POSTERIOR CERVICAL DECOMPRESSION SURGERY :C5o
Information for Patients of Mr Hamlyn

Introduction
This information sheet has been prepared primarily for patients undergoing operations to decompress the spinal cord in the neck and the nerves which come off the spinal cord at that level and which serve the arms. Other information sheets concerning different aspects of spinal disorders are available and may be of relevance. Please check with the office what others may be relevant.

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 an 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. You can get this from any member of the team - secretary, spinal nurse, clinical assistants – all will be happy to help. If you feel the information could be improved please let us know.

Certainly no patient should undergo an 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 appraised 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 an 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. You may wish to read the document entitled “Informed Consent for Treatments: Operations and Injections”

Anatomy
The cervical spine, (neck), is made up of seven bones with discs in between. This bony column is surprisingly near the front – you can feel it if you press back and towards the midline at the side of you’re your throat just below the Adam’s apple. Behind this spinal column lies the spinal cord. This is the motorway between the brain and its provinces – your body. It carries all the nerves which govern every function of the body – voluntary or otherwise. It is soft, about the size of a finger, greyish, a rather dull yellow in colour and though it is made of nerves, entirely numb. It is covered over at the back by bony arches (lamina) which come off from each of the seven bones. These have spikes on them (spinous process) which are the nobly bits you can feel at the back of the neck – like the spines on the back of a dinosaur. Between the lamina on each side of the spinous process there is a joint (facet joint) – more of this later.

From the spinal cord emerge nerve roots. These are the size of a standard biro refill. They too are fairly soft but are far from numb; those of you who have had a slipped disc in the neck will testify to this for they hurt like fury when touched.
Aim of the Surgery and symptom relief

The surgery is used to relieve patients of symptoms caused by pressure on the nerve roots which emerge from the spinal cord and go to supply the arms. These symptoms may include pain in the arms or numbness and clumsiness of the arms, hands. The arm pain is due to pressure on the nerve roots. Neck pain comes from the discs and joints in the neck along with associated neck muscles. Surgery may relieve this pain also but seldom is this the prime aim; when pain relief is the target it is usually to relieve arm pain. (This paragraph and the last one from the section above are pivotal to a clear understanding of what you are having done. i.e., don’t move on until you are sure you have got it)

The pressure on the spinal cord and its exiting nerve roots may come from disc bulges (slipped/ bulging/ prolapsed/ herniated discs). Pain in the arm – “brachalgia” is commonly caused by a prolapsed cervical disc pressing on the nerve root just prior to it emerging from the spine. Another common cause is narrowing of the exit foramen (hole at the side of the spine) that the nerve exits the spinal cord and the main central spinal canal via. If you had a prolapsed disc this would lie at the front of the spinal cord and the nerve root. It would squash them backwards against the facet joint and lamina and your surgery would be done through the front of the neck. However, if there is a more general narrowing of the exit foramen, especially if this is at multiple levels, it is better to do the surgery from the back. The disc is left undisturbed and all the movement can be preserved.

These narrowings, by pressing on the nerve root, give rise to a sensation of pain in the arm and may induce loss of function in the nerve root and thence numbness or weakness affecting the arm and hand. “Radiculopathy” is the term given when the pressure is severe enough to stop the nerve root working i.e., when numbness or weakness arise. The commonest functions to be affected are elbow movements and sensation around the hand and forearm though shoulder and can be involved. The primary aim of operations is usually to relieve pain though it may additionally be targeted at improving strength in the weakened muscles or the relieving of numbness. Nearly always the pain will go, many will get some power back and several of you a full return in strength. Sensation too is likely to return though often not fully. Pain relief tends to be immediate, power comes back over the course of weeks or months though sensation may take many months or a year and more.

