

PATIENT APPROVED 

How to contact us:

Neurosurgery Patients

Anita Philip
Laura Hughes



0117 414 7532
Monday – Friday
7.30 am- 4pm,
24 hour answerphone

Physiotherapy Advice

Inpatients
0117 414 4412



Outpatients
0117 414 4413



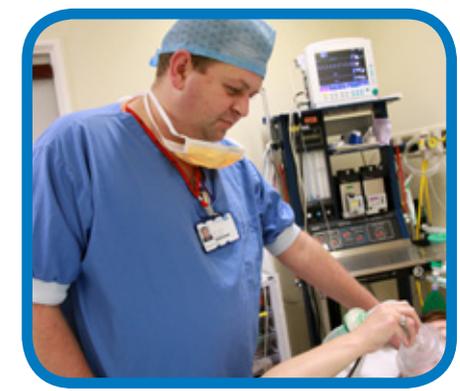
www.nbt.nhs.uk/spine

Orthopaedic Patients



Marie Gibson
07748184170
(answer phone)

Information for patients undergoing Lumbar Microsurgeries



If you or the individual you are caring for need support reading this leaflet please ask a member of staff for advice.

© North Bristol NHS Trust. This edition published November 2016. Review due November 2018. NBT002413

Help to support North Bristol NHS Trust:



www.southmeadhospitalcharity.org.uk
Registered Charity Number 1055900



Join us as a foundation trust member and help shape the future of your local healthcare. Find out more:
www.nbt.nhs.uk/ft

Exceptional healthcare, personally delivered

Welcome to the spinal service. This booklet aims to give you and your family information about your forthcoming spinal operation. It is intended to answer most of the common questions regarding your recovery, going home and returning to normal activities.

During your outpatient appointment your operation will be discussed with you by your surgeon. Elective patients are seen in Pre-Assessment clinic (NPAC) and have a chance to discuss information with a Neurosurgical Nurse Practitioner (NNP). Prior to signing a consent form you have an opportunity to ask questions and to discuss your concerns. After the operation should there have been any variation on the original operation the doctor or nurse will inform you.

Spinal anatomy (in brief):

The spinal vertebra consists of:

Term	No. of Vertebrae	Body Area	Abbreviation
Cervical	7	Neck	C1 - C7
Thoracic	12	Chest	T1 - T12
Lumbar	5 or 6	Low Back	L1 - L5
Sacrum	5 (fused)	Pelvis	S1 - S5
Coccyx	3	Tailbone	None

The intervertebral disc is firmly bonded to the vertebrae both above and below. The disc is a specialised joint which permits the spine to bend and twist. The disc has a tough fibrous outer casing and a softer water filled jelly-like interior. Running through the spinal column is the spinal cord, which contains nerves that come from the brain. Nerves from the spinal cord come out from between the vertebrae and send and receive messages to and from various parts of the body. The true spinal cord ends at approximately the L1 level. A collection of nerve roots at the end of spinal cord is called the "cauda equina," (means horse's tail).

The following conditions may contribute to your symptoms:

Degeneration:

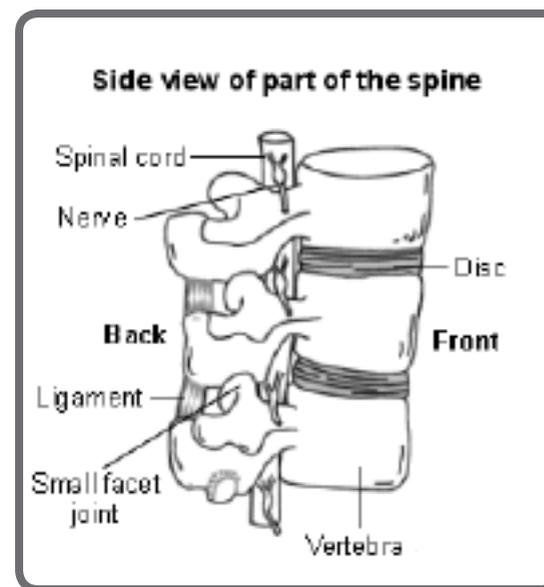


Diagram (c)EMIS 2010 as distributed at:

<http://www.patient.co.uk/health/Cervical-Spondylosis.htm> used with permission.

