

RE: Robert Plock
OPERATIVE REPORT
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ANESTHESIOLOGIST: Sang Chae-Kim, M.D.

ESTIMATED BLOOD LOSS: 150 mL total.

IV FLUIDS: 1 liter crystalloid.

SPINAL INSTRUMENTATION: Titan anterior intervertebral body cage with fixation screw and Spinal USA Posterior lumbar Pedicle Screw System posteriorly.

INDICATIONS FOR PROCEDURE: This is a 45-year-old male with a history of isthmic spondylolisthesis with low back pain and bilateral L5 radiculopathy. The patient has failed nonsurgical treatment, including lumbar epidural steroid injection, physical therapy, and activity modification. Due to the failure of nonsurgical treatment, I have recommended surgical treatment in order to address his condition, including fixation of the fracture, addressing the instability and decompression of the neurologic elements. Risks, benefits, and alternative treatments were discussed with this patient. Informed Consent was signed, obtained on the chart.

DESCRIPTION OF PROCEDURE: The patient was brought to the operating room. The patient was correctly identified. The patient was intubated by the Anesthesia staff. The patient was positioned on a Jackson table, and all bony prominences were padded.

Anterior retroperitoneal exposure was performed by Dr. Randall Kirby, and the disc space of L5-S1 was marked. Radical discectomy was carried out, and the disc material was removed with a pituitary rongeur. Disc material was scraped down subchondral bone, and the disc material was all removed with the use of the pituitary rongeur and a straight curette.

At this point, once all the disc material had been removed from the disc space, the endplates were prepared for fusion. The 4-mm egg-shaped burr was used to perform a partial corpectomy at the anterior aspect of the L5 vertebral body in order to decompress the neurologic elements in the neural foraminal zone bilaterally.

The intervertebral body cage trial was placed into the interspace, and excellent interference fit was accomplished with the 13-mm cage. The wound was irrigated with normal saline. The cage was filled with bone graft and inserted into the interspace at L5-S1. A single fixation screw was then placed into the sacrum in a downward direction, measuring 30 mm. The remaining bone graft was placed overlying this disc space. Hemostasis was achieved.

At this point, the retroperitoneal exposure was closed by Dr. Randall Kirby. The patient was dressed with sterile dressings and repositioned in the prone position on the Jackson table.

The posterior lumbar region was prepped and draped in a sterile fashion. The skin and subcutaneous tissues were infiltrated with 0.25% Marcaine with epinephrine.