

## **TAYLOR SPINE CLINIC**

- Due to the complex nature of the spine there will be a delay in your appointment. Please expect to wait 1 to 2 hours before being seen. Please understand Dr Taylor will spend as much time with each patient as needed. If you are not able to wait please ask for the first appointment of the day to avoid a delay in your appointment or you may call prior to your scheduled visit to determine how long your wait will be prior to being seen on any given date.

### **LUMBAR SPINAL STENOSIS**

**DEFINITION:** This refers to a narrowing of the spinal canal. Certain individuals may have a narrow canal from birth, but the majority of individuals develop narrowing with age. With age, wear and tear arthritic spurs build up on the facet joints in the posterior part of the spine. These arthritic spurs then encroach on the spinal canal and pinch the lumbar nerve roots. This condition can be worsened as well by narrowing and degeneration of the disc at that level as the space for exit of the nerve root (called the foramen) is narrowed further by a degenerated disc. Spinal stenosis is most common in the last three levels of the lumbar spine, namely L3-4, L4-5, and L5-S1. It is diagnosed and confirmed by an MRI or CAT scan/myelogram.

**SYMPTOMATOLOGY:** There are various signs and symptoms of spinal Stenosis. A common one is referred to as spinal claudication. This refers to pain in the legs, the calves or the buttocks. This pain is associated with activity. The pain is often relieved by sitting and resting. It will then often times start up again with activity. A common complaint is that an individual will be able to walk several blocks then develops leg pain, is able to get rid of the leg pain by sitting and resting for five to ten minutes and then, upon trying to walk another several blocks, the pain will return. The pain may be a radiating pain like a sciatica or it may be a cramping pain. At times though, the stenosis may be severe enough that the leg pain is constant and unremitting. It may, at times, be indistinguishable from the kind of pain that occurs with a herniated disc.

Spinal stenosis is uncommon in younger people. It usually occurs at age 40 or older. Leg pains from spinal pathology are more common from herniated discs in people under 40. Over 40, it is more common that spinal stenosis will be the problem. In addition to developmental degenerative spinal stenosis, entrapped nerve roots may be caused as well by spondylolisthesis and scoliosis. It will rarely cause paralysis. The condition will tend to gradually worsen with time and cause increasing pain, however. Patients with congenital spinal stenosis (such as achondroplastic dwarfs) may develop symptomatic stenosis as early as age 15 or 20.

**TREATMENT:** Spinal stenosis can be relieved by removing the overgrown portions of the facet joints posteriorly. At times, only parts of the facet joint have to be removed. In more severe cases, most of the facet joint will have to be removed in order to adequately decompress the nerve roots. Whether or not a fusion has to be performed at the same time as a decompression is dependent upon many factors, including the stability of the spine, the age of the patient, and the amount of bone being removed. The reason for doing the fusion after the decompression is so that instability does not develop and forward slippage or spondylolisthesis does not occur after a decompression.

**POSTOPERATIVE COURSE:** There is a fair amount of discomfort for about 2 weeks after surgery. On the first postoperative day, the individual can sit and dangle off the side of the bed, as well as stand. Over the next couple of days, he/she is able to ambulate fairly comfortable and is able to walk up and down stairs without too much trouble. Average hospital stay after a spinal stenosis decompression is approximately 3 days. Recovery will be quicker if a fusion is not performed simultaneously. If a fusion is performed, then this adds 2 to 3 days on to the hospital stay. Generally within 6 weeks after the surgery, the patient should feel good enough that he/she can go back to a desk job. The results with this kind of surgery are quite good. On the order of 90% of patients have relief of their pain after the surgery.

**BRETT A. TAYLOR, M.D.**

**DO YOU KNOW THE FACTS?**

## **MICRO LUMBAR DISCECTOMY**

You are having surgery for a herniated lumbar disc. The discs between your vertebrae serve as cushions or shock absorbers for the spine. Spinal discs are made of tough fibrous rings that hold a soft cushion like substance called the nucleus. The tough outer ring can rupture or tear. The nucleus inside of the ring can extrude or poke out of the opening created by the rupture or tear. The nucleus can extrude far enough to pinch a spinal nerve root and cause severe pain.

Dr. Taylor will remove only the portion of the disc material that is herniated. This procedure will relieve pressure off of the spinal nerve root that is being compressed by the herniated disc.

