Neurosurgery55
Brain and Spine Specialists
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INFORMATION SHEET

SCOLIOSIS SURGERY / CORRECTION OF DEFORMITY

AIM

The procedure is to straighten the spine and correct deformity. It is done to improve pain and to prevent nerve and spinal cord damage.

OVERVIEW

The procedure could be performed in 1 or 2 stages. If the procedure is performed in 2 stages, the first stage will be performed from the side – either right or left flank. This part is called direct lateral discectomy and fusion.

The second stage is performed from the back. This part of the operation will require laminectomy and decompression of the cord and nerves to free them from pressure. Screws will be placed to stabilise the spine. The number of screws required will depend on the level fused. Screws may be placed into your pelvis as well.

DIRECT LATERAL DISCECTOMY AND FUSION

The operation is performed under general anaesthetic. The appropriate area is prepared with antiseptic solution and then draped. A cut is made in the flank/loin approximately 5cm in length after an X-ray has confirmed the level. The muscles are then split so that the *"retroperitoneal space"* is entered (ie the fatty space behind the bowel structures). The disc involved is identified with X-rays and removed with surgical instruments. Constant nerve monitoring is used so that nerves are not injured. Usually the disc space is *"jacked up"* to correct deformity of the spine. A spacer called *"cage"* will be used. More than one disc could be operated on as suggest by your surgeon. The wound is then closed with sutures. A drain tube may be used.

Sometimes, screws are used to fix the cage in place. The screws stay permanently.

POSTERIOR FIXATION AND DECOMPRESSION

Under the same anaesthetic, you will be repositioned so that you are facing downwards. Your back will be exposed to do the surgery. The incisions on your back could be small (2mm) incisions to allow placement of screws, or a longer midline incision to allow decompression of nerves/spinal cord and to fixate the spine. The length of the incision would depend on the number of levels that require decompression and fusion.

Rods will be placed, usually one on each side to stabilise the construct.

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COMPLICATIONS

Anaesthetic:

General, local or regional anaesthesia may be used in your case; you will be informed prior to your operation, which it is likely to be. Anaesthesia is quite safe. The death rate due to anaesthesia for fit, healthy people is very low. Risks may be increased due to smoking, being overweight, diabetes, heart disease, kidney disease, high blood pressure, and other serious medical conditions. Risks are also increased in the elderly.

Serious complications from anaesthesia are very uncommon and care is taken to prevent these problems. They include:

a) Severe allergic reactions
b) Breathing difficulties
c) Stroke or brain damage, which may cause permanent disability
d) Strain on the heart, which may result in a heart attack
e) Awareness whilst under general anaesthetic.
f) Weakness or numbness from pressure on peripheral nerves (eg elbow, hip, knee)
g) Skin reaction to tapes used, particularly around the face, lips and/or chin.
h) Blood clots.
i) Aspiration/regurgitation of stomach content.

Damage to teeth may occur, but this is uncommon. Minor problems may include nausea and vomiting, general aches and pains, pain at operation and injection sites, sore throat and fatigue.

General Risks Associated with the Procedure:

1. Increased risks in obese people of wound infection, chest infection, heart and lung complications and thrombosis. The risk can be reduced by weight loss, however small, prior to surgery.

2. Increased risk of smokers of wound and chest infection and thrombosis. Giving up smoking before operation will help.

3. It is advised that you should not drive, operate heavy machinery, or witness and/or sign documents until after your first postoperative discharge appointment when you should discuss this with your doctor.

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Specific Risks of this Procedure:

1. Infection: superficial, resulting in redness to the wound or stitch abscesses. These may require antibiotics.

2. Infection: deep, which could result in infection of the disc space (discitis) or infection of the bone (osteomyelitis). These are rare, but if they do occur, most likely they will require intravenous antibiotics and possibly a second operation.

3. Damage to nerves; which could result in weakness, numbness or paralysis of the lower half of the body. This may be temporary or permanent. This is extremely rare.

4. Damage to the covering of the nerves and spinal cord which could result in leakage of spine fluid from that sac which is usually repaired at the time.

5. Bleeding, which could result in swelling and bruising around the wound or if deep, could result in damage to nerves.

6. Persistence of preoperative symptoms, in particular back pain, leg pain and/or numbness.

7. Recurrence of symptoms at a later date due to a recurrent disc prolapse or recurrence of symptoms to a lesser degree secondary to scar tissue.

8. Thigh pain and sometimes a burning or numbing sensation could occur on the same side of surgery. This could be related to stretching of nerves at the time of surgery. These symptoms usually resolve with a few weeks.

9. Adjacent segment disease can happen. In other words, the disc above or below the fusion can wear out over time and may subsequently require further surgery.

Disclaimer:
This brochure provides a general overview of the surgery and does not represent individual medical advice. Changes to your medication or lifestyle, and specific questions concerning surgery must be discussed with your Doctor.

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