If the process narrows the main central canal the spinal cord itself is pressed on and “myelopathy” occurs. This is classically a painless process whereby the arms go numb and weak, the hands clumsy and the legs weak and stiff. Commonly it causes difficulty with fine movements in the hands such as doing up buttons and writing or brisk movements in the legs such as running or skipping down stairs. It is relatively rare and the onset insidious so patients are often quite markedly affected by the time the penny drops with them and their attending doctor. In addition the spinal cord has many spare nerve cells and these can be lost in large numbers before weakness, stiffness or numbness arise. This silent damage may be costly in future years because these “spare” neurones are there to help you cope with the normal loss of nerve cells that occurs with age. Thus even if recovery follows surgery a later deterioration may occur as a spinal cord develops its own version of early “dementia”. The aim of surgery here is to reverse or at least halt the deterioration. Broadly, half can expect to have progress halted, 45% to have the situation actually get better but sadly around 5 to 10% eventually find the symptoms simply progress despite a successful surgical decompression. This unhappy minority have presumably silently lost too much of their neuronal reserve.
The Nature of a Spinal Degenerative Disease

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 disc disease. Prolapsing of a disc also has many names: ruptured disc, herniated disc, prolapsed disc and slipped disc.

As the degenerative process proceeds 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 spinal cord or its emerging nerve roots and thus the generate brachalgia/radiculopathy. 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 spinal canal becomes narrow.

The removal of the osteophytes and the widening of the nerve’s exit hole (foramen) is called “nerve root decompression”. If the central part of the canal has also been narrowed and the spinal cord compressed this is widened by performing a “central canal decompression” You may need both regions decompressed. You may need to have more than one level and perhaps both sides operated on.

The “access” for any of these operations is the name of the hole through which an operation is performed: skin, subcutaneous fat, muscle. In this instance it is at the back, in the middle and runs up and down. Its length depends on the number of levels requiring decompression. For one level and side it is essentially keyhole though for multiple levels and both sides it might be 10cm or more.

What to expect on the day of surgery

Let’s run through the day’s journey from your point of view. It will begin with you in the ward. You will have had nothing to eat or drink for a substantial period before the anaesthetic. The precise length of this period, (often 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 for you with the anaesthetist.

One of the hospital porters will come and collect you from the ward to 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 or thereabouts. After asking you to breathe some oxygen they will put you to sleep by an injection into the drip.

The next thing you are aware of is waking up in the recovery area or back on the ward. We often waken folk following surgery on the neck adjacent to the wind pipe in the special care unit so that close monitoring can be performed overnight. The next day you go back to your own room.
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. Known as “patient controlled analgesia” (PCA) 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 of this kind of analgesia causes headache. 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 as required.

Pain in the wound at the back of the neck is sometimes marked and that instance try to keep on top of it with the PCA system. i.e., press it early and often.

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. Again if you have needed a bone graft there is often a drain from that wound too.

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 begins to look grubby but the dressing remains intact it is better to put one over the top than to take it off.

If you need to go to the toilet to pass urine or open your bowels you may normally get up and use the facilities in your bathroom. If you are on bed rest or are in too much pain to do that then ask for a bottle or bed pan. Rarely will you have a urinary catheter – this is a tube passed into the bladder during the procedure.

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.

A collar is very seldom used – they do not seems to help reduce pain.

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 elevate the head. The head is held in place with a special frame so as to avoid pressure on the eyes and nose from being face down for a prolonged period. This will leave three pin sites in the scalp area which heal well but are sore in the first few days. An incision is made on the back of the neck. 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 anaesthetic by reducing the adjacent blood flow and thus its washing out. This is called “a local block”. The muscles on the side of the neck are then parted and the spine’s front identified and exposed. The correct level is then again confirmed with an X-ray. Special retractors are brought in to hold the soft tissues safely aside. This done the back of the spinal bones can be seen. A further X-ray is taken to confirm the correct level has been found. This first part of the procedure is referred to as “the access”.

About now the operating microscope will be brought in. The gap between the lamina is now exposed and is widened to gain access to the spinal canal – this is called a “fenestration” (from the French for window) and allows the main elements of the operation to follow. First the central canal is widened - this is the “central canal decompression” and once complete the nerve exiting the spine on this side and at this level can now cleared of any osteophytes and ligament thickening - this is the “Discectomy” completed and the “nerve root decompression” done. For those of you having more than level or side operated on the procedure is now completed repeated at these sites. For those of you having a more extensive bone removal so as to decompress the central canal more fully the entire lamina and spinous process may be removed though this is unusual and the need for it will have been discussed with you beforehand. The bone removal is mainly carried out with a specifically designed high speed air drill under an operating microscope.