After the procedure, you will be taken to a regular hospital room. You have a choice of going home the same evening, or leaving the next morning. If you are having complications, or more pain than expected, you will need to stay overnight.

You will be given pain medication after surgery and progress back to a regular diet slowly.

At discharge, the floor nurse will give you pain medication prescriptions that you can take to your pharmacy to be filled.

Please see the attached for discharge instructions and office phone numbers.

## **LUMBAR DECOMPRESSION**

This procedure is done for SPINAL STENOSIS.

Spinal Stenosis is a condition in which the opening for spinal nerve roots and/or spinal column and its contents is being made smaller, or compressed, by certain portions of the lumbar vertebrae that are degenerated. The compression of the nerve roots and/or spinal column can cause symptoms such as pain, numbness, tingling, or weakness of the lower extremities.

In this procedure, Dr. Taylor will remove portions of the lumbar vertebrae that are causing the compression. Not the entire vertebrae, but just the select areas that is causing the squeezing of nerve root or spinal column. The decompression works to free up some space for the nerve roots or spinal column and relieve you of the symptoms you are having.

After the procedure, you will be taken to a regular hospital room. You will stay overnight and leave the next morning. If your lower extremities have been weak, to the point that your walking has been affected, you may need to stay an extra day for rehabilitation.

You will be given pain medication after surgery and progress back to a regular diet slowly. After the anesthesia wears off, you can get up and walk with the assistance of a nurse.

At discharge, the floor nurse will give you pain medication prescriptions that you can take to your pharmacy to be filled.

Please see the attached for discharge instructions and office phone numbers.

## **TOTAL DISC REPLACEMENT**

The present standard of care to treat painful spinal problems is a lumbar decompression or a lumbar decompression and fusion. During a fusion operation, spinal bones are grown together using either donated bone, the patient's bone from the pelvis and/or metal screws and rods. A successful fusion may increase a patient's risk of arthritis developing above or below the operative level. This may result in a requirement for additional surgery. Lumbar total disc replacement was developed in hopes of alleviating pain and allowing persistent motion at the spine. Disc replacements were begun in the 1950's and continued to develop through the 60's and 70's. The Charité total disc replacement was first developed in the 1980's in Germany. The disc is made out of a cobalt chrome metal sandwiching a classic or polyethylene center portion. The Charité artificial disc has been FDA approved for use at the L4-5 or L5-S1 disc. This treatment is an option for patients with discogenic back pain who have failed non-operative treatment for at least six months. If you have low back pain, which is persistent greater than six months, and minimal leg pain, you may be a candidate for lumbar total disc replacement. If you have osteoporosis or osteopenia, you cannot have a lumbar total disc replacement. As well if you have scoliosis or curvature of the spine, or any form of spinal instability, you cannot have a total disc replacement. If you have central spinal stenosis, a tumor in the spine, scarring of the spinal nerve roots, have chronically used steroids, have advanced disease in the posterior facets of the spine, metal allergies, pregnancy, severe nerve root compression, a herniated disc, infection, cancer or autoimmune disease, you cannot have a total disc replacement. As well if you have severe vascular disease with calcification of the vessels in the anterior lumbar region, or have had a major vascular surgery, or if you are overweight (100 lbs. over your ideal body weight), or have had previous retroperitoneal procedures, such as surgery on your kidneys or certain organs, you should not have a disc replacement.

To better help you decide if you would like to consider total disc replacement, I have provided you a list of data which was developed during the FDA trial at 15 centers in the United States to determine if the Charité total disc replacement would be a successful treatment. This study was performed on patients 18 to 60 years of age. There were 15 hospitals that performed this procedure and the procedure was performed at the L4-5 or L5-S1 level. The average surgical time for a total disc replacement is approximately 1 1/2 hours. The blood loss is on average is 150cc and patients stayed in the hospital up to three days after surgery. Complications which have occurred in patients include pain in the back or lower extremities in 52% of patients, problems with the surgical approach in approximately 10% of patients and the requirement for additional surgery in approximately 5% of patients. Of the approximately 16% of patients who had some type of nerve damage with surgery, 2-3% had burning pain in their legs after surgery, 1 1/2% had some type of weakness after surgery and less than 1% was felt to have a nerve injury. The complications related to the surgery, getting to the spine to replace the disc include 4% of patients having damage to vessels, 1 1/2% patients having retrograde ejaculation which can lead to sterility in men and abnormal sexual function, and less than 1% of patients had either a hernia, bowel ileus, a blood clot, vessel damage, which was life threatening, an epidural blood clot which pressed on the nerves, or scar formation.

