Disc Prolapse

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Terminology

- Prolapse
- Protrusion
- Rupture
- Herniation
- Extrusion
- Sequestration
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- Herniation
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Prevalence

• 1-3% and highest in 30-50 year old
• Male to Female ratio 2:1
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• Who has had a disc prolapse?
A Typical Story

• A true story
• 33 yr old carpenter
• Lifts a compressor
• Feels “something go” in his back with “electric shock” down his leg
• Continues working, but back pain worse
A typical Story

- Next morning – “can’t get out of bed”
- Thigh pain worse with bending
- Takes some tablets
- Drives to work – “can’t get out of car”
- Tries to work, but pain worse
- Numbness in his foot
A Typical Story

• Quits work early
• Sees physio
Physiotherapy + Psychology

- Often first port of call
- Trusted profession
- Care for body and mind
A Typical Story

• Quits work early
• Sees physio
• Worried by pain
• Worried about future
• Progressive symptoms
Physiotherapy + Psychology

- Often first port of call
- Trusted profession
- Care for body and mind
- Give physical relief
- Reassurance
- Prognosis is good
Neurogenic Pain

• Progressive
  – Down arm
  – Down leg
  – Abnormal feelings
  – Worse with posture
• Constant like a toothache
• Debilitating
Neurogenic Pain
Neurogenic Pain
A typical Story

- Fortified with hot packs, gentle exercise, anti-inflammatories, reassurance
- Advised to rest
- Tries a day at work, but gives up
- Financial worries
- Will injections help?
When to scan?

- Natural history favorable
- Beware of
  - Red flags – tumour and infection
  - Progressive weakness
  - Bladder and bowel dysfunction
- Failure to improve
- Severe pain
MRI

- Gold standard
- Good for soft tissues
  - discs and nerves
  - CSF – spare room
- No radiation
- But expensive and claustrophobic
- Occasionally not possible - implants
MRI – L4/5 Disc
MRI – 2 Discs
CT Scan
CT Myelogram
Synovial Cyst
Epidural Abscess
Spinal Stenosis

Dr Andreas Loeﬂer
Spine Surgery & Joint Replacement
Discitis
Injections

- Steroids with LA
- Diagnostic and therapeutic
- Short term relief
- Severe pain
- Can be repeated 2-3x
- CT guided – epidural or trans-foraminal
A Not So Typical Story

- After 3 weeks our man is no better
- Frustrated and a little angry
- Debts increasing
- MRI L4/5 disc prolapse
- When to see a surgeon?
Surgery

• Cauda equina syndrome
• Progressive weakness
• Persistent severe pain
• After 4-6 weeks of non-operative care
• When symptoms, signs, and scan correlate
• When the patient decides
Discectomy

- 3-4cm incision
- Check level with x-ray
- Magnification
- Laminotomy
- Remove prominent disc material
- Decompress nerve
Discectomy

- 1-2 ml
- 10-20%
- Firm fibrous
- Fragmented
Discectomy

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Discectomy
Discectomy

- 1 hour
- Most stay overnight
- Cautiously active 1-2 weeks
- Post-op physio
  - Core strengthening
  - ROM
  - Gradual increase
Our Story

• Our patient opted to have surgery
• At 5 weeks
• Simple discectomy and L5 decompression
• Leg pain was instantly relieved
• One night in hospital
• Two weeks off work
• Resumed normal duties
Unusual Challenge

• Tattoo
Prognosis

• Generally very good
• Occasional back pain
• Most return to work and sports
• Recurrence 5-10%
• Rarely progressive degeneration
Prognosis – Cervical discs

- Better, but slower
- Often take 2-3 months to settle
- Can be debilitating
- Occasionally a collar helps

- Cervical surgery more complex and risky
Core Strengthening

• Post op exercises
• Pilates
• Swimming
• Gym based strengthening
• Caution
• Improved posture and work practices
Chronic Pain

• “Window of opportunity”
• 6 weeks to 6 months
• Thereafter risk of chronic pain
• Depression
• Analgesic dependence
• Social disintegration
Cervical and Lumbar Discs

• Frequently injured
• An emotional organ
• Fear and misunderstandings
• The wheelchair paranoia
• Mostly an excellent prognosis
• Well managed with physio and time