously. Postoperative pain management initiated. Patient advised strict immobilization and regular follow-up examinations.

5. Patient presented with severe pyogenic infection of the intervertebral disc at C3-C4, affecting the extreme moving joint. Surgical intervention involved discectomy, meticulous debridement, joint resection, and stabilization performed to remove infected tissue, address joint erosion, and restore joint mobility. Intraoperative samples obtained for culture and sensitivity testing. Wound closed meticulously in layers. Postoperative pain management initiated. Patient instructed to observe strict immobilization and scheduled for follow-up evaluation.

6. Operative intervention conducted for severe pyogenic infection of the intervertebral disc at T12-L1, involving the extreme moving joint. Discectomy, thorough debridement, joint debridement, and joint fusion performed to remove infected tissue, address joint erosion, and restore joint stability. Intraoperative cultures obtained for analysis. Closure achieved with layered sutures. Postoperative antibiotics initiated. Patient advised strict bed rest and regular follow-up appointments.

7. A case of severe intervertebral disc infection at L4-L5, affecting the extreme moving joint, was surgically treated. Discectomy, extensive debridement, joint curettage, and joint fusion performed to remove infected tissue, address joint erosion, and restore joint functionality. Intraoperative samples collected for microbial analysis. Closure achieved with meticulous technique. Postoperative antibiotics initiated. Patient instructed to adhere to strict immobilization and scheduled for regular follow-up examinations.

8. Patient presented with symptoms of severe pyogenic infection at the extreme moving joint, involving the intervertebral disc at C1-C2. Surgical intervention involved discectomy, thorough debridement, joint resection, and joint fusion performed to remove infected tissue, restore joint stability, and alleviate pain. Intraoperative cultures obtained for microbiological analysis. Closure achieved meticulously. Postoperative antibiotics initiated. Patient advised strict immobilization and regular monitoring.

9. Operative intervention carried out for severe pyogenic infection of the intervertebral disc at T5-T6, affecting the extreme moving joint. Discectomy, extensive debridement, joint resection, and joint fusion performed to remove infected tissue, address joint erosion, and restore joint functionality. Intraoperative samples obtained for analysis. Closure achieved meticulously. Postoperative antibiotics initiated. Patient instructed to adhere to strict bed rest and follow-up visits scheduled.

10. A case of severe infection in the intervertebral disc at L3-L4, involving the extreme moving joint, was surgically treated. Discectomy, thorough debridement, joint resection, and joint fusion performed to remove infected tissue, address joint erosion, and restore joint stability. Intraoperative samples collected for culture and sensitivity testing. Wound closed meticulously. Postoperative antibiotics administered. Patient advised strict immobilization and regular monitoring.

1. Surgical intervention conducted for pyogenic infection of the intervertebral disc at T4-T5 with severe inflammation. Discectomy, thorough debridement, and anti-inflammatory irrigation performed to remove infected tissue and reduce inflammation. Intraoperative cultures obtained for analysis. Closure achieved with layered sutures. Postoperative antibiotics and anti-inflammatory medications initiated. Patient instructed to maintain strict immobilization and scheduled for regular follow-up visits.

2. Patient presented with symptoms of intervertebral disc infection at L1-L2, accompanied by significant inflammation. Surgical intervention involved discectomy, extensive debridement, and intraoperative corticosteroid administration to address infected tissue and reduce inflammation. Intraoperative samples collected for microbiological analysis. Closure performed meticulously. Postoperative antibiotics and anti-inflammatory medications initiated. Patient advised strict immobilization and regular monitoring.

3. Operative intervention carried out for pyogenic infection of the intervertebral disc at C7-T1 with severe inflammation. Discectomy, thorough debridement, and anti-inflammatory irrigation performed to remove infected tissue, alleviate inflammation, and promote healing. Intraoperative cultures obtained for analysis. Closure achieved meticulously. Postoperative antibiotics and anti-inflammatory medications initiated. Patient instructed to adhere to strict bed rest and follow-up visits scheduled.

4. A case of intervertebral disc infection at T6-T7 with severe inflammation was surgically managed. Discectomy, extensive debridement, anti-inflammatory irrigation, and spinal fusion performed to remove infected tissue, reduce inflammation, and restore spinal stability. Intraoperative cultures collected for microbiological analysis. Wound closed meticulously. Postoperative pain management, antibiotics, and anti-inflammatory medications initiated. Patient advised strict immobilization and regular follow-up examinations.

5. Patient presented with pyogenic infection of the intervertebral disc at C3-C4 with marked inflammation. Surgical intervention involved discectomy, meticulous debridement, intraoperative anti-inflammatory agent administration, and spinal fusion performed to address infected tissue, mitigate inflammation, and restore spinal stability. Intraoperative samples obtained for culture and sensitivity testing. Wound closed meticulously in layers. Postoperative antibiotics and anti-inflammatory medications initiated. Patient instructed to observe strict immobilization and scheduled for follow-up evaluation.

6. Operative intervention conducted for pyogenic infection of the intervertebral disc at T12-L1 with significant inflammation. Discectomy, thorough debridement, anti-inflammatory irrigation, and spinal fusion performed to remove infected tissue, reduce inflammation, and promote spinal stability. Intraoperative cultures obtained for analysis. Closure achieved with layered sutures. Postoperative antibiotics and anti-inflammatory medications initiated. Patient advised strict bed rest and regular follow-up appointments.

7. A case of intervertebral disc infection at L4-L5 with severe inflammation was surgically treated. Discectomy, extensive debridement, anti-inflammatory irrigation, and spinal fusion performed to remove infected tissue, alleviate inflammation, and restore spinal stability. Intraoperative samples collected for microbial analysis. Closure achieved with meticulous technique. Postoperative antibiotics and anti-inflammatory medications initiated. Patient instructed to adhere to strict immobilization and scheduled for regular follow-up examinations.

8. Patient presented with symptoms of intervertebral disc infection at C1-C2, accompanied by pronounced inflammation. Surgical intervention involved discectomy, thorough debridement, intraoperative corticosteroid administration, and spinal fusion performed to remove infected tissue, reduce inflammation, and restore spinal stability. Intraoperative cultures obtained for microbiological analysis. Closure achieved meticulously. Postoperative antibiotics and anti-inflammatory medications initiated. Patient advised strict immobilization and regular monitoring.

9. Operative intervention carried out for pyogenic infection of the intervertebral disc at T5-T6 with significant inflammation. Discectomy, extensive debridement, anti-inflammatory irrigation, and spinal fusion performed to remove infected tissue, reduce inflammation, and promote spinal stability. Intraoperative samples obtained for analysis. Closure achieved meticulously. Postoperative antibiotics and anti-inflammatory medications initiated. Patient instructed to adhere to strict bed rest and follow-up visits scheduled.

10. A case of intervertebral disc infection at L3-L4 with severe inflammation was surgically treated. Discectomy, thorough debridement, anti-inflammatory irrigation, and spinal fusion performed to remove infected tissue, alleviate inflammation, and restore spinal stability. Intraoperative samples collected for culture and sensitivity testing. Wound closed meticulously. Postoperative antibiotics and anti-inflammatory medications administered. Patient advised strict immobilization and regular monitoring.

1. Surgical intervention conducted for severe pyogenic infection of the intervertebral disc at T4-T5. Discectomy, extensive debridement, and spinal fusion performed to remove infected tissue and restore spinal stability. Intraoperative cultures obtained for analysis. Closure achieved meticulously. Postoperative antibiotics initiated. Patient instructed to maintain strict immobilization. Follow-up visits scheduled based on severity and response to treatment.

2. Patient presented with symptoms of intervertebral disc infection at L1-L2. Surgical intervention involved discectomy, thorough debridement, and spinal fusion performed to address infected tissue and restore vertebral stability. Intraoperative samples collected for microbiological analysis. Closure performed meticulously. Postoperative antibiotics initiated. Patient advised strict immobilization. Follow-up frequency determined by the severity of the infection and patient's response to treatment.

3. Operative intervention carried out for pyogenic infection of the intervertebral disc at C7-T1. Discectomy, thorough debridement, and bone grafting performed to remove infected tissue and promote spinal stability. Intraoperative cultures obtained for analysis. Closure achieved meticulously. Postoperative antibiotics initiated. Patient instructed to adhere to strict bed rest. Follow-up appointments scheduled according to the severity of the infection and the patient's clinical progress.

4. A case of intervertebral disc infection at T6-T7 with severe bone erosion was surgically managed. Discectomy, extensive debridement, bone resection, and spinal fusion performed to remove infected tissue, address bone erosion, and restore spinal stability. Intraoperative samples collected for microbiological analysis. Wound closed meticulously. Postoperative antibiotics initiated. Patient advised strict immobilization. Follow-up visits scheduled based on the severity of the infection and the patient's response to treatment.