If you choose to have a total disc replacement, I would like to provide you information regarding your hospital care after surgery. Most patients will be treated with a pain medicine which will be provided to them through an intravenous injection (IV). This is called a PCA (patient controlled analgesia). We will try to get you onto oral pain medicine as quickly as possible. We will ask that you begin sitting with gentle, abdominal flexion immediately after surgery and that you use a lumbar corset and avoid extreme ranges of motion in the initial months after surgery. We will ask that you begin walking as soon as possible and that you use special compressive stockings to prevent your risk of blood clots forming in the legs. We will ask that you sit as much as tolerated and use ice on your abdominal incision. It is ideal that you discontinue narcotic usage as soon as possible and you may need to work with your pain specialist in doing this if you have been on high dose narcotics for a number of weeks to months. Patients should avoid hyperextension which is bending backwards as if to touch your head to your back. This activity can threaten the stability of your disc replacement. As well, in physical therapy you should avoid heavy lifting and impact loading activities, such as jumping or running, as well twisting activities such as tennis or golf.

Again, a special note for patients who have been on high dose narcotics for a long period of time: Your body may need to detoxify with the aid of your pain specialist and this process might take 1-2 months. You should not immediately stop taking high dose narcotics without the guidance of your pain management doctor. I suggest that you avoid extreme activities for a minimum of three months. However, if you have a sedentary job, you may be able to resume work at one month.

If you have additional questions, please see the patient information packet or discuss your questions with Dr. Taylor or his nurse, Lori Burke.

## **SPINAL FUSION INSTRUCTION BOOKLET**

You are having a SPINAL FUSION. Dr. Taylor has discussed with you why you need surgery and what specifically will be done. The type of surgery you are having is based on where and what your spine problem is and what will best alleviate your symptoms. Dr. Taylor's nurse will be available to answer any questions you have about the particular procedure you are having. This booklet gives you information on what you will need to do before surgery and what you can expect after surgery.

### **BEFORE SURGERY**

There are several things to do to prepare for surgery.

1. Before your operation, it will be necessary to have blood tests. If you are over forty, you will also need an EKG and chest x-ray to evaluate your general condition before undergoing anesthesia. If you are over 40, or have significant health problems, you will need a medical clearance by your internist (medical doctor/family doctor).
2. You may want to get your home ready for after surgery. During your six week to six-month recovery period, you will have a weight lifting restriction, and will need to maintain back precautions, which will limit some of your routine activities around the home. Also, if bone graft was used from your hip, you will be experiencing soreness at this site. For these reasons, it will be difficult and risky to bend, stoop, or reach for overhead or under waist objects. It is advisable to place frequently used objects at an easily obtainable height.
3. Loose fitting clothes may be preferred in the immediate weeks after surgery. If you are to be braced post-operatively, you will need tee shirts to wear under your brace. The tee shirt must cover the buttocks. These tee shirts help absorb some of the body's perspiration, and prevent skin breakdown. Brace application does require the help of another person. You may receive a second brace for showering.
4. You may need to walk with a walker after surgery, due to pain and weakness. Remove all throw rugs or items blocking the walkway to prevent tripping or falling.

### **DONATING BLOOD BEFORE SURGERY**

Dr. Taylor may ask you to donate blood for your surgery. The nurse will let you know if you need to donate. Blood loss during this surgery is common, and often the patient needs to get a blood transfusion to accommodate for this loss. The blood from the blood bank is safe and tested for

infectious diseases. Dr. Taylor feels it is even safer for the patient to get back his or her own blood. Your nurse will give you specific information on donating blood.

## **INCISION**

The incision will be made according to the location of the spinal problem. The length of the incision depends on how many levels of the spine that needs to be operated on. Most incisions are no longer than four to five inches long.

## **BRACE**

You may or may not need to wear a brace after surgery. Dr. Taylor's nurse will let you know if you have to wear a brace. The type of surgery you have and how many levels are operated on, determine the type of brace you wear. The brace serves to limit motion of the spine, and protect and support the spine while it is healing. You will be fitted for a brace prior to surgery. You may need to wear the brace whenever you are out of bed.

