

# Information for patients

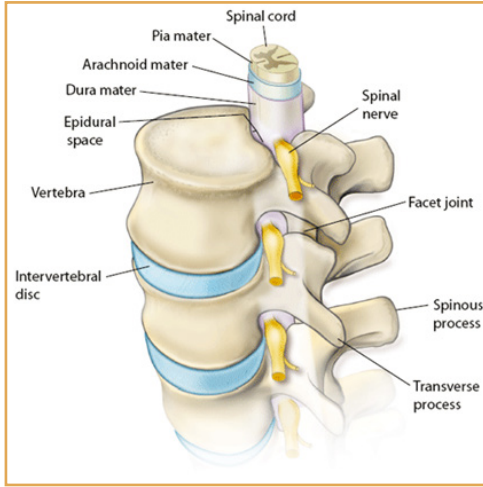
## Lumbar Discectomy



## Spinal Disorders

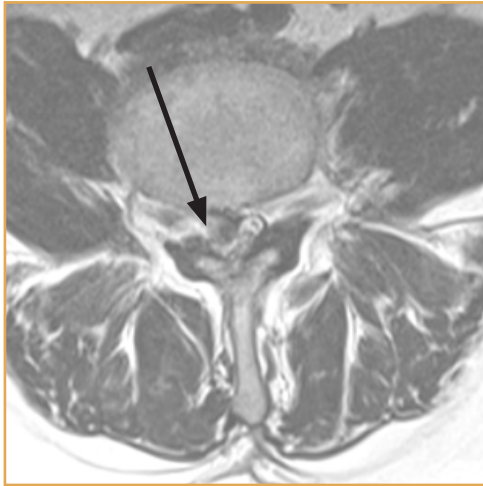
## Introduction

You have been scheduled for a procedure called a lumbar discectomy. This is one of the commonest operations performed on the low back. The lumbar discs are the joints at the front of the spine that give the spine its flexibility:



You will have had an MRI scan which confirms that there is a degree of compression upon one of the nerves in your lower back caused by a herniation (disc material extending outside its normal confines) in one of the discs. Usually, you will be suffering with pain down one of your legs (see below).

Arrow points to a disc prolapse



Discectomy is a very successful operation aimed at relieving leg pain associated with nerve compression problems. It is not an operation to cure low back pain. The operation is performed through a small incision at the base of the spine. During the surgery, the disc material pressing on the nerve is removed. Any potentially loose disc material still within the disc may also be excised.

## Indications for surgery

Usually patients for discectomy have severe leg pain often extending the full length of the leg in the territory supplied by the nerve root. An MRI scan will have confirmed nerve compression in the low back. The vast majority of patients with disc prolapse do not need an operation and many will get better with either conservative treatment such as physiotherapy, with medication, or with the passage of time. 90% of patients recover from their leg pain within 3-6 months.. The reason you are undergoing an operation is because your symptoms are still significantly troubling you and have failed to respond to non-surgical treatment. It is a joint decision taken between the Surgeon and the patient when it is decided that the potential rewards of an operation exceed the possible small risks of complications.

## Rewards of surgery

The main anticipated outcome after discectomy surgery is relief of your leg pain. The success rate varies. We believe that it is reasonable to say that 80-90% of patients who have a discectomy are satisfied with the relief of leg pain that they achieve. Patients who have tingling in the leg associated with nerve compression, find in many cases that this tingling settles down. Most patients are relieved of pain and tingling although some minor residual symptoms are not uncommon. It is difficult to predict if symptoms of numbness or weakness will improve and the chance of recovery of numbness or weakness is 6/10 with equal chances of recovery whether patients have surgery or not. These symptoms are due to damage to internal fibres of the nerves and although pressure on a nerve can be relieved by passage of time or surgery, the healing of the internal fibres of the nerve depends on the degree of damage and the natural healing potential - surgery cannot improve this.

Improvements in nerve function may take up to two years to occur from the time of surgery, and recovery is not guaranteed. If two years after the operation your leg remains numb and weak, it is likely to remain numb and weak forever. Please remember that discectomy is not an operation for the relief of back pain.

## Risks of surgery

The vast majority of discectomy operations are carried out with no problems. There are however, some small risks associated with any operation. Whilst the chances of these happening are quite small, it is important that you understand that potential problems can occur.

## Potential risks include:

### The risks of a general anaesthetic

General anaesthetics have some risks, which may be increased if you have chronic medical conditions, but in general they are as follows:

- Common temporary side effects (risk 1:10 to 1:100) include bruising or pain, blurred vision and sickness, these can usually be treated and pass off quickly.
- Infrequent complications (risk of 1 in 100 to 1 in 10,000) include temporary breathing difficulties, muscle pains, headaches, damage to teeth, lip or tongue, sore throat and temporary problems speaking.
- Extremely rare and serious complications (risk of less than 1 in 10,000). These include severe allergic reactions and death, brain damage, kidney and liver failure, lung damage, eye injury, and damage to the voice-box. These are very rare and may depend on whether you have other serious medical conditions.
- There have been cases of “wrong level surgery” where the surgeon has mistakenly operated on the incorrect disc level.

## Blood clot

Deep vein thrombosis is a possible problem, but is uncommon. If you are at particular risk then special precautions will be taken to reduce the risk. Moving your legs and feet as soon as you can after the operation and walking about early, all help to stop thrombosis occurring. In rare cases, a blood clot can pass to the chest and is life threatening.

