DR SHANU GAMBHIR
NEUROSURGEON AND SPINE SURGEON

PATIENT INFORMATION SHEET

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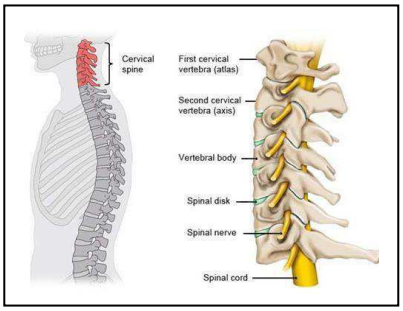
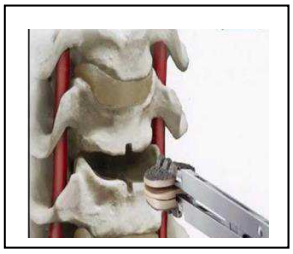
ANTERIOR CERVICAL DISCECTOMY AND DISC REPLACEMENT

INDICATION FOR SURGERY



Cervical disc replacement surgery involves removing a diseased cervical disc and replacing it with an artificial disc. It is done when the space between the vertebrae has become too narrow and part of the vertebrae or cervical disc is pressing on the spinal cord or spinal nerves. It is recommended once conservative options have failed or if symptoms such as pain, weakness, unsteady walk, bowel and bladder disturbance or clumsy hand function are worsening. Surgery aims to reduce pressure on the nerve and therefore relieve symptoms or stop them from getting worse.

SURGICAL PROCEDURE



The patient is given a general anaesthetic at the start of the procedure to stay asleep. 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.

RISKS

Generally, this type of 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%.

Risks specific to this procedure include (but not limited to): 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. (All surgeries carry a risk that can be related to medication, operation or anaesthetic. Risks related to the anaesthetic depend on other medical issues and to the medications used and include heart and lung problems, clots in the lungs or legs etc.)

DISCHARGE AND HOME CARE

Patients can go home after being reviewed by the physiotherapist. The patient should be able to drink, eat and have normal bladder/bowel movement prior to discharge. Most patients go home 3 to 4 days after surgery.

The patient may continue to have a sore or hoarse throat which will go away over time. It may take weeks to feel normal. Pain can be controlled with tablet pain killers. Any other medications that have been stopped prior to surgery (such as blood thinners) should only be continued after discussion with the surgeon.

Activates such as heavy lifting, bending, twisting of the neck, or moving objects should be avoided. Swimming should be avoided for three weeks after surgery. No heavy lifting for 12 weeks. Patients should continue with exercises prescribed by the physiotherapist. Patients should not drive if they are taking narcotic pills and until they can turn their head adequately to check for blind spots. Driving should be limited to short trips and slowly increased.

Patients may require anywhere between two to six weeks off work (depending on the nature of work).

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.

The wound should heal within two weeks from your surgery. Patients 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, the patient should see their GP immediately.

FOLLOW UP

Dr. Shanu Gambhir would like to see the patient (with a neck x-ray) six weeks after the surgery for a post-operative review.