Healthy Driven™
Edward-Elmhurst
HEALTH

CERVICAL SURGERY

THANK YOU

Thank you for choosing Edward-Elmhurst Health for your spine surgery. We know you have a choice of where to go for your procedure.

Our goal is to ensure that your stay with us is as pleasant and comfortable as possible. We do this through our unique program that helps to guide you through your journey – so you know what to expect before, during and after your spine surgery. Our dedicated care team is here for you every step of the way.

Again, we're so glad that you chose us for your care.

Your Care Team

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Section One:

General Information

Welcome

Thank you for choosing the Orthopedic Center. We follow a patient-focused clinical pathway, which accounts for our high levels of patient satisfaction. The Orthopedic Center has a specialized spine unit staffed by physicians, physician assistants, nurse practitioners, nurses, patient care techs, physical and occupational therapists in addition to other professionals trained in the care of patients undergoing spine surgery.

More than 200,000 people undergo cervical spine surgery each year. Most people undergo surgery due to pain that they no longer wish to tolerate. Many suffer from nerve compression, which may produce numbness, tingling or weakness. Surgery aims to relieve pain, restore independence and return patients to work or daily activities.

Most patients having cervical spine surgery recover quickly. Most patients may be able to walk and some may even go home the day of surgery. Generally, patients can return to driving in two weeks; to sedentary jobs and activities in three to four weeks; and to vigorous physical activities in six to 12 weeks. Patients undergoing more complicated operations such as multilevel cervical spinal fusion may require three to six months to return to full activities.

The Orthopedic Center has developed a comprehensive treatment program. We believe that patients play a key role in ensuring a successful recovery. Our goal is to involve patients in their treatment through each step of the program. This Guidebook provides the information needed to maximize a safe and successful surgical experience.

Every detail, from pre-operative teaching to post-operative exercising, is considered and reviewed with each patient. The care coordinator will assist to guide patients through the surgical experience and help develop individualized discharge plans.

Features of the Center's program include:

- Nurses and therapists who specialize in the care of spine surgery patients
- Private rooms
- Emphasis on individual care
- Family and friends participating as "coaches" in the recovery process
- A spine care coordinator who facilitates discharge planning
- A comprehensive patient Guidebook to follow pre-op and beyond

You can find your Patient Guidebook online at
https://www.eehealth.org/ortho-spine

Using the Guidebook

Preparation, education, continuity of care, and a pre-planned discharge are essential for optimal results in spine surgery. Communication is essential to this process. The Guidebook is a communication tool for patients, physicians, physical and occupational therapists, and nurses. It is designed to educate you so that you know:

- What to expect every step of the way
- What you need to do
- How to care for yourself after spine surgery

Remember, this is just a guide. Your physician, physician assistant, nurses, or therapist may add to or change any of the recommendations. Always use their recommendations first and ask questions if you are unsure of any information. Keep your Guidebook as a handy reference for at least the first year after your surgery.

Instructions for Patients

- Read Sections 1 and 2 for general information.
- Use Section 2 as a checklist.
- Read Sections 3, 4, and 8 for surgical and post-op information.
- Read Sections 5, 6, and 7 for exercise and activity guidelines.
- Bring your Guidebook with you to the hospital, outpatient therapy, rehab facilities, and all physician visits.

Frequently Asked Questions about Cervical Decompression, Discectomy and Laminectomy

Q. What is wrong with my neck?
A. You have a “pinched nerve.” This can be produced by a ruptured disc or by bone spurs. Discs are rubbery shock absorbers between the vertebrae, and are close to the nerves which travel down to the arms. If the disc is damaged, part of it may bulge or even burst free into the spinal canal, putting pressure on the nerve and causing arm pain, numbness, or weakness. Bone spurs, usually the result of arthritis, can also put pressure on nerves. Occasionally, pressure from bone spurs or a ruptured disc may affect the spinal cord and cause abnormalities in either or both arms.

Q. What is required to fix the problem?
A. In most cases, a small (three to four inch) incision is made. Muscles supporting the spine are pushed aside temporarily, and a small “window” is made into the spinal canal. The spinal nerve is protected, and the ruptured part of the disc or the bone spur is removed. If bone spurs and arthritis are the cause of your problem, you may require a bigger incision and more bone may have to be removed.

Q. When is this operation necessary?
A. In almost all cases, the major reason for spine surgery is arm or neck pain which is intolerable to the patient or neurological problems. Often non-surgical measures can control the pain satisfactorily. However, if the pain persists at an unacceptable level, if you cannot function because of pain, or if weakness or other neurologic problems develop, then surgery may be necessary to relieve the problem.

Q. Who performs this surgery?
A. Both Spine Fellowship trained Orthopedic Surgeons and Neurosurgeons are trained in cervical spinal surgery and both specialists may perform this surgery. It is important that your surgeon specialize in this type of procedure.

Q. How long will I be in the hospital?
A. This procedure can be performed as either an outpatient or inpatient procedure. Inpatient stays are usually 1 day for one to two levels. For multiple levels it may be a 2-3 day stay.

Q. Will I need a blood transfusion?
A. There is usually very little blood loss with this operation, and transfusions are almost never necessary.

Q. What can I do after surgery at home?
A. You should try to get up and move around as much as your symptoms allow. You may walk as much as you like.

Q. What shouldn't I do after surgery?
A. For at least six weeks, you should avoid lifting (no more than **5** pounds), overhead lifting, frequent or repetitive neck movements and vigorous sports until instructed otherwise by your surgeon.

