PREOPERATIVE DIAGNOSES,1. Neck pain with bilateral upper extremity radiculopathy, left more than the right.,2. Cervical spondylosis with herniated nucleus pulposus, C5-C6.,POSTOPERATIVE DIAGNOSES,1. Neck pain with bilateral upper extremity radiculopathy, left more than the right.,2. Cervical spondylosis with herniated nucleus pulposus, C5-C6.,OPERATIVE PROCEDURES,1. Anterior cervical discectomy with decompression, C5-C6.,2. Arthrodesis with anterior interbody fusion, C5-C6.,3. Spinal instrumentation, C5-C6 using Pioneer 18-mm plate and four 14 x 4.0 mm screws (all titanium).,4. Implant using PEEK 7 mm.,5. Allograft using Vitoss.,DRAINS: , Round French 10 JP drain.,FLUIDS: ,1200 cc of crystalloids.,URINE OUTPUT: , No Foley catheter.,SPECIMENS: , None.,COMPLICATIONS: , None.,ANESTHESIA: , General endotracheal anesthesia.,ESTIMATED BLOOD LOSS: , Less than 50 cc.,INDICATIONS FOR THE OPERATION:, This is a case of a very pleasant 38-year-old Caucasian female who has been complaining over the last eight years of neck pain and shoulder pain radiating down across the top of her left shoulder and also across her shoulder blades to the right side, but predominantly down the left upper extremity into the wrist. The patient has been diagnosed with fibromyalgia and subsequently, has been treated with pain medications, anti-inflammatories and muscle relaxants. The patient's symptoms continued to persist and subsequently, an MRI of the C-spine was done, which showed disc desiccation, spondylosis and herniated disk at C5-C6, an EMG and CV

revealed a presence of mild-to-moderate carpal tunnel syndrome. The patient is now being recommended to undergo decompression and spinal instrumentation and fusion at C5-C6. The patient understood the risks and benefits of the surgery. Risks include but not exclusive of bleeding and infection. Bleeding can be in the form of soft tissue bleeding, which may compromise airway for which she can be brought emergently back to the operating room for emergent evacuation of the hematoma as this may cause weakness of all four extremities, numbness of all four extremities, as well as impairment of bowel and bladder function. This could also result in dural tear with its attendant symptoms of headache, nausea, vomiting, photophobia, and posterior neck pain as well as the development of pseudomeningocele. Should the symptoms be severe or the pseudomeningocele be large, she can be brought back to the operating room for repair of the CSF leak and evacuation of the pseudomeningocele. There is also the risk of pseudoarthrosis and nonfusion, for which she may require redo surgery at this level. There is also the possibility of nonimprovement of her symptoms in about 10% of cases. The patient understands this risk on top of the potential injury to the esophagus and trachea as well as the carotid artery. There is also the risk of stroke, should an undiagnosed plaque be propelled into the right cerebral circulation. The patient also understands that there could be hoarseness of the voice secondary to injury to the recurrent laryngeal nerve. She understood these risks on top of the risks of anesthesia and gave her consent for the

procedure.,DESCRIPTION OF PROCEDURE: ,The patient was brought to the operating room, awake, alert and not in any form of distress. After smooth induction and intubation, the patient was positioned supine on the operating table with the neck placed on hyperextension and the head supported on a foam doughnut. A marker was placed. This verified the level to be at the C5-C6 level and incision was then marked in a transverse fashion starting from the midline extending about 5 mm beyond the anterior border of the sternocleidomastoid muscle. The area was then prepped with DuraPrep after the head was turned 45 degrees to the left.,After sterile drapes were laid out, an incision was made using a scalpel blade #10. Wound edge bleeders were carefully controlled with bipolar coagulation and the platysma was cut using a hot knife in a transverse fashion. Dissection was then carried underneath the platysma superiorly inferiorly. The anterior border of the sternocleidomastoid was identified and dissection was carried out lateral to the esophagus to trachea as well as medial to the carotid sheath in the sternocleidomastoid muscle. The prevertebral fascia was noted to be taken her case with a lot of fat deposition. Bipolar coagulation of bleeders was done; however, branch of the superior thyroid artery was ligated with Hemoclips x4. After this was completed, a localizing x-ray verified the marker to be at the C6-C7 level. We proceeded to strip the longus colli muscles off the vertebral body of the C5 and C6.
Self-retaining retractor was then laid down. An anterior osteophyte was carefully drilled using a Midas 5-mm bur and

the disk together with the inferior endplate of C5 and the superior endplate of C6 was also drilled down with the Midas 5-mm bur. This was later followed with a 3-mm bur and the disk together with posterior longitudinal ligament was removed using Kerrison's ranging from 1 to 4 mm. The herniation was noted on the right. However, there was significant neuroforaminal stenosis on the left. Decompression on both sides was done and after this was completed, a Valsalva maneuver showed no evidence of any CSF leakage. The area was then irrigated with saline with bacitracin solution. A 7 mm implant with its inferior packed with Vitoss was then laid down and secured in place with four 14 x 4.0 mm screws and plate 18 mm, all of which were titanium. X-ray after this placement showed excellent position of all these implants and screws and _____ and the patient's area was also irrigated with saline with bacitracin solution. A round French 10 JP drain was then laid down and exteriorized through a separate stab incision on the patient's right inferiorly. The catheter was then anchored to the skin with a nylon 3-0 stitch and connected to a sterile draining system. The wound was then closed in layers with Vicryl 3-0 inverted interrupted sutures for the platysma, Vicryl subcuticular 4-0 Stitch for the dermis, and the wound was reinforced with Dermabond. Dressing was placed only at the exit site of the catheter. C-collar was placed. The patient was extubated and transferred to recovery.