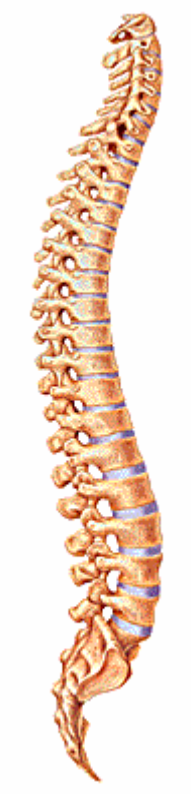
ADVICE TO PATIENT DUE TO HAVE

MICRODISCECTOMY / SPINAL STENOSIS DECOMPRESSION

Under the Care of Mr M Paterson



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Royal United Hospital Bath NHS
NHS Trust

Dear Patient

You are on the waiting list to have spinal surgery. The details of your admission will be sent or telephoned though to you by the Orthopaedic Bed Managers close to the time of your surgery.

PACKING FOR THE HOSPITAL

1. Bring your pajamas, nightdress, slippers, toothbrush, comb, towel, etc., as well as a small selection of day clothes and underwear. Please do not bring any valuables with you.

   You should expect to stay in hospital for approximately 3 – 7 days depending on your age, operation, home circumstances etc.

2. Choose light loose pajamas or nightdress that can go over your corset which you will need to wear after the operation. You can bring a well fitting cotton T-shirt or vest that can go underneath the corset, as this will be more comfortable. A track suit or loose top and leggings are usually easy and comfortable to wear. Bring slip on shoes.

PRE-ADMISSION CLINIC

You will be asked to attend the pre-admission clinic up to two weeks before your operation. At this time any blood tests, x-rays and heart traces etc that are necessary will be done. You will be measured for a corset.

The duty doctor will take your medical history, including medical complaints and record any allergies that you may have. After describing to you about your operation and what

4. Any spinal operation involves working on or around your spinal cord and nerves for most of the operation. There is always a chance that the nerves going down to your legs, bowel or bladder are damaged during an operation. Once again the chances of this happening are extremely small. Damage to these nerves would affect the use of the legs, bowel and bladder. As mentioned every precaution is taken to try and prevent any injury.

It is important that you are aware of these potential complications. By law we have to tell you about them. The chances of them occurring are ‘small but not zero’.

Singularly, the major concern regarding any spinal surgery is that we unfortunately cannot guarantee that the surgery is going to resolve your symptoms completely.

Sometimes with the nerves having severe pressure on them for a prolonged period of time the damage can already be done to the nerves prior to the operation. The operation to relieve this pressure on the nerves, therefore, sometimes cannot reverse all the damage that has already been done by your disc to these nerves – even if the operation is ‘successful’. This would mean that the improvement that you may get is not as much as you would like or expect. Unfortunately this is the nature of spinal surgery. We will gladly answer any queries you may have.

Yours sincerely

Mr M Paterson Consultant Orthopaedic Spinal Surgeon
FRC Ortho SA, FRCS (Ed) Orth.

procedures. Spinal surgery as a general rule cannot be done under local anaesthetic.

2. Wound infection occurs very infrequently (in much less than 1% of patients). All precautions will be taken to prevent a wound infection. You are given antibiotics, meticulous sterile techniques are used, suction drains are inserted and a special surgical operating theatre is used to try and minimize infection.

   When having a repeat operation or revision surgery the chances of infection are higher, particularly if you did have an infection in the first operation. Diabetic patients, generally speaking, have a higher chance of infection. The chances overall of infection occurring are, however, extremely small.

3. Deep Vein Thrombosis (clots in the legs) and Pulmonary Embolism (these clots moving from your legs to your lungs) are potential life threatening complications.

   Once again with any operative procedure there is a chance that one develops one or both of the above two problems, but the chances, particularly in spinal surgery, are exceptionally small and far less than for hip or knee surgery. Blood thinning agents are not used as a matter of routine in spinal surgery because bleeding around the spinal cord / nerves would have a harmful effect.

   You will be shown exercises to try and minimize the chance of blood clots forming in your legs. Special stockings (TEDS) will also be given to you to help to try and prevent them forming.

the aim, implications and the possible complications are, the doctor will take your consent for the operation.

The Consultant or Registrar will be available some time during your visit to the pre-admission clinic to answer any questions you may have. The Nursing Staff in the clinic will guide you through the clinic and explain to you how the other members of the Health Care Team are involved in your case whilst in hospital, i.e. the Anaesthetist, Physiotherapist, Occupational Therapist and Pain Control Team. You will also be given advice regarding your discharge plans. Please hand in the list of heights form to you pre-admission nurse.