5. Patient presented with pyogenic infection of the intervertebral disc at C3-C4 with bone erosion. Surgical intervention involved discectomy, meticulous debridement, bone grafting, and spinal fusion performed to remove infected tissue, address bone erosion, and restore vertebral stability. Intraoperative samples obtained for culture and sensitivity testing. Closure achieved meticulously. Postoperative antibiotics initiated. Patient instructed to observe strict immobilization. Follow-up frequency determined by the severity of the infection and the patient's clinical progress.

6. Operative intervention conducted for pyogenic infection of the intervertebral disc at T12-L1. Discectomy, thorough debridement, and bone grafting performed to remove infected tissue, address bone erosion, and promote spinal stability. Intraoperative cultures obtained for analysis. Closure achieved with layered sutures. Postoperative antibiotics initiated. Patient advised strict bed rest. Follow-up appointments scheduled based on the severity of the infection and the patient's response to treatment.

7. A case of intervertebral disc infection at L4-L5 with bone erosion was surgically treated. Discectomy, extensive debridement, bone curettage, and spinal fusion performed to remove infected tissue, address bone erosion, and restore spinal stability. Intraoperative samples collected for microbial analysis. Closure achieved with meticulous technique. Postoperative antibiotics initiated. Patient instructed to adhere to strict immobilization. Follow-up visits scheduled according to the severity of the infection and the patient's clinical progress.

8. Patient presented with symptoms of intervertebral disc infection at C1-C2. Surgical intervention involved discectomy, thorough debridement, bone grafting, and stabilization using specialized implants to remove infected tissue, restore spinal stability, and alleviate pain. Intraoperative cultures obtained for microbiological analysis. Closure achieved meticulously.Postoperative antibiotics initiated. Patient advised strict immobilization. Frequency of follow-up examinations determined by the severity of the infection and the patient's response to treatment.

9. Operative intervention carried out for severe pyogenic infection of the intervertebral disc at T5-T6. Discectomy, extensive debridement, bone grafting, and spinal fusion performed to remove infected tissue, address bone erosion, and restore spinal stability. Intraoperative samples obtained for analysis. Closure achieved meticulously. Postoperative antibiotics initiated. Patient instructed to adhere to strict bed rest. Follow-up appointments scheduled based on the severity of the infection and the patient's response to treatment.

10. A case of intervertebral disc infection at L3-L4 with severe bone erosion was surgically treated. Discectomy, thorough debridement, bone resection, and spinal fusion performed to remove infected tissue, address bone erosion, and restore spinal stability. Intraoperative samples collected for culture and sensitivity testing. Wound closed meticulously. Postoperative antibiotics administered. Patient advised strict immobilization. Follow-up visits scheduled depending on the severity of the infection and the patient's response to treatment.

## M46.4 Discitis, unspecified

1. Patient presented with severe back pain and tenderness. MRI revealed discitis at the L4-L5 level. A percutaneous needle biopsy was performed to obtain tissue for culture and sensitivity testing. Antibiotic therapy initiated based on preliminary results.

2. Discitis confirmed on MRI at the C6-C7 level. Patient underwent an anterior cervical discectomy and fusion (ACDF) procedure to remove the infected disc. Intraoperative cultures obtained for pathogen identification. Postoperative antibiotic therapy initiated.

3. Patient with a history of IV drug use presented with discitis at the T12-L1 level. CT-guided percutaneous drainage and irrigation performed to evacuate the abscess and obtain samples for microbiological analysis. Empirical broad-spectrum antibiotic therapy started.

4. Suspected discitis at the L3-L4 level in an immunocompromised patient. Open discectomy performed, and infected disc material sent for histopathological examination. Intraoperative cultures obtained to guide antibiotic selection. Intravenous antimicrobial therapy initiated postoperatively.

5. Discitis suspected in a child with persistent back pain. MRI revealed vertebral endplate changes at the L2-L3 level. Patient underwent percutaneous aspiration and biopsy under fluoroscopic guidance. Blood cultures obtained. Empirical antibiotic therapy initiated pending culture results.

6. Patient with a history of spinal surgery presented with discitis at the L5-S1 level. Surgical exploration and debridement performed to remove infected tissue. Intraoperative cultures collected for microbial analysis. Postoperative antibiotic therapy initiated based on culture sensitivities.

7. Discitis suspected in a patient with recent spinal trauma. CT-guided needle biopsy performed at the T10-T11 level to confirm the diagnosis. Empirical antibiotic therapy initiated while awaiting culture results. Close monitoring of patient's clinical response.

8. Patient with diabetes and back pain diagnosed with discitis at the T8-T9 level. CT-guided percutaneous drainage performed to evacuate the abscess. Abscess fluid sent for culture and sensitivity testing. Empirical broad-spectrum antibiotic therapy initiated.

9. Discitis identified on MRI at the L2-L3 level in an elderly patient. CT-guided biopsy performed to confirm the diagnosis and identify the causative pathogen. Blood cultures obtained. Antibiotic therapy initiated based on preliminary results.

10. Suspected discitis at the L4-L5 level in a patient with a recent spinal procedure. Surgical exploration and curettage performed to remove infected disc material. Intraoperative cultures obtained to guide antibiotic selection. Postoperative antimicrobial therapy initiated.

1. Patient presented with localized back pain and limited mobility. MRI findings confirmed discitis at the T11-T12 level. A percutaneous needle biopsy was performed to obtain tissue samples for microbiological analysis. Empirical antibiotic therapy initiated pending culture results.

2. Discitis suspected in a patient with a history of intravenous drug use. MRI revealed disc space narrowing and vertebral endplate changes at the L3-L4 level. CT-guided biopsy performed to obtain tissue samples for histopathological examination. Empirical antibiotic therapy started.

3. Patient with persistent back pain diagnosed with discitis at the C4-C5 level. An anterior cervical corpectomy and fusion (ACCF) procedure performed to remove the infected disc and stabilize the spine. Intraoperative cultures obtained for pathogen identification. Postoperative antibiotic therapy initiated.

4. Discitis suspected in an immunocompromised patient presenting with worsening back pain. MRI demonstrated disc space edema and inflammation at the T9-T10 level. Percutaneous image-guided biopsy performed to obtain tissue samples for culture and sensitivity testing. Empirical antibiotic therapy initiated.

5. Patient with a history of spinal surgery presented with recurrent discitis at the L4-L5 level. Repeat surgical debridement and removal of infected disc material performed. Intraoperative cultures collected for microbial analysis. Postoperative antibiotic therapy initiated based on culture sensitivities.

6. Discitis identified on MRI at the L1-L2 level in a child with persistent back pain. CT-guided percutaneous aspiration and biopsy performed to confirm the diagnosis and obtain samples for microbiological analysis. Empirical antibiotic therapy initiated pending culture results.

7. Patient with a known history of tuberculosis presented with discitis at the T6-T7 level. Image-guided percutaneous biopsy performed to obtain tissue samples for acid-fast bacilli (AFB) staining and mycobacterial culture. Anti-tuberculosis therapy initiated based on preliminary results.

8. Suspected discitis at the L5-S1 level in a patient with severe lumbar pain. Open discectomy and decompression performed to remove the infected disc and alleviate pressure on neural structures. Intraoperative cultures obtained for pathogen identification. Postoperative antibiotic therapy initiated.

9. Discitis suspected in a patient with a recent spinal procedure presenting with localized back pain. CT-guided biopsy performed at the T12-L1 level to confirm the diagnosis. Empirical antibiotic therapy started pending culture results. Close monitoring of patient's clinical response.

10. Patient with chronic back pain and spinal implants diagnosed with discitis at the L3-L4 level. Surgical exploration and debridement performed to remove infected tissue and hardware. Intraoperative cultures collected for microbial analysis. Postoperative antibiotic therapy initiated based on culture sensitivities.

1. Patient presented with acute back pain and limited mobility. MRI confirmed discitis at the T11-T12 level. Percutaneous needle biopsy performed under local anesthesia to obtain tissue samples for microbiological analysis. Empirical antibiotic therapy initiated with adjusted dosage due to patient's renal impairment.

2. Discitis suspected in a patient with a history of intravenous drug use. MRI revealed disc space narrowing and vertebral endplate changes at the L3-L4 level. CT-guided biopsy performed under moderate sedation to obtain tissue samples for histopathological examination. Empirical antibiotic therapy initiated with appropriate dosage adjustments.

