

observation where he was extubated without any complications and was shifted to ward on the same day. Patient received regular antibiotics, analgesics, physical therapy as well as regular dressing was done. On discharge his condition was stable (Figures 1 and 2).

the choice. If the collapse of anterior vertebral height becomes more than 40% it indicates damage of posterior ligament. Patients with fracture with paraplegia patient will need nursing care post-surgery so hospital stay is shortened to fasten the rehabilitation. In fracture dislocation with a partial neurological deficit, there is also no evidence that surgical stabilization and decompression provides a better neurological outcome than conservative treatment [8]. If surgical decompression and stabilization are performed, this may require a combined posterior and anterior approach. In fracture dislocation without neurological deficit, surgical stabilization will prevent future neurological complications and allow earlier rehabilitation [9]. When specialized surgery cannot be performed, these injuries can be managed non-operatively with postural reduction, bed rest and bracing. For patients with neurological impairment who have the benefit of being treated in a specialized spinal injuries unit, a strong case can be made for managing them also by non-operative methods (Figure 3) [10].

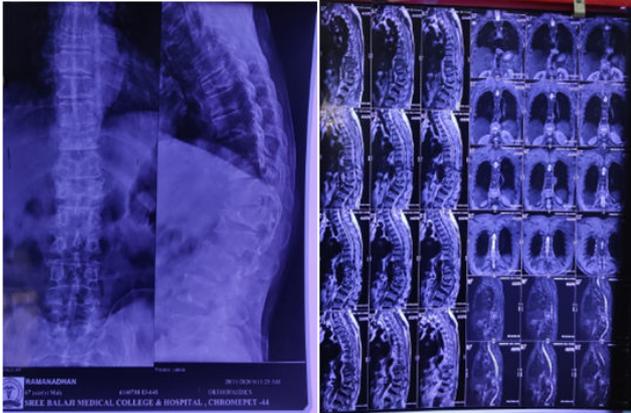


Figure 1: Pre OP x-ray and MRI.



Figure 2: MRI of the patient.



Figure 3: Post OP x-ray.

DISCUSSION

Treatment depends on: Type of fracture, neurological involvement, and concomitant injuries. In case of minor injuries of fracture of transverse process and that of pars interarticularis if an acute fracture heals properly if patient is prepare to forego sporting activity for several months. Unilateral pars fractures usually go to union with conservative treatment. In patients of flexion injury with minimal wedging and with stable fracture they are kept in bed for 1-2 weeks before mobilizing [7]. Those with 20-40% moderate wedging can be mobilised after a week with patient wearing thoraco lumbar brace with back being in extension. After 3 months repeat x-ray is taken and if no instability is present the brace is discarded gradually. On the other hand, if deformity increases or patient starts to have neurological signs surgery becomes

CONCLUSION

Management for D10-D11 and L1-L2 wedge compression fracture with spondylodiscitis of D11 in this case was managed through posterior stabilisation at D8, D9, D10, D12, L2, and L3 with laminectomy at D11 and discectomy at D10-D11. Postoperatively, patient’s condition was getting better as shown by increasing motoric power. We can now conclude that the best management for thoraco lumbar fracture with or without comorbid disease is surgery.

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