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Postoperative Patient Instructions:
Lumbar Discectomy

What to Expect

Following lumbar disc surgery, patients typically return home the evening of surgery or after an overnight stay if the surgery is performed later in the day. Generally the discharge time has been discussed between yourself and Dr. Spivak prior to surgery, but this can be changed based on how you feel shortly after the operation.

In general, you can expect your back to be sore immediately following surgery, and this should improve day-to-day over the first postoperative week. Your leg pain may be immediately improved or even gone, or you may continue to experience some leg pain for a number of days to weeks. Even if your leg pain is completely gone after surgery, you can expect some intermittent pain in the affected leg over the first six weeks after surgery, as the surrounding tissues heal and inflammation subsides. Do not worry if this happens; it is a normal occurrence. Severe persistent leg pain should not recur, and should be reported to Dr. Spivak.

During the first few days home, contact Dr. Spivak's office to schedule your first postoperative office visit, generally at 2-3 weeks from the time of surgery. The second visit will usually be six weeks after surgery, and future visits only as needed after that time.

Caring for the Surgical Wound

At the time of hospital discharge, your wound is being covered by an outer gauze dressing held on by clear plastic, and an inner dressing of white tape strips applied directly to the skin. You may shower with the outer dressing still on, but this should be covered by an additional protective barrier of plastic wrap or a plastic bag taped to the skin over this dressing. Bathing should be avoided until after the first postoperative office visit.

The outer dressing should be removed on the morning of the third day after surgery. If the gauze on this dressing is completely clean or with only dried blood, this dressing can be left off. If there is any fluid draining from the wound, a new sterile gauze dressing should be applied and changed twice a day. Persistent drainage lasting more than two days should be reported to Dr. Spivak.

If there are tape strips on the skin, they should be left in place. They may get wet in the shower, but should not be rubbed with a washcloth or a drying towel or they may fall off. Carefully pat this area dry. The tape strips will fall off on their own, or if they are still in place they will be removed at the time of the first postoperative office visit. The wound stitches (sutures) are absorbable. The ends of the suture may be protruding from the skin at the top and bottom of the wound. These should be left alone, or covered with a gauze if they are irritating under your clothes. These ends will be removed at the first postoperative visit, if they have not fallen off on their own. Again, do not bathe or soak the wound site until after the first postoperative visit.

Medications

Discharge medications may include antibiotics, anti-inflammatory medications, and pain relievers. Patients may or may not need medications from these three broad categories, but all patients should have at least one prescription pain reliever prescribed for discharge for use if needed at home. Antibiotics (such as Keflex) may be needed for an additional few postoperative doses. If an antibiotic is prescribed, it should be used until finished.

Many patients will be prescribed Decadron (dexamethasone) using a decreasing dosage schedule for 3-6 days. This is a potent steroid anti-inflammatory, and should be used in the diminishing dosing as prescribed. Nonsteroidal anti-inflammatory medications such as Motrin, Naprosyn (Aleve), and aspirins should not be used at the same time, but can be restarted after the last day of Decadron use.

Pain relievers include non-narcotic medicines such as Toradol and Tramadol, and narcotic medications such as Tylenol with Codeine, Vicodin (hydrocodone/apap), and Percocet (oxycodone/apap). These should be used only as needed for pain, usually diminishing in need over the first few days after surgery. When you are comfortable enough, only over-the-counter pain relievers such as Tylenol (acetaminophen), Advil (ibuprofen), Aleve (naproxen), or aspirin should be needed.

Activity

All patients should be up and walking, including going to the bathroom, the evening of surgery. In general, over the first 6 weeks after surgery lifting and bending at the waist should be avoided. Walking is strongly encouraged, including up and down steps and on a treadmill. Use of a cross-training or elliptical machine is allowed as well. Upright sitting, especially unsupported such as on the side of the bed, should be limited for the first 2 weeks after surgery, except as needed for eating meals and bathroom use. This position puts additional pressure on the low back, and may increase pain and risk for reherniation of a new disc fragment before initial healing of the disc can occur.

Outpatient postoperative physical therapy may be prescribed at the first postoperative office visit if needed. This tends to be more useful in patients with preoperative muscle weakness, patients who are deconditioned by a longer preoperative period of symptoms, and patients with greater than average postoperative muscle spasm and tightness. Many patients, however, can exercise at home on their own and do not need prescribed physical therapy.

In general, most patients will be cleared for driving after the two-week postoperative visit. Persistent leg pain and muscle weakness, especially in the right leg, may delay the return to driving. Return to desk-type work can be allowed 2-6 weeks after surgery, depending on postoperative symptoms and expected commute. Return to physical labor is usually at 6-12 weeks after the operation. Resumption of previous recreational physical activities is generally begun at 6 weeks postoperatively.