

ANTERIOR CERVICAL DISCECTOMY AND FUSION

This surgery may be used in patients who have nerve or spinal cord compression from in front by disc, bone or ligament. Surgery involves removing the disc from in front and replacing it with a cage. 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).

REASONS FOR SURGERY

Surgery is indicated in patients whose symptoms are not settling or becoming intolerable. 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 involved with anterior cervical discectomy and fusion, include

- ✧ spinal cord injury – weakness, numbness, altered bowel/bladder/sexual function, paralysis
- ✧ stroke
- ✧ spinal fluid leak
- ✧ difficulty swallowing
- ✧ hoarse voice
- ✧ failure of fusion or hardware
- ✧ persistent or recurrent symptoms
- ✧ bleeding
- ✧ infection

- ✧ general surgical risks – anaesthetic complications, heart or lung problems, clots in the legs/lungs
- ✧ scar formation
- ✧ death

PROCEDURE

The surgery will involve a general anaesthetic so you are asleep throughout the procedure. The surgery is performed with microscopic magnification. A linear incision is made on the left hand side of the neck and a path made between the oesophagus (food pipe) and trachea (wind pipe) on one side and the carotid artery and neck muscle on the other. This allows us to reach the anterior aspect of the spine.

The disc is removed and any bony lipping or compressive ligament is also removed. The disc space is prepared for the implant. A cage containing calcium material is placed into the disc space and a plate with screws applied to the front for added stability.



The wound is closed with a dissolving suture underneath the skin and reinforced with sticky paper strips, with a sterile dressing over the top. At the end of the procedure, the general anaesthetic is reversed and you will be taken to the intensive care unit for observation overnight. X-rays are performed the following day to ensure adequate placement of the hardware.

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 Dr McMaster 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.

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.

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 Dr McMaster 6 weeks after surgery. X-ray imaging is performed at regular intervals after the surgery to ensure adequate fusion is taking place.