Introduction

This information sheet has been prepared primarily for patients undergoing the keyhole operations of microdiscectomy and nerve root decompression who have some other degenerative lesion causing pressure on the spinal nerves such as a synovial cyst or a mass of scar tissue and who have had previous surgery on this part of the spine. Other information sheets concerning different aspects of spinal disorders are available and may be of relevance. (You may obtain a Title List of other information sheets from my office)

This information is intended to supplement the interview and examination sessions at which advice specific to your individual case will have been given. If you are considering this operation this document should be viewed as only part of the information you will have received.

The information provided below is intended to be clear. Inevitably when dealing with complex and important issues difficulties may arise. If you are anxious about any element you should seek further information. If you feel the information could be improved please let us know.

Certainly no patient should undergo any operation without feeling that they have all the information that they wish concerning the aims, risks, benefits, nature of the surgery and the usual post-operative recovery, in addition to having been apprised of the alternative lines of management and what happens if nothing is done (the natural history of the condition). If you feel that any of these aspects have not been covered to your satisfaction you should ask for more detail and certainly not consent to any operation until you are entirely satisfied. It is your right to have this information and indeed your responsibility to ensure that you have understood it. There is also a general document entitled “Informed Consent for Treatments: Operations and Injections”

Aim of the Surgery

Microdiscectomy and nerve root decompression are almost exclusively used to relieve patients of leg pain – “sciatica”. Sciatica is commonly caused by a prolapsed lumbar disc pressing on the nerve root just prior to it emerging from the lumbar spine. Another common cause is narrowing of the lumbar spinal canal (the main nerve channel down the centre of the spine) or the exit foramen (hole at the side of the spine) that the nerve exits the main canal via. You may have both a prolapse and a narrowing which then act together. Each lumbar nerve root is about the size of a biro refill and the disc prolapses are often not much bigger than a pea. These prolapses or narrowings, by pressing on the nerve root, give rise to a sensation of pain in the leg and may induce loss of function in the nerve root and thence numbness or weakness affecting the leg. The commonest functions to be affected are ankle movements and sensation around the foot, calf and ankle. The primary aim of the operation is usually to relieve pain though it may additionally be targeted at improving strength in the weakened muscles or the relieving of numbness.
Some of you may have had previous surgery and the operation may then also involve the excision of a mass of scar tissue which itself may be causing pressure on the nerves. Others amongst you may have developed a more unusual manifestation of wear and tear arthritis of the spine; a synovial cyst. These are bean size fluid filled or semi-solid bags of tissue that develop in the degenerate ligaments and on the small joints (facet joints) of the spine. They are notoriously painful and can cause all the same symptoms as a slipped disc.

**The Nature of Disc Prolapses, Scarring and Synovial Cysts**

The lumbar discs are flat circular objects. They consist of a central firm jelly (nucleus pulposus or pulp) contained within a hard fibrous ring (annulus fibrosus or capsule). It is rather like a thick walled tyre (capsule) filled with stiff jelly (pulp).

In the classical form an acute disc prolapse occurs when the capsule tears and the pulp herniates backwards onto the nerve root. In practice however this situation often arises when the disc is already worn by the effects of age/wear and tear.

This ageing of the disc occurs early and can often be seen in the late teens or early twenties. As a process it has many different names: wear and tear, arthritis, osteoarthritis of the spine, spondylosis and degenerative lumbar disease. Prolapsing of a lumbar disc also has many names: ruptured disc, herniated disc, prolapsed disc and slipped disc.

Finally, as the degenerative processes proceed swellings on the bone adjacent to the disc may develop and give rise to narrowing of the canal or foramen and this in turn to pressure on the nerve roots and thus the generation of sciatica. These bony swellings are called osteophytes. They may arise not only adjacent to the disc but also on the small hinge joints at the back of the spine – the facet joints. In addition the disc loses height as it wears and the gap between the bones is therefore reduced. As a result of these processes the canal through which the nerve root normally exits from the spine, the foramen, becomes narrow. This situation may itself give rise to sciatica and certainly will reduce the size of the disc prolapse that may be tolerated before sciatic symptoms develop.

