PRE AND POSTOPERATIVE DIAGNOSIS:, Left cervical radiculopathy at C5, C6,OPERATION: , Left C5-6 hemilaminotomy and foraminotomy with medial facetectomy for microscopic decompression of nerve root.,After informed consent was obtained from the patient, he was taken to the OR. After general anesthesia had been induced, Ted hose stockings and pneumatic compression stockings were placed on the patient and a Foley catheter was also inserted. At this point, the patient's was placed in three point fixation with a Mayfield head holder and then the patient was placed on the operating table in a prone position. The patient's posterior cervical area was then prepped and draped in the usual sterile fashion. At this time the patient's incision site was infiltrated with 1 percent Lidocaine with epinephrine. A scalpel was used to make an approximate 3 cm skin incision cephalad to the prominent C7 spinous processes, which could be palpated. After dissection down to a spinous process using Bovie cautery, a clamp was placed on this spinous processes and cross table lateral x-ray was taken. This showed the spinous process to be at the C4 level. Therefore, further soft tissue dissection was carried out caudally to this level after the next spinous processes presumed to be C5 was identified. After the muscle was dissected off the lamina laterally on the left side, self retaining retractors were placed and after hemostasis was achieved, a Penfield probe was placed in the interspace presumed to be C5-6 and another cross table lateral x-ray of the C spine was taken. This film confirmed our position at C5-6 and therefore the operating microscope was

brought onto the field at this time. At the time the Kerrison rongeur was used to perform a hemilaminotomy by starting with the inferior margin of the superior lamina. The superior margin of the inferior lamina of C6 was also taken with the Kerrison rongeur after the ligaments had been freed by using a Woodson probe. This was then extended laterally to perform a medial facetectomy also using the Kerrison rongeur. However, progress was limited because of thickness of the bone. Therefore at this time the Midas-Rex drill, the AM8 bit was brought onto the field and this was used to thin out the bone around our laminotomy and medial facetectomy area. After the bone had been thinned out, further bone was removed using the Kerrison rongeur. At this point the nerve root was visually inspected and observed to be decompressed. However, there was a layer of fibrous tissue overlying the exiting nerve root which was removed by placing a Woodson resector in a plane between the fibrous sheath and the nerve root and incising it with a 15 blade. Hemostasis was then achieved by using Gelfoam as well as bipolar electrocautery. After hemostasis was achieved, the surgical site was copiously irrigated with Bacitracin. Closure was initiated by closing the muscle layer and the fascial layer with 0 Vicryl stitches. The subcutaneous layer was then reapproximated using 000 Dexon. The skin was reapproximated using a running 000 nylon. Sterile dressings were applied. The patient was then extubated in the OR and transferred to the Recovery room in stable condition.,ESTIMATED BLOOD LOSS:, minimal.