3. Patient with persistent back pain diagnosed with discitis at the C4-C5 level. An anterior cervical corpectomy and fusion (ACCF) procedure performed under general anesthesia to remove the infected disc and stabilize the spine. Intraoperative cultures obtained for pathogen identification with careful anesthetic titration.

4. Discitis suspected in an immunocompromised patient presenting with worsening back pain. MRI demonstrated disc space edema and inflammation at the T9-T10 level. Percutaneous image-guided biopsy performed under monitored anesthesia care to obtain tissue samples for culture and sensitivity testing. Empirical antibiotic therapy initiated with individualized anesthetic management.

5. Patient with a history of spinal surgery presented with recurrent discitis at the L4-L5 level. Repeat surgical debridement and removal of infected disc material performed under general anesthesia. Intraoperative cultures collected for microbial analysis with precise anesthetic dosage administration.

6. Discitis identified on MRI at the L1-L2 level in a child with persistent back pain. CT-guided percutaneous aspiration and biopsy performed under conscious sedation to confirm the diagnosis and obtain samples for microbiological analysis. Empirical antibiotic therapy initiated with careful monitoring of anesthetic depth.

7. Patient with a known history of tuberculosis presented with discitis at the T6-T7 level. Image-guided percutaneous biopsy performed under local anesthesia to obtain tissue samples for acid-fast bacilli (AFB) staining and mycobacterial culture. Anti-tuberculosis therapy initiated with appropriate anesthesia dose adjustments.

8. Suspected discitis at the L5-S1 level in a patient with severe lumbar pain. Open discectomy and decompression performed under spinal anesthesia to remove the infected disc and alleviate pressure on neural structures. Intraoperative cultures obtained for pathogen identification with meticulous anesthesia dosage control.

9. Discitis suspected in a patient with a recent spinal procedure presenting with localized back pain. CT-guided biopsy performed at the T12-L1 level under moderate sedation to confirm the diagnosis. Empirical antibiotic therapy started pending culture results with careful monitoring of anesthetic effects.

10. Patient with chronic back pain and spinal implants diagnosed with discitis at the L3-L4 level. Surgical exploration and debridement performed under general anesthesia to remove infected tissue and hardware. Intraoperative cultures collected for microbial analysis with adjusted anesthetic dosing considering the patient's comorbidities.

1. Patient presented with severe back pain and imaging revealed discitis at the L4-L5 level with associated bone erosion. Percutaneous needle biopsy performed under local anesthesia to obtain tissue samples for culture and sensitivity testing. Empirical antibiotic therapy initiated with increased dosage due to the presence of bone erosion.

2. Discitis suspected in a patient with a history of intravenous drug use and imaging showed discitis at the L3-L4 level with significant bone erosion. CT-guided biopsy performed under moderate sedation to obtain tissue samples for histopathological examination. Empirical antibiotic therapy initiated with careful consideration of bone erosion and appropriate dosage adjustments.

3. Patient with persistent back pain diagnosed with discitis at the C6-C7 level with evidence of bone erosion on imaging. An anterior cervical corpectomy and fusion (ACCF) procedure performed under general anesthesia to remove the infected disc and stabilize the spine. Intraoperative cultures obtained for pathogen identification with meticulous attention to bone erosion.

4. Discitis suspected in an immunocompromised patient presenting with worsening back pain and imaging revealed discitis at the T9-T10 level with extensive bone erosion. Percutaneous image-guided biopsy performed under monitored anesthesia care to obtain tissue samples for culture and sensitivity testing. Empirical antibiotic therapy initiated with adjusted dosages considering the extent of bone erosion.

5. Patient with a history of spinal surgery presented with recurrent discitis at the L5-S1 level and imaging indicated significant bone erosion. Repeat surgical debridement and removal of infected disc material performed under general anesthesia. Intraoperative cultures collected for microbial analysis with meticulous attention to bone erosion and appropriate anesthetic dosage adjustments.

6. Discitis identified on MRI at the T12-L1 level in a child with persistent back pain and evidence of bone erosion. CT-guided percutaneous aspiration and biopsy performed under conscious sedation to confirm the diagnosis and obtain samples for microbiological analysis. Empirical antibiotic therapy initiated with careful monitoring of anesthetic depth and consideration of bone erosion.

7. Patient with a known history of tuberculosis presented with discitis at the L2-L3 level and imaging revealed extensive bone erosion. Image-guided percutaneous biopsy performed under local anesthesia to obtain tissue samples for acid-fast bacilli (AFB) staining and mycobacterial culture. Anti-tuberculosis therapy initiated with adjusted antibiotic dosages due to the presence of bone erosion.

8. Suspected discitis at the T6-T7 level in a patient with severe lumbar pain and imaging demonstrated significant bone erosion. Open discectomy and decompression performed under spinal anesthesia to remove the infected disc and alleviate pressure on neural structures. Intraoperative cultures obtained for pathogen identification with meticulous attention to bone erosion and precise anesthetic dosage administration.

9. Discitis suspected in a patient with a recent spinal procedure presenting with localized back pain and imaging revealing bone erosion at the L3-L4 level. CT-guided biopsy performed under moderate sedation to confirm the diagnosis. Empirical antibiotic therapy started pending culture results with careful monitoring of anesthetic effects and consideration of bone erosion.

10. Patient with chronic back pain and spinal implants diagnosed with discitis at the T8-T9 level with evidence of bone erosion on imaging. Surgical exploration and debridement performed under general anesthesia to remove infected tissue and hardware. Intraoperative cultures collected for microbial analysis with adjusted anesthetic dosing considering the presence of bone erosion.

1. Patient presented with severe back pain and excruciating bone pain localized to the affected area. Imaging revealed discitis at the L4-L5 level with extensive bone erosion. Percutaneous needle biopsy performed under local anesthesia to obtain tissue samples for culture and sensitivity testing. Empirical antibiotic therapy initiated with intensified dosage to address both discitis and severe bone pain.

2. Discitis suspected in a patient with a history of intravenous drug use experiencing severe bone pain. MRI showed discitis at the L3-L4 level with significant bone erosion and adjacent vertebral involvement. CT-guided biopsy performed under moderate sedation to obtain tissue samples for histopathological examination. Empirical antibiotic therapy initiated with tailored dosages to alleviate severe bone pain.

3. Patient with persistent back pain diagnosed with discitis at the C6-C7 level accompanied by severe bone pain. An anterior cervical corpectomy and fusion (ACCF) procedure performed under general anesthesia to remove the infected disc and stabilize the spine. Intraoperative cultures obtained for pathogen identification, with attention given to addressing severe bone pain through appropriate anesthetic management.

4. Discitis suspected in an immunocompromised patient presenting with excruciating back pain and severe bone pain. Imaging revealed discitis at the T9-T10 level with extensive bone erosion. Percutaneous image-guided biopsy performed under monitored anesthesia care to obtain tissue samples for culture and sensitivity testing. Empirical antibiotic therapy initiated, considering severe bone pain and individualized dosage adjustments.

5. Patient with a history of spinal surgery presented with recurrent discitis at the L5-S1 level and severe bone pain. Repeat surgical debridement and removal of infected disc material performed under general anesthesia. Intraoperative cultures collected for microbial analysis, with meticulous attention given to addressing severe bone pain through optimized anesthetic dosage management.

6. Discitis identified on MRI at the T12-L1 level in a child with persistent back pain and severe bone pain. CT-guided percutaneous aspiration and biopsy performed under conscious sedation to confirm the diagnosis and obtain samples for microbiological analysis. Empirical antibiotic therapy initiated, with careful monitoring of anesthetic depth and individualized pain management targeting severe bone pain.

7. Patient with a known history of tuberculosis presented with discitis at the L2-L3 level, accompanied by severe bone pain. Imaging revealed extensive bone erosion. Image-guided percutaneous biopsy performed under local anesthesia to obtain tissue samples for acid-fast bacilli (AFB) staining and mycobacterial culture. Anti-tuberculosis therapy initiated, addressing severe bone pain through optimal analgesic regimens.

8. Suspected discitis at the T6-T7 level in a patient with severe lumbar pain and debilitating bone pain. Imaging demonstrated significant bone erosion. Open discectomy and decompression performed under spinal anesthesia to remove the infected disc and alleviate pressure on neural structures. Intraoperative cultures obtained for pathogen identification, with attention given to managing severe bone pain through comprehensive pain management strategies.

9. Discitis suspected in a patient with a recent spinal procedure presenting with localized back pain and severe bone pain. Imaging revealed bone erosion at the L3-L4 level. CT-guided biopsy performed under moderate sedation to confirm the diagnosis. Empirical antibiotic therapy started pending culture results, addressing severe bone pain through tailored analgesic approaches.

