PREOPERATIVE DIAGNOSIS:, Cervical spondylosis.,POSTOPERATIVE DIAGNOSIS:, Cervical spondylosis.,OPERATION PERFORMED:, Radiofrequency thermocoagulation (RFTC), medial branch posterior sensory rami of cervical at ***.,SURGEON:, Ralph Menard, M.D.,ANESTHESIA:, Local and IV.,COMPLICATIONS:, None.,DESCRIPTION OF PROCEDURE: , After proper consent was obtained, the patient was taken to the fluoroscopy suite and placed on a fluoroscopy table in a prone position with a chest roll in place. The neck was placed in a flexed position. The patient was monitored with blood pressure cuff, EKG, and pulse oximetry and given oxygen via nasal cannula. The patient was lightly sedated. The skin was prepped and draped in a sterile classical fashion.,Under fluoroscopy control, the waists of the articular pillars were identified and marked. Local anesthesia infiltrated subcutaneously and deep extending down toward these previously marked points. Once the anesthesia was established, an insulated 10-cm, 22-gauge needle with a 5-mm non-insulated stimulating tip was placed in contact with the waists of the articular pillars at the affected levels that were previously mentioned. This was done under direct fluoroscopic control utilizing a gun barrel technique with PA views initially for orientation and then a lateral view to determine the depth of the needle. For C3 to C6 medial branch RFTC's, the needles are placed along the ventral aspect of a line that connects the greatest antero-posterior diameter of the articular pillar but remains dorsal to the

foramen as seen on lateral imaging. For a C7 medial branch RFTC, the needle tip is positioned more superiorly such that it overlies the superior articular process. For a C8 medial branch RFTC, the needle is placed at the junction of the superior articulating facet and the base of the transverse process of T1.,Sensory stimulation was carried out at 50 Hz from 0 to 2.0 volts. Stimulation was stopped once the maximum voltage was delivered or the patient either described a buzzing sensation indicating that it was a nonpainful nerve, or it caused replication of their concordant pain. The stimulation was then changed to 2 Hz for motor stimulation and advanced up to 2.0 volts or until motor stimulation was found at that level. If motor stimulation occurred, the needle was repositioned to abolish it but still cause concordant pain, or the RFTC was aborted at this level.,If the sensory stimulation caused concordant pain without motor stimulation, the area was then anesthetized with 1 cc of Marcaine 0.5% with 5 mg of methyl prednisolone acetate. Once the anesthesia was established, a radiofrequency lesioning was then done at 65 degrees for 60 seconds. The same procedure was carried out at all the affected levels. The patient tolerated the procedure well without any difficulties or complications.