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Neck Surgery

Information for patients having spinal surgery

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This information is intended to help you understand

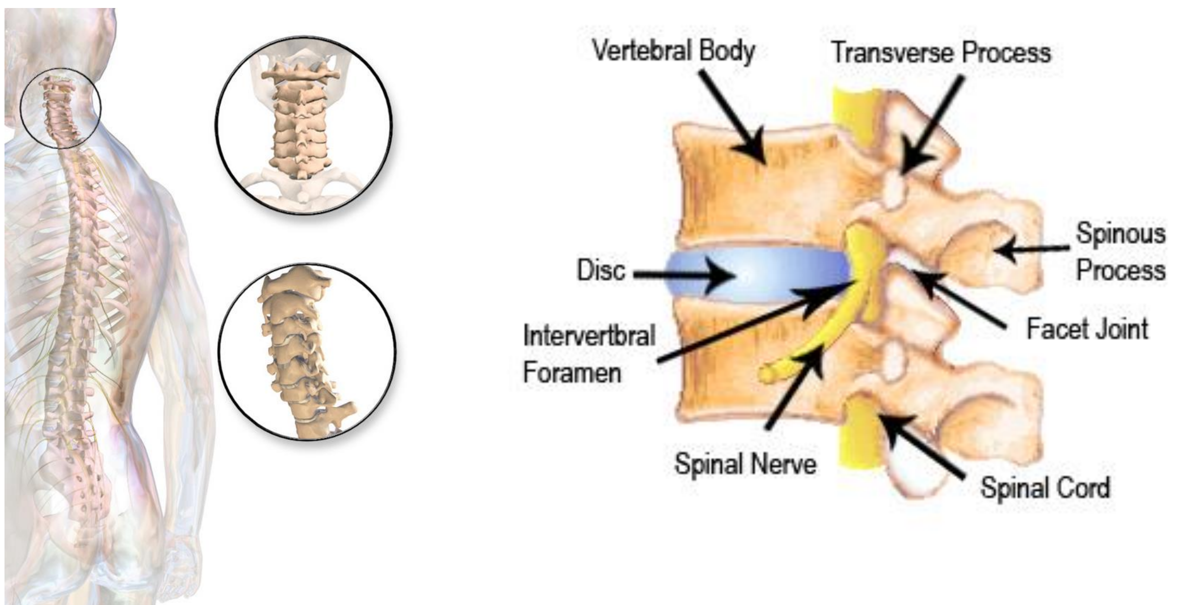
- what will happen when you have your neck operation
- What you can do to help you recover as quickly as possible

It has been written by multiple healthcare professionals including Physiotherapists, Nurses and Spinal Surgeons.

The information is of a general nature and may vary according to your individual situation. This information will answer some of the questions you may have. If there is anything you and your family are not sure about then please contact your consultant or appropriate healthcare professional.

Your Spine

Your neck or cervical spinal column is made up of squares of bone (vertebrae) stacked on top of each other with shock absorbers (discs) in between them. The spinal cord sits behind this, lying in a hole through the centre with nerves coming off it to your arms and legs. Joints and more bone (where muscles and ligaments attach) lie behind the spinal cord protecting it from behind.



Why are you having spinal surgery?

Operations for the neck are usually done to remove pressure on the nerves that go down your arm and on the spinal cord.

Pressure on the nerves in your neck (Cervical Radicular Pain or Radiculopathy) can cause arm pain, weakness, tingling or numbness, leading you to struggle with using your arm.

Pressure on your spinal cord can cause damage to the cord (Myelopathy) and have one or more of the following symptoms:

- Numb, clumsy hands (pins and needles)
- Heavy legs feelings
- Inability to walk at a hurried pace
- Balance issues like stumbling or unsteadiness, as if you were 'drunk'
- Struggle with handwriting, grip or buttoning shirt
- Intermittent 'electric shock' type of pains into arms and legs especially when bending head forward

Taking the pressure off your nerves will help offer relief and improvement of arm symptoms. Good relief from arm pain following surgery usually happens in approximately 85-90% of cases (9 out of 10 people).

Cervical myelopathy is a serious on-going condition and the damage to the cord can continue without surgery. Taking the pressure off the spinal cord aims to stop the progression of the damage and weakness and to keep the current muscle and nerve function.

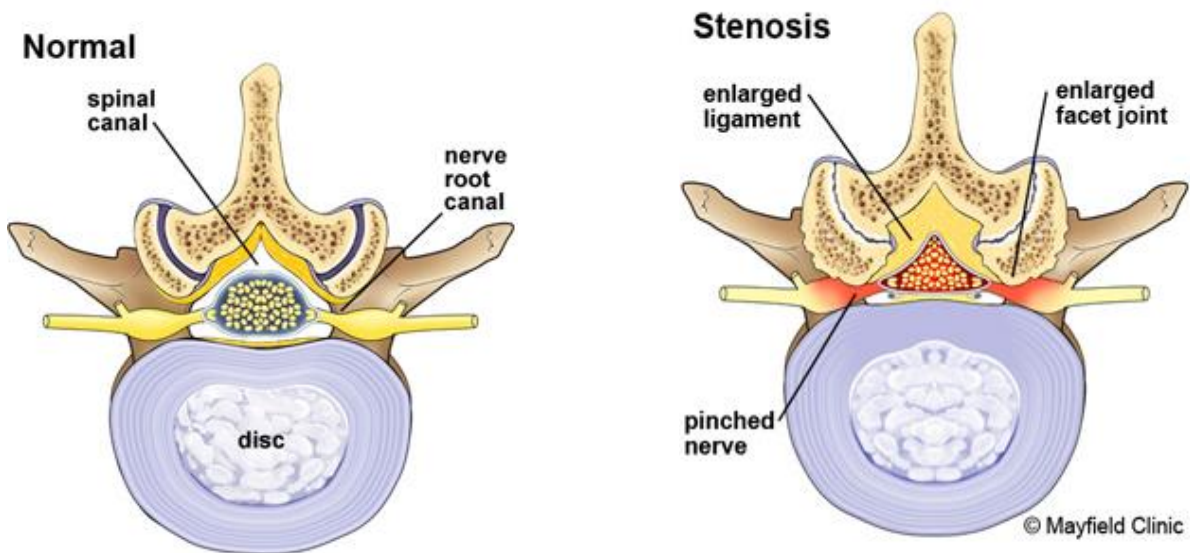
Relief from neck pain is more difficult to predict and is not the main aim of the surgery.