Just as with a disc, if the other soft tissues which hold the spine together degenerate they too may give rise to lesions which press on the spine. One of the commonest is the synovial cyst. It has many cousins but in its classic form it derives from the lining of the facet joint just behind the nerve root and presses against the nerve root from behind to cause the self same symptoms a disc prolapse does when it presses from the front. Usually they are a similar size to a prolapse. They are tricky to remove as often they are intimately connected to the lining of the spine (dura) and so CSF leaks are relatively common after this surgery (see later section on CSF leak). The results of excision are usually good and the postoperative course the same – perhaps a little slower. There is and incidence of recurrence with these cysts though this is unusual. They are not cancers and have no nasty connotations/implications. The removal of these synovial cysts is referred to as an “excision of lesion of spine” in surgical classification systems.

The removal of the disc prolapse (not the whole disc but the “pea”) is what is referred to as “discectomy” and when performed through a keyhole “microdiscectomy”. The removal of the osteophytes and the widening of the nerve’s exit hole (foramen) is what is meant by “nerve root decompression”. If the central part of the canal has also been narrowed and all the nerves are compressed (ie not just the nerve root exiting the spine at that level), or if the canal needs to be
widened before the disc can be safely removed or foramen widened, this central canal is opened up. This widening is called a “central canal decompression”. You may need one, two or all three of these procedures.

When surgery has been undertaken in the past scar tissue around the nerve is found. This may be encountered with virgin spines just from the prolapse itself though seldom is it then a significant issue. In revision surgery so much scar tissue may be found that it creates its own mass which then itself presses on the nerve. On the pre-operative imaging (scans etc) it can be difficult to confidently predict the how much of a lesion is scar and how much recurrent disc prolapse or even cyst formation. Again surgery can be prolonged as careful dissection is required and CSF leak is relatively common. However, the outcome is usually good though again perhaps a little slower than for first time around.

**Keyhole**

Nearly always the incision, (cut in the skin), is in the region of 1.5 to 2cm in length. By using an operating microscope we can do all we need through this small hole. The muscle is then parted to reveal the bone over the back of the spine. The internal opening into the spinal canal itself is called a “fenestration”. All this is called the “access”. It is through the fenestration that the procedures, (microdiscectomy, nerve root decompression, central canal decompression), are carried out.

**The day of surgery**

The day will begin with you in the ward. Some of you will have come in the night before though increasingly patients come in on the morning of surgery which may mean a very early start as you are often needed at the hospital by 7am. My office or our Spinal Nurse will be able to tell you when.

**Make sure you have your scans – no scan no operation.**

The night before or that morning you will sign your consent form and meet the anaesthetist.

You will have had **nothing to eat or drink** for a substantial period before the anaesthetic. The precise length of this period, (usually 6 hours), is prescribed by the anaesthetist and you need to be clear about this the day before the surgery. My secretarial team or our Spinal Nurse will clarify this also.

One of the hospital porters will come and collect you from the ward and will take you to theatre, with one of the ward staff. They deliver you, on a trolley, to the anaesthetic ante-room adjacent to the operating theatre. There you will meet the anaesthetist again. They will usually put a small drip into a vein on the back of the hand. After asking you to breathe some oxygen they will send you off to sleep with an injection into the drip.

The next thing you are aware of is waking up in the recovery area or back on the ward.

**The post operative period**

There will usually be an intravenous drip in one of the veins in your arm. This gives you fluids so you do not need **to eat or drink** if you feel sick. The anaesthetist may wish for you not to eat or drink for a while after the operation and will advise you of this. Most of you are soon having a cup of tea.
In addition there will often be a separate small drip providing you with **pain relief**. Usually there will be a button for you to press in order for the pain relief to be delivered i.e., you will control the amount of pain relief you get. This is a very safe and effective way of making sure you get analgesia when you need it. You cannot overdose yourself by pressing it too much – the device will simply fire blanks when the maximum safe dose has been reached. Often you only really get pain when you move. It takes a little time for the pain relief to work. A good tip is to press the button a few minutes before you want to move. Some patients find that too much causes a headache or nausea. If this is a significant problem we will need to use a different system but for most people it is the most effective way to deliver pain relief.

There will usually be a drain coming from the wound. This is like a drip and will be connected to some sort of collection device (small plastic bottle) next to you. This is usually removed the next day.

**Wound care** is important. You will have some form of surgical dressing on the wound – usually a light non-waterproof dressing. The wound should not be allowed to get wet until the day after the suture is removed (see below). In general we like to disturb the dressing as little as possible. If it becomes stained but is intact it is often better to put one over the top rather than to take it off.