After making certain that there is no further pressure or active bleeding there comes the “closure”. Again meticulous care is taken to stop any bleeding and the wound is then stitched in layers 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 simple clips are used – rather like staples. If the operation has taken a long time a top up to the local block is given. A dressing is applied.

You are then woken up and I write some notes on how things went and what we found. I call any relatives who may be waiting for news – please, when I come to do your consent form before the surgery give me the name and number of anyone you would like me to call.

**Removal of the sutures** occurs at approximately 10 days with special clip remover which we the nursing staff/my spinal nurse will give before you leave so this can be done either at the hospital or at your GP’s surgery or at home by district nurse. The precise arrangement needs to made before you go.

**Aims**

The operation is designed to relieve arm pain and or numbness and weakness affecting the arms or the legs. It is not designed to relieve neck pain. It is basically never recommended in the absence of significant limb symptoms. For those of you with neck pain too you will usually find that it improves, with time, after the procedure.

Often you need to do physiotherapy exercise to relieve the preoperative symptoms. 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 will usually take months and may take over year to improve.
Risks

No procedure is without risk though these are routine operations which rarely cause harm and usually work. A reasonable account of 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. Parts of the blood clots may break off and fly up to the lung where they block the blood flow. Very rarely people die from these blockages. You may have heard of these complicating long plane journeys. They are called deep vein thrombosis and pulmonary embolus. 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 cervical operation could mean loss of all arm, leg, bowel, bladder and sexual function. At its worst this may be complete and permanent and leave you requiring long term ventilation – an iron lung. For this reason we very closely monitor these functions in the immediate post-operative period. However, such disasters as these are extraordinarily 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.

Nerve root injury affecting the nerve that has been pressed on is not as rare. Obviously the nerve root is handled during the procedure and even though the microsurgical techniques reduce this to a minimum the risk of an individual nerve being permanently lost is around 1%. This might mean the loss of the ability to perform certain arm or hand functions. Temporary and partial reductions in function occur more frequently. If you are unfortunate and have a permanent problem you may find comfort in the fact that the risk of this increases the longer the problem is left and the more severe the pre-operative problem. i.e., waiting makes your prospects worse.

Failure of an operation to achieve its intended goal is always possible. In this instance it will mean the persistence of arm pain, and or arm and leg weakness and numbness, as it was before. This is uncommon though remember the purpose of these particular operations is to relieve limb symptoms and not neck pain. The latter may remain though is often reduced to some degree. Further, rehabilitation physiotherapy for the neck pain is more likely to prove effective when the nerves are no longer compressed and the legs are free. It is not uncommon for a degree of pre-existing weakness and numbness to persist. The longer they have been present the more likely this is. However, most patients experience some 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. Neck pain may occur in acute bouts and can be minimised by your being diligent with the post-operative physiotherapy. Arm pain may arise from a the same processes occurring at an adjacent level, a recurrence at the original site, scarring occurring around the original nerve root, or, damage caused by the original pressure and surgery leaving the nerve root hypersensitive as it attempts to recover in the post-operative months. You will appreciate that several of these pathologies may operate together to cause recurrent arm 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 they occur 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 none drop out during that time. There is no perfect study but it is my impression from those that have been done and my experience of the surgery, that perhaps 1 in 10 patients at some point in the future get into substantial 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 – the post-operative physiotherapy perhaps does.

**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 affects fewer than 1% of patients. Quite a few patients may have a transient increase in numbness or weakness though persistent significant problems are rare.

