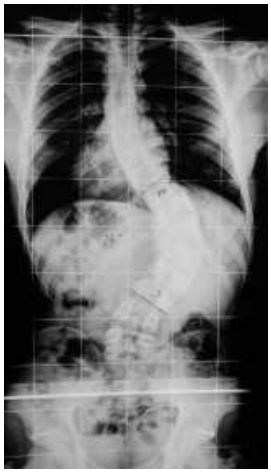
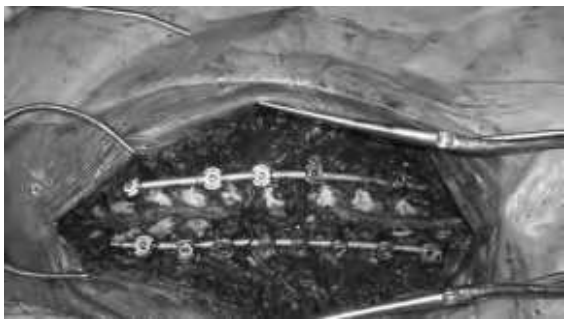
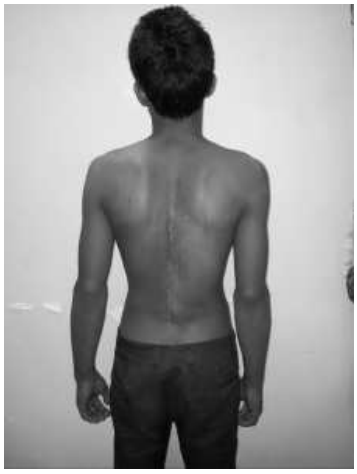
Md. Sultan (18 yrs, Male)

Date of Admission : 25-09-2011 Date of Surgery : 26-09-2011 Date of Discharge : 02-10-2011

Medical Profile :

Gradually progressive deformity of the back noticed for the last 4 years. No history of any weakness or sensory defecit. No history of fever or trauma. For the last one year, he is having significant back pain which is limiting his activities of daily living.

Clinical Finding :

Right thoracolumbar scoliosis with stiff kyphosis and hump. Right UL and LL was hyperreflexic with absent abdominal jerks -- Left Lower limb also slightly hyperrefelxic, plantars right side extensor, left - equivocal. No sensory or motor deficit.

Investigations :

Xray/MRI -- T10 to L3 right sided curve (Cobb angle 74 degrees correctable to 58 degrees on the bending views) with throacolumbar kyphosis of 54 degrees. Cervical syrinx with Chirai malformation (Type I).

Management :

Neurosufical consultation was done first -- the opinion was not to offer surgery for the Chiari malformation now -- to go ahead with corrective sciloiosis surgery and then later on reassess.
Posterior instrumentation (One Alpha /Gesco/ Titanium) from T9 to L4 was done.Rod rotation along with segmental compression - distraction for curve correction. Reduction screws were put at the apex. Local bone used for posterior spinal fusion. Wound closed in layers over a drain. Procedure done u/GA at Park Clinic on 26.09.2011.

Post Operative Protocol :

Uneventful postoperative recovery. Mobilised on the 4th day, discharged subsequently. At the time of discharge, the patient was walking comfortably with significant relief of pain.

Advice :

1. Do not bend forwards to pick up heavy objects / not permitted to sit on the floor or squat / must use western type toilet /not permitted to take long jerky journeys.
2. Encouraged to walk within residence and to perform regular daily exercises as shown.
3. Tab Voveran SR 100 mg SOS (on severe pain only).
4. Report after one month at clinic for follow up (please take prior appointment before 3 weeks).
5. Report after 5-7 days for wound check up / suture removal (contact: Dr A. Tikoo -- 9874658510)).
6. Cap Ceftum 500mg twice daily for one week.
7. Tab Alevo 500mg once daily for one week.
8. Follow other medicines according to discharge certificate.

(Dr. SAUMYAJIT BASU)