1966

1965-1967

Bifrontal decompressive craniectomy (BDC) was initially described by Miyazaki in 1966¹⁾ and was popularized by Kjellberg and Prieto in 1971²⁾.

The term laser thermotherapy is an acronym for Light Amplification by Stimulated Emission of Radiation, which first appeared as a term in 1959. Laser thermal therapy was clinically used for tissue ablation in 1966, based on the theory that the energy produced by laser light could achieve a high peak power through a ruby tip and could be absorbed by the surrounding tissue as heat ³⁾.

The origins of lumbar disc replacement started in 1966 with Fernström ⁴⁾ who implanted a stainlesssteel ball within 191 lumbar and 13 cervical discs spaces of 125 patients with clinical outcomes similar to fusion. However, the ball was associated with significant complications caused by subsidence and extrusions. A couple of decades later, in the early 1980s, at Charité Hospital, Dr Karin Buettner-Janz, an orthopedic spine surgeon as well as former Olympic gymnast, and Kurt Schellnack, an engineer, published their first experience with the original Charité artificial disc for the lumbar spine, which ushered in the modern era for lumbar arthroplasty ⁵⁾.

The first high cervical anterolateral retropharyngeal approach (HCALR) was reported by Stevenson et al. for a clivus chordoma in 1966. Anterior approaches to the spine have often been developed in response to problems presented by tuberculous spondylitis. This approach is indicated in anterior high cervical spine cases such as tumour resection, abscess drainage, Atlanto-axial subluxation; decompression and stabilization.

Only 21 papers in the literature have mentioned this approach. Its main advantage over posterior approaches is easy positioning and minimal need for soft tissue dissection. The HCALR approach provides wide exposure (of the anterior upper cervical spine, lower clivus and brainstem region) and feasibility for instrumentation. The limited space in which important neurovascular and visceral structures course and overlap contributes to the complexity of the anatomy. Navigating this intricate anatomy is essential for the safety of this approach and has been a drawback for utilization of the retropharyngeal corridor. This approach is one of the safest and most effective methods available to access the craniocervical junction. The benefits clearly outweigh the risks and complications ⁶⁾.

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