University of Maryland Medical System

Patient Name: [redacted]
Medical Record Number: [redacted]
Account Number: [redacted]

DATE OF PROCEDURE: 01/14/2004

SURGEON: [redacted]

FIRST ASSISTANT: [redacted]

SERVICE: SNG - NEUROSURGERY

PREOPERATIVE DIAGNOSIS: C6-C7 discectomy and fusion.

POSTOPERATIVE DIAGNOSIS: C6-C7 discectomy and fusion.

SKIN PREPARATION: Dura-Prep.

INDICATIONS: The patient is a 50-year-old white American who was recently involved in a motor vehicle accident and started to have left upper extremity pain into C7. On physical examination, no major findings, and MRI showed left C6-C7 disc herniation. There was a large osteophyte also at C6-C7 on that side. We treated her conservatively, but eventually she failed and decided to go ahead with surgical intervention.

PROCEDURE: Today at 8 o'clock in the morning, the patient was taken to the OR and, after preliminary steps, was induced and intubated. The head of the patient was put on horseshoe, and her neck was prepped and draped in the usual fashion. We localized the C6-C7 interspace using image intensifier. After the prep and drape, incision was made over the top of C6-C7 disc medial to the sternocleidomastoid, the platysma was cut. I dissected the omohyoid and through the medial aspect of the carotid, reached the anterior aspect of the vertebral column. We inserted the Cloward retractors and using Kitners, exposed the C6-C7 which, again, was verified using fluoroscopy. A 15-blade knife was used to resect some of the disc at C6-C7, and then I went ahead and after dissection of the medial aspect of the longus colli, we went ahead and inserted the shadow line retractor system. Some of the anterior annulus was again resected, and the majority of the disc wasremoved and eventually we inserted the vertebral body spreaders which spread the bodies between C6 and C7. The microscope was brought into the operative field, and the rest of the disc close to the oncovertebral joint was resected. Then I used a high-speed drill to resect the posterior osteophyte. As I was performing that, a small free fragment of disc was discovered near the C7 nerve root on the left side. This was removed, and then foraminotomy was completed on each side with free combination of a micro nerve hook into the foramina of C7 bilaterally. I even could see a small amount of epineural fat on the left side. After the C7 nerve roots were quite free, we drilled the cartilage in its endplate and placed an 8 mm VG-2 between the bodies of C6 and C7 and then used a 25 mm plate to fuse the bodies of C6 and C7 together. Then 15 mm screws were used, and the plate was 25 mm. After the bodies of C6 and C7 were fused, I checked for any bleeders and withdrew the shadow line retractor system. After the shadow line was removed, we went

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ahead and controlled the bleeders and closed the platysma with 3-0 Vicryl and the skin was closed with 2-0 Vicryl and subcuticular stitch and Steri-Strips. The patient tolerated the operation well, and during the entire surgery, there was no change in the evoked potential duration and latency. At this time, the wound was covered without application of a collar. The patient was sent to the recovery room.

********** End of Dictated Report **********
This document has been read and signed. Please contact the medical records department for any questions regarding this document.