If you need to go to the **toilet** you may normally get up and use the facilities in your bathroom. If you are on bed rest (see paragraph below) or are in too much pain to do that then ask for a bottle or bed pan.

Nearly always you can **get up** immediately if you wish. Of course you should have a nurse or physiotherapist with you on the first occasions.

**CSF Leaks**

Because of the attachment to the dural sack of the cysts as many as one in ten operations will lead to leakage of fluid from the sack. The sack contains the nerves and needs to heal **before you get up**. The fluid, cerebrospinal fluid, or CSF, is clear and watery. I can see the leak at the operation and will tell you of the event. Whilst this does not adversely affect the outcome of the operation it does mean you have to lie flat for five days. You may not get up at all for any reason. This is a great bore though as mentioned does not alter the outcome of the operation. During this time you can role over or lie on your front if you wish but you must not end up with your head higher than your bottom. The column of fluid in the spine extends up to the head and thus if the head is high compared to the base of the spine fluid will tend to escape into the wound.

**How is the Operation Performed**

Once you are anesthetised you are taken through into the operating theatre. You are placed face down on the operating table and a slight curve is placed in the operating table so as to open up the spine. An incision approximately 1.5cm long is made vertically on the lumbar spine. Where precisely this incision is made is determined using an x-ray machine (Image Intensifier). I usually inject local anaesthetic to numb the area of skin where the incision is to be made and the tissues below. This reduces the amount of painkiller the anaesthetist has to use with the general anaesthetic and makes it safer. The local anaesthetic has adrenaline added so as to constrict the local blood vessels. This decreases bleeding which makes the operation safer and lengthens the effect of the local which makes the immediate post operative pain. This is called “**a local block**”. The muscles on the side of the
Sciatica are then parted and the spine’s canal entered through one of the normal gaps. The ligaments that would normally block the way are divided and the nerve root being compressed is located. This is the “fenestration”. By now the operating microscope will have been bought in. If the central canal is also narrowed or if the disc fragment is too big to deliver without first widening the central canal this procedure is performed first. This is the central canal stenosis or “central canal decompression”. The nerve is then mobilised away from the disc prolapse and the prolapse removed. Any pulp lying within the disc that seems likely to herniate in the days, weeks or months thereafter is also cleared. This is the “microdiscectomy”. (If you are having a decompression, central canal +/- nerve root, this element is not done.) The foramina (hole) which the nerve root exits from the spine is widened as necessary by shaving bone and ligament from the walls which have thickened to cause the narrowing. This is the “nerve root decompression” or undercutting facetectomy done.

Now, if you have had previous surgery it is likely that there will be scar tissue around the nerves and this will need to be “taken down” or cleared. This may involve cutting through quite tough tissue. Certainly this will take time and more often than in first time surgery the sac which contains the nerves may leak fluid i.e., CSF leaks are relatively common here. (see above)

Once the nerves are well decompressed it is possible to access any synovial cyst or other lesion and remove it. Again careful dissection is required as it is often stuck to the nerve sack, (dura), and leaks may occur. (Once removed the lesion is sent off for analysis, histopathology tests, to confirm what it is. These tests take a few days to come back and is often we will discuss the results when we meet in outpatients after you have gone home.) If the cyst is connected to the lining of the facet joint then this lining is also stripped out so as to reduce the likelihood of recurrence.

If a CSF leak has been encountered it is now repaired under the microscope with tissue glue and very fine stitches.

After making certain that there is no further pressure, active bleeding or leakage of spinal fluid the wound is then closed using internal absorbable stitches. A drain is usually placed at the base of the wound. This is rather like a drip and is removed at 24 hours. The skin may be closed in a number of ways though most commonly a single stitch made of nylon will be passed under the skin from one end to the other. If the operation has taken a long time I will top up the local block.

**Removal of the suture** occurs at approximately 10 days by simply pulling on one end. This can be done either at the hospital or at your GP’s surgery or at home by district nurse.