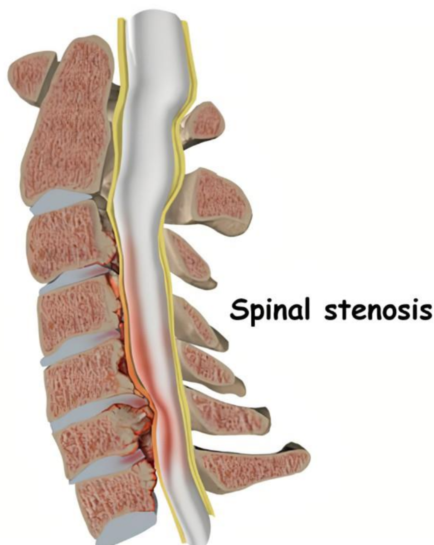
The surgeon removes the tissues (disc or bone) pressing on the nerve and spinal cord. There are no gaps left in the spine. Modern techniques mean that healing takes place very quickly and once it is healed the neck is as strong as ever.

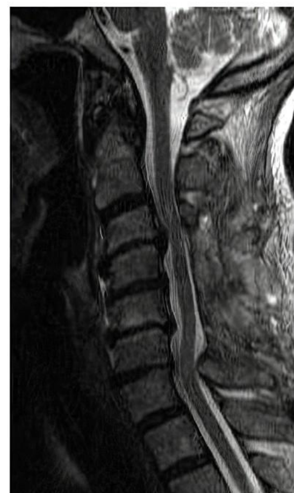
Why are you having spinal surgery?

As part of the normal ageing process soft tissues and bones in your neck may harden and become thickened. Over time, the discs will also lose water and sometimes bulge. These changes together can narrow the central passageway where the nerves and the spinal cord pass through. As the narrowing worsens, the cord can be compressed and damaged (myelopathy) and cause arm symptoms and problems with your balance or walking, and hand function. **Central stenosis** means narrowing of the central canal where the spinal cord lies.

Treatment for this is called **decompression surgery,** which is done to make more space around the nerve and spinal cord by taking out bone or disc material. It is mostly done to stop further damage to the spinal cord and reduce loss of use of your arm and walking.



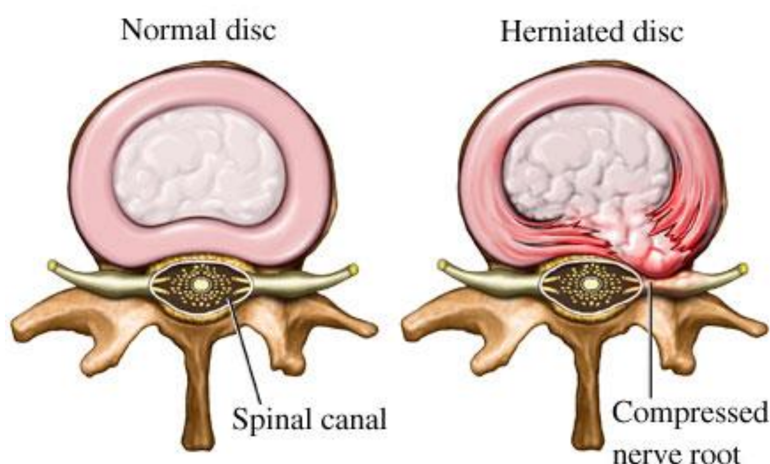




What types of surgery can be done?

As you get older it is normal for the discs between the vertebrae to be less plump and to bulge a little. Despite the term 'slipped disc', the disc doesn't slip in and out however some of the disc material can protrude backwards and pinch a nerve. In the vast majority of cases the body will reabsorb this material and heal itself.

Sometimes the bulge doesn't heal itself and can be near a nerve and large enough to push on it, causing arm symptoms. These might include pain, pins and needles, numbness or weakness, differing between individuals. Treatment for this can include **discectomy surgery** where the piece of disc pressing on the nerve is removed.



This surgery is mostly done to reduce the arm pain caused by the compressed nerve. The arm pain doesn't always improve immediately after surgery but can improve over a period of time, often months, as the nerve recovers.

Discectomy and decompression can be performed in one operation if needed.

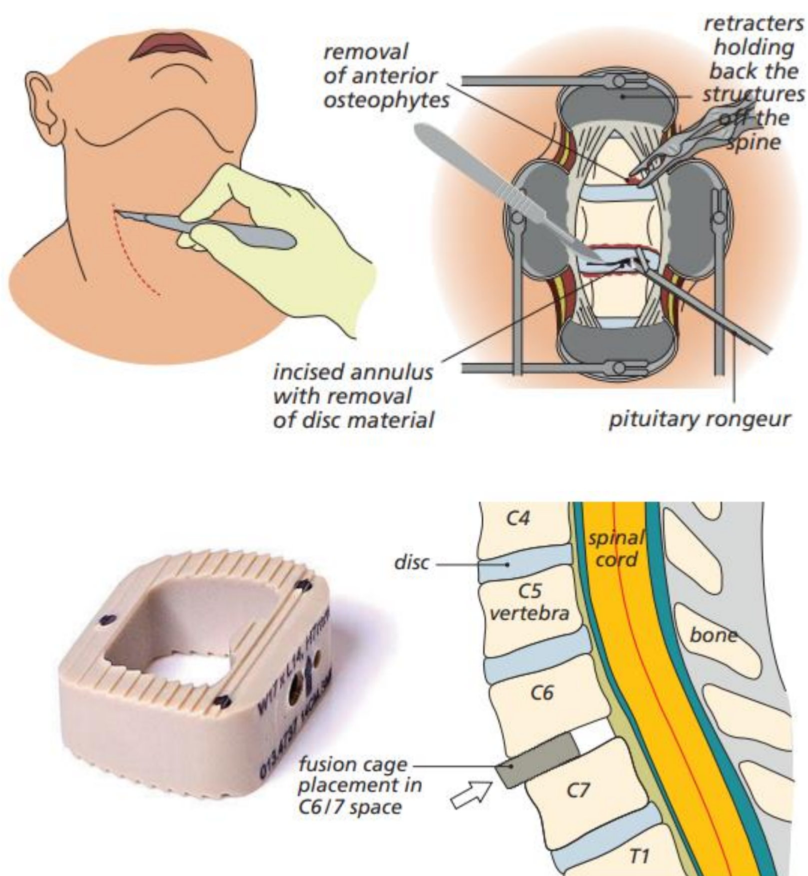
There are different techniques used to remove the pressure from the nerves and the spinal cord. The way in (approach) to the cervical spine can differ from either the front (anterior) or back (posterior) of the neck. The choice of approach will depend on where most pressure on the nerve is coming from.