This is 'wear and tear' of the spine. With age the disc loses water and the composition of the disc alter. This is normal and happens to us all. The reduced height of the disc leaves less space for the nerves and may cause one or more spinal nerve to be trapped. Symptoms include: pain down the leg or into the foot, pins and needles and numbness. Sometimes back pain is confined to one particular spinal segment and surgery may be required.

Spinal Stenosis:

This is narrowing of spinal canal through which the spinal nerves pass and therefore pinches one or more nerve root. This could occur as a result of degenerative process or osteophytes (bony outgrowths or ridges) can form at the edges of the vertebrae and may cause narrowing in the spinal canal. Other causes include inflammatory arthritis, trauma, previous surgery and other birth defects.

Disc prolapse or protrusion:

The outer wall of the disc becomes weakened and can deteriorate with age or as a result of excessive loading. The prolapsed disc bulges out and starts to irritate spinal nerves supplying your leg. The term "slipped disc" is misleading in that the disc cannot slip out and cannot be pushed back in.

Cauda equina syndrome (CES):

Compression of the cauda equina can happen due to fracture, dislocation, spinal bleeding, herniated disc, infections, tumours or spinal narrowing. Symptoms may begin with pain or sciatica, loss of sensation in buttock area, bladder and bowel disturbances. An acute CES is a medical emergency and is treated by lumbar decompression surgery.

What investigations do I need?

Generally a MRI scan is performed to confirm the diagnosis and to identify the level of the problem. At pre-assessment clinic the nurse will take blood tests, a nasal swab to screen for MRSA screen and if problems are identified they will refer

you for additional investigations such as heart trace, scans (i.e. ECG, ECHO), exercise test that are required to decide if you are suitable to undergo anaesthesia. If your blood pressure is raised you may have to visit your GP on 3 further occasions to make sure it is within acceptable limits. X-rays are ordered before surgery if you are to have an artificial cervical joint inserted

What are my treatment options?

Maintaining an ideal body weight, exercises to improve posture also strengthen abdominal and spinal muscles should accompany any form of treatment, surgical or conservative. Conservative treatment such as physiotherapy, painkillers and the passage of time can reduce the symptoms. Nerve root block injections are sometimes useful as diagnostic procedures and treatment for back and leg symptoms. In some circumstances the specialists in the pain clinic see patients before surgery is indicated. Surgery is not always offered and it is rarely offered for long term chronic back pain alone as it may not help.

Lumbar Surgeries

These operations are performed under general anaesthetic and normally take 60-90 mins.

Discectomy/Microdiscectomy: The part of the disc that is protruding (not whole disc) and any disc fragments that are pressing on the nerve root are removed. It involves removing the damaged disc using a microscope to operate through a small incision at the back of the spine.

Spinal decompressions: This is a widely used term whereby the pressure is taken off from one or more nerves in the spine. Degenerative changes account for the majority of nerve root compressions as the nerves exit from the spinal canal resulting in lumbar spinal stenosis or narrowing. Different terminologies are used for decompression based on the anatomical area that is being decompressed.

- Central decompression - Central narrowing
- Lateral recess decompression - removal of lateral part of the vertebrae in lateral stenosis
- Undercutting facetectomy - removal of the facet joint in foraminal stenosis
- Foraminotomy- decompression of the nerve where it passes through the spinal foramen
- Laminectomy- entire lamina removed from back of vertebra
- Hemilaminectomy- half of lamina on one side is removed
- Intersegmental decompression or bilateral laminectomy - removing part of lamina at 2 levels to decompress the central canal
- Indirect decompression - without entering spinal canal, using a spacer or interspinous device

What are the risks associated with spinal surgery?

There are risks involved in having any form of surgery, especially those requiring a general anaesthetic. Common problems in spinal surgery involve:

Bleeding: from the veins around the nerve and rarely require blood transfusion.

Wound infections: currently our infection rate is 1%. However infections can range from minor to moderate and include redness, tenderness, improper healing or wound gaping and raised temperature. Usually it is easily treated with antibiotics. We kindly ask you to complete a questionnaire about wound healing at 30 days after surgery and to post back the questionnaire.

Other types of infections include urinary tract infection and chest infection which can be treated with antibiotics.

