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What is going on with my spine?

A disc herniation can be the result of many things including but not limited to repeated wear and tear on the spine (constant lifting, twisting, bending etc.), an injury or trauma. Evidence suggests that there is a strong genetic component as well. An intervertebral disc is made up of two parts-the outer part is called the annulus, and the innermost part is called the nucleus pulposus. A disc herniation means that the inner-most part, or nucleus pulposus, has herniated or ruptured through the annulus or outer part of the disc. Disc herniations come in all shapes and sizes. Small herniations are typically left alone as they do not compress the neighboring nerves. However, larger herniations can cause nerve compression and irritation. This results in inflammation, nerve pain in the distribution where the nerve goes or innervates (lumbar disc herniations usually cause pain down the leg), numbness/tingling and even weakness. An abnormal physical exam can point to this diagnosis, but the only way to confirm a disc has herniated is by obtaining an MRI.

How is the procedure performed?

A small incision is made vertically on the center of the low back for a single level procedure. Dr. Hoffman will perform careful dissection through the soft tissue. This is done in a minimally invasive manner to minimize muscle dissection. An x-ray is used to make sure this is done in the correct location. Dr. Hoffman will enter the spinal canal by removing a small window of bone. This is necessary to visualize and access the disc herniation(s). Great care is taken to preserve as much soft tissue, muscle and bone as possible. The compressed nerves are gently pulled aside and the disc herniation removed to alleviate the compression. The amount of disc removed depends on the size of the disc herniation but no disc tissue is removed from within the healthy part of the disc, only the part pushing on the nerves. Dr. Hoffman will then follow the nerve as it leaves the spine through the nerve tunnel or foramen. Once she has confirmed the tunnel is also wide and the nerve is no longer compressed, the wound will be washed out with antibiotic containing fluid and closed.

Who will be with me in the operating room?

The operating room team is well versed in spine surgery. Your surgeon will lead the team which will include the following:

-Anesthesiologist/nurse anesthetist

-First assist: the physician assistant or orthopedic resident (all have trained to be a surgical assistant; be advised ONLY Dr. Hoffman will perform the operation). The role of the first assist consists of assisting with positioning, draping, suction, retraction and wound closure.

-Scrub nurse or tech: responsible for handing the surgeon any instruments or items needed for the procedure

-Circulator nurse: responsible for obtaining any items the surgeon requests as well as putting information in the medical record via the computer regarding the case

What type of anesthesia will be used for my procedure?

All spine surgery is done under general anesthesia. This is required because we are working next to nerves, spinal cord, etc. and patients need to remain still during the procedure. This can only be achieved with general anesthesia and is the standard of care for spinal surgery.

How big is the incision?

A single level incision is approximately an inch and a half long. For a multilevel surgery, the incision can be longer as each level requires an additional 1-2 inches.

How long will my surgery take?

The procedure takes approximately one hour once incision is made. If it is a revision operation or a multilevel procedure, expect it to go 1-2 hours. However, there is significant amount of time spent in the operating room prior to the procedure in preparing for anesthesia, making sure the patient goes to sleep safely, and in positioning the patient appropriately. Similarly, awakening from anesthesia takes a variable amount of time. Therefore, the time in the operating room is often significantly longer than the duration of the surgery itself.

Do I need to stop any medications prior to surgery?

All blood thinning medications need to be stopped at least a week prior to surgery. This includes but is not limited to NSAIDs (non-steroidal anti-inflammatory drugs) such as ibuprofen (Motrin, Advil), aspirin, celecoxib (Celebrex), meloxicam (Mobic), etodolac (Lodine), prescription blood thinning drugs like warfarin (Coumadin), rivaroxaban (Xarelto), apixaban (Eliquis). If you are taking any medications for autoimmune disease, they may need to be stopped as they affect the immune system and can increase the risk of infection. These medications should be discussed with either your surgeon, physician assistant, primary care physician or rheumatologist.

Will I need to stay in the hospital?

Most microdiscectomy patients go home the same day.

What is the infection risk?

The risk of infection is very low, however anytime you make an incision on the body the risk does exist. This risk is elevated in diabetics, patients with autoimmune disease (lupus, rheumatoid arthritis, etc.) and obese patients. The risk of infection after microdiscectomy surgery is approximately 0.25%.

Will I lose range of motion?

Loss of range of motion is not expected as this is not a fusion procedure and many patients (after proper healing) have increased range of motion as their pre-surgery pain improves.

Will I need plates, rods, screws or bone grafting?

No.

Can the surgery be done with a laser?

No. Contrary to what many patients have heard, the laser instrument is only used for cautery and a traditional incision is required regardless of whether a laser is used or not. Lasers are available at the hospital and can be effective for other types of surgery (eye surgery, urology, dermatologic surgery, etc.). The laser also generates a significant amount of heat, which can increase scarring and damage to the soft tissue. The cautery instrument used in your procedure to control bleeding generates less heat and is accompanied by saline which helps to keep the tissue cool. There is no evidence to support claims of 98%

satisfaction with laser spine surgery. If a laser were that successful, your surgeon would of course use one.

