PREOPERATIVE DIAGNOSES: ,1. Large herniated nucleus pulposus, C5-C6 with myelopathy (722.21).,2. Cervical spondylosis.,3. Cervical stenosis, C5-C6 secondary to above (723.0).,POSTOPERATIVE DIAGNOSES: ,1. Large herniated nucleus pulposus, C5-C6 with myelopathy (722.21).,2. Cervical spondylosis.,3. Cervical stenosis, C5-C6 secondary to above (723.0), with surgical findings confirmed.,PROCEDURES: , ,1. Anterior cervical discectomy at C5-C6 with spinal cord and spinal canal decompression (63075).,2. Anterior interbody fusion at C5-C6, (22554) utilizing Bengal cage (22851).,3. Anterior instrumentation for stabilization by Uniplate construction, C5-C6, (22845); with intraoperative x-ray times two.,ANESTHESIA: , General.,SERVICE: , Neurosurgery.,OPERATION: ,The patient was brought into the operating room, placed in a supine position where general anesthesia was administered. Then the anterior aspect of the neck was prepped and draped in a routine sterile fashion. A linear skin incision was made in the skin fold line from just to the right of the midline to the leading edge of the right sternocleidomastoid muscle and taken sharply to platysma, which was dissected only in a subplatysmal manner bluntly, and with only blunt dissection at the prevertebral space where a localizing intraoperative x-ray was obtained, once self-retaining retractors were placed along the mesial edge of a cauterized longus colli muscle, to protect surrounding tissues throughout the remainder of the case. A prominent anterior osteophyte at C5-C6 was then localized, compared to preoperative studies in the usual fashion

intraoperatively, and the osteophyte was excised with a rongeur and bony fragments saved. This allowed for an annulotomy, which was carried out with a #11 blade and discectomy, removed with straight disc forceps portions of the disc, which were sent to Pathology for a permanent section. Residual osteophytes and disc fragments were removed with 1 and 2-mm micro Kerrison rongeurs as necessary as drilling extended into normal cortical and cancellous elements widely laterally as well. A hypertrophied ligament and prominent posterior spurs were excised as well until the dura bulged into the interspace, a sign of a decompressed status. At no time during the case was evidence of CSF leakage, and hemostasis was readily achieved with pledgets of Gelfoam subsequently removed with copious amounts of antibiotic irrigation. Once the decompression was inspected with a double ball dissector and all found to be completely decompressed, and the dura bulged at the interspace, and pulsated, then a Bengal cage was filled with the patient's own bone elements and fusion putty and countersunk into position, and was quite tightly applied. Further stability was added nonetheless with an appropriate size Uniplate, which was placed of appropriate size with appropriate size screws and these were locked into place in the usual manner. The wound was inspected, and irrigated again with antibiotic solution and after further inspection was finally closed in a routine closure in a multiple layer event by first approximation of the platysma with interrupted 3-0 Vicryl, and the skin with a subcuticular stitch of 4-0 Vicryl, and this was Steri-Stripped for

reinforcement, and a sterile dressing was applied, incorporating a Penrose drain, which was carried from the prevertebral space externally to the skin wound and safety pin for security in the usual manner. Once the sterile dressing was applied, the patient was taken from the operating room to the recovery area having left in stable condition.,At the conclusion of the case, all instruments, needle, and sponge counts were accurate and correct, and there were no intraoperative complications of any type.