Deep vein thrombosis (DVT): during the weeks following surgery there is 5 -10% risk of developing a blood clot in your leg as you have reduced mobility for a short period of time during and after the operation. You will be asked to wear thrombo-embolitic stockings (TEDS) before the operation and in theatre they use mechanical pneumatic pumps & boots, both of these may be used initially in the post-op phase until you are able to mobilise. It is essential to perform deep breathing exercises to prevent any respiratory problems. Also wriggle your toes and get out of bed as soon as advised by your surgeon. Should you remain in bed after a period of 24 hours or have reduced mobility your surgeon may prescribe a blood thinning injection until you are discharged from hospital.

Pulmonary Embolism (PE): Occasionally a clot can break off from DVT and passes to the lungs via the heart causing PE in 0.1% of patients who undergo surgery. This is a life threatening complication and needs immediate treatment.

Nerve damage: can occur during the operation; however this is classed as low risk in less than 1% of patients. It can result in numbness and/or pins and needles and in rare cases significant damage to bladder and bowel function, or paralysis. You will be assessed after surgery for any of these issues by both the nursing and medical team.

Dural tear: the spinal cord is lined by three layers one of those layers is called the dura, which can get torn during the operation. This then results in leakage of spinal fluid. It can occur in 1% -5% of patients. You may be advised to undertake a period of bed rest for 48-72hours and you may experience severe headache, wound leakage of clear fluid or wound swelling.

Re-prolapse: Recurrence of 5-10% risk irrespective of activity, however it is important to follow the advice given to you. If you notice any acute worsening of your pre-surgical symptoms please contact the Spinal NNP. Sometimes MRI & further surgery at same level or other levels may be indicated.

Back pain: This often improves after surgery but may continue to be a problem for 3-6 months. Remember, this surgery is to relieve your leg pain! Back pain is minimal initially due to local anaesthetics used during operation which will wear off in 24-48hrs and you may need to carry on taking pain killers for at least 2 weeks. Occasionally back pain may be worse following spinal surgery.

What are the other complications?

Fortunately most complications can be treated and although they are inconvenient and cause setbacks there are no long-term consequences. Although total paralysis with these types of surgeries is extremely rare, it can occur.

Bladder hesitancy: Anaesthesia can sometimes affect the prostate in men and this can lead to urinary retention. Patients may be catheterised short term and if subsequently are unable to successfully pass urine normally they may be sent home with urinary catheter and referred to the local Urology Clinic. Patients who have surgery following cauda equine syndrome may need longer term rehabilitation to resolve their bladder symptoms.

Constipation: Some of the analgesics can cause constipation. It is important you are able to empty your bowel daily to avoid straining as it can increase your back pain and affect your bladder emptying. Daily walking, exercises, fibre rich diet, oral laxatives can help if bowels are not open for 3 days after which sometimes you may need a dose of suppository.

Before Surgery

What preparation should I undertake?

We advise you to have a shower on the day or night before your surgery and wear freshly laundered clothes to the hospital. This is to minimize the risk of surgical site infections. Please avoid any perfumes or make up. We advise you to remove your nail varnish and where not possible, at least one finger nail in the case of false nail/acrylic nail should be exposed.

What time should I starve for the operation?

The hospital nil-by-mouth policy allows patients to eat 6 hours prior to their operation and 3 hours to drink clear fluids such as water/black coffee or black tea (**NO** milk). Please avoid chewing gum. Please follow the instructions provided in your admission letter for exact time. There is a chance your operation might be rescheduled.

What medication can I take prior to surgery?

Please bring your usual medications and ensure you have enough supplies. All patients can continue to take their usual medications (except those listed below) with 60mls of water even when fasting.

Special notes for opposite table:

¹ Insulin depended patients may be put on an Insulin pump on the day of your surgery while fasting.

² These drugs are stopped a few days prior to surgery to reduce the risk of bleeding. At NPAC your ANP will take your drug history. The decision to stop is made after the ANP discusses with your spinal surgeon, weighing the risk versus benefits as you might be taking them to prevent any future cardiovascular complications.

³ To reduce the risk of thrombo-embolism during surgery.

⁴ Herbal medications may need to be stopped one week prior to surgery due to lack of evidence about adverse interactions with a general anaesthetic

Please contact your ANP if you are unsure. After surgery you will be informed when to restart these medications.

