Lumbar disc herniation

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Symptomatic lumbar disc herniation occurs during the lifetime in approximately 2–4% of the population. Risk factors include family history , male gender, age (30–50 years), heavy lifting or twisting, stressful occupation, lower income and cigarette smoking. Over 90% of lumbar disc herniations occur at the L4/5 or L5/S1 levels. A posterolateral disc protrusion will a ff ect the traversing root, e.g. an L4/5 disc protrusion will a ff ect the L5 nerve root. A far-lateral disc protrusion (extraforaminal) will a ff ect the exiting nerve root, e.g. a far-lateral L5/S1 disc protrusion will a ff ect the L5 nerve root. Symptoms typically commence with a period of back pain followed by sciatica. There may be paraesthesia, motor weakness, loss of reflexes and a reduction in SLR. For simple sciatica, a period of 6–12 weeks of conservative treatment is advised. Up to 70% of patients will settle within this period. A trial of pregabalin (GABA analogue) and/or a transforaminal epidural steroid injection may be helpful. Microdiscectomy is the standard surgical intervention f or those in whom conservative treatment has failed. The procedure is carried out in the prone position with radiographic confir mation of the correct level. Loupes with a headlight or use of the operating microscope greatly facilitate the procedure. the multifidus. The spinal canal is entered via r emoval of the ligamentum flavum under the lamina. The thecal sac and tra - versing nerve root are identified. T he dura and nerve root are retracted medially and the o ff ending disc prolapse incised via - a transverse annulotomy . The disc fragment is removed and the disc space cleared of any remaining nuclear material with r ongeurs and multiple washouts of the disc space. The wound is closed. Patients are generally discharged the next morning. Lumbar disc herniation

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