All these operations are done under general anaesthetic (so you are fully asleep).

What types of surgery can be done?

Anterior Cervical Discectomy and Interbody Fusion (ACDF)

This surgery is done to remove the problem disc. The surgery is done through the front of the neck, usually on the right hand side of the neck where one small muscle is cut. They go through here to get to the disc causing the pressure on the nerve. Once the disc is removed, the space left by the disc will be replaced with a cage, which is a metal or synthetic implant to help keep the vertebrae together, and sometimes a bone graft (usually taken from the patient's pelvis). These two bones will grow together (called fusion) so there is complete loss of movement at the level of the operation. Occasionally, plates and screws will be used to further improve the stability.

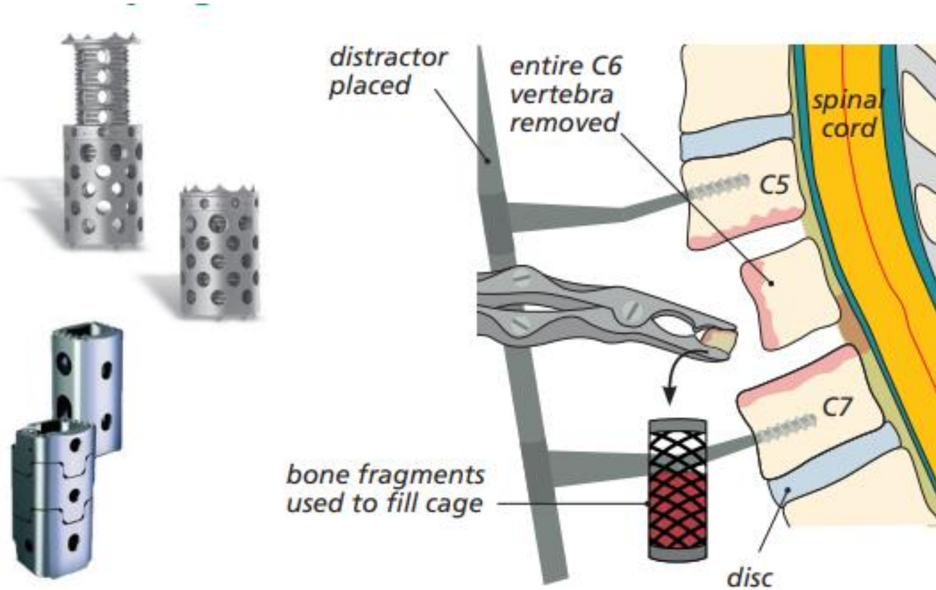


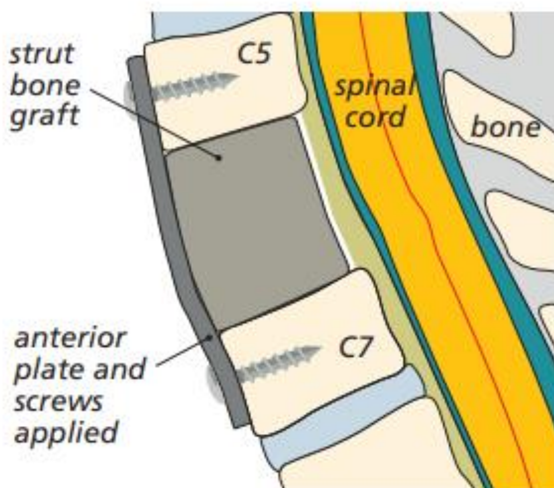
Anterior Cervical Disc Replacement (ACD-R)

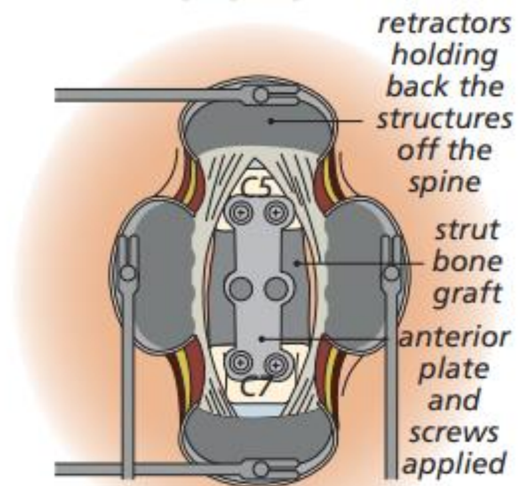
This surgery is done to remove the problem disc and the procedure is very similar to ACDF, where the surgeon goes through the front of the neck to remove the disc pinching on the nerve. An artificial disc goes into the space where the disc was removed. This metal implant allows for motion to be maintained between the two vertebrae, therefore avoids the need for fusion.

Corpectomy

When the stenosis is due to more than just the disc problem, and when there is more than one level that has narrowing, then Corpectomy is done. As with ACDF (procedure above), the surgery is through the front of the neck. The surgeon removes the disc and the vertebral body (bone) itself to open up room for the spinal cord and the nerves. The vertebrae are then replaced with a vertebral body cage or sometimes a solid piece of bone graft. A metal plate that can be put on the front of the spine to add stability and stop the cage/graft from moving out of place.



