**Kyphoplasty**

FACILITY:

PATIENT:

DOB/MRN:

DATE of PROCEDURE:

ATTENDING:

ASSISTANT:

PREOPERATIVE DIAGNOSIS:

[1. Compression fracture of thoracic vertebrae: ICD-10 S22.000A]

[2. Compression fracture of lumbar vertebrae: ICD-10 S32.000S]

POSTOPERATIVE DIAGNOSIS:

[1. Compression fracture of thoracic vertebrae: ICD-10 S22.000A]

[2. Compression fracture of lumbar vertebrae: ICD-10 S32.000S]

PROCEDURE:

1. Transpedicular kyphoplasty at [X]

INDICATION:

ANESTHESIA:

TECHNIQUE:

A description of the procedure and its risks, benefits, and alternatives, were provided to the patient and informed consent was obtained prior to procedure commencement. The patient was taken to the operating room and carefully placed in the prone position. The back was prepped and draped in sterile fashion. Fluoroscopy was brought into the field and the [X] pedicle was identified and marked with a skin marker. The skin was anesthetized with lidocaine 1% via a 30-gauge needle. The subcutaneous tissue was anesthetized with a 25-gauge needle all the way to the periosteum of the desired pedicle. A 3 mm longitudinal incision was made with a #11 blade. Using a transpedicular approach, an 11-gauge needle was advanced through the [X] pedicle to the junction of the pedicle and vertebral body on the [right, left] side. Positioning was confirmed frequently in the anteroposterior and lateral plane. Following satisfactory placement of the needle, the stylet was removed. Once in the posterior vertebral body, the hand drill was advanced under lateral fluoroscopy until positioned at the anterior one-third of the vertebral body. The kyphoplasty balloon was then introduced through the trocar. Once the balloon was in position, it was inflated slowly with attention being paid to the inflation pressures and balloon position. The inflation was monitored with anteroposterior and lateral imaging. The final balloon volume was [x cc]. There was no breach of the lateral wall or anterior cortex of the vertebral body. The methyl methacrylate resin was mixed together and [3.5cc] was applied. No escape was observed while introducing the cement under live fluoroscopy. The cannula was reinserted into each trocar under live fluoroscopy as well. Each trocar and cannula was removed under live fluoroscopy in a very slow fashion to observe the contrast-impregnated cement; no contrast was observed flowing into the canal or through the pedicle. Direct reduction of the fracture was achieved, end plate movement was noted and height restoration was achieved. Post-procedure, all incisions were closed with Dermabond. The patient was observed moving both lower extremities at this time.

The patient tolerated the procedure well, with no complication, and was taken to the recovery area in stable condition. The patient was kept in the supine position for approximately 20 minutes post cement injection. The patient was observed in the recovery area for an appropriate period of time, discharged to home in stable condition with careful precautions, with follow-up in the office and availability by telephone for advisement if needed.

FINDINGS:

ESTIMATED BLOOD LOSS:

SPECIMEN: