Microdiscectomy

This is the name of a very commonly performed operation performed in the lumbar spine for prolapsed disc. 'Micro' relates to the fact that a microscope is used – although it is used in many other spinal procedures and the term is not added to the front e.g. cervical surgery.

Indications

Lumbar disc prolapse is very common and fortunately in the vast majority of patients resolves to an extent that no treatment is needed. What actually happens is that the middle of the disc is squeezed out like toothpaste out of a tube and this then presses against a nerve as it leaves your back and goes into your leg causing 'sciatica'. The nerve becomes swollen inflamed and painful. Sometimes manual therapy may help or a nerve root block injection can be organised to take away the pain while the problem heals itself but in some patients surgery is indicated e.g. when the pain is uncontrolled by other means, pain not resolving after 6 weeks, weakness, bladder/bowel problems, recurrent problem. Any incontinence caused by a prolapsed disc needs to be treated urgently.

Aims of Surgery

The main aim of surgery is alleviate limb pain and this occurs in excess of 90% of patients. Most experience immediate relief, although because the nerve is swollen complete relief may take longer to occur. If weakness has been a problem then this does not always improve, but the surgery should stop it getting worse. Likewise for numbness, although pins and needles usually do resolve. It is entirely within normal limits to have twinges and some numbness after surgery but any concerns can be raised with Mr Harding

Procedure

Prior to surgery, you will be seen in the pre-operative clinic and consent will be obtained prior to the surgery on the ward. An incision is made at the level of the disc prolapse and the size of this will depend on the size of the patient. Careful blunt dissection to the spine is performed, retracting the muscle gently. A piece of ligament and often bone is then removed to reveal the spinal nerve as it leaves the spinal canal. The nerve is gently retracted to one side and the disc prolapse identified. All loose disc material in the canal is searched for and removed. As much disc as possible remaining in the disc space is left behind (where it has a job to do), but loose fragments are always removed. Closure is with internal sutures although clips are very occasionally used. Local anaesthetic is placed in the skin and muscle. A small dressing is used. The usual post-operative plan is to commence mobilisation as soon as possible with the nurses and physiotherapists on the ward.

Post-operative care

Sutures	Often none, just paper strips. Bigger wounds may have clips
Physiotherapy	Instructions given on discharge. Formal physiotherapy sometimes arranged depending on individual
Driving	When safe. Could you do an emergency stop and be in complete control of your car? Normally 3-4 weeks but variable
Work	Desk based 4-6 weeks, Heavy manual 3 months. From home sooner
Exercise	It is important to keep the wound dry until it has healed and not to do anything that will overstretch the sutures. Once the wound is dry, a gradual and progressive return to activities is possible. Do not suddenly go back to full activity and take things sensibly. No heavy lifting or contact sports for 3 months following surgery (i.e. no straining). Normally, from 2 weeks can swim or cycle on exercise bike. When running, to start on a treadmill, then soft surfaces before road running.

Complications

All operations have risk attached which is why in most circumstances, non-operative measures are pursued first. Fortunately most complications can be treated and although they are inconvenient and cause setbacks there are often no long term consequences. Total paralysis cannot occur from this type of surgery but a nerve has to be retracted and can theoretically be damaged, as can the nerves going to the bladder and bowel. Fortunately this is very rare (<0.1% cases).

Other complications include:

Bleeding	- if significant may need further surgical exploration
Infection	- often antibiotics suffice, may need surgical washout
CSF leak	- spinal fluid may leak (1%) and you may need to lie flat post-operatively
Recurrence	- 5-10% risk irrespective of activity, sometimes needs further surgery
Scarring	- some is inevitable, but sometimes the nerve becomes stuck down which is why early mobilisation is important
Back pain	- sometimes post-discectomy back pain develops – especially in the big prolapses. Often physiotherapy suffices, sometimes further surgery may be indicated.

These are the main surgical complications, but of course, any operation is a major undertaking for you and a large stress on your body and so can cause cardiorespiratory, vascular, renal or gastrointestinal problems. If you have other medical conditions then this can affect the outcome of your surgery and these should all be notified to Mr Harding, the nurses in clinic and the anaesthetist prior to your operation.

The BASS website – see links page – has further useful information regarding consent

The aim of this is to inform and reassure. The list describes the main problems that may occur and if you have any concerns, worries or questions regarding these or others not listed then please discuss these with Mr Harding in clinic.

Follow up

After surgery at the Spire the ward should give you an appointment with Mr Harding for follow up if needed. If this does not happen please contact his PA. At the Nuffield follow up is arranged via the PA.