DAY OF OPERATION

You will not be allowed to have anything to eat for 6 hours or drink for 4 hours before your operation as a routine precaution for the anaesthetic. You will have been given medication to help you to relax for the time that you are waiting before your operation. The anaesthetist will begin preparation for your surgery and will put you to sleep after your arrival in the theatre complex.

A catheter tube is most often inserted into your bladder just before the operation starts (but while you are asleep). This is to try and avoid any discomfort when trying to pass urine for the first day or so after the surgery. We also frequently give patients laxatives to try and help reduce constipation in the post-operative phase.

After the operation you may be transferred back to the Recovery Ward. Most patients having major procedures go back to the Orthopaedic Recovery Area as a routine for close and careful monitoring.

For the first 6 hours after the operation you should lie on your back only as this allows the wound to be compressed and reduces the amount of bleeding. Later you can start turning approximately every 2 hours and lie on your side as is appropriate and as feels comfortable.

You will have an intravenous drip in your arm which will be used to give you fluids, painkillers and also other medication. This is important because the first day after the operation you will not be able to take anything by mouth while we are waiting for your stomach / intestines to start working again. You can however, have some ice to suck during that period to keep your mouth moist.

During you post-operative period you will be given painkillers using a special pump which you control or by mouth. All you need to do is to ask the nurses caring for you for the medication if necessary.

On the first day after your operation you will be transferred back to the ward. The drip will be removed from your arm and you will be able to start taking a light diet. You will be shown exercises by the Physiotherapist to help you get moving and you will also be shown how to turn in bed on your own.

Over the next few days while you are settling down after the operation you will be mobilised with the help of the Physiotherapist. Usually on the first or second post-operative day you will get up and start walking around.

The Occupational Therapists will visit you and discuss your requirements for when you return home, give you advice regarding appliances to help you with your daily activites and arrange any equipment needed.

13. Sexual intercourse should initially preferably be avoided. Make sure that you are always the passive partner whether male or female for the first few weeks.

14. Do not run, jump, go boating, or do gardening for a minimum 3 – 4 months after the surgery. From approximately 3 months after the surgery you should be able to walk longer and longer distances, do gentle swimming and cycling etc.

RETURN TO WORK

It is not possible to give you an exact time as to when you may resume work. It is unrealistic to expect to get back to heavier types of work in under 4 – 6 months. Some people doing a heavy type of work may never return to bending, stooping, and lifting types or work. Generally speaking people show have had microdiscectomies should be able to return to work at approximately 4 to 6 weeks and spinal stenosis 8 – 12 weeks. Preferably try and arrange things such that you do mornings only for the first 2 – 3 weeks back at work.

COMPLICATIONS OF SPINAL OPERATIONS

Any operation has potential complications whether it is a minor or major procedure. The major procedures do have higher chances of complications. All spinal surgery is major surgery.

Every possible precaution is taken to prevent any complications occurring. One cannot outline each and every complication that could occur, but the more common complications will be discussed.

1. There are certain possible complications relating to having a general anaesthetic for even the smallest

8. Preferably try not to bend down and pick objects off the floor. Should you not have anyone in attendance a 'helping-hand' device may be purchased to help lift objects. Always try and keep your spine straight. If you do need to pick something up, preferably take your weight through your arm by placing your hand on a near-by piece of furniture, table, etc.

9. There is no golden rule, recipe of formula as to how much you should or shouldn't do. Generally speaking try and sit for short periods of time only. Gradually lengthen the time, but frequently get up and about and move around. Don't' lie there frightened to move!! You can do gentle stretching exercises from about 10 days onwards – bend from side to side and backwards. Avoid forward bending and stopping as in making a bed, vacuuming etc;

10. Preferably use a shower for the first 6 weeks after the surgery. When washing your hair get close to the shower and take the corset off. Then move into the shower and wash. Let somebody help you wash and dry and don't try and wash your own knees and ankles, etc.

11. Do not drive your car for the 4 – 6 weeks after surgery.

12. To get into a car have the back rest of the passenger seat in a partially reclined position. Sit down on the car seat facing sideways. Ensure not to bend your hips up more than 45°. Slide backwards towards the drivers' seat until your lower legs can be moved into the recess in front of the passenger seat. Then slide into the passenger seat keeping the backrest inclined somewhat. This applies for travelling short distances (20 – 30 minutes).