Drugs (see tick below for medications relevant to you)	When to stop (see tick)
Blood pressure medications ending with –opril and -artan:	
<input type="checkbox"/> Lisinopril <input type="checkbox"/> Ramipril <input type="checkbox"/> Perindopril <input type="checkbox"/> Losartan <input type="checkbox"/> Candesartan	<input type="checkbox"/> Omit on day of surgery
¹ Diabetic medications	
<input type="checkbox"/> Metformin <input type="checkbox"/> Gliclazide <input type="checkbox"/> Glipizide <input type="checkbox"/> Glibenclamide <input type="checkbox"/> Glitazones <input type="checkbox"/> Insulin	<input type="checkbox"/> Omit on day of surgery
² Anticoagulants and Antiplatelets:	
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Stop 7 days before surgery
<input type="checkbox"/> Clopidogrel	<input type="checkbox"/> Stop 10 days before surgery <input type="checkbox"/> Switch to Aspirin 75 mg, 10 days before surgery <input type="checkbox"/> Instructions to follow
<input type="checkbox"/> Dipyridamole <input type="checkbox"/> Prasugrel <input type="checkbox"/> (Persantin/Asasantin) Ticagrelor	<input type="checkbox"/> 4 days before surgery <input type="checkbox"/> Instructions to follow
<input type="checkbox"/> Warfarin <input type="checkbox"/> Rivaroxaban <input type="checkbox"/> Dabigatran <input type="checkbox"/> Apixaban	<input type="checkbox"/> Instructions to follow days pre-op
<input type="checkbox"/> ³ Oestrogen containing contraceptive pills and HRT	<input type="checkbox"/> 4-6 weeks prior to surgery
<input type="checkbox"/> ⁴ Herbal medications	<input type="checkbox"/> 1 week before surgery

After Surgery

Will I experience pain?

Most lumbar microsurgery is undertaken to relieve leg pain and associated symptoms. Good relief from leg pain occurs in approximately 75%-90% of patients. However long standing back pain tends to persist and can be expected. Some worsening of chronic low back pain may occur in the first few weeks following surgery this should then settle to your pre-op level. Some patients may find surgery could result in significant improvement in their long term back pain, though this is not the primary goal of surgery.

What tablets will I take home with me?

You will be required to have a good stock of your usual supply of medications prior to admission. Patients usually require some painkillers for 2-4 weeks post operatively. The hospital is not obliged to supply any over-the-counter medications. Should you require, you will be issued with around two week worth of painkillers, only if you do not have sufficient supply of your own. After that time you are expected to visit your GP for additional supplies. Any medications that you brought into hospital will be returned to you on discharge, as appropriate. The common painkillers used are:

- **Paracetamol** – used as first-line painkiller which you should take regularly if you are still in pain at home. You can take a maximum of eight tablets in any 24 hours leaving a 4 hour period between doses
- **Codeine/tramadol** – mild opioid-based painkillers which can be taken in addition to paracetamol if you are still in pain. Common side effects include drowsiness and constipation
- **Ibuprofen/diclofenac** – anti-inflammatory painkillers, usually used for relatively short periods. These must be taken with food. They can also be taken in addition to paracetamol, codeine and tramadol. Avoid taking them if you have a previous history of stomach ulcers because

codeine/tramadol can cause constipation you may also be given some laxatives, such as:

- **Senna** – a laxative which usually takes effect within 12 to 24 hours

Seek advice from your GP if you have constipation for more than three days after taking the laxatives.

You can then begin to slowly reduce your pain killers when you feel the pain is settling. At the time of stopping medications such as opiates, Gabapentin, Amitriptyline etc we strongly advise you to slowly taper them off in small doses over a period of time to minimise withdrawal effects.

When will I be discharged home?

If you have had the operation as an inpatient the estimated discharge time following routine lumbar surgery is 1 to 2 days depending on their post operative recovery and home circumstance. A majority of our patients attend as a day case for microdiscectomy.

When should I get my wound checked?

The skin is closed with paper strips (steristrips) which are left in place for 7-10 days (depending on Consultant's preference). They may then be peeled off or fall of themselves. On occasions clips or sutures are used which are removed after 5-7 days. For Orthopaedic Spinal patients the clips and sutures are left in place for 12 days. If this is the case the ward nursing/day case staff will provide you with the clip remover and a letter to take to your local treatment room nurse. Please book an appointment with your local surgery well in advance.

