

The wounds are then closed with an invisible dissolvable suture, so there are no stitches or clips to be removed later on.

The Hospital Stay

Normally you would be admitted to hospital the day before the operation. You will be encouraged to get out of bed and walk around the day after surgery. Most people are well enough to go home between two and four days after their operation.

Post Operative Course

When you first go home you will need to take things easy for a few weeks. The wounds will need to be kept dry for the first week, so it would be better to shower around them rather than lie in the bath. You will be encouraged to keep mobile by going for a walk or two every day and there is no particular need to immobilise your neck in any form of collar after this procedure. Car journeys can sometimes be a little uncomfortable, and, as your neck may also be a little sore initially, it is best to avoid the car for a few weeks (apart from your journey home).

Your symptoms may not settle immediately, particularly if the spinal cord itself has been compressed as well as an exiting nerve. There is in fact a great variation in both the amount and speed of recovery, depending largely on the degree and duration of symptoms pre-operatively.

Getting back to work and the long term

The main aim of this procedure is to relieve the compression of the spinal cord and/or nerve. Exactly what you are capable of doing in the future depends to a large extent on the severity and duration of symptoms beforehand, and the extent to which they recover. A large proportion of people, however, make a full recovery (particularly those with purely arm symptoms)

and are able to return to work, sports and other activities without problems.

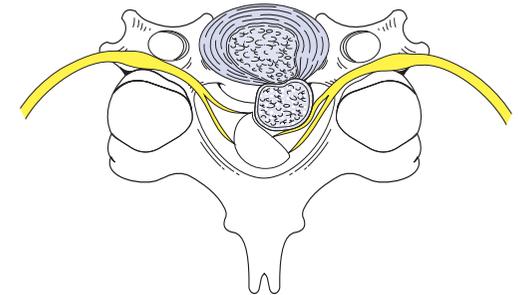
Follow up

You will be reviewed regularly after your discharge, initially after a few weeks, and then at longer intervals until your recovery is complete

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Anterior Cervical Discectomy and Fusion

A Patient's Guide



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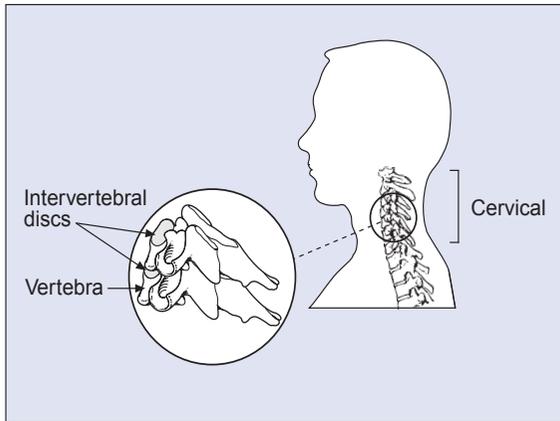
Introduction

This leaflet is intended to reinforce the things that have already been discussed about your neck and forthcoming operation.

Anatomy

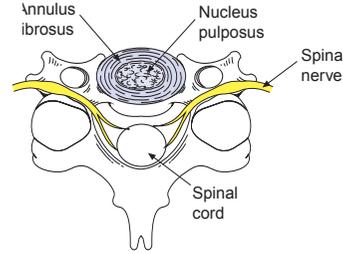
The spinal column consists of twenty four bones called vertebrae. They are connected together by small joints (called facet joints) and a spongy intervertebral disc, which together allow a small amount of movement between each vertebra, and a large amount of flexibility over the spine as a whole (Fig. 1). There are seven vertebrae which make up the cervical (neck) part of the spinal column, which is one of the more flexible areas. Each disc consists of a soft spongy central portion (the nucleus pulposus) and a tougher fibrous outer coat (the annulus fibrosus). Directly behind the disc is the spinal cord and the exiting spinal nerves (Fig. 2).

Fig. 1



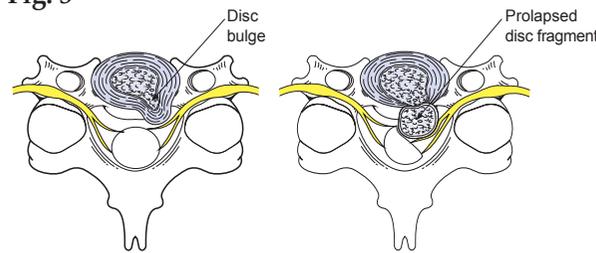
As we get older the disc dries out and becomes less spongy and small tears start to occur in the fibrous coat. As the fibrous coat is thinnest at the back (by the spinal cord and nerves) this is where problems usually develop. Eventually the fibrous coat may become torn to such an extent that the spongy nucleus within may cause it to bulge out and press

Fig. 2



on the spinal cord and/or an exiting nerve root. Alternatively a piece of the nucleus may squirt out of the disc and press directly on the spinal cord and exiting nerves (Fig. 3). This is a prolapsed intervertebral disc (slipped disc). This may cause severe pain as well as weakness and/or sensory changes in an area of the arm or hand supplied by the compressed nerve. Symptoms of weakness and sensory change in the legs, or bladder and bowel dysfunction, can also occur as a consequence of the disc compressing the spinal cord itself.

Fig. 3



Can it get better on its own?

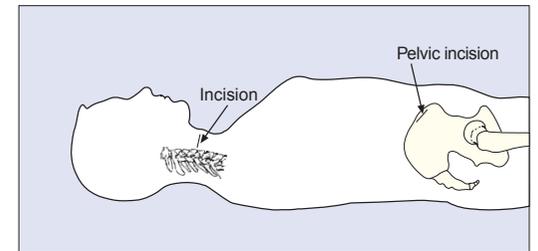
If the disc bulge is not too large, and if there is sufficient room within the spinal canal, symptoms of arm pain, weakness and sensory change may recover over a period of weeks. Symptoms affecting the legs, as a consequence of pressure on the spinal cord, are less likely to settle spontaneously.

If however the disc fragment is large, and the symptoms do not settle, or even deteriorate, then surgical removal of the offending disc is indicated.

Anterior Cervical Discectomy and Fusion

This is one of the commoner neurosurgical procedures and is performed under a general anaesthetic (so you are asleep). A short incision is made horizontally at the front of the neck, usually on the right hand side. The muscles and other structures of the neck are gently separated so that the front of the vertebrae and discs can be seen (Fig. 4). Then, using the operating microscope, the appropriate disc is removed from the front in order to decompress the spinal cord and nerves behind.

Fig. 4



A further short incision is then made over the front of the pelvic bone, again usually on the right hand side, and a small piece of bone is cut from the pelvis. This is then cut to the same shape as the disc that has been removed and inserted in between the two vertebrae in place of the disc. This acts as a spacer, keeping the vertebrae apart, and, over a period of some months, will eventually fuse the vertebrae together (Fig. 5).

Fig. 5

