Proximal Junctional Kyphosis (PJK) has 2 criteria:

1. Proximal junctional angle $\geq 10^\circ$ and (2) proximal junctional sagittal Cobb angle at least $10^\circ$ greater than the pre-operative measurement. The incidence of PJK ranges from 17-61.7%,

   a. most sources report a rate of 20-40%.

2. PJK may have increased pain levels and worse clinical outcomes

(3) Causes:

   a. Radiographic risk factors

      i. Failure to appreciate sagittal parameters

      ii. Overcorrection

      iii. Failure of rod contouring

      iv. Modulus Mismatch

      v. Role of cervical compensation

   b. Medical Risk Factors

      i. BMI
ii. Bone Quality

iii. Smoking

iv. Medical Conditions

v. Parkinsons and Neuromuscular conditions

(4) Operative vs Nonoperative Intervention

a. Role for Bracing

b. Operative Intervention
   i. Neuro Deficits
   ii. Paralysis

c. Fusion levels

d. Paradox of Cervical Spine
   i. Cephalad Extension into Cervical Spine
   ii. Crossing or stopping at Cervicothoracic Junction

(5) What is the role of the cervical spine in PJK?

a. When to prophylactically include cephalad extension

b. What is role of leaving segments cephalad to UIV to allow for force dissipation?

(6) Timing of PJK

a. Acute (same hospitalization)
b. Subacute – within 3 months

c. Chronic with compression Fracture

d. Majority occur within first year

(7) Proximal Junctional Failure vs Proximal Junctional Kyphosis

(8) What is the Proper Operation to address

a. PCO

b. PSO

c. VCR

d. In situ Fusion