## **RISKS**

All of the following risks are very unlikely to occur. But, you do need to be aware of them.

- Side effects from the anesthesia
- Infection
- Damage to nearby structures
- Bone graft shifting or displacement
- Spinal cord or nerve damage
- Bleeding or possible need for transfusion
- Failure of the bone to heal
- Problems with the metal plates and screws
- Problems with the bone graft site

## **AFTER SURGERY IN THE HOSPITAL**

The average length of stay for this type of surgery is three to five days.

### ***THE EVENING OF THE SURGERY***

1. Activity: You will be on bedrest.
2. Diet: You will be started on a clear liquid diet.
3. Pain Control: When you return from the Recovery Room, you will have intravenous (IV) fluids running into your arm. A device called a PCA (patient controlled analgesia) will be connected to your IV fluids. This PCA will allow you to administer your own pain medication by pressing the button whenever you have pain. This is a very small dose, which goes directly into the vein and should relieve your pain quickly.

4. You will have drains coming out of your incision. The drains collect excess bleeding and drainage from under the skin. This keeps your wound from swelling, and helps the nurses and doctors to estimate your blood loss.

5. You will have a urine catheter, which will drain your bladder until you can safely make it to the bathroom, or a bedside commode safely. Expect the catheter for one to two days after surgery.

### ***FIRST DAY AFTER SURGERY (POST-OP DAY 1)***

1. Activity: Physical Therapy (PT) will come in the morning to get you up and ambulating. PT will then determine if you need a walker. It may be difficult to walk at first, due to the soreness from the bone graft. PT will also show you proper ways to position yourself, get out of bed, and instruct on measures to prevent stress on your spine after surgery. You will need to follow back precautions. Following is the list of back precautions.

a. When turning in bed, the head of the bed should be flat. Hips and shoulders should turn together as a unit, in log roll fashion.

b. Hips and shoulders need to be in alignment.

c. No twisting.

d. Placing a pillow between your knees, when turning, will help maintain alignment and provide comfort.

e. No bending, stooping, or heavy lifting. DO NOT carry more than five pounds. (One gallon of milk weights 8 to 9 pounds)

Your doctor will also prescribe Occupational Therapy. Post-operative precautions and/or the brace can make some self-care activities difficult, if not impossible. The occupational therapist will assist you in learning alternate methods to perform these tasks. The occupational therapist will work with you and address any concerns of how to perform bathing, dressing, toileting, cooking, or light chores safely and independently, at home.

2. Diet: You should be able to advance to a regular diet. A soft diet may still be needed if you are not passing gas yet.

3. Pain Control: You have the option of staying with the PCA or starting pain pills.

### ***SECOND DAY AFTER SURGERY (POST OP DAY 2) AND ANY DAYS AFTER***

Post-op Day 2 and days thereafter are devoted to rehabilitation and sending you home.

1. Activity: PT will be ensuring that you are safely ambulating independently. By discharge, it is important to be getting out of bed, walking, and going up and down stairs independently. It is possible that you will need a cane or walker for a few weeks after surgery.

Occupational therapy will ensure that you are able to perform activities of daily living independently.

If you have had an extensive surgery, or had trouble ambulating or functioning independently before surgery, you may need extra rehabilitation. Extra rehab is made possible through home health physical therapy or occupational therapy, or an extended stay in an inpatient rehab facility. Your physical therapist, occupational therapist, and doctor make the determination for extra rehab. Extra rehab is subject to insurance approval.

1. Pain Control: You will be taken off the PCA and switched to pain pills. Prescriptions for pain pills will be given to you at discharge.
3. You may be sent for x-rays of your spine.
4. The spine nurse will give you going home instructions, that include information on incision care, activity, and the back brace.

**You will need to have a bowel movement before you go home, in order to prevent constipation. After surgery, constipation can be a problem because of the pain medication and immobility. If you are having trouble with having a bowel movement after surgery, please inform your nurse or doctor.**

### ***AFTER DISCHARGE***

Showering: You can shower 5 – 10 days after returning home. DO NOT take a bath or get into a pool for TWO WEEKS following your surgery.

CAUTION: The bathtub floor and/or shower stall are potential sites for accidents because of wet surfaces. The bathing environment should be slip free.

Driving: This will be discussed after surgery and depends on how extensive your surgery was. Your doctor will determine when it is safe to return driving.