Your wound will be inspected at approximately 3 – 4 days after the surgery. There should be no sutures that need to be removed because a dissolvable stitch will have been put in. Only short little adhesive tapes (which are not painful to remove) will be across the wound. You should be able to have a shower about 4 – 5 days after your operation.

DISCHARGE

Depending on how things are going you will be discharged approximately 3 – 5 days after the surgery. Please make sure you follow the instructions outlined below. There are however, no rules, recipes or formulae that you must follow that will ensure you get a better result. *These are only general guidelines*.

Your progress will be followed up in outpatients by your doctor. Prior to your discharge you will be given the date of your follow up visit as well as a weeks supply of painkillers to help control any further pain you may be experiencing. It is normal to have a certain amount of pain after any operation, but as time goes by this will gradually become less and less.

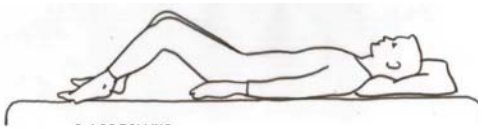
MOBILISING INSTRUCTIONS AFTER DISCECTOMY / SPINAL STENOSIS DECOMPRESSION

1. Getting up – 'log roll' (turn on your side – hips and shoulders move together) to get out of bed as instructed by the Physiotherapist. Mobilisation will usually begin the first day after surgery.

2. Remember that no two backs are the same and you must not compare yourself to anyone else regarding your own back problem and your own mobilisation.

3. Having your bed at home raised on blocks approximately 20cm (8") or more will make getting in and out of bed a lot easier. The Occupational Therapists (OT) can help you organize this if required.

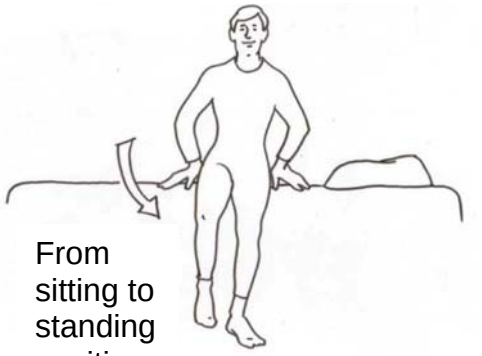
4. Pull one knee up at a time in a lying position to avoid straining the spine.



Log Rolling

Log Rolling

Lying down to sitting position



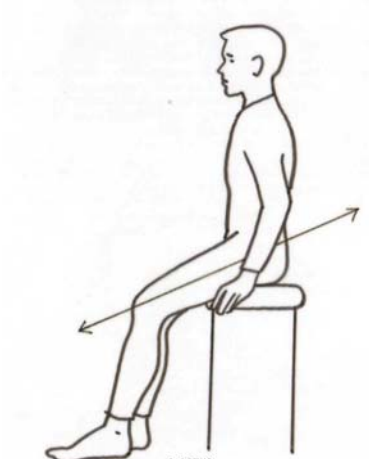
From sitting to standing position

5. To sit up on the edge of the bed – first get as close to the edge of the bed as possible in a side lying position, then use your upper arm to help push yourself from a lying to a sitting position and at the same time lower your legs over the edge of the bed.

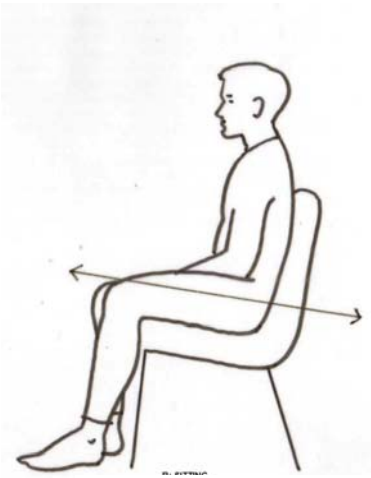
6. To stand up from a perching position, pull feet close the bed or chair and with your hands supporting you on the bed behind your hips or on the arms of the chair, slide your pelvis forward, extend your knees and stand.

   Do not bend forwards, but keep your spine reasonably straight.

7. Perch / sit down – stand with your feet close to the bed or chair. Reach behind you for support with both hands. At the same time bend the knees and sit down, ensuring that the hips never bends more than 45° In the first month to 6 weeks it is preferable to sit in a chair with a high seat with arms to make getting in and out of the chair easier.



Perching (knees below hips)



(AVOID) Low sitting