

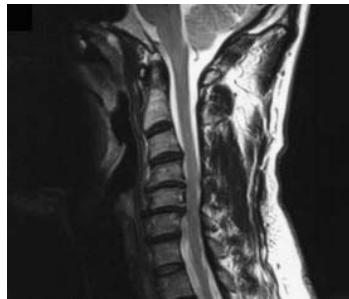
## CERVICAL LAMINECTOMY

This surgery is indicated in those patients who have symptoms as a result of posterior spinal compression in the neck (cervical canal stenosis). Compression may be caused by one or a combination of disc protrusion, ligament thickening, growth of bony spurs. Cervical laminectomy removes the bone and ligament that runs along the back of the spine in order to decompress the nerve roots.

Most patients present with symptoms of spinal cord compression (known as myelopathy) of varying degrees.

This may include

- ✧ clumsy hands
- ✧ unsteady gait
- ✧ pins and needles/numbness in arms or legs
- ✧ bowel or bladder disturbance
- ✧ arm or leg weakness



### REASONS FOR SURGERY

Cervical myelopathy is a progressive although unpredictable condition. The surgery aims to prevent deterioration but cannot be guaranteed to improve symptoms, although this is desirable. Since damage to the spinal cord is irreversible, surgery should be performed before the symptoms become too severe in order to prevent permanent spinal cord damage. The benefits of the surgery should always outweigh the risks.

### RISKS OF SURGERY

All surgery has some risks and these vary between procedures. The risks involved with lumbar laminectomy, include

- ✧ bleeding
- ✧ infection
- ✧ nerve root injury – weakness, numbness, altered bowel/bladder/sexual function
- ✧ spinal cord injury – weakness/numbness in any or all 4 limbs
- ✧ spinal fluid leak
- ✧ persistent or recurrent symptoms
- ✧ general surgical problems – anaesthetic complications, chest infection, heart problems, clots in the legs/lungs
- ✧ scar formation
- ✧ death

### PROCEDURE

The surgery will involve a general anaesthetic so that you are asleep throughout the procedure. The surgery is performed with microscopic magnification. An incision is made in the centre of the back of the neck and the muscles divided from the bone on both sides. An X-ray is performed to ensure the correct level. The bone along the back of the spinal cord is removed with a high speed drill. The ligament compressing the nerve roots is also removed.

Once the surgery is complete, the anaesthetic is reversed and you are woken up and taken to the recovery room.

### DISCHARGE

Most patients go home 5-7 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. In some cases, it is necessary to have some rehabilitation before going home. This will be organised during your hospital stay.

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, bending or twisting, prolonged sitting or standing

### 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.