While removing dressings it is important for a nurse or a family member/friend to inspect your wound for gaping, leaking or inappropriate healing.

How long will my wound take to heal?

Wound healing goes through several stages. You may experience tingling, numbness or some itching around the wound. The scar

may feel a little lumpy as the new tissue forms and it may also feel tight. These are all usual features of the healing process. Do NOT be tempted to pull off any scab which acts as a protective layer as it can delay wound healing and introduce infection. Please note scarring is expected.

If you develop any redness, swelling, wound opening or discharge please contact your GP immediately who may wish to refer back to us. Please ask your GP to take a wound swab and full blood count prior to an antibiotic prescription. The Spinal NNP will contact you within three weeks to check your wound healing status.

Please send the completed wound healing questionnaire after four weeks after your operation.

Can I have a Shower?

Keep wound dry until healed. You may shower/ bath as long as the wound is protected. Most wounds are covered with a waterproof dressing to allow you to shower and maintain hygiene needs. You may request additional dressing & waterproof dressing from the ward nurses or your GP surgery.

When will I be able to drive?

You may drive when comfortable (usually around 2-3 weeks) & able to control your vehicle safely including executing an emergency stop. Your surgeon may wish to give independent advice. Please follow their instructions if different from this sheet. Please ensure you check your insurance details.

Where can I obtain a sick certificate?

The discharging nurse can provide you with a certificate for the duration of your hospital stay. You will have to ask your GP for any further certificates.

When can I start any activity?

Sitting: You are asked to avoid sitting for prolonged lengths of time in the first week. Avoid sitting or standing in one position for a long time as this will lead to stiffness. Please use a reclining seat to drive back home from hospital. It is important to maintain the

lower lumbar curve while sitting as this will help to ensure a good position for your shoulders, head and neck. Sustained slumping in a chair is not a good position and puts an abnormal strain on your spinal ligaments, joints and discs.

Seats vary tremendously in height, shape and firmness. The following guidelines will help you select the most appropriate.

Seat height: Your feet should rest comfortably on the floor, with your thighs supported almost as far forward as your knees. A low seat will cause your lumbar spine to bend too much, also causing strain in your neck.

Seat angle: For some activities, such as working at a desk, it is helpful if the seat slopes forward slightly, enabling you to keep your lumbar curve while your trunk is leaning forwards.

Seat firmness: A seat does not have to be very firm to be good for you, but if it is very soft, you will sink into it, causing your lumbar spine to bend too much.

Lumbar support: Using some form of lumbar support helps to keep the whole spine in a good position. You can buy lumbar rolls or backrests from specialist shops, but simply using a rolled up towel or a small cushion can be very effective.

Arm rests: Use arm rests when possible. By supporting your arms, they take the strain off the muscles of your shoulder girdles and spine. The arm rests have also been shown to lower disc pressures in your back, especially when writing and typing.

Walking: Walking is a good exercise. It promotes fitness, improved circulation and general strength. Start by walking a short distance and then build up your speed and distance as you are able.

When can I start lifting?

Avoid heavy lifting (a full kettle) for up to six weeks post surgery (for Orthopaedic patients this could be 3-6 months depending on Consultant's preference). Please pay careful attention when bending or lifting. Please follow these steps before you start lifting.

- **Preparation:** Before you lift think - Do you need to lift the weight?
- If the weight is heavy, can you seek assistance?
- If you are going to lift the weight, is the route clear of obstructions?
- **Positioning:** Stand close to the load, feet on both sides and facing the way you intend to move. Ensure your weight is spread evenly over each foot. Keeping your back straight bend your hips and knees until you are level with the load. Take a firm hold of the load using your whole hand, not just your fingertips
- **The lift:** Keep your back straight and the load close to your body. Lift the load by straightening your hips and knees smoothly
- **Lowering:** The action above is reversed, taking the same care to ensure that your back is straight, the load is securely held close to your body and you use your legs to do the work. Whenever possible, avoid twisting while lifting

When will I be able to return to work?

This will depend to some extent on age, duration of pre op symptoms, level of fitness, other medical conditions and the nature of your work. Generally most fit patients make an uncomplicated recovery and return back to light work in 2-4 weeks. Balance periods of standing/sitting according to your own tolerance levels. Take regular rest periods. If your work involves heavy manual work then you may need to speak to your Consultant or GP.

