

Patient: John Russom

DATE OF ADMISSION: 10/09/2000

DATE OF OPERATION: 10/09/2000

SURGEON: TODD MOLDAWER, M.D.  
ASSISTANT SURGEON: JEFF BARON, M.D.  
SECOND ASSISTANT: NONE  
ANESTHESIOLOGIST: REZA EHSAN, M.D.

PREOPERATIVE DIAGNOSIS: Herniated disk,  
C6-7 on the right.

POSTOPERATIVE DIAGNOSIS: Herniated disk,  
C6-7 on the right.

OPERATIONS AND PROCEDURES: 1. Anterior cervical microdiscectomy at C6-7. 2. Anterior cervical interbody arthrodesis at C6-7. 3. Right iliac bone graft. 4. Cosmetic wound closure (5 cm left cervical, 3 cm right iliac). 5. Lateral localizing cervical radiographs (two).

ANESTHESIA: General endotracheal.

ESTIMATED BLOOD LOSS: 25 cc - none replaced.

DRAINS: Two medium Hemovac drains employed in the right iliac wound and a quarter-inch Penrose drain in the cervical wound.

COMPLICATIONS: None.

PERTINENT HISTORY AND PHYSICAL: The patient is a 48-year-old male who sustained an injury to his neck in the course of his employment on 05/31/2000. He has had extensive care since that time and has remained symptomatic with moderately severe to severe neck and right arm symptoms which have been unrelieved by appropriate conservative measures. He has undergone a number a diagnostic studies including a magnetic resonance imaging of the cervical **spine which demonstrated a right-sided herniation of C6-7**. Treatment options were discussed with the patient and he elected to proceed with surgery.

OPERATIVE FINDINGS AT SURGERY: A small right-sided herniation at C6-7 was confirmed.

OPERATIVE PROCEDURE:

With the patient in the supine position after satisfactory induction of general endotracheal anesthesia by Dr. Ehsan, the patient was positioned in the supine position with a five-pound sandbag under his shoulders and right buttock. The anterior cervical spine and the right iliac crest areas were prepped and draped in the usual sterile fashion. Athrombic pumps were applied to the legs below the knees to prevent venostasis during and after the procedure.

A 5 cm incision was carried down in the anterior aspect of the cervical spine to the left of midline, parallel to the clavicle, and approximately one-and-a-half fingerbreadths above the clavicle through the skin and subcutaneous tissue to the platysma fascia. Superficial retractors were placed, and hemostasis secured with electrocautery.

The platysma fascia **was divided transversely, and the interval between the sternocleidomastoid and the strap was entered with blunt dissection.** The esophagus and trachea were mobilized to the right and protected with a Cloward hand-held retractor. The peanut elevators were used to clear the soft tissues over the anterior aspect of the cervical spine, and an 18 gauge spinal needle that was carefully angulated to prevent over penetration was placed in what was felt to be the C5-6 and C6-7 disks. The first lateral roentgenogram was taken which demonstrated the needles to be at the C6-7 to C7-T1 level.

While the radiograph was being developed, attention was turned to the right iliac crest, which as described above, was prepped and draped in the usual sterile fashion. An oblique incision, approximately 1 inch proximal and 1 inch lateral, to the anterior superior iliac spine in line with the iliac crest was then made through the skin and subcutaneous tissue to the fascia. The skin was then retracted to the level of the iliac crest where the deep fascial incision was made through the fascia overlying the iliac crest and the subperiosteal dissection carried out on the inner and outer table of the right ilium. Throughout the procedure, copious amounts of antibacterial irrigating solution were used to periodically irrigate both wounds.

A tricortical iliac bone graft was then harvested with a reciprocating saw measuring approximately 1 cm in depth and 1 cm in width. The donor bone edges were carefully waxed with bone wax and additional hemostasis secured with electrocautery.

Attention was then turned to the cervical wound where the needles were noted

to be at the C6-7 and C7-T1 level. The Caspar self-retaining retractors were then placed underneath the longissimus coli muscles bilaterally. The 15 blade knife was then used to cut a rectangular window in the annulus in the anterior longitudinal ligament, and the operating microscope was then moved into place. The 0, 2-0, 3-0, and 4-0 straight and angulated Carlens curettes were then used to evacuate the nuclear contents back to the level of the posterior longitudinal ligament. The Cloward interbody distractors were used to facilitate disk space distraction to facilitate the exposure. The posterior longitudinal ligament was taken down in the midline and carried over to the right foramen, and some additional nuclear material was removed in that location. The high-speed Anspach bur was then used to abrade the cartilaginous end plates down to subchondral bleeding bone. The bone plug which was harvested from the right iliac crest was then carefully trimmed to approximately 8 mm in height and 8 mm in depth. It was carefully impacted at the C6-7 interspace with the Caspar bone holding instrument, and the final impaction was done with the Cloward impaction instruments. When the interbody distractor was removed, the bone plug appeared to be quite securely locked in place and resisted removal with a Kocher clamp.

The anesthesiologist was there to put the neck **through** a full range of motion throughout which the plug appeared stable. The wound was then closed in layers over a quarter-inch Penrose drain using 0 Vicryl sutures to reapproximate the interval between the sternocleidomastoid muscles and strap muscles, 0 Vicryl sutures to reapproximate the platysma fascia, 3-0 Vicryl subcutaneous reapproximating sutures on the subcutaneous tissue, and a 4-0 Maxon subcuticular cosmetic closing suture on the skin. The right iliac wound was closed using 0 Vicryl sutures on the fascia, 2-0 Vicryl sutures on the subcutaneous tissue, and 4-0 Maxon subcuticular cosmetic closing suture on the skin. The iliac wound was infiltrated with 0.25 percent Marcaine without epinephrine postoperative analgesia. Steri-Strips and Xeroform gauze were placed over both incisions and covered with dry sterile dressings.

The patient's neck was then immobilized in a Philadelphia collar prior to extubation by Dr. Ehsan.

The patient was transported to the recovery room in satisfactory condition. At the conclusion of the procedure, sponge, instrument, and needle counts were all correct.

TDM/cb '

TODD D. MALDAWER, MD

MR. NO. : 735771  
OPERATIVE RECORD  
ROOM NO. : 270

PHYSICIAN:

Dictated by: TODD D. MOLDAWER, MD

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