PREOPERATIVE DIAGNOSIS:, C4-C5, C5-C6 stenosis.,PREOPERATIVE DIAGNOSIS: , C4-C5, C5-C6 stenosis.,PROCEDURE: , C4-C5, C5-C6 anterior cervical discectomy and fusion.,COMPLICATIONS: , None.,ANESTHESIA: , General.,INDICATIONS OF PROCEDURE: , The patient is a 62-year-old female who presents with neck pain as well as upper extremity symptoms. Her MRI showed stenosis at portion of C4 to C6. I discussed the procedure as well as risks and complications. She wishes to proceed with surgery. Risks will include but are not limited to infection, hemorrhage, spinal fluid leak, worsened neurologic deficit, recurrent stenosis, requiring further surgery, difficulty with fusion requiring further surgery, long-term hoarseness of voice, difficulty swallowing, medical anesthesia risk.,PROCEDURE: ,The patient was taken to the operating room on 10/02/2007. She was intubated for anesthesia. TEDS and boots as well as Foley catheter were placed. She was placed in a supine position with her neck in neutral position. Appropriate pads were also used. The area was prepped and draped in usual sterile fashion. Preoperative localization was taken. _____ not changed. Incision was made on the right side in transverse fashion over C5 vertebral body level. This was made with a #10 blade knife and further taken down with pickups and scissors. The plane between the esophagus and carotid artery was carefully dissected both bluntly and sharply down to the anterior aspect of the cervical spine. Intraoperative x-ray was taken. Longus colli muscles were retracted laterally. Caspar retractors were used. Intraoperative

x-ray was taken. I first turned by attention at C5-C6 interspace. This was opened with #15 blade knife. Disc material was taken out using pituitary as well as Kerrison rongeur. Anterior aspects were taken down. End plates were arthrodesed using curettes. This was done under distraction. Posterior longitudinal ligament was opened with a nerve hook and Kerrison rongeur. Bilateral foraminotomies were done. At this point, I felt that there was a good decompression. The foramen appeared to be opened. Medtronic cage was then encountered and sent few millimeters. This was packed with demineralized bone matrix. The distraction was then taken down. The cage appeared to be strong. This procedure was then repeated at C4-C5. A 42-mm AcuFix plate was then placed between C4 and C6. This was carefully screwed and locked. The instrumentation appeared to be strong. Intraoperative x-ray was taken. Irrigation was used. Hemostasis was achieved. The platysmas was closed with 3-0 Vicryl stitches. The subcutaneous was closed with 4-0 Vicryl stitches. The skin was closed with Steri-strips. The area was clean and dry and dressed with Telfa and Tegaderm. Soft cervical collar was placed for the patient. She was extubated per anesthesia and brought to the recovery in stable condition.