PREOPERATIVE DIAGNOSES:,1. Epidural hematoma, cervical spine.,2. Status post cervical laminectomy, C3 through C7 postop day #10.,3. Central cord syndrome.,4. Acute quadriplegia.,POSTOPERATIVE DIAGNOSES:,1. Epidural hematoma, cervical spine.,2. Status post cervical laminectomy, C3 through C7 postop day #10.,3. Central cord syndrome.,4. Acute quadriplegia.,PROCEDURE PERFORMED:,1. Evacuation of epidural hematoma.,2. Insertion of epidural drain.,ANESTHESIA: , General.,COMPLICATIONS: ,None.,ESTIMATED BLOOD LOSS: ,200 cc.,HISTORY: ,This is a 64-year-old female who has had an extensive medical history beginning with coronary artery bypass done on emergent basis while she was in Maryland in April of 2003 after having myocardial infarction. She was then transferred to Beaumont Hospital, at which point, she developed a sternal abscess. The patient was treated for the abscess in Beaumont and then subsequently transferred to some other type of facility near her home in Warren, Michigan at which point, she developed a second what was termed minor myocardial infarction.,The patient subsequently recovered in a Cardiac Rehab Facility and approximately two weeks later, brings us to the month of August, at which time she was at home ambulating with a walker or a cane, and then sustained a fall and at that point she was unable to walk and had acute progressive weakness and was identified as having a central cord syndrome based on an MRI, which showed record signal change. The patient underwent cervical laminectomy and seemed to be improving

subjectively in terms of neurologic recovery, but objectively there was not much improvement. Approximately 10 days after the surgery, brings us to today's date, the health officer was notified of the patient's labored breathing. When she examined the patient, she also noted that the patient was unable to move her extremities. She was concerned and called the Orthopedic resident who identified the patient to be truly quadriplegic. I was notified and ordered the operative crew to report immediately and recommended emergent decompression for the possibility of an epidural hematoma. On clinical examination, there was swelling in the posterior aspect of the neck. The patient has no active movement in the upper and lower extremity muscle groups. Reflexes are absent in the upper and lower extremities. Long track signs are absent. Sensory level is at the C4 dermatome. Rectal tone is absent. I discussed the findings with the patient and also the daughter. We discussed the possibility of this is permanent quadriplegia, but at this time, the compression of the epidural space was warranted and certainly for exploration reasons be sure that there is a hematoma there and they have agreed to proceed with surgery. They are aware that it is possible she had known permanent neurologic status regardless of my intervention and they have agreed to accept this and has signed the consent form for surgery.,OPERATIVE PROCEDURE: ,The patient was taken to OR #1 at ABCD General Hospital on a gurney. Department of Anesthesia administered fiberoptic intubation and general anesthetic. A Foley catheter was placed in the bladder. The

patient was log rolled in a prone position on the Jackson table. Bony prominences were well padded. The patient's head was placed in the prone view anesthesia head holder. At this point, the wound was examined closely and there was hematoma at the caudal pole of the wound. Next, the patient was prepped and draped in the usual sterile fashion. The previous skin incision was reopened. At this point, hematoma properly exits from the wound. All sutures were removed and the epidural spaces were encountered at this time. The self-retaining retractors were placed in the depth of the wound. Consolidated hematoma was now removed from the wound. Next, the epidural space was encountered. There was no additional hematoma in the epidural space or on the thecal sac. A curette was carefully used to scrape along the thecal sac and there was no film or lining covering the sac. The inferior edge of the C2 lamina was explored and there was no compression at this level and the superior lamina of T1 was explored and again no compression was identified at this area as well. Next, the wound was irrigated copiously with one liter of saline using a syringe. The walls of the wound were explored. There was no active bleeding. Retractors were removed at this time and even without pressure on the musculature, there was no active bleeding. A #19 French Hemovac drain was passed percutaneously at this point and placed into the epidural space. Fascia was reapproximated with #1 Vicryl sutures, subcutaneous tissue with #3-0 Vicryl sutures. Steri-Strips covered the incision and dressing was then applied over the incision. The patient was then log rolled

in the supine position on the hospital gurney. She remained intubated for airway precautions and transferred to the recovery room in stable condition. Once in the recovery room, she was alert. She was following simple commands and using her head to nod, but she did not have any active movement of her upper or lower extremities. Prognosis for this patient is guarded.