Working: Keep in mind that you will not be able to lift more than five pounds for six weeks to three months after surgery. Working depends on what type of job you have and how extensive your surgery was. If you have a job that does not require physical labor, you can return to work within three to four weeks. If you do have a job that requires physical labor, your doctor may want you to stay off work for six weeks or longer, depending on how you are doing after surgery. Regardless of what type of work you do, your doctor will allow six weeks off, following surgery.

### **CONCLUSION**

The spinal fusion is done to reduce pain, prevent any deterioration of neurological symptoms, and provide stabilization for the spinal column and spinal cord. Before you undergo this operation, you should be fully aware of what the procedure is all about, and that all of your questions are answered in complete detail, and to your satisfaction. If other questions arise prior to surgery, please do not hesitate to call or to make an appointment for another visit. Your spine nurse will be available to answer any questions you have. Every question or concern you have is considered important.

## **SPINAL FUSION**

Dr. Taylor feels that spinal fusion is indicated for spinal infections, tumors, fractures or dislocations. In rare circumstances, we may also fuse the spine if there is slippage or motion and a laminectomy is required to decompress neural elements. A spinal fusion rarely cures the patient. We encourage all patients to avoid spinal fusion for back pain. In this circumstance, we feel that exhaustive non-operative treatment should be the standard for back pain related to degenerative arthritis. Patients who present to our clinic who have had a previous spinal fusion, and now present with persistent or recurrent complaints, are an extremely challenging medical condition to evaluate and treat. Often times, psychological disturbances, litigation, compensation issues, and ill-defined pain generators, as well as scar formation, cloud our ability to adequately diagnose this post-surgical problem.

It is thought in some patients that pain after a spinal fusion is due to a pseudarthrosis. There are a number of factors that can increase a patient's chance of developing pseudarthrosis or a failed fusion. These include hormonal imbalances, osteoporosis, medication such as steroids or chemotherapy, radiation, non-steroidal anti-inflammatory medications, cigarette smoking and nicotine usage. As well, the number of levels fused negatively affects the rate of fusion. In other words, the more levels a surgeon attempts to fuse, the higher the chance that a fusion will not occur. As well, there are a number of systemic factors which can increase the chance of failed fusions, including nutritional issues such as diabetes, cardiovascular disease, and obesity. It is felt that the use of instrumentation or screws and rods will increase the rate of radiographic fusion. To truly diagnose a pseudarthrosis, one must wait at least one year after surgery to assess whether adequate fusion mass has developed.

Patients who have been treated with stand-alone titanium cages create a unique challenge for our surgical team. Pseudarthrosis or failure of healing is a more common problem with this treatment method. It is incredibly difficult to determine if pseudarthrosis exists in patients with these devices. Once a pseudoarthrosis has been established, revision surgery is significantly challenging due to postsurgical scarring. If the titanium or metal cages are in good position, we elect to treat this problem with a posterolateral instrumented fusion. We only remove the cages when it is necessary due to migration or initial malposition that results in neurologic or vascular injury. All patients with pseudoarthrosis must understand that successful surgery does not mean that they will have a normal spine. Most patients with this type of problem have a return to work rate less than 50%, and at best only a 50% reduction in their pain, after complete recovery. Surgery for pseudoarthrosis is very expensive and very complicated. For this reason, we encourage patients to exhaust non-operative treatment before considering a surgical intervention for this pathology.



## When is Spinal Surgery Necessary?

Brett A. Taylor, MD — Adult Spine Specialist

As a Board Certified Orthopaedic Spine Specialist, my practice focuses on spinal disorders. Back problems can be debilitating for many people. The most common spinal problems are a result of long-term wear and tear, or an ongoing degenerative process. The more common reasons for which patients seek spinal surgery include arthritis, instability and nerve dysfunction, as well as incapacitating back pain that has failed to improve with two (2) to four (4) months of non-operative treatment. When patients are unable to walk, or have bowel or bladder dysfunction, we need to address their problems urgently with surgical intervention. Other problems that can occur include herniated discs, loss of bone mineral density or osteoporosis, which can result in fractures.

Should you experience prolonged back or neck pain, your family physician will most likely refer you to a specialist who is trained in diagnosing and treating spinal disorders. I encourage patients to consult their primary care doctors when choosing a specialist. Other sources of information include friends and national associations such as the American Academy of Orthopaedic Surgeons (AAOS). The AAOS has an on-line database to assist patients in locating *certified* providers. Patients should ask tough questions of their potential surgeon and should not be afraid to ask questions about his or her credentials. If your instincts tell you that you should get more information, you should seek a second opinion. Patients should avoid surgeons who discourage second opinions, or use scare tactics to encourage surgery.

