

Cervical spinal stenosis surgery

Posterior approaches

a) [cervical laminectomy](#): not typically used for a herniated cervical disc, more common for cervical spinal stenosis, [OPLL](#)

After ventral decompression of monosegmental cervical spondylotic stenosis, a [stand-alone cage](#) (SC) or [cage-with-plate](#) (CP) can be inserted for [fusion](#). Postoperative radiological evaluation can be achieved using different imaging modalities.

Coincident symptomatic [lumbar spinal stenosis](#) and [cervical spinal stenosis](#) is usually managed by first decompressing the [cervical region](#), and later operating on the [lumbar region](#) (unless severe [neurogenic claudication](#)).

Mild [myelopathy](#) (mJOA score > 12): in the short-term (3 years) patients may be offered the option of surgical decompression or nonoperative management (prolonged immobilization in a rigid cervical collar, anti-inflammatory medications, and “low-risk” activities or bed rest (Level C Class II)). patients with mJOA scores > 12 may not always be mildly impaired, they may derive significant improvement from surgery, and deterioration from this point may be ominous.

More severe myelopathy: should be treated with surgical decompression with benefits maintained at 5 and 15 years post-op (Level D Class III)

Level B Class I

Degenerative cervical radiculopathy: patients do better with anterior decompression ± fusion (compared to conservative management) for

- rapid relief (within 3–4 months) of arm & neck pain and sensory loss
- relief of longer-term (≥ 12 months) symptoms of weakness of wrist extension, elbow extension, shoulder abduction, and internal rotation.

Intraoperative electrophysiologic monitoring

Use of intra-op [electrophysiologic monitoring](#) during routine surgery for CSM or [cervical radiculopathy](#) is not recommended as an indication to alter the surgical plan or administer [steroids](#) since this paradigm has not been observed to reduce the incidence of neurologic injury (Level D Class III).

Outcome

Results suggest no significant improvement in overall erectile function postoperatively for patients with preoperative [erectile dysfunction](#). This is important to address during patient counseling for [decompression](#) surgery candidates with [cervical spinal stenosis](#) and/or [lumbar canal stenosis](#) to manage expectations. ¹⁾

¹⁾

Wottrich S, Kha S, Thompson N, Bakar D, Yee P, Melillo A, Nash C, Healy AT, Steinmetz M, Mroz T. The Effect of Cervical and Lumbar [Decompression](#) Surgery for [Spinal Stenosis](#) on [Erectile Dysfunction](#). Global Spine J. 2022 Oct 25:21925682221136493. doi: 10.1177/21925682221136493. Epub ahead of print. PMID: 36281560.

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