Case Description:

A 76-year-old male with a history of mechanical fall and resultant cervical spine injury underwent multilevel cervical decompression from C3 to C7 with posterior fusion instrumentation at C3-7 laminectomy, facetectomy, and foraminotomy with posterolateral arthrodesis at C3-T1. After the patient's cervical surgery, he was assessed and admitted to acute rehabilitation. His admitting physical exam showed bilateral proximal upper extremity muscle weakness. This combined with chronic fine motor hand deficiencies and increased motivation and feelings of helplessness. He found support through psychology therapies proved to be trying for him as he was found with deficits in the C5 myotome and/or the C5 dermatome, which includes sensory loss or pain. Symptoms can include deficiencies in the C5 myotome and/or the C5 dermatome, that could place greater shifting movement at this segment. This combined with chronic fine motor hand deficiencies and increased motivation and feelings of helplessness. He found support through psychology therapies proved to be trying for him as he was found with deficits in the C5 myotome and/or the C5 dermatome, which includes sensory loss or pain.

Background:

Unilateral C5 palsy is a well-known possible complication after cervical spine surgery, including multilevel anterior corpectomy, posterior laminoplasty, posterior laminectomy and fusion, or combined anterior corpectomy followed by posterior fusion.1 There is no significant difference in incidences when comparing types of cervical spine decompressive surgery. There are some anatomical considerations hypothesized. The rootlet and root of C5 are shorter than in other segments and may be more prone to injury. C5 is usually the apex of cervical lordosis and the midpoint of decompression, which could place greater shifting movement at this segment. This combined with chronic fine motor hand deficiencies and increased motivation and feelings of helplessness. He found support through psychology therapies proved to be trying for him as he was found with deficits in the C5 myotome and/or the C5 dermatome, which includes sensory loss or pain. Symptoms can include deficiencies in the C5 myotome and/or the C5 dermatome, which includes sensory loss or pain.

Discussion:

A 76-year-old male with known severe C3-4 to C6-7 stenosis and previous proximal instrumentation at C3-7 laminectomy, facetectomy, and foraminotomy with posterolateral arthrodesis at C3-T1.

Unilateral C5 nerve palsy is a well-known possible complication after cervical spine surgery. This combined with chronic fine motor hand deficiencies and increased motivation and feelings of helplessness. He found support through psychology therapies proved to be trying for him as he was found with deficits in the C5 myotome and/or the C5 dermatome, which includes sensory loss or pain.

Conclusion:

While 70% of affected patients show complete recovery from paralysis within 7.9 months, 30% remain with residual motor paralysis. While 70% of affected patients show complete recovery from paralysis within 7.9 months, 30% remain with residual motor paralysis.

References:


5. C5 is at the apex of the lordosis5

6. Note possible direct caudal pull on C5.6

7. To find this poster and other research: www.neuroradiologycases.com.