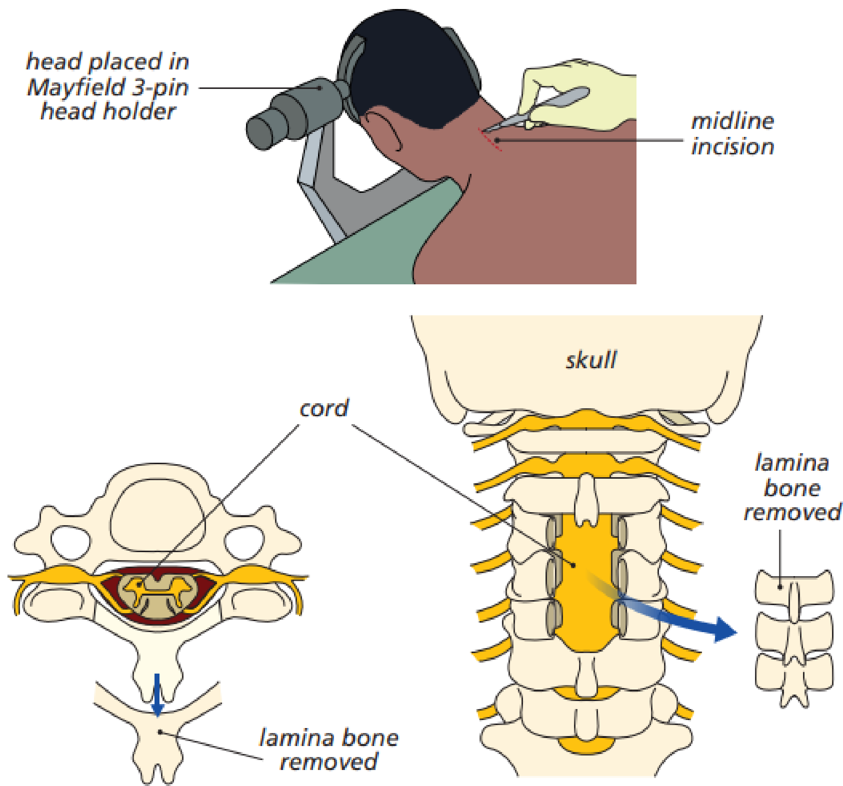




Posterior Approach

Cervical Laminectomy

This operation is carried out from the back of your neck. Your head and neck are kept still and suspended securely over the operating table using a special clamp applied temporarily to your skull with pins. The surgeon removes the back of your vertebrae that covers the spinal canal (lamina) to enlarge the space and take away the pressure on the spinal cord or nerves, allowing the nerves to 'float backwards.' This is often performed because of many levels of narrowing because of bone growing into the space for the nerves or 'thickened' ligaments on the bony arch (lamina) at the back of the neck.



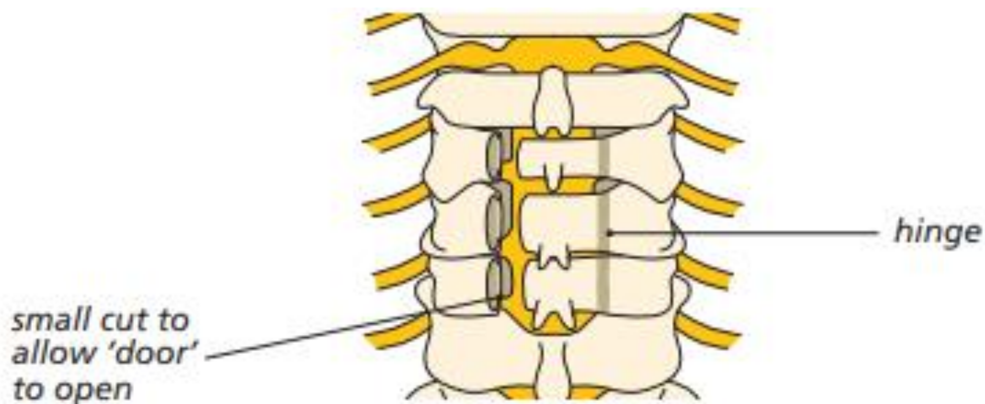
Posterior Approach

Cervical Laminectomy with Fusion

Removing the cervical lamina completely can cause problems with the stability of the cervical spine. The surgeon may decide to add steadiness to the spine by placing a rod on the side of the spine and attaching them by screws.

Cervical Laminoplasty

With a similar approach to cervical laminectomy, the lamina bone is only partly cut on one side and completely cut on the other. The lamina bone is then rotated to an open position like opening a door. The bone is held open in the open position with the use of small metal plates and screws, like a hinge. The metalwork connects the same bone back to itself, just in a new position. These techniques increase the space for the spinal cord and take the pressure off it.



What are the possible risks or complications of surgery?

- **Deep infection** – approx. 1 in every 100 cases. You would usually be given antibiotics into a vein at the time of surgery to reduce this risk.

- **Superficial wound infections** – 4 in every 100 patients get this and may need a short course of antibiotics.

- **Bleeding** – less than 1 in every 100 patients have a major bleed, which may need treatment.

- **Durotomy** – the dura is the delicate sac that contains the spinal nerves inside the spinal canal. Occasionally, 1 in 25, this can become snagged or torn by accident during the surgery. This can usually be repaired at the time and not cause any long term problems. You might have a headache for a couple of days afterwards.

- **Blood Clots** – in the deep veins of the legs or lungs. You will be given surgical stockings and pumps on your legs during surgery to lessen this risk, although we cannot eradicate it.

- **Sensory change or muscle weakness in arms**– is uncommon, approximately 1 in 100 cases due to damage to a nerve root. When it happens, it is usually temporary but on occasion can be long-standing. Problems with nerve function in up to 31% of patients are mostly temporary.

- **Post-op bladder or bowel dysfunction** – The risk of damage to the nerves that supply your bladder and bowel is very rare, 1 in 1000.

- **Repeat surgery** – 1 in every 100 patients have further back surgery during the ten years that follow due to ongoing wear and tear changes elsewhere in the spine.

- **Age** - For elderly patients some risks are slightly increased. Risk of blood clots, heart attacks, urine/chest infection, and heart failure are all increased with advancing age.

- **Return of Pain** – In less than 1-5 in 100 people the natural process of healing by scar tissue causes pain to return by covering the nerves in too much scar tissue. This is treated by Physiotherapists and sometimes referral to the Pain Team after surgery.

- **Temporary damage** to blood vessels, urinary tract infection, urinary retention and vertebral fracture, each in up to 1% of patients.

- **Digestion** problems affecting up to 7% of patients.

What are the possible risks or complications of surgery?

- **Problems with metal work –** this may involve breaking of screws or rods or the bone failing to heal around the metal leading to movement of the screws. This may or may not need further surgery in the future. Problems with the cage supporting the vertebrae, or the bone graft affect 5 out of 100 cases.