This advice regarding failure, recurrence and deterioration is relevant to those with simple pressure on a nerve root and arm pain. In **myelopathy** the situation is less favourable because the spinal cord has less capacity for recovery than a nerve root. As I have mentioned above, broadly half can expect to have progress halted, 45% to have the situation actually get better but sadly around 5 to 10% eventually find the symptoms simply progress despite of successful decompression. But, the longer such patients wait and the more serious the myelopathy is before it is operated on the more likely an unfavourable outcome.

**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.

**What happens if you don’t have it done?**
The natural history will be lived out and this must be balanced with the symptoms and 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 of acute arm pain 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 point there needs to be a good reason – progressive motor or sensory loss or worsening rather than consistent pain. However, if after this time there is no clear pattern of decline in symptoms many of you are stuck and often go onto have surgery. Into this picture it may be reasonable to integrate any social, personal, occupational and domestic pressures. Again this relates to the average patient who is seeking relief of arm pain from a nerve root compression. For those of you with a myelopathy the progress is usually relentless though often very slow in its rate of progression.

**What alternative procedures are there?**
Much of this is 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 – this is mostly of relevance to myelopathy patients though also to some arm pain folk. In these circumstances
there is little choice but to proceed. This is rare and 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 putting yourself through 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. **Remember to take you X-rays and scans with you.**

**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.

**Post-operative neck care**

Before you go home after your operation, we will have discussed some details of how to care for your neck 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.** See details on how to contact us at the end of this information sheet

**Physiotherapy**

*You may well have been given specific instructions by the hospital’s physiotherapist. Indeed you may be given a sheet with diagrams of various exercises/stretches. The precise details of these exercises and how often they should be done will vary from one individual to another. However, these details 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 wound and neck 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 sit upright and not to have the neck bent by cushions and when lying on your back in bed do not use too many pillows. Be careful about time spent sitting at a computer as this tends to stiffen the neck.

**Baths and showers**
You should in the early days avoid baths as any waterproof dressing is unlikely to keep out all water if submerged. (see Removal of Stitches below) Showers or and assisted standing baths are better. Please don’t fall over.

**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. That is to say, whilst you should cover the wound in a waterproof dressing for showers this should usually be replaced by a dressing which breathes. Cunningly, there are now dressings which let moisture out but not in. These are ideal. Ask the nursing staff/my spinal nurse which it is you have on.

**Removal of Stitches**
The stitches, of which ever type, should be removed at or shortly after the tenth day. 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 –the ward nurses will liaise with your GP, district nurse or one of the local hospitals as is appropriate. I often use skin clips. These are like small staples and are removed with a special instrument. You will be given a “clip remover” for you to give the nurse who will be doing the removal.

**Bending, lifting, carrying**
In the first few weeks you should not be doing this. The physiotherapy, which will usually 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. Unless you can look over your shoulder you are not considered safe to drive. Those of you with myelopathy and or severe radiculopathy may, for neurological reasons, not be safe to drive. If in doubt don’t drive until I give it the all clear.
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 neck and arm 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. For example it is O.K. to be driven home a few days after the surgery but that does not mean it is alright to drive each day into the office.

Follow-up
My usual routine is to see patients three or four weeks after discharge and it is at this point that we can start the physiotherapy. Often there is a need for follow-up X-rays – it is useful then to have old ones for comparison so please bring these with you. 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 to work 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 the rehabilitation has to prepare you for. You will get back later as you need to fully recovered before starting. If there is a long commute to be added to your day it is longer still. 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 may 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., a 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.

Firstly, 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.

Secondly, you may ring the hospital and ask to speak to my Spinal Nurse Specialist. 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: Lumbar disc and spinal decompression**
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 information sheets**
I produce a number of other information sheets listed below. (**You should all read these.**)

**Disorders and Treatment:** Neck Care*, Back Care, Medications: Read this before you take them, Spinal injections, Informed Consent For Treatments: Operations and Procedures.

**Administrative:** Essential Information for Private Patients of Mr Hamlyn*, Fees for cervical spine surgery*, About Mr Hamlyn, Complaints and How to Make One, Your Medical Insurance, The Clinics, The Hospitals and How to Find Us.

**Other sources of information**
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 an 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 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.

**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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