CERVICAL DISCECTOMY

This leaflet is intended to provide you with general information. It is not a substitute for advice from your neurosurgeon. Discuss the benefits and risks of cervical discectomy with your neurosurgeon. This is an abridged version of the NSA patient education pamphlet: Cervical Discectomy – a guide for patients. The complete pamphlet is available from your neurosurgeon.

Cervical discectomy is a surgical procedure to treat symptoms due to a damaged disc that may be pressing on spinal nerve roots or the spinal cord in the neck. Symptoms may include pain, numbness, tingling, weakness and clumsiness of the upper limbs. Pressure on the spinal cord may cause altered sensation of the torso, difficulty walking, bowel or bladder dysfunction, and impotence in males.

Symptoms can be associated with neck pain, shoulder pain, pain between the shoulder blades, and headaches.

Surgery to remove part of a damaged disc can relieve pressure on nerve roots and the spinal cord. The surgeon removes the damaged part of the disc to create more space near the nerve roots or spinal cord.

This may reduce the inflammation and irritation of nerves. A cervical discectomy is also called an anterior decompression.

Discs are soft, strong cushions of tissue that sit between each vertebra. Each disc is made of a strong outer wall, the annulus. In the middle is a gel-like core, the nucleus.

Discs act as shock absorbers for the spine during daily movements. They maintain the correct spacing between vertebrae and allow bending and rotation between vertebrae.

Discs are resilient to forces but can be weakened due to age, disease or trauma. Disc herniation is a protrusion of the soft nucleus through or into the annulus, which can press on the spinal nerves and spinal cord.

Disc herniation can occur in four ways:

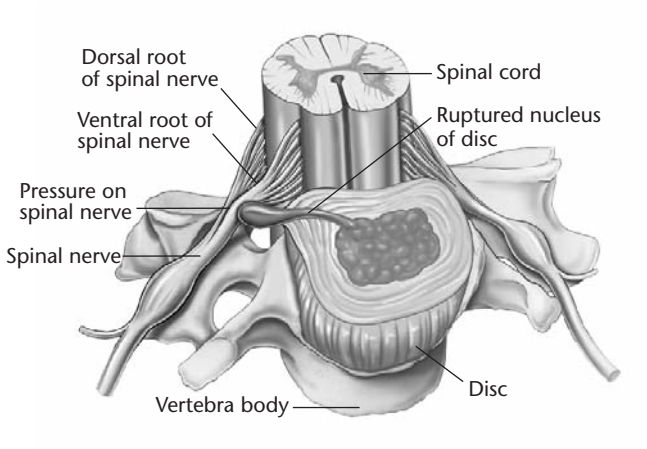
- degeneration - the disc is weak and thin, but the nucleus does not break through the annulus
- prolapse - the disc has a bulge
- extrusion - nucleus ruptures through the annulus but stays in one piece
- sequestration - the nucleus ruptures through the annulus, and fragments separate from the disc.

Ask your surgeon which type has occurred in your case.

The most common levels for disc problems are C5-C6 in about two patients in 10, and C6-C7 in about seven patients in 10.

Uncommonly, some patients have two or more disc herniations that need surgery.

Compression of the spinal cord can require urgent surgery to relieve pressure.



Diagnosis

Diagnostic imaging can provide pictures of vertebrae, other spinal structures and abnormalities. Magnetic resonance imaging (MRI), computer tomography (CT), and X-ray examination may reveal the precise location of abnormalities. One or more of these tests may be necessary. Your surgeon will examine you to determine strength, reflexes, ability to feel pain, ability to move, and any bowel or urinary problems.

Your medical history

Your surgeon needs to know your medical history to plan the best treatment. Tell your surgeon about any health problems you have. Some may interfere with surgery, anaesthesia or recovery.

A decision about surgery

As you make the decision whether to have surgery, make sure that you understand its risks, benefits and limitations. If you do not have surgery to relieve compression of a spinal nerve or the spinal cord, further damage may occur, with more pain, numbness, paralysis or loss of bladder or bowel control.

Only you can decide if surgery is right for you. If you have questions, ask your surgeon.

Anaesthesia

Cervical laminectomy is usually performed under general anaesthesia.

Possible risks and complications

Modern laminectomy procedures are safe but do have risks of side effects. Although uncommon, complications are possible. These are more fully outlined in the complete NSA patient education pamphlet on cervical discectomy and should be discussed with your neurosurgeon.©

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