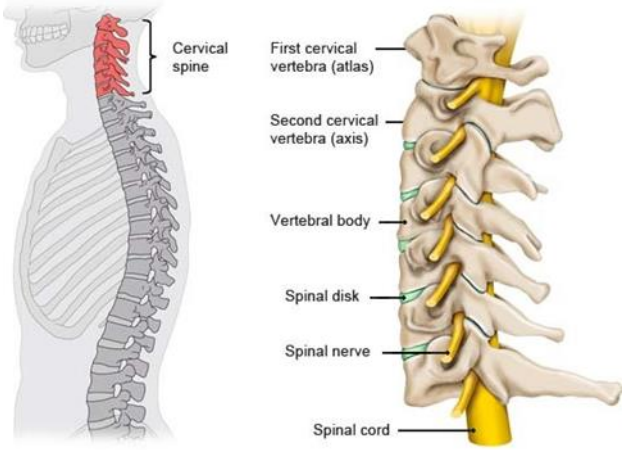
ANTERIOR CERVICAL DISCECTOMY AND DISC REPLACEMENT

BRAIN & SPINE CENTRE SYDNEY



Cervical disc replacement surgery involves removing a diseased cervical disc and replacing it with an artificial disc. It is done when the space between your vertebrae has become too narrow and part of your vertebrae or your cervical disc is pressing on your spinal cord or spinal nerves, causing you pain, numbness, or weakness. Symptoms vary from arm pain/weakness or numbness (with nerve compression) to unsteady walking, bowel/bladder disturbance or clumsy hand function (with spinal cord compression).

When these symptoms do not respond to nonsurgical types of treatment, disc surgery may be recommended.

REASONS FOR SURGERY

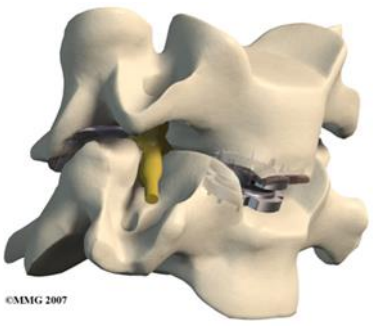
Surgery is indicated in patients whose symptoms are not settling or becoming unmanageable. Generally, surgery is offered after most conservative options have failed. Early surgery may be performed in patients who have worsening weakness or symptoms suggestive of spinal cord compression. The benefits of the surgery should always outweigh the risks.

Surgery aims to reduce pressure on the nerve and therefore relieve symptoms. With compression of the spinal cord, the main aim is to prevent worsening of symptoms, as it may not be possible to reverse symptoms.

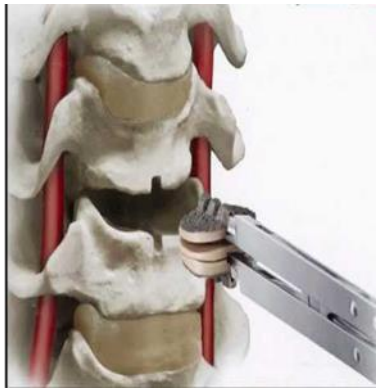
RISKS OF SURGERY

All surgery has some risks and these vary between procedures. The risks with surgery can be related to the anaesthetic, medication or the operation. Risks related to the anaesthetic depend on your other medical issues and to the medications used and include heart and lung problems, clots in the lungs or legs, bleeding and infection. Generally, surgery is safe and major complications are uncommon. The chance of a minor complication is around 3 or 4%, and the risk of a major complication is 1 or 2%. Over 90% of patients should come through their surgery without complications. All surgeries carry a small risk of something catastrophic such as death.

The risks involved with anterior cervical discectomy and fusion include: failure to fuse/pseudo arthrosis (risk higher in smokers and in those having >1 level fused), adjacent level disease, droopy eye (Horner's syndrome), damage to the carotid or vertebral artery resulting in a stroke or excessive bleeding, even death, damage to the recurrent laryngeal nerve resulting in a hoarse voice (either temporary or permanent), damage to the superior laryngeal nerve resulting in difficulty swallowing, tracheal (wind pipe) or oesophageal (food pipe) injury, implant failure, movement or malposition, recurrent disc prolapse or nerve compression, spinal cord injury – weakness, numbness, altered bowel/bladder/sexual function, paraplegia or quadriplegia, spinal fluid leak, difficulty swallowing, persistent or recurrent symptoms, bleeding and infection.



PROCEDURE



The standard surgical procedure for a cervical disc replacement requires an anterior approach (from the front) to the cervical spine. This surgical approach is the same as that used for an anterior cervical discectomy and fusion (ACDF) operation.

The cervical anterior disc replacement surgery will typically include the following: an incision is made in the front of the neck, the affected disc is completely removed, as are any disc fragments or osteophytes (bone spurs) that are pressing on the nerve or spinal cord, the disc space is distracted (jacked up) to its prior normal disc height to help decompress (relieve pressure) on the surrounding nerves. Restoring the original disc height is important; when a disc becomes worn out, it will typically shrink in height, which can contribute to the pinching of the nerves in the neck. Using X-rays or fluoroscopy as guidance, the artificial disc device is implanted into the prepared disc space.

DISCHARGE

Most patients go home 3-4 days after surgery. You will be reviewed by the physiotherapist to determine suitability for discharge. You must also be able to eat, drink and go to the bathroom prior to discharge. Your sore or hoarse throat will go away over time. Each person varies, but it may take weeks for it to feel normal. The pain should be easily controlled with tablet pain killers. You should discuss with your surgeon when to resume any blood thinning medications which have been stopped for the surgery.

You should continue with regular gentle exercise on discharge as well as any exercises given to you by the physiotherapist. You should avoid activities such as heavy lifting, moving objects or bending/twisting the neck. You should not swim for 3 weeks after surgery.

You may drive when you are no longer taking narcotic pain pills and can turn your head to adequately check your blind spots. Limit driving to short trips and slowly increase your driving time. You may need to make plans to be off 2-6 weeks depending on the work you do. Heavy lifting may not be allowed for 12 weeks.

WOUND CARE

The wound will be closed with dissolving stitches and reinforced with sticky paper strips. The wound must stay covered for 1 week and the dressing changed each day after showering. After one week, the dressing may be removed and left off. The paper strips will fall off over 1-2 weeks.

Your wound will be healed within two weeks from your surgery unless there has been some reason to delay that healing. In addition people that have other medical problems such as: diabetes, people who need to take daily steroids for other conditions, and those people whose immune system may be compromised, may need additional time for their wounds to completely heal.

If there is any redness, tenderness, swelling or discharge of the wound, you should see your family doctor immediately.

FOLLOW UP

You will need to be seen again by your surgeon 6 weeks after surgery with a cervical X-ray. X-ray imaging is performed at regular intervals after the surgery to ensure adequate fusion is taking place.

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