Office work

When using the telephone hold the receiver rather than placing it on your shoulder. Consider a hands-free set or speakerphone if you use the telephone a lot. Fit castors to heavy furniture as this allows them to be moved easily for cleaning. If you need to stand to work, ensure the work height is approximately 5cm

below elbow height. Use a high stool if you can to alternate your position, or try using a block to place your foot on as it alternates the weight through your legs but keep you hips in alignment.

When filing always sit down to reach lower drawers and push/close them with your feet. Organise filing so that documents you use regularly are in a drawer at waist height. When opening/closing drawers, stand as close as possible.

Will I need to see an Occupational Therapist?

Patients who have problems after surgery and are unable to cope with activities of daily living are referred to an Occupational therapist in hospital.

Aims of Occupational Therapy: to optimise independence in everyday activities and for these activities to be performed in a manner conducive to good back care.

With elective surgery many of the problems experienced with everyday activities can be addressed prior to admission and should be discussed in NPAC and thus minimise possible delays in your discharge from hospital to home.

Activities of daily living

Incorporate the guidance given elsewhere in this leaflet re: posture, seating and lifting into your everyday activities.

You may need to seek help of family and friends with some aspects of domestic activities (laundry, ironing, cleaning, vacuuming, bed making, shopping & gardening) in the first 3-4 weeks until you feel you have allowed enough time to feel stable; alternatively consider short-term paid domestic help or partial support from a Voluntary Service (see later). Most important is to do these activities little and often rather than all at once. Get food delivered if possible. Avoid staying in one position for long periods of time and avoid heavy activities especially in the early stages of recovery. Consider alternative ways of carrying out tasks and possible use of long-handled equipment.

When bathing use a non-slip mat in the bath and take care getting in and out of the bath. If you have difficulty with safe bathing while you are awaiting admission to hospital or after surgery, once your stitches have been removed, and you do not have access to a shower you may need to consider strip washing at a sink for a while until your spine's stability, strength and mobility improve or consider using adaptive bathing equipment (A 'bath board' may help if you cannot stand to get into the bath, or if you have an over-bath shower). A raised seat and/or rails may help if you experience difficulty getting on/off a toilet because of leg weakness. You can view/try bathing and other adaptive equipment at Living Centres where an Occupational Therapist can also advise you (by appointment); alternatively you can self refer to a Social services Occupational Therapist or seek advice at local mobility stores.

While dressing if you have difficulty reaching your feet you could try: placing your foot on a stool in front of you, or bring your foot up to you, bending at the hip and knees and maintaining the back's natural curves or lie on a flat surface and bring your knees up to you, one at a time.

Make sure work surfaces are level with your elbows. If you need to do any significant amount of reading or writing use a work surface rather than your lap and consider a writing slope.

Will I need to see a Social worker?

To avoid unnecessary extended periods of hospitalisation patient's needs are assessed in NPAC. You may be advised to seek the help of a social worker prior to admission. This may be by self referral or via GP. In some areas support may also be available from Voluntary Services e.g. British Red Cross, Age Concern.

Will I need to see a Physiotherapist?

A Physiotherapist will see you prior to discharge if you are admitted to the ward in the week. They will assess your mobility, posture and muscle strength and will inform the medical team if they feel you are safe for discharge. The Physiotherapist will make a referral to your local outpatients department. This will be an assessment and consideration for a back class or exercise/reconditioning

programme. This is at approximately 6 weeks after your surgery (depending on local waiting times). For day case patients or those treated at the weekend your GP can also organise if you have not been seen by a physiotherapist.

Physiotherapy is only recommended after six weeks following surgery. The Physiotherapist can offer you advice on how best to protect your back in the future and appropriate exercises.

Exercise is a vital part of your rehabilitation following your surgery and will improve your general fitness and wellbeing. Walking is the best exercise and it is essential that you regularly get up and walk for short distances to ensure movement of your blood circulation and prevention of future complications. Do continue to progress your walking distances and increase your exercise tolerance over the first few weeks post op.

What advice may be given by the physiotherapist?

Physiotherapy aims:

Guidelines for exercise:

Swimming – Generally after 2 weeks, when your wound has healed.

Exercise classes i.e. Gym/ Pilates/ Tai Chi – inform your instructor about your back surgery and seek appropriate exercises.

Contact sports – discuss with your consultant/ NNP who will advise you.