10. Patient with chronic back pain and spinal implants diagnosed with discitis at the T8-T9 level, experiencing severe bone pain. Imaging revealed bone erosion. Surgical exploration and debridement performed under general anesthesia to remove infected tissue and hardware. Intraoperative cultures collected for microbial analysis, with individualized anesthetic management considering severe bone pain.

1. Patient presented with severe back pain and underwent surgical intervention for discitis at the L4-L5 level. A discectomy procedure was performed to remove the infected disc, followed by interbody fusion using a cage and bone graft to stabilize the affected segment. Postoperative pain management and antibiotic therapy initiated.

2. Discitis confirmed on imaging at the C6-C7 level, necessitating a surgical intervention. The patient underwent an anterior cervical discectomy and fusion (ACDF) procedure to remove the infected disc and restore spinal stability. Intraoperative cultures obtained for pathogen identification. Postoperative antibiotic therapy initiated.

3. Patient diagnosed with discitis at the T10-T11 level, requiring surgical intervention. A minimally invasive approach was utilized, with percutaneous endoscopic discectomy performed to remove the infected disc material and alleviate pressure on neural structures. Postoperative antibiotic therapy and pain management implemented.

4. Suspected discitis at the L3-L4 level in an immunocompromised patient. Surgical intervention involved an open transforaminal lumbar interbody fusion (TLIF) procedure with extensive debridement of the infected disc and adjacent tissues. Intraoperative cultures obtained to guide antibiotic selection. Postoperative antimicrobial therapy initiated.

5. Discitis suspected in a patient with a history of spinal surgery. Surgical intervention involved a posterior lumbar interbody fusion (PLIF) procedure at the L5-S1 level, with thorough debridement of the infected disc and placement of interbody cages. Intraoperative cultures collected for microbial analysis. Postoperative antibiotic therapy initiated.

6. Patient with chronic back pain diagnosed with discitis at the L2-L3 level. Surgical intervention consisted of a posterior spinal fusion procedure, using pedicle screw instrumentation and bone grafting to stabilize the affected segment. Intraoperative cultures obtained for pathogen identification. Postoperative antibiotic therapy initiated.

7. Discitis identified on imaging at the T9-T10 level, necessitating surgical intervention. The patient underwent a microdiscectomy procedure to remove the infected disc material and alleviate neural compression. Intraoperative cultures collected for microbial analysis. Postoperative antibiotic therapy and pain management implemented.

8. Suspected discitis at the L4-L5 level in a patient with severe lumbar pain. Surgical intervention involved a posterior lumbar discectomy, with meticulous debridement of the infected disc and decompression of nerve roots. Intraoperative cultures obtained to guide antibiotic selection. Postoperative antimicrobial therapy initiated.

9. Discitis suspected in a patient with a recent spinal procedure. Surgical intervention consisted of a minimally invasive percutaneous discectomy at the T12-L1 level, removing the infected disc material and relieving pressure on neural structures. Intraoperative cultures collected for microbial analysis. Postoperative antibiotic therapy initiated.

10. Patient with chronic back pain and spinal implants diagnosed with discitis at the T8-T9 level. Surgical intervention involved a revision procedure, with removal of the infected hardware and debridement of the adjacent tissues. Intraoperative cultures obtained for microbial analysis. Postoperative antibiotic therapy and pain management implemented.

1. Patient with discitis at the L3-L4 level underwent surgical intervention in the form of a posterior lumbar fusion. The infected disc was excised, and pedicle screw fixation with interbody cage placement was performed to stabilize the affected segment. Intraoperative cultures were obtained for pathogen identification. Postoperative antibiotic therapy and pain management initiated.

2. Discitis confirmed at the C4-C5 level, necessitating surgical intervention. The patient underwent an anterior cervical discectomy and fusion (ACDF) procedure, with removal of the infected disc and implantation of a bone graft and cervical plate for stabilization. Intraoperative cultures obtained for microbial analysis. Postoperative antibiotic therapy and pain control initiated.

3. Patient diagnosed with discitis at the T11-T12 level underwent surgical intervention in the form of a minimally invasive discectomy. The infected disc material was removed using specialized endoscopic techniques. Intraoperative cultures collected for pathogen identification. Postoperative antibiotic therapy and pain management implemented.

4. Suspected discitis at the L5-S1 level in an immunocompromised patient. Surgical intervention involved a posterior lumbar interbody fusion (PLIF) procedure, with debridement of the infected disc and insertion of an interbody cage. Intraoperative cultures obtained for microbial analysis. Postoperative antibiotic therapy and pain control initiated.

5. Discitis suspected in a patient with a history of spinal surgery. Surgical intervention involved an anterior lumbar interbody fusion (ALIF) procedure at the L2-L3 level, with removal of the infected disc and placement of a cage and bone graft. Intraoperative cultures collected for pathogen identification. Postoperative antibiotic therapy and pain management implemented.

6. Patient with chronic back pain diagnosed with discitis at the T7-T8 level underwent surgical intervention in the form of a posterolateral fusion. The infected disc was excised, and bone grafting with pedicle screw fixation was performed to stabilize the affected segment. Intraoperative cultures obtained for microbial analysis. Postoperative antibiotic therapy and pain control initiated.

7. Discitis identified on imaging at the T12-L1 level, necessitating surgical intervention. The patient underwent a microdiscectomy procedure to remove the infected disc material and alleviate neural compression. Intraoperative cultures collected for pathogen identification. Postoperative antibiotic therapy and pain management implemented.

8. Suspected discitis at the L4-L5 level in a patient with severe lumbar pain. Surgical intervention involved a lateral lumbar interbody fusion (LLIF) procedure, with removal of the infected disc and insertion of a cage. Intraoperative cultures obtained to guide antibiotic selection. Postoperative antimicrobial therapy and pain control initiated.

9. Discitis suspected in a patient with a recent spinal procedure. Surgical intervention consisted of a posterior spinal fusion procedure, using pedicle screw instrumentation and bone grafting to stabilize the affected segment. Intraoperative cultures obtained for pathogen identification. Postoperative antibiotic therapy and pain management implemented.

10. Patient with chronic back pain and spinal implants diagnosed with discitis at the T9-T10 level. Surgical intervention involved a revision procedure, with removal of the infected hardware and debridement of the adjacent tissues. Intraoperative cultures obtained for microbial analysis. Postoperative antibiotic therapy and pain control initiated.

1. Patient presented with severe infection in the hip joint, necessitating surgical intervention. An open arthrotomy procedure was performed to debride the infected tissues, followed by irrigation and placement of antibiotic-loaded cement spacers. Postoperative antibiotic therapy initiated, targeting the severe joint infection.

2. Severe infection observed in the shoulder joint of a patient, requiring surgical intervention. Arthroscopic debridement and lavage performed to remove infected tissues and flush out debris. Intraoperative cultures collected for pathogen identification. Postoperative antibiotic therapy initiated to address the severe joint infection.

3. Patient diagnosed with severe infection in the knee joint. Surgical intervention involved a total knee arthroplasty procedure, with removal of the infected joint components, thorough debridement, and implantation of a new prosthetic joint. Intraoperative cultures obtained for microbial analysis. Postoperative antibiotic therapy initiated to treat the severe joint infection.

4. Severe infection identified in the ankle joint, necessitating surgical intervention. An open arthrotomy procedure was performed to thoroughly debride the infected tissues, followed by irrigation and placement of antibiotic-impregnated beads. Postoperative antibiotic therapy initiated, targeting the severe joint infection.

5. Patient with severe infection in the elbow joint underwent surgical intervention. An open surgical approach was used to debride the infected joint tissues, followed by irrigation and placement of a drain. Intraoperative cultures collected for pathogen identification. Postoperative antibiotic therapy initiated to address the severe joint infection.

6. Severe infection observed in the hip joint, requiring surgical intervention. A two-stage revision procedure was performed, involving removal of the infected joint components, thorough debridement, and temporary placement of antibiotic-impregnated spacers. Intraoperative cultures obtained for microbial analysis. Postoperative antibiotic therapy initiated to treat the severe joint infection.

7. Patient diagnosed with severe infection in the shoulder joint. Surgical intervention involved an open arthroplasty procedure, with removal of the infected joint components and placement of a temporary antibiotic spacer. Intraoperative cultures collected for pathogen identification. Postoperative antibiotic therapy initiated to target the severe joint infection.

8. Severe infection identified in the knee joint, necessitating surgical intervention. A two-stage revision procedure was performed, involving removal of the infected joint components, thorough debridement, and temporary placement of antibiotic-loaded cement spacers. Intraoperative cultures obtained for microbial analysis. Postoperative antibiotic therapy initiated to address the severe joint infection.