**Aims**

The operation is designed to relieve leg pain. It is not designed to relieve back pain. Very rarely would it be recommended in the absence of significant leg pain. It may be used to improve muscle weakness or numbness though seldom is this done when there is not also pain. For those of you with back pain, numbness or weakness as well as leg pain you will usually find that they improve with time after the procedure. Often you need to do physiotherapy exercise to relieve the back pain though this is something tackled in the weeks that follow. Often the weakness takes several months to improve. In general the greater the pre-operative weakness and the longer it has been present, the longer the recovery time and the less certain full recovery is. Numbness may take over a year to improve.
Risks

No procedure is without risk though this is a routine operation which rarely causes harm and usually works very well. The risks are as follows.

Complications of any operation and indeed any long period spent in bed include chest infection and blood clots forming in the deep veins of the legs (deep venous thrombosis or DVT). Parts of the blood clots may break off and fly up to the lung where they block the blood flow, (Pulmonary embolus or PE). Very rarely people die from these blockages. You may have heard of these complicating long plane journeys. We can reduce the incidence of these by giving you injections to thin the blood, supportive stockings (which I request you wear at all times whilst in hospital) and compression pumps on the legs worn while in bed. We use the stockings and pumps in theatre but do not start the injections until 24 hours after the surgery so as not to provoke bleeding into the fresh wound.

There is a risk to life and limb. Any anaesthetic and any operation may kill you. Any spinal surgery may paralyse you which in the instance of a lumbar operation will mean loss of all leg, bowel, bladder and sexual function. At its worst this may be complete and permanent. Such disasters are extremely rare and are in the order of the risk of your being run over by a bus. People do get run over by buses but it is exceptionally rare. Of course if you do not have the operation the disc may fully prolapse and paralyse you itself. Again I see this though very rarely. In other words there are buses on which ever road you choose, they occur in approximately equal numbers on the two routes and rationally they should not influence your decision – though they clearly often do. These buses are indeed extraordinarily rare and you can usually see them coming and so take evasive action.

The “cauda equina syndrome” is the term used to describe paralysis of this part of your nervous system. The patient usually have a phase of excruciating pain followed by numbness, paralysis and an inability to pass urine which classically is painless. i.e., you know you have an overfull bladder but it does not hurt – “painless retention”. An early warning may be numbness around the private parts and buttock – the part covered by your pants. If you notice anything like this you need to see a doctor, any doctor – don’t wait for me - immediately. This syndrome is a surgical emergency. You need to have the disc removed immediately i.e., that day / night.

Nerve root injury affecting just the nerve that is being pressed on by the disc prolapse is not quite so rare but is far from common. Obviously the nerve root is handled during the procedure and even though microsurgical techniques reduce this to a minimum the risk of an individual nerve being permanently lost remains. It is low – less than 1 %. This might mean that the ability to stand on tip toe is lost or to lift up the foot (a foot drop) results. Again, if you do not have the operation pressure from the disc prolapse may do this anyway.

The spinal nerves are contained in a sack and this is filled with fluid secreted by and in communication with the brain. As the disc fragment presses directly on this sack it may leak cerebrospinal fluid during the course of the operation. This should not adversely affect the outcome of the operation though does mean you will need to lie flat for five days as described above. Nearly always the leak can be seen during the surgery and therefore I will give instructions for you not to be mobilised for the five days. If you are told you may get up then I have not encountered a leak. This occurs about 1 in 20 times though is more frequent when patients have had surgery before.

Failure of an operation to achieve its intended goal is always possible. In this instance it will mean the persistence of leg pain as it was before. This is uncommon though remember the purpose of these
particular operations is to relieve leg and not back pain. The latter may remain though is often reduced to some degree. Further, rehabilitation for the back pain is more likely to prove effective when the nerves are no longer compressed and the legs are free. Having said this persistence of some non-disabling levels of back pain is common after disc prolapse. For some years fusion was added to the operation in an attempt to reduce the numbers of patients left with back pain. However, this involves a major opening of the spine, the insertion of large screws and rods along with bone grafting. The outcome was worse than with microdiscectomy alone and now fusion is no longer done in this context. It is not uncommon for a degree of pre-existing weakness and numbness to persist particularly if it was severe before hand. The longer they have been present the more likely this is. However, most patients experience an improvement in weakness and numbness if not complete resolution.

