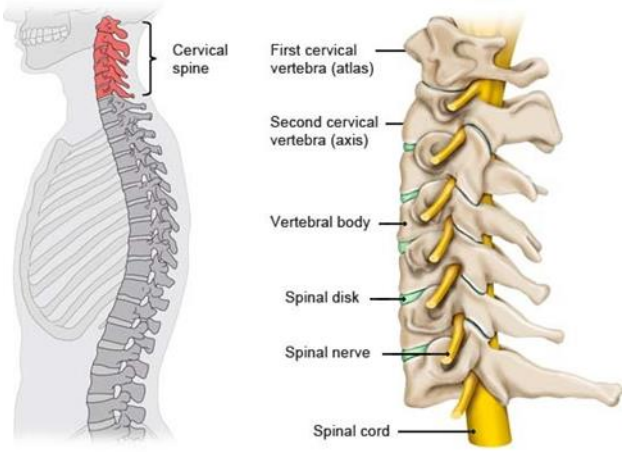
CERVICAL FORAMINOTOMY

BRAIN & SPINE CENTRE SYDNEY

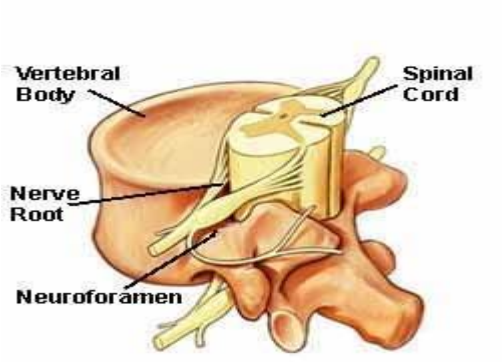


This surgery may be indicated in those patients who have compression of a cervical nerve root from behind by bone and/or ligament. Cervical foraminotomy removes the bone and ligament from behind and opens up the canal for the exiting nerve root. The most common symptoms are: pain, pins and needles/numbness or weakness.

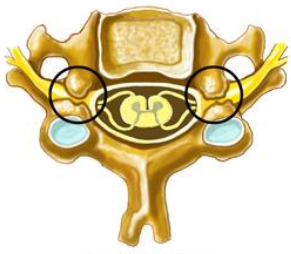
Where is the neuroforamen?

The neuroforamen are passageways that are naturally formed on either side (left, right) between an upper and lower vertebra. In between each upper and lower vertebra is an intervertebral disc. The height of the disc separates the two vertebrae and creates the size of the neuroforamen. Below is an illustration of the neuroforamen with the nerve root exiting the spinal cord

Disorders that can cause nerve root compression include spinal stenosis, degenerative disc disease, a bulging or herniated intervertebral disc, bone spurs (osteophytes), and spondylosis (spinal osteoarthritis). If you have a severe case of one or more of these conditions, your doctor may recommend a spinal decompression surgery, such as a foraminotomy. Spinal decompression surgery creates more space around the nerve, which may relieve pain.



REASONS FOR SURGERY



Foraminal Stenosis

Surgery is indicated in patients whose symptoms are not settling or becoming intolerable. Generally, surgery is offered after most conservative options have failed e.g. medication, physiotherapy, spinal injections. Early surgery may be performed in patients who have worsening symptoms e.g. weakness. The benefits of the surgery should always outweigh the risks.

Surgery aims to reduce pressure on the nerve and therefore relieve symptoms.

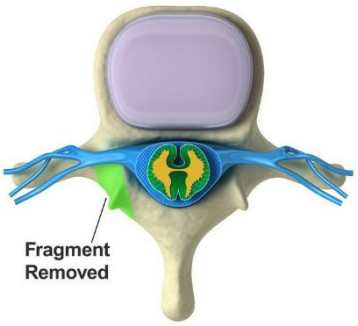
RISKS OF SURGERY

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. 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 specific risks involved with a cervical laminectomy (but are not limited to): failure to improve symptoms or to prevent deterioration, worsening of pain/weakness/numbness, infection, blood clot in wound requiring urgent surgery to relieve pressure, spinal fluid (CSF) leak, recurrent disc prolapse or nerve compression, nerve damage (weakness, numbness, pain) occurs in less than 1%, quadriplegia (paralysed arms and legs), incontinence (loss of bowel/bladder control),impotence (loss of erections), chronic pain and stroke (loss of movement, speech etc).

PROCEDURE

You will be given a general anaesthetic so you are asleep throughout the procedure. The surgery is performed with microscopic magnification. A small midline cut is made in the back of the neck. The muscle is stripped away from the bone on one side. An X-ray is performed to ensure the correct level. A small amount of bone and ligament is removed to decompress the nerve. At the end of the procedure, the anaesthetic is reversed and you are woken up and taken to the recovery room.



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. 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 six weeks after surgery.

Suite 19 Westmead Private Hospital WESTMEAD 2145 Ph: 96331013 FAX: 96335207
brainspinesydney@gmail.com

Suite 19 Westmead Private Hospital WESTMEAD 2145 Ph: 96331013 FAX: 96335207
brainspinesydney@gmail.com

Suite 19 Westmead Private Hospital WESTMEAD 2145 Ph: 96331013 FAX: 96335207
brainspinesydney@gmail.com