9. Patient with severe infection in the ankle joint underwent surgical intervention. An arthroscopic debridement procedure was performed to remove infected tissues and flush out debris, followed by irrigation and placement of antibiotic-impregnated dressings. Intraoperative cultures collected for pathogen identification. Postoperative antibiotic therapy initiated to treat the severe joint infection.

10. Severe infection observed in the elbow joint, requiring surgical intervention. An open arthrotomy procedure was performed to thoroughly debride the infected tissues, followed by irrigation and placement of antibiotic-impregnated sponges. Intraoperative cultures obtained for microbial analysis. Postoperative antibiotic therapy initiated to target the severe joint infection.

1. Patient presented with severe joint infection and marked inflammation in the hip joint. Surgical intervention involved an open arthrotomy procedure with extensive debridement of infected tissues and irrigation. Intraoperative cultures obtained for pathogen identification. Postoperative antibiotic therapy and anti-inflammatory medications initiated to address the severe joint infection and reduce inflammation.

2. Severe joint infection with significant inflammation observed in the shoulder joint, necessitating surgical intervention. Arthroscopic debridement and lavage performed to remove infected tissues and reduce inflammation. Intraoperative cultures collected for microbial analysis. Postoperative antibiotic therapy and anti-inflammatory medications initiated to target the severe joint infection and manage inflammation.

3. Patient diagnosed with severe joint infection accompanied by extensive inflammation in the knee joint. Surgical intervention involved a total knee arthroplasty procedure, with meticulous debridement, irrigation, and implantation of a new prosthetic joint. Intraoperative cultures obtained for pathogen identification. Postoperative antibiotic therapy and anti-inflammatory medications initiated to treat the severe joint infection and reduce inflammation.

4. Severe joint infection and intense inflammation identified in the ankle joint, necessitating surgical intervention. An open arthrotomy procedure was performed to debride infected tissues, flush out debris, and reduce inflammation. Intraoperative cultures collected for microbial analysis. Postoperative antibiotic therapy and anti-inflammatory medications initiated to address the severe joint infection and manage inflammation.

5. Patient presented with severe joint infection and pronounced inflammation in the elbow joint. Surgical intervention involved an open surgical approach to debride infected joint tissues, reduce inflammation, and promote healing. Intraoperative cultures obtained for pathogen identification. Postoperative antibiotic therapy and anti-inflammatory medications initiated to treat the severe joint infection and alleviate inflammation.

6. Severe joint infection with notable inflammation observed in the hip joint, requiring surgical intervention. A two-stage revision procedure was performed, involving removal of infected joint components, extensive debridement, and temporary placement of antibiotic-impregnated spacers. Intraoperative cultures collected for microbial analysis. Postoperative antibiotic therapy and anti-inflammatory medications initiated to target the severe joint infection and manage inflammation.

7. Patient diagnosed with severe joint infection accompanied by significant inflammation in the shoulder joint. Surgical intervention involved an open arthroplasty procedure, with removal of infected joint components, debridement, and temporary placement of antibiotic spacers. Intraoperative cultures obtained for pathogen identification. Postoperative antibiotic therapy and anti-inflammatory medications initiated to treat the severe joint infection and reduce inflammation.

8. Severe joint infection and marked inflammation identified in the knee joint, necessitating surgical intervention. A two-stage revision procedure was performed, involving removal of infected joint components, extensive debridement, and temporary placement of antibiotic-loaded cement spacers. Intraoperative cultures obtained for microbial analysis. Postoperative antibiotic therapy and anti-inflammatory medications initiated to address the severe joint infection and manage inflammation.

9. Patient presented with severe joint infection and significant inflammation in the ankle joint. Surgical intervention involved an arthroscopic debridement procedure to remove infected tissues, flush out debris, and reduce inflammation. Intraoperative cultures collected for pathogen identification. Postoperative antibiotic therapy and anti-inflammatory medications initiated to treat the severe joint infection and alleviate inflammation.

10. Severe joint infection and notable inflammation observed in the elbow joint, requiring surgical intervention. An open arthrotomy procedure was performed to debride infected joint tissues, reduce inflammation, and promote healing. Intraoperative cultures obtained for microbial analysis. Postoperative antibiotic therapy and anti-inflammatory medications initiated to target the severe joint infection and manage inflammation.

1. The patient was diagnosed with a mild case of discitis, and conservative management was deemed appropriate. Follow-up scheduled in 2 weeks for reassessment of symptoms and response to oral antibiotics. Patient advised to continue pain management and adhere to the prescribed antibiotic regimen.

2. Given the moderate severity of discitis, the patient was recommended a combination of conservative management and close monitoring. Follow-up scheduled in 1 week for reevaluation of symptoms, laboratory markers, and response to intravenous antibiotic therapy. Imaging studies to be considered if there is no improvement or worsening of symptoms.

3. The diagnosis revealed a severe case of discitis, requiring immediate surgical intervention. The patient underwent a discectomy procedure and was transferred to the intensive care unit for postoperative monitoring. Follow-up planned in 48 hours for assessment of surgical site, pain control, and initiation of intravenous antibiotic therapy.

4. A moderate-to-severe case of discitis was diagnosed, necessitating hospital admission and intravenous antibiotic therapy. Follow-up scheduled in 3 days to assess the response to treatment, pain control, and laboratory markers. If there is no significant improvement, further imaging studies and consultation with a spine specialist will be considered.

5. The patient's discitis diagnosis indicated a mild-to-moderate severity. Conservative management with oral antibiotics and pain control was initiated. Follow-up scheduled in 1 week for reassessment of symptoms, adherence to the antibiotic regimen, and consideration of additional imaging studies if necessary.

6. Given the severity of discitis, immediate hospitalization and intravenous antibiotic therapy were initiated. Follow-up planned in 48 hours for assessment of clinical response, pain management, and laboratory markers. Additional imaging studies may be considered based on the patient's progress.

7. The diagnosis revealed a severe case of discitis, necessitating urgent surgical intervention. The patient underwent a discectomy procedure and was admitted to the intensive care unit for postoperative care. Follow-up scheduled in 24 hours to monitor surgical site, pain control, and response to intravenous antibiotic therapy.

8. A moderate-to-severe case of discitis was diagnosed, requiring hospital admission and intravenous antibiotic therapy. Follow-up scheduled in 3 days to assess the response to treatment, pain control, and laboratory markers. If there is no significant improvement, further imaging studies and consultation with a spine specialist will be considered.

9. The patient's discitis diagnosis indicated a mild-to-moderate severity, and conservative management with oral antibiotics and pain control was initiated. Follow-up scheduled in 2 weeks for reassessment of symptoms, adherence to the antibiotic regimen, and consideration of additional imaging studies if necessary.

10. Given the severity of discitis, immediate hospitalization and intravenous antibiotic therapy were initiated. Follow-up planned in 24 hours for assessment of clinical response, pain management, and laboratory markers. Additional imaging studies may be considered based on the patient's progress.

## M46.5 Other infective spondylopathies

1. Operative Note - Other Infective Spondylopathies: A posterior approach was utilized to access the affected vertebrae. After meticulous debridement of infected tissues, an autograft from the iliac crest was inserted and secured with pedicle screws. Wound irrigation and closure were performed using layered sutures. The patient tolerated the procedure well and was transferred to postoperative care for further management and monitoring.

2. Operative Note - Other Infective Spondylopathies: Through an anterior approach, the affected vertebral bodies were exposed and meticulously debrided. A structural allograft was inserted, providing stability and promoting fusion. The wound was meticulously irrigated and closed using layered sutures. Postoperatively, the patient was transferred to the recovery unit for continued care and monitoring.

3. Operative Note - Other Infective Spondylopathies: A minimally invasive technique was employed to access the infected vertebrae. After thorough debridement, a bone graft substitute was placed to restore vertebral height. The surgical site was meticulously irrigated and closed using absorbable sutures. The patient was extubated successfully and transferred to the post-anesthesia care unit for further recovery.

4. Operative Note - Other Infective Spondylopathies: Under fluoroscopic guidance, a percutaneous approach was used to access the affected vertebrae. A combination of curettage and local antibiotics was employed to clear the infection. Hemostasis was achieved, and the wounds were closed using steri-strips. The patient was transferred to the orthopedic ward for postoperative monitoring and further management.

5. Operative Note - Other Infective Spondylopathies: Through a lateral retroperitoneal approach, the infected vertebral bodies were accessed. Debridement and irrigation were performed meticulously, followed by placement of a titanium mesh cage and posterior instrumentation. The surgical incisions were closed layer by layer, and the patient was transferred to the intensive care unit for close postoperative monitoring.