**Recurrence** of symptoms may occur. That is to say you may get better only for things to get worse again later. There are a number of reasons why and again this may be in the form of back or leg pain. Back pain may occur in acute bouts and can be minimised by your being diligent with the post-operative physiotherapy. Leg pain may arise from a disc prolapse occurring at an adjacent level, a recurrence of the original disc prolapse, scarring occurring around the nerve root affected by the original disc prolapse, or, damage caused by the original prolapse leaving the nerve root hypersensitive as it attempts to recover in the post-operative months. Usually it is an element of each of these pathologies which operate together to cause recurrent leg pain. A degree of pain is not uncommon at times in the early phase though will usually settle over a period of a few weeks or months. Seldom are the troubles serious and rarely do they then persist though precisely how often is still a matter for some debate. To find out a true recurrence rate thousands of patients need to be followed for tens of years and for none drop out during that time. There is no perfect study but it is my impression from those studies that have been done and from my experience, that perhaps 1 in 10 patients at some point in the future get into substantial recurrent trouble. This of course largely reflects the natural history of disc disease rather than anything relating to the surgery itself though it is important that you appreciate the operations simply tackle current troubles and offer no protection against future problems at other levels – the post-operative physiotherapy perhaps does. Obviously I would not offer the surgery if I did not think that without it you are likely to fair worse than you are with it.

**Deterioration** is a possibility. Operations can make you worse, can do you harm or may leave you with new problems to cope with. This is rare and I suspect deterioration directly as a result of the surgery probably affects a fraction of 1% of patients. Quite a few patients may have a transient increase in numbness or weakness though persistent significant problems are rare indeed.

**Wound infection** can occur with any operation. In the spine it is rare as there is so much muscle covering it. Muscle fights infection well. However, if an infection ever sets in the effects can be very serious. Again the risks are less than 1%. Diabetic patients are at slightly higher risk of this.

**What happens if you don’t have it done?**
The “natural history” is what happens when nothing is done and this must be compared with the scale of risks associated

with the procedure. Eventually many people’s troubles will settle though again good data is hard to find. A general rule of thumb is that within the first six to ten weeks spontaneous resolution occurs for about 95% of patients – or at least a substantial and consistent decline in symptoms is evident. If you
are having surgery before this time there needs to be a good reason – progressive motor or sensory loss, worsening rather than consistent or declining pain or a disc prolapse of such immense proportion that it threatens paralysis. You should know what the reason is for such rapid progress. However, if after this time there is no clear pattern of decline in symptoms most of you are stuck at least for a long time. Into this picture it may be reasonable to integrate any social, personal, occupational and domestic pressures.

What alternative procedures are there?
Much of this has been covered in other information sheets and in our discussions. Essentially and operation is always the last resort. Instead you could try injections or further conservative treatment (physiotherapy, osteopathy, chiropractic, acupuncture, tablets and time.) Obviously I will usually have formed the view that these are unlikely to bring you to comfort any time soon before recommending surgery. Occasionally I will have warned you that bad paralysis of nerves may occur if things are left and in these circumstances there is little choice but to proceed Though this is rare. For the majority it is pain that drives the surgery. In these circumstances you have to feel that the degree of pain warrants the risk and effort involved in having the operation.

Discharge
Most people go home on or around the third post-operative day. However, there is no rush and you should stay until you can manage the journey home, life at home and have not needed the pain relief drip for 24 hours. If you live along way off, are on your own or have a dependant young family you will need to stay for longer. Occasionally the less able who live alone might sensibly use a convalescent facility. Equally, some go home on day one or two though if you are an early leaver you should rest at home as if you were still in hospital. Don’t rush it.

How to get home
The front passenger seat in a standard car is fine. If the journey is long get out of the car every hour and do some simple stretches. Then get back in and carry on. It is often sensible to take some tablets before you leave the ward. Go to bed when you get home regardless of how you feel.

Done once even a long journey is OK. This is not a licence to drive every day – see below.

Post-operative back care
Before you go home after your operation, we will have discussed some details of how to care for your back in the weeks that follow. In addition other team members will have discussed issues with you. Below is a general summary.

If you feel you are developing unexpected troublesome or worrying symptoms, do not hesitate to call my office or the ward staff, who will be able to guide you or if necessary contact me. If troubles arise out of hours call the hospital and ask for the sister in charge.