Will a medical team be involved in my care?

Your surgeon may call upon a medical team to perform a medical clearance prior to surgery. This is decided on a case by case basis and determined based on age, type of surgery and the patient's overall medical health. If the patient spends the night in the hospital, a hospitalist or internist may be consulted to help manage any medical conditions.

Is there a risk of paralysis with the procedure?

No unless you are working at L1 or higher. The spinal cord ends at L1 in most people. Most lumbar herniations occur below L1. When working on the lumbar spine below the level of the spinal cord there is a small risk of injury to individual nerve roots which would affect one specific part of your leg or foot. This very rarely may result in pain, numbness or weakness in one part of the leg or foot which may be temporary or occasionally permanent.

When will my symptoms improve?

Leg pain usually improves first. In some patients, relief is immediate and others it is more gradual. The likelihood of alleviating leg pain is approximately 90-95%. This often depends on the severity of compression, how much the nerve was irritated, and how long the problem went on before surgery. Numbness/tingling is typically the slowest symptom to improve. It does not always resolve in every patient but can take up to 18 months before you can say whether or not it has resolved or improved. In some patients, numbness/tingling may improve immediately. While the purpose of the surgery is not to alleviate back pain, incisional back discomfort improves each week. Most patients find their incisional pain to be at its worst for the first few days to a week. The more you walk, the better the back will feel. Remember the purpose of the surgery is to alleviate leg pain (also known as sciatica or radiculopathy).

Should I go to physical therapy?

The decision on whether to order physical therapy or not is decided on a case by case basis. The most important therapy is walking and this can be done at home. It is more about frequency than length. Walk every 20-30 minutes. This will help minimize back pain as prolonged sitting causes the back muscles to stiffen up. Typically, physical therapy is not prescribed until at least 6 weeks post op. At 6 weeks, restrictions are lifted. Starting outpatient physical therapy too early can also increase the risk of recurrent disc herniation. Do not start lifting weights or resume gym activities until released by your care team.

Wait, I can re-herniate?

The risk of a recurrent disc herniation is approximately 5-10%. The reason this can happen is because the original disc herniation has caused a break or tear in the annulus (outer part of the disc). Even though the gel deep inside (nucleus pulposus) that is sticking out is removed, there is still a hole in the outer part of the disc. In 5-10% of patients, more disc material can herniate through that hole. There are measures to help decrease this risk. Abide by your restrictions even if you feel better and think you can bend, lift and twist. Recurrent disc herniation also tends to be more common in females (it is not known why) and in obese patients. Over time, the tear or hole in the outer part of the disc may scar or calcify and this can also prevent a recurrent disc herniation. As you get further and further out from surgery, the risk goes down dramatically.

What are my restrictions after surgery?

It is very important to abide by your restrictions. No bending, lifting, or twisting until released by your care team. These restrictions typically stay in place for 6 weeks after surgery. Your surgeon or physician assistant may permit you to do some light lifting but this will be discussed at your office visits. Walk

every 20-30 minutes. Walking is the most important part of recovering from a spinal operation. The more you walk, the better the incision will feel and the better you will feel. Stamina is decreased after any type of surgery and walking helps energy levels come back and will decrease post-operative fatigue.

How will Dr. Hoffman control my pain?

Dr. Hoffman is committed to minimizing your post-operative pain. Protocols for pain control have been developed based on evidence-based medicine on what works best while also minimizing side effects and abuse potential. The hospital team, which includes surgeons, medical physicians and anesthesiologists, has developed a protocol for pain control based on these studies. Pain control begins before surgery as your anesthesia team will begin to give you medication through your intravenous line prior to surgery. These medications are also continued during the operation. You will also be given medication to prevent post-operative nausea, and an intravenous antibiotic to prevent post-operative infection. After surgery, patients will usually receive a narcotic script as this is typically needed short term following spine surgery. You will also be given a script for a stool softener to prevent constipation as this often occurs following anesthesia and is a side effect of narcotic pain medication. You will also receive a prescription for a short course of antibiotics. While anti-inflammatory medication such as ibuprofen is prohibited at least a week prior to surgery, you are not restricted from taking it after surgery for pain control unless advised not to do so for a medical reason (ex. you already take a prescription blood thinner such as warfarin/Coumadin, history of severe kidney disease).

Will I need to wear a brace after surgery?

A brace is not typically required after microdiscectomy surgery.

What if I have increased numbness after surgery?

It is not uncommon to experience numbness/tingling after surgery since it is the slowest symptom to resolve. Initially, the numbness may be of greater intensity than before surgery, but increased numbness will subside over time as you heal. Please report any new locations of numbness or new sensations, but be aware this typically occurs from nerve manipulation and will decrease with time.

If I take narcotic pain medicine, do I need to be aware of anything specific?