6. Operative Note - Other Infective Spondylopathies: Using a transforaminal approach, the affected vertebral bodies were accessed. Extensive debridement and irrigation were performed to remove infected tissues. A bone graft and cage were placed for fusion and stabilization. The wound was closed with absorbable sutures, and the patient was transferred to the recovery area for further observation.

7. Operative Note - Other Infective Spondylopathies: An open anterior approach was used to access the infected vertebral bodies. The affected tissues were meticulously debrided, and a structural allograft was inserted to restore spinal alignment. The wound was irrigated and closed using absorbable sutures. The patient was extubated and transferred to the surgical ward for postoperative care and monitoring.

8. Operative Note - Other Infective Spondylopathies: A combination of anterior and posterior approaches was employed to address the infective spondylopathies. The anterior segment was approached first, followed by meticulous debridement and allograft insertion. The posterior approach involved pedicle screw fixation and fusion. Wound closure was performed using layered sutures. The patient was extubated successfully and transferred to the intensive care unit for further management.

9. Operative Note - Other Infective Spondylopathies: Utilizing a lateral extracavitary approach, the infected vertebral bodies were accessed. After thorough debridement, a combination of autograft and allograft was placed for fusion. The surgical site was irrigated meticulously, and the wound was closed using a layered suture technique. The patient was transferred to the post-anesthesia care unit for recovery and monitoring.

10. Operative Note - Other Infective Spondylopathies: A posterior midline approach was employed to access the affected vertebrae. Extensive debridement was performed, and a titanium mesh cage was inserted to restore stability. Posterior instrumentation and fusion were achieved using pedicle screws and rods. The wound was closed meticulously using absorbable sutures. The patient was transferred to the recovery area for postoperative care and monitoring.

1. Operative Note - Other Infective Spondylopathies: Through a posterior-lateral approach, the infected vertebral bodies were accessed. Debridement and irrigation were meticulously performed, followed by placement of a bone graft and anterior plate fixation for stabilization. The surgical site was closed layer by layer using absorbable sutures. The patient tolerated the procedure well and was transferred to the intensive care unit for postoperative monitoring and further management.

2. Operative Note - Other Infective Spondylopathies: Using a transoral approach, the affected vertebral bodies were accessed. Extensive debridement and irrigation were performed to eliminate the infection. An anterior cage and plate fixation were placed to restore stability. The wound was meticulously closed using absorbable sutures. Postoperatively, the patient was transferred to the neurological unit for close observation and further care.

3. Operative Note - Other Infective Spondylopathies: Under image guidance, a percutaneous approach was employed to access the infected vertebrae. Debridement and thorough irrigation were performed to eradicate the infection. A synthetic bone substitute was used to fill the defect. The surgical incisions were closed using steri-strips. The patient was transferred to the orthopedic ward for postoperative monitoring and continued management.

4. Operative Note - Other Infective Spondylopathies: Utilizing a minimally invasive lateral approach, the infected vertebral bodies were accessed. Debridement and meticulous irrigation were performed, followed by placement of a structural allograft and posterior screw-rod fixation. The wound was closed layer by layer using absorbable sutures. The patient was extubated successfully and transferred to the post-anesthesia care unit for further recovery and monitoring.

5. Operative Note - Other Infective Spondylopathies: A combination of anterior and posterior approaches was employed to address the infective spondylopathies. The anterior segment was approached first, involving thorough debridement and allograft insertion. The posterior approach included pedicle screw fixation and fusion. The surgical site was meticulously irrigated and closed using absorbable sutures. The patient was extubated and transferred to the surgical ward for postoperative care and close monitoring.

6. Operative Note - Other Infective Spondylopathies: Through a thoracolumbar approach, the infected vertebral bodies were accessed. Debridement and irrigation were performed meticulously to remove infected tissues. A titanium mesh cage and posterior instrumentation were placed for stabilization and fusion. The wound was closed using absorbable sutures. Postoperatively, the patient was transferred to the orthopedic intensive care unit for continued observation and further management.

7. Operative Note - Other Infective Spondylopathies: Utilizing a retroperitoneal approach, the infected vertebral bodies were accessed. Thorough debridement and irrigation were performed, followed by placement of an expandable cage and posterior pedicle screw fixation. The wound was meticulously closed using layered sutures. The patient tolerated the procedure well and was transferred to the post-anesthesia care unit for further recovery and monitoring.

8. Operative Note - Other Infective Spondylopathies: An anterior retropharyngeal approach was used to access the infected vertebral bodies. Debridement and irrigation were meticulously performed to remove infected tissues. An anterior plate and cage were placed for stabilization and fusion. The surgical incision was closed layer by layer using absorbable sutures. Postoperatively, the patient was transferred to the neurosurgical unit for close observation and further care.

9. Operative Note - Other Infective Spondylopathies: Through a lateral transpsoas approach, the infected vertebral bodies were accessed. Extensive debridement and irrigation were performed to eradicate the infection. A structural autograft was inserted, providing stability and promoting fusion. The surgical site was meticulously closed using absorbable sutures. The patient was transferred to the recovery unit for postoperative monitoring and further management.

10. Operative Note - Other Infective Spondylopathies: Using a posterior-lateral extracavitary approach, the infected vertebral bodies were accessed. Debridement and irrigation were meticulously performed to remove infected tissues. A combination of bone graft and cage was placed for fusion and stabilization. The wound was closed with layered sutures. The patient tolerated the procedure well and was transferred to the orthopedic ward for postoperative care and close monitoring.

1. Operative Note - Other Infective Spondylopathies: Under general anesthesia with endotracheal intubation, a posterior approach was utilized to access the affected vertebrae. After meticulous debridement of infected tissues, an autograft from the iliac crest was inserted and secured with pedicle screws. The patient tolerated the procedure well, and anesthesia dosage was carefully monitored throughout the surgery.

2. Operative Note - Other Infective Spondylopathies: Using monitored anesthesia care (MAC) with intravenous sedation, a lateral retroperitoneal approach was employed to access the infected vertebral bodies. Debridement and irrigation were meticulously performed, followed by the placement of a titanium mesh cage and posterior instrumentation. The patient remained stable under the controlled anesthesia dosage, and recovery was smooth.

3. Operative Note - Other Infective Spondylopathies: A combination of general anesthesia and regional anesthesia was administered to the patient. A transforaminal approach was used to access the infected vertebrae. Extensive debridement and irrigation were performed, and a bone graft substitute was placed. The anesthesia dosage was adjusted carefully to ensure optimal pain management and patient comfort.

4. Operative Note - Other Infective Spondylopathies: Under general anesthesia with controlled hypotension, a minimally invasive technique was employed to access the infected vertebrae. Thorough debridement and irrigation were performed, followed by the placement of a bone graft and cage. The anesthesia dosage was adjusted to maintain appropriate blood pressure levels throughout the surgery.

5. Operative Note - Other Infective Spondylopathies: Utilizing spinal anesthesia combined with sedation, a posterior midline approach was employed to access the affected vertebrae. Extensive debridement and irrigation were performed, followed by the placement of a structural allograft and posterior instrumentation. The anesthesia dosage was carefully adjusted to ensure the patient's comfort and minimize intraoperative pain.

6. Operative Note - Other Infective Spondylopathies: Under general anesthesia with controlled ventilation, a transoral approach was used to access the infected vertebral bodies. Extensive debridement and irrigation were performed, followed by the placement of an anterior cage and plate fixation. The anesthesia dosage was meticulously adjusted to maintain optimal airway control and ventilation throughout the procedure.

7. Operative Note - Other Infective Spondylopathies: Using monitored anesthesia care (MAC) with regional nerve block, a percutaneous approach was employed to access the infected vertebrae. Debridement and thorough irrigation were performed, followed by the placement of a bone graft substitute. The anesthesia dosage was carefully titrated to ensure effective pain control and patient comfort during the surgery.

8. Operative Note - Other Infective Spondylopathies: Under general anesthesia with controlled hypotension, a combination of anterior and posterior approaches was employed to address the infective spondylopathies. The anterior segment involved thorough debridement and allograft insertion, while the posterior approach included pedicle screw fixation and fusion. The anesthesia dosage was adjusted to maintain optimal blood pressure levels throughout the surgical procedure.

9. Operative Note - Other Infective Spondylopathies: Using a regional anesthesia technique with conscious sedation, a thoracolumbar approach was employed to access the infected vertebral bodies. Debridement and irrigation were meticulously performed, followed by the placement of a titanium mesh cage and posterior instrumentation. The anesthesia dosage was carefully monitored to ensure patient comfort and cooperation during the surgery.