Physiotherapy
You may well have been given specific instructions by the hospital’s physiotherapist. Indeed you are likely to be given a sheet with diagrams of various exercises. The precise details of these exercises and how often they should be done are of less importance than your response to them. That is to say, if you
develop pain on doing these exercises, you should stop them. In the first few weeks all that can occur is
the simple healing process. Physiotherapy maintains your mobility during this time but should not be
allowed to interfere with the healing process. Therefore, if it hurts, you should stop and you should not
be anxious if, as a result, you are quite stiff by the end of this early period. Physiotherapy begins in
earnest around the fourth week when the back will be stable enough to allow real progress to be made.

Exercise
The aim here is to do small amounts but often. For most of the first week you will either be in hospital
or should be pottering about inside your home. For the second week the amount of activity undertaken
should essentially be unchanged. You should simply be moving about as if you were in fact still in
hospital. It would be perfectly reasonable to fix your own meals and to look after yourself though you
should not be doing housework or looking after others. You may go out for short walks. From the second
week onwards, light exercise may be taken. You may go on very short car journeys (10-15 minutes) and
go out for longer walks. Prolonged outings, lengthy or frequent trips to the office will be bad for you.
Problems most often arise when patients do a little too much a little too often, i.e., one trip to the office
may be alright but three cause troubles.

Sitting
You are better to be standing or lying following back surgery. If you wish to sit, a high, upright dining
room style chair is the most appropriate. It is certainly reasonable to start sitting for your meals when
you have gone home but it is sensible to stand up and stretch between courses. This should be back to
normal around about the four to six week mark. However, it will always be advisable to avoid
prolonged periods sitting and very soft or low armchairs.

Sex
If it hurts, don’t. If you think it will hurt, don’t - until of course you think it won’t and it doesn’t.

Wound care
You should not get the wound wet until the day after the sutures have been removed. It is perfectly
reasonable to have a shower, providing the wound is covered with a waterproof dressing. The ward
may provide you with this before you leave. In general, we like to change the dressings on wounds as
infrequently as possible. The wound should be kept dry and a non-waterproof dressing used so that the
wound may breathe.

Removal of Stitches
The stitches should be removed at or shortly after the tenth day. I mostly use a single stitch which runs
under the skin and can be pulled from one end. (Get an adult to help you.) I also usually put steristrips
(small sticky tapes) across the wound and two in parallel with the wound to hold the stitch ends. The
ones holding the stitch ends need to be pulled off and then the suture can be removed. Most often a nurse
linked to your G.P. or the district nursing service do this. If you are near one of my hospitals you may be
able to have these removed there. You need have agreed an arrangement for this to be done before you,
leave hospital - our ward nurses who will liaise with your GP, district nurse or one of the local hospitals
as is appropriate.

Bending, lifting, carrying
In the first few weeks you should not be doing this. The physiotherapy, which will begin about the fourth
to sixth week, will teach you how to bend correctly and how best to lift. It should certainly be something
that you keep to a minimum in the first months.
Driving

In the first few weeks you should be driven i.e., you should not drive the car yourself. In the weeks that follow, you should limit journeys to short periods. As physiotherapy commences and progress is made, you may gradually start to extend this. In general it is best to have the car seat set as high and as upright as possible. If you are becoming uncomfortable you should stop, get out and do some light stretches before continuing.

Sports

You should not do this until we have reviewed your progress. It should be deferred until you have completed the fitness programme that only begins with the physiotherapy at the fourth to sixth week and is likely to take a further four to six weeks at least.

General philosophy

The aim is for you to avoid things which aggravate your pain. Once recurrence of back and leg pain has occurred, it is much more difficult to get it to go away. It is much simpler to avoid it in the first place. If in doubt, err on the side of caution. You can do most things after the first week or so. However, you will not be able to do much of them. “Can I drive?”, “pick up the baby?”, “go into the Office?”, “fly?”, are all frequently asked questions. The answer is usually yes BUT not very often. It is not so much what you do but how often you do it.

Follow-up

My usual routine is to see patients three or four weeks after discharge and it is at that point that we can start the physiotherapy. This will need to be near to home though later may need to move nearer to work. I usually then see you after another six weeks and then a further three months.

Return to work

This may reasonably be anytime between four and twelve weeks post surgery. This might seem like a ridiculously wide window and certainly I will advise you more precisely. In fact some patients are back at work inside two weeks and others still off at four months. A brick layer commuting 50 miles by car each way will take longer than a librarian working next door to home.