The following information is for your guidance only. It is important to remember that regularly changing position will help to prevent muscles from tiring and allows your joints to move, which is essential for their nourishment.

Posture advice

Posture is not just a matter of adopting good positions, it is concerned with the way you move as well. Ideally carrying out all necessary activities in a relaxed and efficient way minimises the stresses on your body and saves energy.

Standing

Maintain the correct amount of curve at the lower part of your spine by “tucking your tail in” and gently tightening your abdominal muscles. Lift your breastbone up slightly to allow your shoulders to relax back. In this position, your head will be balanced over your shoulders, taking any unnecessary strain away from the back of your neck.

Relaxation

You should incorporate rest and relaxation into your daily routine. Choose a method that suits you from many books and tapes, which are available. Your therapist may be able to advise you about this.

Sex

You can resume sexual activity as soon as you feel comfortable. Pelvic activity can help maintain lower back strength and flexibility. However we advise you to take a more passive role in the early stages. Try alternative positions – use pillows to support your back. Try talking to your partner about your concerns to reduce anxiety/fear about causing pain. S.P.O.D. (address at back of leaflet) offer further advice/counselling to people whom may have difficulty with sexual relationships due to physical problems.

What should I be aware of while recovering from my operation?

Recovery after your operation may be gradual; you will not get better overnight. You may experience “off” days where you appear to be in discomfort, do not despair - this is normal. If you experience any of the below you must contact your Spinal NNP in normal working hours or your GP immediately:

- Constant pain which gets worse
- Existing numbness gets worse (or new numbness)
- Muscle weakness
- Change in bladder function

When will I receive a follow-up appointment?

Telephone follow up: Neurosurgical patients will receive a call within 2-4 weeks following discharge. This will give you the opportunity to ask any questions. If you wish to clarify any issues/concerns please feel free to contact them. The Spinal NNP will return any messages left on the answer phone at their earliest opportunity. Outside normal working hours, if your concern is of an urgent nature and you have had recent surgery please contact your GP surgery for medical assistance.

Outpatients: Usually an outpatient follow up is made for you according to what your Consultant decides is the right time to follow up and it could be 6-12 weeks after discharge. Not everyone will require a follow-up appointment, but if one is offered to you this will arrive in the post from your Consultant's secretary. If you feel there is no need to see the surgeon and you are free from symptoms then please contact the appropriate secretary to cancel your appointment.

References and Further Information

For Spinal cord Injury patients

Spinal Injury Association, SIA House, 2 Trueman Place, Oldbrook, Milton Keynes, MK6 2HH, Tel (information / advice): 0800 980 0501; Tel: 0845 678 6633
www.spinal.co.uk [Last Accessed March 2011]

Bladder & Bowel problems with Cauda Equina Syndrome?

Duke of Cornwall spinal injuries unit offers good outreach service and advice in the community. You may be referred by your physiotherapist, Nurse or GP.
<http://www.spinalinjurycentre.org.uk>
[Last Accessed March 2011]

Brain and Spine Foundation

7 Winchester House, Kennington Park, Cramner Road, SW9 6EJ, Tel: 0808 808 1000 (helpline)
Enquiries 020 7793 5900

Motability Scheme

Address: Warwick House, Roydon Road, Harlow, CM19 5PX
Telephone: 0845 456 4566/fax01279 632000/
minicom 01279 632273

Back Care

16 Elm Tree Road, Teddington, Middlesex, TW11 8FT.
020 8977 5474
<http://www.backcare.org.uk> [Last Accessed March 2011]

For sexual & personal relationships for people with a disability (S.P.O.D.)

28 Camden Road, London, N7 OBJ Tel:020 7607 8851

Medical Advisory Branch (DVLC)

Drivers Medical Group, Longview Road, Swansea, SA99 ITU.
Tel: 01792 783686
<http://www.dvla.gov.uk/drivers.aspx> [Last Accessed March 2011]

Patient information from Royal College of Surgeons of England
http://www.rcseng.ac.uk/patient_information [Last Accessed March 2011]

www.allaboutbackandneckpain.com
[Last Accessed March 2011]

<http://www.bnspc.com/education/surgery.php>
[Last Accessed March 2011]

NHS Constitution. Information on your rights and responsibilities.
Available at www.nhs.uk/aboutnhs/constitution