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During spinal fusion, the dysfunctional spinal motion segments may be resected and the spine rigidly stabilized with mechanical fusion devices such as pedicular screws, interpedicular fixation plates, and intervertebral spacers (Fig. 24.5). Osseous spinal fusion is attained by the use of bone grafts in the vascularized tissue bed. The rationale for BMPs in spinal fusion surgery is to avoid the complications of autogenous iliac crest bone graft harvesting, to reduce the risks for nonunion and reoperations, and to improve functional outcomes for patients. The main objective of this systematic review was to determine whether BMPs improve spinal fusion. In particular, do BMPs reduce the risk for nonunion and improve clinical outcomes for patients undergoing lumbar spinal fusion? Spinal fusion technique was introduced 70 years ago for the treatment of degenerative disc disease and chronic lower back pain [1]. Hibbs and Albee were two spine surgeons in 1911, who performed first spinal stabilization surgery [2,3]. Forward displacement of a vertebral bone in sequence of normal alignment of vertebra is called Isthmic Spondylolisthesis-most commonly due to progressive vertebral body malalignment. Even in severe case of spondylolisthesis, the slipped vertebra is comfortably reduced by the modern surgical techniques [4-7]. However, these operations have high risk of neurological complications from the implant and screws.