10. Operative Note - Other Infective Spondylopathies: Under general anesthesia with controlled ventilation and neuromuscular blockade, a retroperitoneal approach was used to access the infected vertebrae. Thorough debridement and irrigation were performed, followed by the placement of an expandable cage and posterior pedicle screw fixation. The anesthesia dosage was meticulously adjusted to maintain optimal muscle relaxation and ventilation throughout the procedure.

1. Operative Note - Other Infective Spondylopathies with Bone Erosion: A posterior approach was utilized to access the affected vertebrae. Extensive debridement was performed to remove infected tissues and address bone erosion. An allograft and anterior cage were inserted for stability and fusion. The surgical site was closed meticulously using absorbable sutures. The patient tolerated the procedure well, and postoperative imaging confirmed successful removal of infected and eroded bone.

2. Operative Note - Other Infective Spondylopathies with Bone Erosion: Using a transoral approach, the infected vertebral bodies with significant bone erosion were accessed. Thorough debridement and irrigation were performed to eliminate infection and remove eroded bone. An anterior cage and plate fixation were placed to restore stability. The wound was meticulously closed using absorbable sutures. Postoperatively, the patient showed improvement in symptoms, and radiographic evaluation demonstrated resolution of bone erosion.

3. Operative Note - Other Infective Spondylopathies with Bone Erosion: Through a lateral retroperitoneal approach, the infected vertebral bodies with severe bone erosion were accessed. Debridement and irrigation were meticulously performed to remove infected tissues and address bone erosion. A combination of autograft and allograft was placed for fusion and stabilization. The wound was closed with layered sutures. The patient showed postoperative improvement, and follow-up imaging revealed resolution of bone erosion.

4. Operative Note - Other Infective Spondylopathies with Bone Erosion: Under general anesthesia, a minimally invasive technique was employed to address infective spondylopathies with bone erosion. Extensive debridement and irrigation were performed, targeting both infected tissues and eroded bone. A structural allograft was inserted to restore vertebral height and stability. The surgical site was meticulously closed using absorbable sutures. Postoperatively, the patient demonstrated resolution of symptoms and improvement in bone erosion on imaging.

5. Operative Note - Other Infective Spondylopathies with Bone Erosion: Utilizing a combination of anterior and posterior approaches, the infected vertebral bodies with bone erosion were addressed. Thorough debridement and irrigation were performed to remove infected tissues and eroded bone. Structural allografts and posterior instrumentation were placed for stabilization and fusion. The wound was meticulously closed using absorbable sutures. Follow-up imaging revealed successful resolution of bone erosion and improvement in spinal alignment.

6. Operative Note - Other Infective Spondylopathies with Bone Erosion: Through a posterior-lateral approach, the infected vertebral bodies with significant bone erosion were accessed. Debridement and irrigation were meticulously performed, targeting both infected tissues and eroded bone. An expandable cage and posterior screw-rod fixation were utilized for stability and fusion. The surgical site was closed layer by layer using absorbable sutures. Postoperatively, the patient demonstrated improved symptoms and resolution of bone erosion on imaging.

7. Operative Note - Other Infective Spondylopathies with Bone Erosion: Using a transforaminal approach, the affected vertebral bodies with bone erosion were accessed. Extensive debridement and irrigation were performed to remove infected tissues and address bone erosion. Bone graft substitute and a cage were inserted for stabilization. The wound was meticulously closed using absorbable sutures. Follow-up imaging revealed successful resolution of bone erosion and restoration of vertebral height.

8. Operative Note - Other Infective Spondylopathies with Bone Erosion: Under general anesthesia, a lateral transpsoas approach was employed to access the infected vertebrae with bone erosion. Debridement and thorough irrigation were performed, targeting both infected tissues and eroded bone. A combination of bone graft and expandable cage was placed to restore vertebral height and stability. The wound was closed with layered sutures. Postoperatively, the patient demonstrated improvement in symptoms and resolution of bone erosion on imaging.

9. Operative Note - Other Infective Spondylopathies with Bone Erosion: Through a retroperitoneal approach, the infected vertebral bodies with bone erosion were accessed. Thorough debridement and irrigation were performed to remove infected tissues and address bone erosion. A titanium mesh cage and posterior pedicle screw fixation were used for stabilization and fusion. The wound was meticulously closed using absorbable sutures. Follow-up imaging confirmed successful resolution of bone erosion and improvement in spinal alignment.

10. Operative Note - Other Infective Spondylopathies with Bone Erosion: Utilizing a thoracolumbar approach, the infected vertebral bodies with bone erosion were accessed. Debridement and irrigation were meticulously performed, targeting both infected tissues and eroded bone. A combination of bone graft and anterior plate fixation was used for stabilization. The wound was closed meticulously using absorbable sutures. Postoperatively, the patient showed resolution of symptoms and improvement in bone erosion on imaging.

1. Operative Note - Other Infective Spondylopathies with Severe Bone Pain: A posterior approach was utilized to access the affected vertebrae in a patient experiencing severe bone pain. Extensive debridement was performed to remove infected tissues and alleviate the source of pain. An autograft and anterior cage were inserted for stabilization. The wound was meticulously closed using absorbable sutures. The patient experienced relief from severe bone pain postoperatively.

2. Operative Note - Other Infective Spondylopathies with Severe Bone Pain: Utilizing a transoral approach, the infected vertebral bodies were accessed in a patient with severe bone pain. Thorough debridement and irrigation were performed to eliminate infection and alleviate bone pain. An anterior cage and plate fixation were placed to restore stability. The wound was meticulously closed using absorbable sutures. The patient reported significant reduction in severe bone pain following the procedure.

3. Operative Note - Other Infective Spondylopathies with Severe Bone Pain: Through a lateral retroperitoneal approach, the infected vertebral bodies were accessed in a patient experiencing severe bone pain. Debridement and irrigation were meticulously performed to remove infected tissues and alleviate bone pain. Structural autografts and posterior instrumentation were placed for stabilization. The wound was closed with layered sutures. The patient reported relief from severe bone pain postoperatively.

4. Operative Note - Other Infective Spondylopathies with Severe Bone Pain: Under general anesthesia, a minimally invasive technique was employed to address infective spondylopathies in a patient with severe bone pain. Extensive debridement and irrigation were performed, targeting infected tissues and addressing the source of severe bone pain. A bone graft and cage were inserted to restore stability. The surgical site was meticulously closed using absorbable sutures. Postoperatively, the patient experienced significant reduction in severe bone pain.

5. Operative Note - Other Infective Spondylopathies with Severe Bone Pain: Utilizing a combination of anterior and posterior approaches, the infected vertebral bodies were addressed in a patient with severe bone pain. Thorough debridement and irrigation were performed to remove infected tissues and alleviate bone pain. Structural allografts and posterior instrumentation were placed for stabilization. The wound was meticulously closed using absorbable sutures. The patient reported relief from severe bone pain following the procedure.

6. Operative Note - Other Infective Spondylopathies with Severe Bone Pain: Through a posterior-lateral approach, the infected vertebral bodies were accessed in a patient experiencing severe bone pain. Debridement and irrigation were meticulously performed, targeting infected tissues and alleviating bone pain. An expandable cage and posterior screw-rod fixation were utilized for stability and fusion. The surgical site was closed layer by layer using absorbable sutures. The patient reported significant reduction in severe bone pain postoperatively.

7. Operative Note - Other Infective Spondylopathies with Severe Bone Pain: Using a transforaminal approach, the affected vertebral bodies were accessed in a patient with severe bone pain. Extensive debridement and irrigation were performed to remove infected tissues and alleviate bone pain. Bone graft substitute and a cage were inserted for stabilization. The wound was meticulously closed using absorbable sutures. The patient reported relief from severe bone pain following the procedure.

8. Operative Note - Other Infective Spondylopathies with Severe Bone Pain: Under general anesthesia, a lateral transpsoas approach was employed to access the infected vertebrae in a patient experiencing severe bone pain. Debridement and thorough irrigation were performed, targeting infected tissues and addressing the source of severe bone pain. A combination of bone graft and expandable cage was placed to restore vertebral height and stability. The surgical site was closed with layered sutures. The patient reported significant reduction in severe bone pain postoperatively.

9. Operative Note - Other Infective Spondylopathies with Severe Bone Pain: Through a retroperitoneal approach, the infected vertebral bodies were accessed in a patient with severe bone pain. Thorough debridement and irrigation were performed, targeting infected tissues and alleviating bone pain. A titanium mesh cage and posterior pedicle screw fixation were used for stabilization and fusion. The wound was meticulously closed using absorbable sutures. The patient reported relief from severe bone pain following the procedure.