Whatever the work a gradual return is best – perhaps two half days the first week (Tuesday and Thursday), three the second (Monday Wednesday and Friday) and four the fourth (Monday, Tuesday and Thursday, Friday). Work five half days the next and then start to increase the length of the days. It is important to keep up the physiotherapy during this phase. The program outlined above is very gradual and more rapid progress may be possible but if pain recurs you should ease off.

Done in a graduated way the return to work is a very positive part of your rehabilitation. It needs to be in your control and with the encouragement of your employer. If they will put up with you being part-time and unreliable they will see you sooner.

If by contrast your job is one whereby you have to be there fulltime and reliably or not at all, it will take longer. Then the job is not a part of the rehabilitation but the hurdle rehabilitation has to prepare you for. You will get back later as you need to fully recovered before starting. If you have a long commute your return will be further delayed. The average commute time for my patients is in the
region of one hour each way. From the spinal perspective that is a two hour physical job in addition to your real work. Days spent working from home help.

Discuss this advice with your employer and make a plan. Obviously the best laid plans may change due to circumstances and I will advise on how likely your plan is to come off at the first out-patient session post surgery i.e., at about the four week mark.

**What do you do in the event of problems?**

If, once you have got home, problems arise, help is available from a number of sources.

First, you may ring my office number. If it is during working hours this is certainly what you should do. My secretarial staff will be able to contact myself, my clinical assistants or our spinal nurse and obtain advice for you. If it is out of hours you may also ring this number and the machine will tell you what to do in the event of an urgent enquiry or you may leave a message.

Secondly, you may ring the hospital and ask to speak to my Spinal Nurse. In her absence you should ask to speak to the hospital’s Duty Manager or to the ward staff. Telephone numbers are given at the end of this information sheet.

You may of course contact your general practitioner or any emergency service should you so wish or if the other avenues fail.

**I do not provide a 24 hour emergency service but can respond on most occasions.**

**Costs, Codes and Authorisation**

A separate information sheet is available which covers all aspects of this. Please obtain this and read it before you confirm your surgery. The costs of private surgery are considerable and if you are hoping to use insurance you will need to obtain authorisation from your insurer and register this with us prior to admission. Some insurers/policies may not pay all my fees All costs remain your responsibility even if your insurer has agreed to help/pay direct. There are usually three bills you need to know about; the hospital, the anaesthetist and the surgeon (me). You are responsible for ensuring all are paid.

**Other sources of information**

I produce a number of other information sheets. You may obtain a title list from my office.

**The Princess Grace Hospital** produces information on a number of surgeries including spinal procedures. I was also involved in their production so they are not entirely independent. However, the physiotherapy and nursing issues are given a airing. You can obtain these from my Spinal Nurse – see contact details below.
Your **General Practitioner** will have seen other patients going through this kind of procedure and they can offer valuable insights into the practicalities behind the surgery. Of course they may also be familiar with any other health concerns you have and be able to offer advice on how these might impact on recovery.

There are free information packs provided by the **Brain and Spine Foundation** which covers issues related to this surgery. You may obtain a copy by telephoning their help-line number on 0808 808 1000, by writing to them at The Brain and Spine Foundation, 7 Winchester House, Kennington Park, Cranmer Road, London SW9 6EJ, or by downloading it from their web site which you will find by searching their name and specifically at [www.brainandspine.org.uk](http://www.brainandspine.org.uk). Their telephone help line will also offer useful information specific to this surgery and many patients have found it invaluable. The Brain and Spine Foundation is a charitable organisation and they would receive any contribution you can make with gratitude. They fund valuable research and education programs into the neurological disorders.

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### Contact Telephone numbers

**The office**  
020 7935 3721 - between 9.00am and 5.00pm. A recorded message out of hours gives instructions as to what to do in the event of an emergency.

**Spinal Nurse**  
Call the Princess Grace Hospital Switchboard on 020 7486 1234 - and request Spinal Nurse Specialist on Pager 150  
Or, call directly on her mobile - 07917 374 372  
Or, on her direct line 0207 908 3682

**Hospital Duty Manager**  
Call the Princess Grace Hospital switchboard and request the Nurse in Charge on pager 009

**The ward of the Princess Grace Hospital** – 0207 486 1234

**The Chaucer Hospital** – 01227 455466 = switchboard

**Remember in the event of an emergency or if urgent help is needed the usual health service provisions are available via your GP or your local hospital accident and emergency department.**

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