### *What to expect when you come to my office*

As an orthopaedic spine specialist, I seek to help my patients understand that spine surgery **cannot** offer a 100% cure for most spinal problems. Spinal surgery is a last resort to offer some improvement in your function. For these reasons the surgical goal is to improve function, but rarely to cure all problems. Many people are surprised when they realize that most of the patients I see in my clinic do not need spinal surgery. Fewer than 20% of the patients I see in my practice eventually go on to have surgery. Most can be helped with nonoperative treatments. These include anti-inflammatory medications, physical therapy and rehabilitation, or injection therapy, which often alleviate the symptoms that patients suffer. Also, weight loss, exercise, and limiting alcohol and tobacco use will frequently improve the patient's condition. I ask that my patients try to exercise regularly to keep their back muscles strong, and use correct lifting techniques.

### *What if surgery is necessary?*

It is critically important that you have been well informed and adequately educated when you decide to have your spinal surgery. Patients frequently ask, "Who can best perform spine surgery, a neurosurgeon or orthopaedic spine surgeon?" In my opinion, either specialty can perform safe, and competent spinal surgery if he or she has had training in a *Spine Fellowship* at an approved hospital training program. Your surgeon should be board certified, fellowship trained, and focused on spinal surgery.

### *Putting the patient first*

If you do require surgery, I will explain the natural history of your particular spinal illness, all of the alternatives to surgery, as well as, the risks and complications of surgery. In my spine practice, patients are also provided with written information about their surgery. It is important that you understand and have appropriate expectations of surgery. I encourage you to write down your expectations from surgery so that we can answer specific questions related to your personal experience. After all of your questions are answered, I will describe the potential surgical procedure in detail with a model of the spine.

Whenever possible, a second visit is scheduled after you and your family have had some time to think more about the problem. You should write down further questions at home, so that during the clinic visit, you can have all your concerns addressed.

During our pre-operative consultation, we inform you of the risks involved with surgery. We discuss the type of implants that might be used in your surgery. In general, we only use surgical implants that have had a long, successful track record of use in spine surgery.

We discuss with you all of the postoperative activity limitations including recreational activities, such as golf or jogging. We will help you estimate your time off of work after a surgical procedure. As well, we will make sure that you understand your requirements for follow-up visits.

It is important for you and your family to have reasonable expectations on the hospital stay, the pain involved with the surgical procedure, and the post-operative limitations of function. Frequently, we will need to arrange post-operative extended stay at a rehab facility.

Years ago, spinal surgery meant that the patient would never return to full function. New advances in spinal procedures, including instrumentation, and advances in anesthesia, minimally invasive procedures, and motion sparing technology have allowed both younger and older patients to resume a full and active life. We often operate successfully on patients 80 years of age offering them better independent function.

There are a number of new technologies which will become available and which will greatly improve our ability to treat spinal abnormalities. At this point, these new technologies have not been tested adequately to determine their effectiveness. However, my personal research interest is in disc replacement technology. I feel that this will greatly improve our ability to treat patients with back problems.

I hope this information will be useful to you in determining proper care and treatment of your condition. My staff and I are happy to provide further service to you. If you have questions, please do not hesitate to call my nurse, Lori Burke, at **314-336-2555**.

*Accessible, Approachable, Interested.  
Top Treatment – Patients First*

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*After completing a Bachelor of Science degree in biology at Yale University and a medical degree at the Harvard Medical School, Dr. Taylor fulfilled residency training at the Harvard Orthopaedic Surgery Residency Training Program. Subsequently, he completed fellowship training in adult spine surgery at the Thomas Jefferson University School of Medicine, and served thereafter as a Major in the United States Air Force at Wilford Hall Medical Center in San Antonio, Texas.  
He has now returned to his hometown — St. Louis.*

*Dr. Taylor's clinical specialty is adult reconstructive spinal surgery with particular emphasis on cervical, thoracic and lumbar pathologies related to traumatic and degenerative spinal disorders. His clinical interests also include oncologic spinal surgery, and his research interests are in disc reconstruction and health care disparities research.*