- Possible complications associated with taking a bone graft from the iliac crest (pelvis) **include graft site pain and damage to sensory nerve supplying sensation to front of thigh**

- **Pain can start from other levels in the neck, in the long term or years to come**

- **Positioning during surgery** - in rare cases this can cause pressure problems, skin and nerve injuries and eye problems (very rarely blindness). Special operating tables are used to lessen these risks. Shoulder problems and upper limb nerve problems are also a risk.

- **Very rare but serious complications include:**

- Damage to the spinal cord resulting in paralysis or loss of bowel and bladder function. This can happen due to bleeding into the spinal canal after the surgery (a haematoma). Every effort would be made to reverse this by returning to surgery to wash out the haematoma, however recovery of the nerve damage cannot be guaranteed.

- Stroke, Heart Attack or other medical or anaesthetic problems. Please check RCOA (Royal College of Anaesthetists) patient information. See link: :03-YourSpinal2020web.pdf (rcoa.ac.uk)

- General anaesthetic fatal complications which have been reported in 1 out of 250,000 cases Extremely rare death, reported in 1 out of 250000 cases under general anaesthetic.

What are the possible risks or complications of surgery?

Specific Risks associated with Anterior Surgery

- Stroke. There is a slight risk when the cervical vertebral body is removed that the vertebral artery (blood vessel) that runs the side of the spine is injured; this could lead to stroke and/or life threatening bleeding.

- Bleeding in the wound and swelling in the windpipe, which could result in difficulty breathing or swallowing, this is rare but if this occurs, you may need to go back to theatre to stop the bleeding.

- Bone graft/cage/artificial disc movement can occur in 2 out of 100 cases, re-operation may be needed; in very rare cases, movement can cause severe damage and paralysis.

- Damage to the windpipe (trachea) or food pipe (oesophagus) in fewer than 1 in 100 cases

- Injury to the small nerve that supplies the vocal cords which can cause temporary (or rarely, permanent) hoarseness of the voice, temporary strained and uncomfortable swallowing; you may need to eat soft food for a few days.

- Droopy eyelid in 1 in 100 patients which is not usually obvious and nearly always improves.

What can you do to prepare for surgery?

- Stay healthy, eat a well balanced diet and try and keep your weight down

- Ask questions so you feel informed about the procedure and what you are signing on the consent form

- Make plans for your recovery at home following surgery. This may include letting your employer know, making sure you have put in a care package if you feel you will need help and that there is someone ready to take you home when discharged. Please ensure you have planned for meals, childcare and carers if these are needed.

- If you smoke, it is very important that you stop, or at least cut down – please speak to the pre-operative assessment department for help and advice via their 'live well stay well' campaign

Pre-operative: before the procedure:

- Prior to admission to the hospital you will be sent an appointment for the pre-operative admission assessment unit

- Plan for half-a-day at the clinic. A family member or another person may come with you. There is a hospital cafeteria on site for refreshments and food.

- A nurse will check whether you are fit for surgery. This involves a general check of your health, laboratory tests (blood and urine), x-rays and any other tests that may be needed.

- You will also be asked about any medication you are taking including herbal medicines. Please bring your medicines to the Pre-Operative Assessment Clinic with you, or if this if not possible bring a list of your current medication.

- Before the day of surgery if you feel that there have been any changes in your medication or health please let the pre-operative assessment department know.

What do you need to bring to the hospital?

Personal care items:

- Brush/comb
- Toothbrush/toothpaste
- Soap/shampoo
- Deodorant
- Shaving gear
- Dressing gown, pyjamas/nightgown
- Daytime clothes
- Supportive slippers/shoes
- Towel/flannel – this can be provided on the ward
- Spectacles and hearing aids with spare batteries

Your current medications

You may also bring small electrical items such as phones, tablets and chargers.

Please label your equipment and belongings. The Trust does not accept liability for loss of any personal belongings.

Please do <u>not</u> bring:

Anything of value e.g. jewellery, credit cards or more than £10.00 cash

What will happen on the day of surgery?

You will be advised when to stop eating and drinking prior to your surgery.

Your anaesthetist will assess you prior to surgery. They may ask your preference as to the type of anaesthetic you would like to have. The final decision will be made by the anaesthetist as to the type that is best for you keeping in mind:

- Your preference
- The type of operation
- Your general condition
- Any previous experiences you have had with different anaesthetics

When you arrive in the Anaesthetic Room, the theatre staff will check your notes and ask you more questions. Do not be alarmed if several people ask you the same questions!

After your surgery you will be taken to the Recovery Room where a nurse will monitor your progress by:

- Checking your breathing, pulse, temperature and blood pressure
- Asking you questions about how you feel
- Asking you to take deep breaths
- Checking the circulation and sensation in your legs and feet
- Asking and assessing if you are having any pain

What will happen while in hospital?

From the Recovery Room, you will be taken to the Orthopaedic Ward to be looked after for the duration of your stay. You may return from theatre with a urinary catheter if needed, and will usually be removed as soon as you are able to walk to the toilet. You may have intravenous fluids or a patient controlled analgesia (PCA) which gives you pain relief through a drip until you are comfortable, but this is not regularly done. Oxygen may be needed and given using a mask or nasal tubing. Very uncommonly, you may also have a drain on your wound.

You may need a soft or hard collar after your operation. This will depend on what type of operation was done. Your Surgeon will recommend which collar is best and how long to use this for. Most of the time, this is given only for comfort and extra support so using this should slowly lessen as you get more comfortable and your pain is more controlled.

On the ward the nurses will check your breathing, pulse, temperature and blood pressure. They will check the dressings applied to your incision and the drain, if this was needed.

What to expect after the operation?

If your pain is controlled, you should be able to sit up in bed and walk to the toilet with assistance after your surgery. You will be seen by a Physiotherapist who will teach you exercises and offer advice on how to increase your mobility and get back to normal. The Physiotherapist will also check you are walking safely and can manage stairs (if needed). Once you are safe on walking, you will be able to go home. This can be the same day as your surgery or the following day.

A Pharmacist will visit the ward to check your medication is right for your needs if you are in over 24 hours. He/she will be available to answer any questions about your medication.

Some people find their arm pain goes immediately after the operation. For others it may take a few weeks to go as the nerve needs time to recover from the pressure it has had on it. This can be up to 8 weeks or longer which means you may still need to take your pain relief (pain killers or neuropathic medication). It is important to slowly stop using them. The wound may be a little sore and you will be offered pain relief for this. The soreness will go in a few days.