10. Operative Note - Other Infective Spondylopathies with Severe Bone Pain: Utilizing a thoracolumbar approach, the infected vertebral bodies were accessed in a patient experiencing severe bone pain. Debridement and irrigation were meticulously performed, targeting infected tissues and alleviating bone pain. A combination of bone graft and anterior plate fixation was used for stabilization. The wound was closed meticulously using absorbable sutures. The patient reported significant reduction in severe bone pain postoperatively.

1. Operative Note - Other Infective Spondylopathies with Surgical Intervention: A posterior approach was utilized to access the affected vertebrae. Extensive debridement was performed to remove infected tissues. A segmental spinal instrumentation system was inserted to provide stability and support. The surgical site was meticulously closed using absorbable sutures. The patient tolerated the procedure well, and postoperative imaging confirmed successful surgical intervention for infective spondylopathies.

2. Operative Note - Other Infective Spondylopathies with Surgical Intervention: Utilizing a transoral approach, the infected vertebral bodies were accessed. Thorough debridement and irrigation were performed to eliminate infection. An anterior cervical discectomy and fusion (ACDF) procedure was performed to stabilize the spine. The wound was meticulously closed using absorbable sutures. The patient reported improvement in symptoms following the surgical intervention.

3. Operative Note - Other Infective Spondylopathies with Surgical Intervention: Through a lateral retroperitoneal approach, the infected vertebral bodies were accessed. Debridement and irrigation were meticulously performed to remove infected tissues. A posterior spinal fusion with pedicle screw fixation was performed to provide stability. The wound was closed with layered sutures. The patient tolerated the surgical intervention well, and postoperative imaging showed successful stabilization of the spine.

4. Operative Note - Other Infective Spondylopathies with Surgical Intervention: Under general anesthesia, a minimally invasive approach was employed to address infective spondylopathies. Extensive debridement and irrigation were performed to remove infected tissues. A posterior interbody fusion with cage and posterior instrumentation was performed to stabilize the spine. The surgical site was meticulously closed using absorbable sutures. The patient demonstrated improvement in symptoms following the surgical intervention.

5. Operative Note - Other Infective Spondylopathies with Surgical Intervention: Utilizing a combination of anterior and posterior approaches, the infected vertebral bodies were addressed. Thorough debridement and irrigation were performed to remove infected tissues. An anterior cervical corpectomy and fusion (ACCF) procedure, along with posterior pedicle screw fixation, were performed to stabilize the spine. The wound was meticulously closed using absorbable sutures. The patient showed improvement in symptoms following the surgical intervention.

6. Operative Note - Other Infective Spondylopathies with Surgical Intervention: Through a posterior-lateral approach, the infected vertebral bodies were accessed. Debridement and irrigation were meticulously performed to remove infected tissues. A circumferential fusion with anterior cage and posterior pedicle screw fixation was performed to provide stability. The surgical site was closed layer by layer using absorbable sutures. The patient tolerated the surgical intervention well, and postoperative imaging confirmed successful stabilization of the spine.

7. Operative Note - Other Infective Spondylopathies with Surgical Intervention: Using a transforaminal approach, the affected vertebral bodies were accessed. Extensive debridement and irrigation were performed to remove infected tissues. A posterior lumbar interbody fusion (PLIF) procedure was performed to stabilize the spine. The wound was meticulously closed using absorbable sutures. The patient reported improvement in symptoms following the surgical intervention.

8. Operative Note - Other Infective Spondylopathies with Surgical Intervention: Under general anesthesia, a lateral transpsoas approach was employed to access the infected vertebrae. Debridement and thorough irrigation were performed to remove infected tissues. A lateral lumbar interbody fusion (LLIF) procedure was performed to stabilize the spine. The surgical sitewas closed with layered sutures. The patient demonstrated improvement in symptoms following the surgical intervention.

9. Operative Note - Other Infective Spondylopathies with Surgical Intervention: Through a retroperitoneal approach, the infected vertebral bodies were accessed. Thorough debridement and irrigation were performed to remove infected tissues. An anterior lumbar interbody fusion (ALIF) procedure was performed to stabilize the spine. The wound was meticulously closed using absorbable sutures. The patient reported improvement in symptoms following the surgical intervention.

10. Operative Note - Other Infective Spondylopathies with Surgical Intervention: Utilizing a thoracolumbar approach, the infected vertebral bodies were accessed. Debridement and irrigation were meticulously performed to remove infected tissues. A posterior spinal fusion with pedicle screw fixation and interbody cage placement was performed to stabilize the spine. The wound was closed meticulously using absorbable sutures. The patient demonstrated improvement in symptoms following the surgical intervention.

1. Operative Note - Other Infective Spondylopathies with Surgical Intervention: A posterior approach was utilized to access the infected vertebrae. Thorough debridement and irrigation were performed to remove infected tissues. A spinal fusion with bone graft and posterior instrumentation was performed to stabilize the spine. The wound was meticulously closed using absorbable sutures. The patient tolerated the surgical intervention well, and postoperative imaging confirmed successful stabilization of the spine.

2. Operative Note - Other Infective Spondylopathies with Surgical Intervention: Utilizing a transoral approach, the infected vertebral bodies were accessed. Debridement and irrigation were meticulously performed to eliminate infection. An anterior cervical discectomy and fusion (ACDF) procedure was performed to stabilize the affected levels. The wound was closed meticulously using absorbable sutures. The patient demonstrated improvement in symptoms following the surgical intervention.

3. Operative Note - Other Infective Spondylopathies with Surgical Intervention: Through a lateral retroperitoneal approach, the infected vertebral bodies were accessed. Extensive debridement and irrigation were performed to remove infected tissues. A posterior spinal fusion with pedicle screw fixation and interbody cage placement was performed for stabilization. The wound was closed with layered sutures. The patient tolerated the surgical intervention well, and postoperative imaging showed successful stabilization of the spine.

4. Operative Note - Other Infective Spondylopathies with Surgical Intervention: Under general anesthesia, a minimally invasive approach was employed to address infective spondylopathies. Thorough debridement and irrigation were performed to remove infected tissues. A posterior interbody fusion with expandable cage and pedicle screw fixation was performed for stabilization. The surgical site was meticulously closed using absorbable sutures. The patient showed improvement in symptoms following the surgical intervention.

5. Operative Note - Other Infective Spondylopathies with Surgical Intervention: Utilizing a combination of anterior and posterior approaches, the infected vertebral bodies were addressed. Debridement and irrigation were meticulously performed to remove infected tissues. An anterior cervical corpectomy and fusion (ACCF) procedure, along with posterior pedicle screw fixation, were performed to stabilize the affected levels. The wound was closed with layered sutures. The patient reported improvement in symptoms following the surgical intervention.

6. Operative Note - Other Infective Spondylopathies with Surgical Intervention: Through a posterior-lateral approach, the infected vertebral bodies were accessed. Thorough debridement and irrigation were performed to remove infected tissues. A circumferential fusion with anterior cage and posterior pedicle screw fixation was performed to provide stability. The wound was meticulously closed using absorbable sutures. The patient tolerated the surgical intervention well, and postoperative imaging confirmed successful stabilization of the spine.

7. Operative Note - Other Infective Spondylopathies with Surgical Intervention: Using a transforaminal approach, the affected vertebral bodies were accessed. Extensive debridement and irrigation were performed to remove infected tissues. A posterior lumbar interbody fusion (PLIF) procedure with pedicle screw fixation was performed for stabilization. The wound was meticulously closed using absorbable sutures. The patient reported improvement in symptoms following the surgical intervention.

8. Operative Note - Other Infective Spondylopathies with Surgical Intervention: Under general anesthesia, a lateral transpsoas approach was employed to access the infected vertebrae. Debridement and thorough irrigation were performed to remove infected tissues. A lateral lumbar interbody fusion (LLIF) procedure with pedicle screw fixation was performed for stabilization. The surgical site was closed with layered sutures. The patient demonstrated improvement in symptoms following the surgical intervention.

9. Operative Note - Other Infective Spondylopathies with Surgical Intervention: Through a retroperitoneal approach, the infected vertebral bodies were accessed. Thorough debridement and irrigation were performed to remove infected tissues. An anterior lumbar interbody fusion (ALIF) procedure with posterior pedicle screw fixation was performed to stabilize the spine. The wound was meticulously closed using absorbable sutures. The patient reported improvement in symptoms following the surgical intervention.

10. Operative Note - Other Infective Spondylopathies with Surgical Intervention: Utilizing a thoracolumbar approach, the infected vertebral bodies were accessed. Debridement and irrigation were meticulously performed to remove infected tissues. A posterior spinal fusion with pedicle screw fixation and interbody cage placement was performed for stabilization. The wound was closed meticulously using absorbable sutures. The patient demonstrated improvement in symptoms following the surgical intervention.