

Cervical pseudarthrosis converted to TDR

The patient is a 59-year-old female who had a C4-7 anterior cervical discectomy and fusion performed in August 2016 at a Laser institution. There was initially pain improvement but it recurred and dysphagia (difficulty swallowing) continued, Fig 1. Two years postoperatively, the patient had a fall with increased pain and presented to Dr. Buttermann. A pseudarthrosis was identified and non-operative treatment was instituted but without success. The patient had revision spinal reconstructive surgery with Dr. Buttermann. This entailed removal of the old plate which cured the dysphagia and conversion of the pseudarthrosis to a motion persevering disc replacement, Fig. 2 & 3. Not only was the dysphagia treated but there was complete resolution of her arm pain and 82% improvement in neck pain.

Fig. 1



Fig. 2



Fig. 3



Cervical spine fracture/dislocation after prior ACDF

The patient is a 49-year-old male who had a remote C5-7 anterior cervical discectomy and fusion performed elsewhere. His prior surgeon was unable to restore lordosis and he developed adjacent segment problems and then underwent an anterior cervical discectomy and fusion at C4-5 above the old fusion, Fig 1. Two months postoperatively, the patient was working on his trailer home getting it ready for the winter. He was on a ladder when the ladder gave out and he fell 5 feet to the ground. He had increased symptoms in the shoulder and neck. He also had more difficulty with shoulder elevation due to weakness and progressive difficulty in swallowing. A CT scan identified a fracture/dislocation and new severe stenosis of C4. There was a cleavage fracture, Fig. 2. The instrumentation was loose and compressed against the esophagus displaying it and the trachea forward. There was also progressive retrolisthesis into the canal with central canal compromise.

The patient underwent spinal reconstructive surgery with Dr. Buttermann. The first stage was a posterior spinal fusion C4-5 with decompression on the right with instrumentation from C4 to C6. A second anterior stage involved removal of the old instrumentation at C4-5, take down the fracture fragments with partial corpectomy and decompression of the esophagus and trachea. Anterior re-instrumentation, Fig. 3, was also performed due to concerns regarding patient's inability to follow postoperative activity restrictions. After healing, the patient had full recovery of his weakness and pain was only 1.5 of 10 pain scale.

Fig. 1

Fig. 2

Fig. 3