Cervical Myelopathy is a form of Myelopathy that involve compression of the spinal cord in the neck. If your surgery was done for cervical myelopathy, any improvement in hand function or walking ability may be slight and can happen slowly over the next year or so. If there was a lot of numbness prior to the surgery, some feeling may return but it probably won't go away completely.

After the surgery you may still have some neck pain.

How is my post-surgical pain going to be controlled?

We aim to make your stay in hospital as comfortable and pain-free as possible. If there are any concerns we have a dedicated Pain Team who will visit if needed.

There are many ways of controlling pain following surgery. You may find you are given one or a combination of drugs and methods depending on the procedure you have had. Some pain relief are given during surgery and others after you wake up.

If you have any questions or concerns about the management of your pain, please do not hesitate to ask any member of the team. There is evidence that reducing pain and anxiety aids recovery following surgery.

During your stay in hospital you will be asked to measure your pain when you move. This is to help the nurse give you the most suitable pain relief to control your pain. The score that is used to measure your pain is on a scale of 0 – 10 where:

0 = no pain, 10 = the worst pain you can imagine

Recovery from Day of Surgery to Discharge

	Day of Surgery	Pre-discharge to Home	Discharge Goals
Nutrition and Elimination	Nil by mouth pre-op intravenous until oral fluids tolerated Eat light supper Sit out on commode	Eat and drink Walk to toilet Bowels opened before discharge	Appetite returned Passing urine with no Problem
Hygiene	Shower/bath pre-op Mouth care post-op	Help with hygiene care Shower with help	Fresh and comfortable
Wound Care	Observation of incision and drainage if required	Check if dressing is dry and intact If yes, no change of dressing needed until appointment for wound check	Healing noted
Pain Control	Intravenous analgesia (uncommon) and oral NSAID (Nonsteroidal Anti-inflammatory drugs e.g. ibuprofen)	Oral pain relief	Pain controlled
Activity and Rehabilitation	As soon as you and the nurses feel you are able to, you may walk to the toilet with assistance. Unless instructed otherwise	Sit in upright chair- dining chair in a supported chair. Sit for meals. Gradually increase sitting time for short period over a week as comfort allows For the first few weeks, until 6/52 post discharge, you should not do any repeated bending or any lifting	Mobilise comfortably
Discharge Planning	Anticipated date of discharge	Follow-up appointment organised and sent Medication TTO's (to take out) written Practice Nurse letter and TTO's supplied Stocking instruction Helpful hints	Everything explained and understood

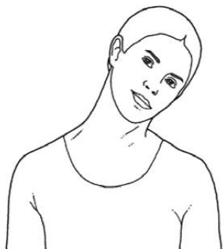
What exercises can you do after surgery?

Following a single level ACDF or ACD-R operation you should start trying to move your neck as soon as you feel able. To begin with this may be a little bit uncomfortable. The aim is to do small amounts of neck movement on a regular basis. You will be seen by the Physiotherapists whilst in hospital, and they will give you some simple exercises to do.

These exercises are intended to help you recover after your neck surgery. Remember these exercises should be slow and gentle and carried out within a comfortable range. At no point should you push exercise into a painful range. You may experience some discomfort, this is normal although if your pain increases try doing the exercises more gently with fewer repetitions. However if your pain becomes prolonged, stop the exercises for a few days and gently build them back up. The pictures below are used as a guide, so you are not expected to necessarily reach the same range.

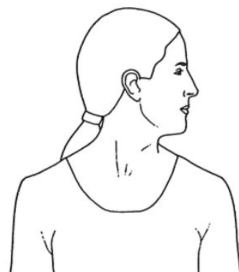
1. Ankle/Quads (thighs)/Glutes (buttocks)

- Bend your ankles up, then point your toes away from you.
- Repeat 20 times
- Circle your ankles clockwise and anticlockwise.
- Repeat 20 circles in each direction.
- Also tense your upper thigh muscles hold 5 seconds and repeat 5-10 times on each leg.
- Repeat tensing your glutes (buttocks) to hold for 5 seconds and repeat 5-10 times on each side.



2. Side Bending movements

Gently tilt your head by bringing your ear towards your shoulder. Repeat on the other side. Repeat 3 to 5 times each side.



3. Head Turning movements

With your chin in, gently turn your head to the side as far as comfortable. Repeat on the other side. Repeat 3 to 5 times each side.

What exercises can you do after surgery?

4. **Neck Bending**

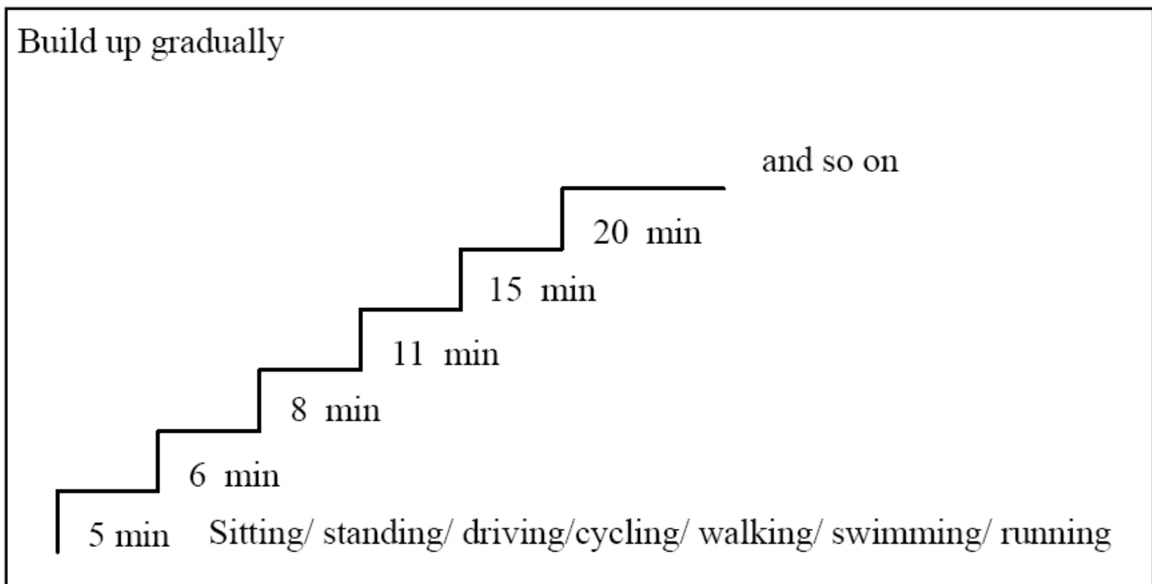
Bend your head down gently but not to the point of pain or stretch. Repeat 3 to 5 times.