Injections and tablets can be given to thin your blood and reduce the risk of such clots from happening. However, these medications have a 3% risk of bleeding in the operated site, which can cause nerve damage and paralysis. The risk of clot formation which goes to the lungs is less than 1 in 200. For most patients, therefore, the hospital policy is to use foot pumps to keep the circulation going during and after surgery and to mobilise patients early. For high-risk patients this may need to be changed or modified and this discussion will take place at the preoperative clinic meeting.

## Wound infection

Superficial wound infection is usually of no significance and settles readily with antibiotics. A deep infection involving the disc (discitis) is potentially more difficult to treat and may require prolonged antibiotics and even further surgery. Out of every 100 patients 1 or 2 patients may develop a wound infection.

## Nerve injury and paralysis

During surgery, the nerve has to be moved to one side and this sometimes can result in the patients reporting more tingling in the leg, more numbness in the leg or in rare circumstances, weakness in the leg. These are usually temporary problems that should resolve. The chance of nerve damage is 1 in 100, with another 1 in 100 patients having problems of nerve irritation due to excessive scarring around the nerve root.

Patients are often extremely concerned that they could end up paralysed after surgery on the spine. This is an extremely rare event and the risk is in the order of 1 in 500. This is also known as Cauda Equina Syndrome and includes the potential to permanently and irreversibly damage the nerves that control the strength and sensation in the legs and also that control your bladder and bowel function.

## Continued pain

Approximately 10% of patients continue with significant symptoms after what is technically a successful operation. It is not always known why this happens. It may be as a result of long standing nerve compression and nerve irritation despite surgical decompression of the nerve. It is rare for patients to say that they are worse after surgery but this has been reported.

## Recurrence

The worldwide literature reports a 10% recurrence rate of disc prolapse at the same place at some time in the future despite a technically successful operation. You could suffer a disc prolapse at a different disc in the spine in the future - in the same way that anybody can be prone to this problem.

## Back Pain

It is reported that up to 15% of patients feel that their back pain is more troublesome after surgery by comparison to how it was before their discectomy procedure. This often takes the form of grumbling, nuisance level backache and is not disabling. Exercises for back muscles can often help with this pain. In some patients when there is worsening of back pain, if this is unmanageable, a second procedure known as a spinal fusion may be required.

## What to expect after surgery

You may have a small drain (tube) coming out of your wound. This prevents any excess blood or fluid from collecting there. This will be removed when the drainage has stopped, usually 24 hours later. You will have some discomfort or pain at the surgical site and also at the site where the bone graft was taken.

**Please contact the ward if you have any of the following:**

- Redness around the wound
- Wound leakage
- High body temperature

## CSF Leak

The fluid filled sac in which the nerves are floating (dural sac) may tear during surgery and this may need to be repaired. Patients will be asked to lie flat in bed for 1-2 days, if this happens. Rarely patients may need to go back to theatre, if the first repair at the time of surgery doesn't work. This is usually not a long-term problem. The incidence of dural tear is 4-5 in 100 for first time surgery.

## Timescales

You may be able to go home on the same day if you are fit and able and have your consultant's approval; otherwise it is likely to be the next day. You will be able to go home walking independently. A wound check with the District Nurse / GP Practice Nurse will be arranged for 2 weeks post op. Most wounds take 2 weeks to heal but muscles and bone take 6 weeks to heal. Lifting and bending should be avoided for 6 weeks at least. You will return to the Hospital at approximately 3 months after the operation for a check up and provided everything has gone satisfactorily, you will be discharged at this time.

Please arrange for a friend or relative to collect you, as driving yourself or taking public transport is not advised in the early stages of recovery. If you are likely to require patient transport please inform one of the nurses as soon as possible.

## Return to normal function

Patients are walking the day after their surgery. The time taken to return to work varies between patients. If you work from home doing office type work, you will probably be working within a few days. Light manual workers will usually return to work at four weeks. Patients who do heavy physical manual work may not return to work for some 6-12 weeks after the surgery and in particular this group of patients will often need a course of physiotherapy to help strengthen the muscles around the spine.

Your surgeon may restrict the amount of time you spend in the sitting posture to 20-30 minutes at a time for the first 4 weeks. This is due to the fact that sitting causes more pressure on your disc than standing and walking.

Provided that the wound has healed satisfactorily, we are happy for patients to return to activities such as swimming at about four weeks after surgery and also cycling. We do not usually recommend a return to contact sports such as football for at least 12 weeks after the operation. If you are planning to return to this level of sport, you may need a course of physiotherapy to help strengthen the spine before returning to such activity. You can resume normal sexual activity 4 weeks after surgery.

## Return to driving

You can usually return to driving 2-4 weeks after your operation but return to driving depends upon different factors including comfort, that you have come off painkillers that have a sedative effect, and that you have good control of the muscles in your legs.

The time spent driving may depend on instructions given regarding sitting time.

## Summary

Discectomy is usually a successful operation for relieving leg pain however the results of surgery cannot be guaranteed. A decision to proceed with surgery is one taken jointly by yourself and by your Surgeon. The vast majority of operations are highly successful. There are some small risks associated with the surgery and if these occur, they can be significant.

## If you require a special edition of this leaflet

This leaflet is available in large print. Arrangements can also be made on request for it to be explained in your preferred language. Please contact the Patient Advice and Liaison Service (PALS) email: [rjah.pals.office@nhs.net](mailto:rjah.pals.office@nhs.net)

## Feedback

Tell us what you think of our patient information leaflet. Please send your comments to the Patient Advice and Liaison Service (PALS) email: [rjah.pals.office@nhs.net](mailto:rjah.pals.office@nhs.net)

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