While narcotics can be an effective option for pain relief, they are meant to be taken short term only. For decompression and fusion surgery, we will only prescribe narcotic pain medicine for a maximum of 12 weeks. Patients should try to begin decreasing usage or use Tylenol after their first post-operative visit and rely less on the narcotic pain medicine. Narcotics also cause a variety of side effects including but not limited to fatigue, nausea, constipation, sweating, flushing, and confusion. You are not permitted to drive a vehicle until you discontinue use of narcotic pain medication. If you are taking narcotics prior to surgery, it would be helpful to either decrease your use or wean off the medicine. Patients who take narcotics prior to surgery, develop tolerance to the medication as the pain receptors in the brain and nervous system become used to having the medication present. These patients tend to have lower pain level tolerance and it becomes increasingly difficult to control their post-operative pain as they require more and more pain medication to achieve the same level of pain control than prior to surgery. The ability to control pain after surgery is much more successful if the patient slowly decreases or weans off the narcotic pre-operatively. Please be advised if you have a pain management physician or an outside provider who prescribes your pain medication, you will need to continue to get your medication from them. Narcotics cannot come from multiple providers and pain management physicians usually have an opioid agreement on file as this is now required by most insurance companies. Obtaining prescriptions from more than one provider would violate this agreement and could result in dismissal from the pain management physician or refusal to write any more prescriptions. The pharmacy may also refuse to dispense the medication. Lastly, the rules regarding dispensing narcotics change frequently and many insurance companies have their own rules regarding the quantity a patient may have at a time and when refills can be obtained. Patients must take the medication as directed. For your protection, you will

receive a narcotic prescription or refill only when you request it and it is deemed medically appropriate by your physician or physician assistant. Refills will not be considered over the weekend, at night through the on-call service or on holidays.

What can I expect with regard to bowel/bladder function after surgery?

A Foley catheter is not typically used for microdiscectomy surgery. Some patients however, are slow to urinate after having surgery. This is thought to be a result of the effects of anesthesia on the smooth muscle in the bladder and will typically resolve on its own. Anesthesia will give you plenty of intravenous fluids during the operation to facilitate urination after surgery. No patient will be discharged home until they have urinated on their own. Some patients have difficulty urinating immediately following surgery. This is not uncommon and as stated will resolve with time. If this occurs, the recovery room nurse will monitor your progress and assist with voiding techniques. Occasionally, this may require temporary placement of a urinary catheter. After surgery, you may also develop constipation from inactivity, anesthesia and pain medication. Take your stool softener twice a day while on pain medication. If you are passing gas, a bowel movement will usually follow. If you need to facilitate it further, you may choose to take a gentle laxative like Miralax, Milk of Magnesia or Sennokot. We do not recommend Dulcolax as it typically causes a significant amount of abdominal cramping which in turn can increase discomfort in the incisional area. If you are very uncomfortable, a Fleet Enema or Magnesium Citrate usually does the trick.

How important is nutrition?

Nutrition is vital to healing-especially protein. Make sure you drink plenty of fluids. Narcotic pain medicine can sometimes suppress appetite. If you have no appetite, please try a Boost protein shake over ice. Nutrition aids specifically with wound healing and return of stamina.

When will I have my follow up appointment?

The post-operative appointment is 2-3 weeks after surgery. This is typically already set up at the time the surgery is booked. Please refer to your checklist which is located in your folder from the surgical scheduler. If you do not have an appointment scheduled, please call (301)657-9876.

How do I take care of my incision?

No baths, pools or hot tubs until cleared by your physician or physician assistant. You can uncover the incision 72 hours after surgery. If steri-strips/butterfly tape are over the incision, you can leave that in place. These will fall off on their own or be removed at your post-operative visit. If the incision is dry, you can leave it open to air. Once you are 72 hours from surgery, you can shower. Focus on the front of the body primarily. If the back gets a little wet, pat dry gently but do not rub the incision. Do not apply any ointments or creams to the incision. Notify the office of any drainage or changes to the incisional appearance. It is not uncommon for the incision to feel warm to the touch, exhibit bruising or itch. Please resist the urge to scratch the incision as this can cause an infection. You can take an anti-histamine such as Benadryl, Claritin, Zyrtec etc. to help with this.

Do I need to monitor my temperature after surgery?

It is common to run a low-grade temperature after any type of surgery. Notify the office if you have a temperature over 101.5 degrees.

What do I need to do regarding short term disability while I recover from my procedure?

Please check with your human resources department regarding what they require for temporary disability. If your employer requires documentation or forms filled out, our office will provide the necessary information. Some patients may return to work sooner than others depending on their job requirements and speed of recovery. All disability matters are handled by contacting our office as we have a dedicated

disability form department located in our central business office. Physician approval is required prior to returning to work.

How can I get in touch if I have a question or concern?

The best way to get in touch is through our dedicated line at **301-657-9876**. Messages will be directed to Dr Hoffman and she or a member of her team will call you back in a timely manner. Our main phone number will be directed through an on-call service after hours, on weekends and holidays. This line is reserved for emergencies only. If your call is not of an urgent nature, please call during normal business hours.