5. Walking

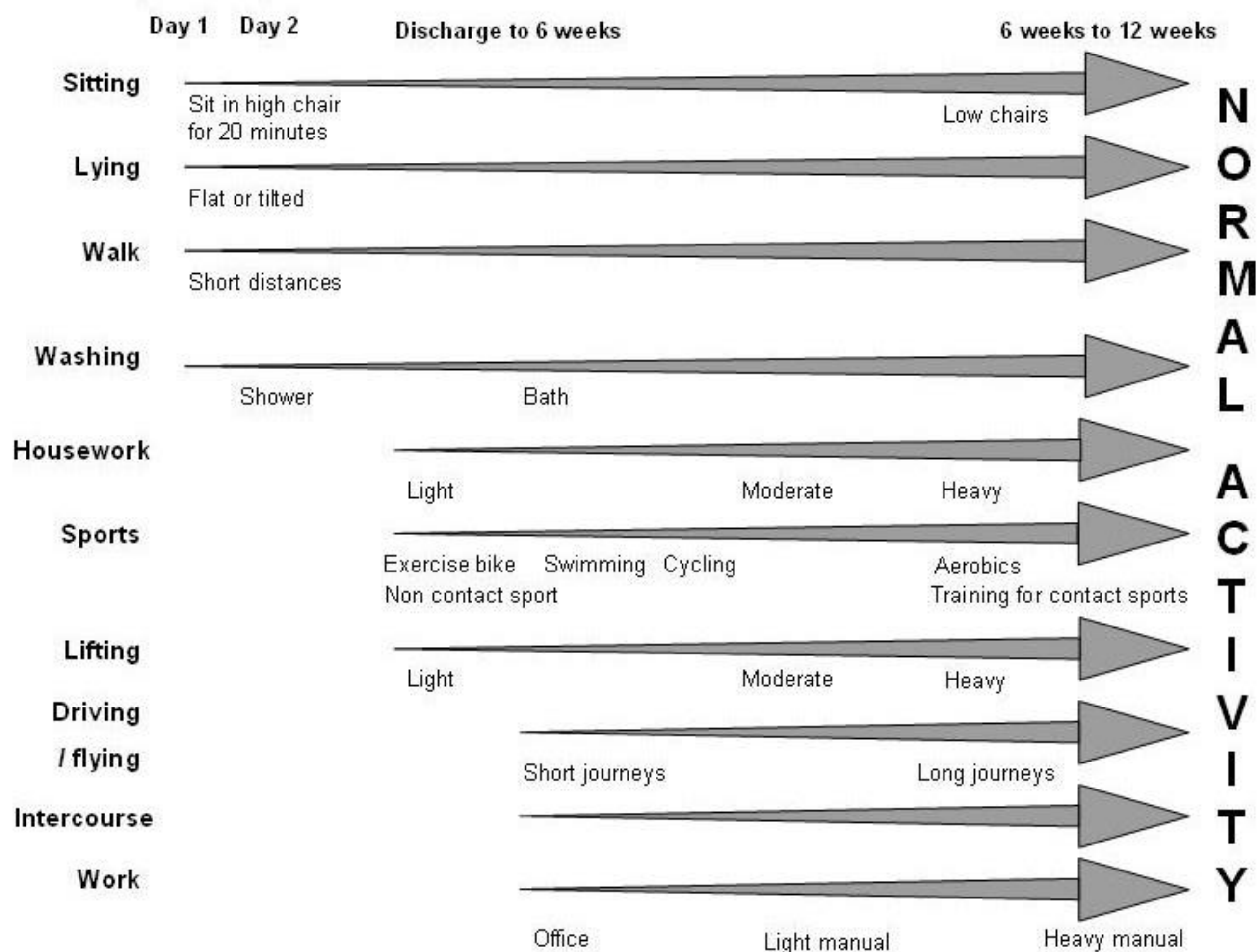
The best exercise you can do is walking. Gradually increase the amount you do each day.

Make sure you change position regularly to avoid feeling stiff, roughly every 30 minutes.

Everyone progresses at different rates post operatively. It is important to do things slowly at first and build up the amount you do gradually (see chart below). Good and bad days are normal.



**If you had a Single level ACDR and ACDF,
this is a Typical Timeline of Return to normal Activities**



What advice can help you recover well after surgery?

- **Pain**: Some pain is normal following surgery. The pain from surgery will lessen to a dull ache after 48 to 72 hours post op. Pain control is important, particularly in the first few days and weeks. It is best to take regular pain relief rather than letting pain build up, so you feel comfortable and are able to get active.

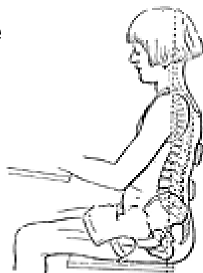
- **Wound**: Your wound, just like any cut, may be a bit sore to begin with, but you will not do any damage by getting moving. The dressing will only be changed as needed. You may need to visit your GP/practice nurse for a wound check or to trim your stitches; you will be informed if this is the case. You should keep your wound clean and dry following surgery. Most dressings are shower proof but ask your nurse before you go home.

- **Lying in bed:** You can lie in whatever position you find comfortable. Although it is normal to spend short periods of time on the bed after surgery, for the first few days in particular, try not to spend long periods in the day lying down.

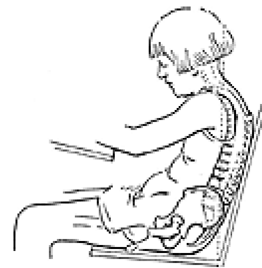
- **Getting out of bed**: You may find it easier initially to roll onto your side, bend your hips and knees, swing your legs over the side, and push up with your hands. You can progress to getting up normally over the next few weeks.

- **Sitting**: You may find you are more comfortable in an upright supportive chair rather than low chairs or sofas for the first couple of weeks. You can try using a lumbar roll or cushion positioned in the small of your back for comfort when sitting. Make sure you change position regularly, alternating between lying, sitting and walking to avoid feeling stiff.

