Date of Procedure: 7/7/2021 PREOPERATIVE DIAGNOSES:

Abbreviated copy

Note From Your **Admission on 07/07/21 Operative Note at 07/07/21 1211**

INDICATIONS: This is a 58-year-old male who presents with cervical spondylotic myelopathy with 3 level cervical spinal stenosis at C4-5 C5-6 and C6-7 who had intractable symptoms despite nonoperative treatments. Ultimately the patient like to proceed with surgery the surgical risk which I described included but were not nested limited to bleeding infection damage to nerves or eyes anesthesia stroke heart attack death PE DVT failed the surgery potential need for revision surgery paralysis and partial paralysis. We also discussed the risk of spinal fluid leak

DESCRIPTION OF PROCEDURE: Once informed consent was obtained the patient brought to the operating room general anesthesia was administered and he was placed supine in the operating room table. 10 pounds of halter traction were applied and arms were tucked and padded to the patient's side. The anterior cervical region left iliac crest region were then prepped and draped in normal sterile fashion. A timeout was then performed.

The procedure was initiated with a single stab incision of the left ilium and a Jamshidi needle was advanced into the ilium and 4 cc of bone marrow was aspirated and used to saturate a collagen sponge on the back table. We then turned our attention of the cervical region and a transverse incision was made over the C5 vertebra. Dissection was carried down to the level deep fascia and platysma. The platysma was then divided in line with skin incision and subplatysmal

flaps were elevated. We then identified the medial border the sternocleidomastoid muscle which was incised vertically we then retracted the medial soft tissues including trachea and esophagus to the patient's right and carotid sheath the patient's left. The precervical fascia was identified and incised vertically as well. The inner stylette of a spinal needle was then used to mark the disc and a lateral fluoroscopic image obtained. Once we confirmed accurate spinal level complete and radical discectomy was performed at C4-5 C5-6 and C6-7 using Caspar pin distraction.

Once all the discectomy was performed we remove the posterior longitudinal ligament and posterior osteophytes at C4-5 C5-6 and C6-7 to fully decompress the spinal cord. We perform foraminotomies at C5-C6 and C7 bilaterally with a 2 mm Kerrison punch. Once the spinal cord and foramen were fully decompressed we templated interbody spacers at each level. Final devices were packed with the bone marrow soaked collagen the back table and gently tamped into position at each level.

Anterior cervical plates were applied using cortical screws at each level. Final AP and lateral fluoroscopic imaging confirmed excellent position of the implants. The wound was then packed for hemostasis and then closed in layered fashion over a Blake drain. Sterile dressings were applied soft collar applied the patient was rolled to the bed, extubated, and to the recovery in stable condition.