DR SHANU GAMBHIR
NEUROSURGEON AND SPINE SURGEON

PATIENT INFORMATION SHEET

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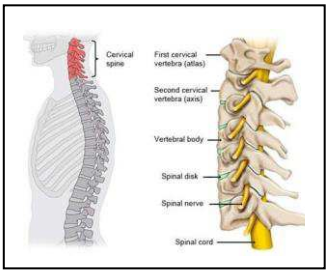
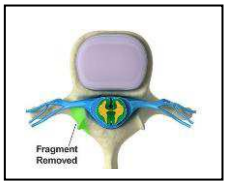
CERVICAL FORAMINOTOMY

INDICATION FOR SURGERY



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 the canal for the exiting nerve root. Surgery is indicated only after conservative options have failed or if symptoms such as pain, weakness, numbness are worsening. Surgery aims to reduce pressure on the nerve and therefore relieve symptoms or stop them from getting worse.

PROCEDURE



The patient is given a general anaesthetic at the start of the procedure to stay asleep. 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.

RISKS

Generally, this type of 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%.

Risks specific to this procedure (but not limited to) include: 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.) or death.

(All surgeries carry a risk that can be related to medication, operation or anaesthetic. Risks related to the anaesthetic depend on other medical issues and to the medications used and include heart and lung problems, clots in the lungs or legs etc.)

DISCHARGE AND HOME CARE

Patients can go home after being reviewed by the physiotherapist. The patient should be able to drink, eat and have normal bladder/bowel movement prior to discharge. Most patients go home 3 to 4 days after surgery. Pain can be controlled with tablet pain killers. Any other medications that have been stopped prior to surgery (such as blood thinners) should only be continued after discussion with the surgeon.

Activates such as heavy lifting, bending, twisting of the neck, or moving objects should be avoided. Swimming should be avoided for three weeks after surgery. No heavy lifting for 12 weeks. Patients should continue with exercises prescribed by the physiotherapist. Patients should not drive if they are taking narcotic pills or until they can turn their head adequately to check for blind spots.

Patients may require anywhere between two to six weeks off work (depending on the nature of work).

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.

The wound should heal within two weeks from your surgery. Patients 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, the patient should see their GP immediately.

FOLLOW UP

Dr. Shanu Gambhir would like to see the patient six weeks after the surgery for a post-operative review.