- Good posture



Bad posture



- **Washing/Bathing**: You may find it easier to shower or strip wash initially. Shower or strip wash for the first few weeks (rather than using the bath) until the wound is healed and dry. Being comfortable getting in and out of the bath and sitting in the bath may take a few weeks.

- **Rest:** It is all right to rest for short periods if you need to, but try to alternate rest with gentle exercise and gradually increasing to normal activity. Go for short walks daily; **do not** spend all day lying down.

When can you restart your normal activities?

Timescales here depend in part on your surgery. If you have had a fusion then the below timescales are likely to take longer.

For some patients, there may already have been problems with balance and weakness affecting walking and arm function before the operation. Expected improvement may be hard to predict and may affect how quickly you can return to normal activities.

- **Lifting*:*** Heavier lifting should be avoided for the first 3 months after surgery. Lighter weights like a full kettle can be lifted with your arms close to your body, with your neck in a good position, from about 3 weeks.

- **Bending forwards**: We ask you to avoid excessive bending forward for the first couple of weeks. It will be easier to bend from your knees rather than your back. You may need some help initially putting on your shoes and socks. Many people get slip-on shoes or put them on in a seated position by crossing their legs over. A shoe horn may be useful.

- **Work**: You need to get fit to return to work which means gradually increasing what you do each day. You do not need to be completely pain free to return to work. You may return to work as soon as you feel comfortable to do so, as discussed with your Surgeon.

- If your work involves sitting at a desk you may return to work after 3-4 weeks providing you can keep moving about. If you have a heavy manual job you may need longer to recover (8-12 weeks). When returning to work it is likely you will need to gradually increase your working hours and days at work over a few weeks rather than starting back full time straight away. This is called a phased return and should be discussed with your employer's HR department or Occupational Health.

- **Driving*:*** As a passenger, recline the passenger seat in the car slightly to make it easier to get in and out of the vehicle.

- You will be unable to drive for at least 2-4 weeks. If you have had a fusion then the below timescales are likely to be longer. When considering whether to drive, and you have no altered sensation or weakness in your arms, and you can move your head around freely, then you may resume driving if you feel safe to do so and confident to do an emergency stop, with full pressure on the brake pedal, without significant neck or arm pain. Break up long journeys so you can change position and move around. Gradually increase the distance you travel (initially no longer than 20 minutes) over the next 4 to 8 weeks.

When can you restart your normal activities?

- **Driving.** Check with your insurance company and with the Drivers Medical Group at the DVLA in Swansea, as they may wish to know that you have had an operation. Further advice can be sought at your outpatient appointment.

- **Sex:** There is no reason to avoid sexual relations during the recovery period. You might prefer to be the passive partner or try different positions to find the most comfortable for you.

- **Activity and exercise**: It is important to keep as mobile as you can after surgery, as this reduces your risk of getting a blood clot in your legs. Get up and move regularly (every 20 minutes or so). Walking is the best activity to start doing following your surgery. Gradually build up the amount of walking you do each day. Walking outside is okay but be careful not to trip over on uneven ground. Try to get into a routine so you gradually get in the habit of walking a bit further. You may find it helpful to use an App in your mobile phone to count your daily steps. Remember to put the phone in your pocket.

- **Exercise/Sport:** Check with your Surgeon and Physiotherapist when you can return to sporting activities like swimming or golf, as advice ranges from between 6 weeks to 3 months.

- For previously fit sports people, you can resume **training** at 12 weeks, or take part in non-contact sports. All activities will need a gradual increase in time spent on the activity, activity intensity, and how frequently you do the activity.

- No impact sports such as jumping, running for the first 12 weeks.

When will you see the Surgeon's Team for a review?

You will be reviewed by the doctor in clinic around 6 weeks after the operation to check your progress. Please discuss any queries you may have when you are at the clinic. Further outpatient appointments are made as necessary. For single-level ACDF or ACDR, your Surgeon will request outpatient Physiotherapy appointment to start 4 weeks after your surgery. For other types of surgery, the Surgeon will decide when Physiotherapy should start.

If you have any queries about the information in this information, please discuss them with the member of your Surgeon's team.

When to seek advice?

If you experience any of the following symptoms:

- leaking fluid or redness at the site of your wound
- your stitches come out
- your dressing becomes soaked with blood
- you have a high temperature (fever) of 38C (100.4F) or above
- you have increasing pain, numbness or weakness in your legs, back or buttocks
- you cannot move your legs
- you cannot pee or control your bladder
- you have a severe headache
- you experience a sudden shortness of breath (this could be a sign of pulmonary embolism, pneumonia or other heart and lung problems)

Contact Ward 1 during office hours at this number 01494 426398 or 111 or

A and E/Emergency Department during out of office hours

How do you contact us?

Outpatient Appointments: **01296 838888**
– (choose option 4 for orthopaedics)

Stoke Mandeville
Ward 1: 01296 315050
Ward 2: 01296 316503

Wycombe Hospital
Ward 12B: 01494 426398

Physiotherapy Departments
Amersham: 01494 734109
High Wycombe: 01494 425431
Stoke Mandeville: 01296 315087

Where else can you find more information?

https://www.spinesurgeons.ac.uk/patient-area

Resources for Neck Pain

•https://www.csp.org.uk/conditions/neck-pain Chartered Society of Physiotherapy
•https://www.versusarthritis.org/about-arthritis/exercising-with-arthritis/exercises-for-healthy-joints/exercises-for-the-neck/
Versus Arthritis
•Arthritis information, Versus Arthritis
•Osteoarthritis information, Versus Arthritis
•Osteoarthritis guide book, Jigsaw-E
•Exercises for arthritis, Arthritis Action

How can I help reduce healthcare associated infections?

Infection prevention and control is important to the well-being of our patients and for that reason we have infection prevention and control procedures in place. Keeping your hands clean is an effective way of preventing the spread of infections. Please follow our infection prevention and control guidelines when visiting our healthcare sites. Further information is available on our website.

Patient Advice Sheet

If you would like a copy of this information on audiotape, in large print or translated, please call the Patient Advice Liaison Service on 01296 831120 or email bht.pals@nhs.net

Please remember that this leaflet is intended as general information only. We aim to make the information as up to date and accurate as possible, but please note that it is subject to change. Please therefore always check specific advice on any concerns you may have with your doctor.