Q. When can I go back to work?
A. That depends on what kind of work you do and how far you have to drive. It can be as little as two weeks, but may be longer if your job involves manual labor or if you have to drive more than 30 minutes to get there. Discuss this with your physician.

Q. What are my chances of being relieved of my pain?
A. 90-95 percent of patients get relief from their nerve symptoms or arm pain. Neck and shoulder pain are less predictably relieved by disc surgery. Up to 15 percent of patients may have some neck and shoulder aching after surgery; this percentage may be higher in patients who have a substantial amount of neck and shoulder pain before surgery. Other conditions such as fibromyalgia may also produce continued pain even after successful disc surgery.

Q. Will my neck be normal after surgery?
A. No. Even if you have excellent relief of pain, the disc has still been damaged. However, most people can resume almost all of their normal activities after disc surgery. People who do heavy work generally take longer to recover and may not be able to do everything they could do before their injury.

Q. What risks are there?
A. There are general risks with any type of surgery. These include, but are not limited to, the possibility of wound infection, bleeding, collection of blood clots in the wound or in the veins of the leg, pulmonary embolism (movement of a blood clot to the lung), heart attack, stroke and death. The chances of any of these events happening, particularly to a generally healthy patient, are low.

Q. Could I be paralyzed?
A. The chances of neurologic injury with disc surgery are very low, and the possibility of catastrophic injury such as paralysis, is highly unlikely, though not impossible. Injury to a nerve root with isolated numbness and/or weakness in the arm is possible.

Q. Is my entire disc removed?
A. Possibly, but it depends on the specific findings in your spine. Your surgeon will determine what is appropriate for you.

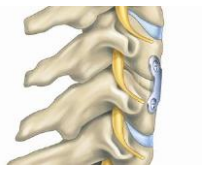
Q. Could this ever happen to me again?
A. Unfortunately, yes. Bone spurs and disc herniations may form again at the levels operated on and at other levels.

Q. Should I avoid vigorous physical activity?
A. No. Exercise is good for you. You should get some sort of vigorous, low-impact aerobic exercise at least 3 times a week. Walking either outside or on a treadmill and using an exercise bike are all examples of the type of exercise which is appropriate for spine patients.

Frequently Asked Questions about Cervical Fusion

Q. What is wrong with my neck?
A. You have one or more damaged discs in your neck. Discs are rubbery shock absorbers between the vertebrae, and are close to the nerves which travel out to the arms. If the disc is damaged, part of it may bulge or even burst free into the spinal canal, putting pressure on the nerves and causing arm pain, numbness, weakness and/or pain in the neck or shoulder area. Occasionally, this pressure may affect the spinal cord and cause abnormalities in the legs or lower parts of the body. Bone spurs, usually the result of arthritis, can also put pressure on nerves or the spinal cord. Loss of the normal "shock absorber" function, or arthritis around the damaged disc, can also produce mechanical pain around the neck or shoulders with neck movement or awkward positions.

Q. What is required to fix the problem?
A. The best approach to your problem is to remove the damaged disc and bone spurs from the front, or anterior part, of the neck and to perform a fusion between the adjacent vertebral bodies. Certain conditions, however, require the surgeon to perform the fusion using a posterior approach, or from the back of the neck, instead.



Q. What is spinal fusion?
A. A fusion is a bony bridge between at least two bones, in this case two vertebrae in your spine. The vertebrae are the blocks of bone which make up the bony part of the spine, much like a child's building

blocks stacked on top of each other to make a tower. Normally each vertebra moves within certain limits in relationship to its neighbors. In spinal disease, the movement may become excessive and painful, or the vertebrae may become unstable and misaligned, putting pressure on the spinal nerves. In cases like this, surgeons try to build bony bridges between the vertebrae using pieces of bone, which we call bone graft. The bone graft may be obtained either from the patient himself, usually from the pelvis, or from a bone bank. There are advantages and disadvantages to either source. The bone graft is laid between the vertebrae. The bone graft has to heal and unite to the adjacent bones before the fusion becomes solid. Spine surgeons often use plates to protect the bone graft and stabilize the spine during the healing period, attaching them to the spine using screws.

Q. How is the operation performed?

A. An incision, usually about one to two inches in length, is made across the front of the neck. The windpipe, esophagus (food pipe) and other tissues are temporarily pushed aside and the abnormal disc or discs are removed completely. Usually, a cadaver bone is used to replace the disk. In most cases this bone will heal or “fuse” to the vertebrae above and below it within three to twelve months, creating a solid bony bridge between the two vertebrae and eliminating movement between them. Typically, internal plates and screws may be used to improve stability and conditions for bone healing.

Q. When is this operation necessary?

A. In most cases, the major indication for spine surgery is arm or neck pain. Weakness, numbness, clumsiness, and gait instability may also be an indication for surgery. Often nonsurgical measures can control the pain satisfactorily. If the pain persists and interferes with daily activities or if other neurologic problems develop, then surgery may be necessary to relieve the problem. In most cases, the patient makes the final decision about surgery because of pain. If neurologic damage is occurring, your doctors may strongly recommend that you proceed with the operation.

Q. How long will I be in the hospital?

A. For one-level fusions, the hospital stay is generally one day. Multi-level fusions may require two to three days.

Q. Will I need a blood transfusion?

A. Transfusions are rarely needed for this kind of surgery.

Q. What can I do after surgery?

A. Please refer to the Cervical Fusion Discharge Instructions for details. You should try to walk and take care of yourself as much as you are able. You should try to exercise (walk) each day; climb stairs

as needed. If a brace is not required, you may drive when allowed by your surgeon. Sleep on your back with pillows placed under knees or sleep on your side with pillows against your back. Use only one pillow under your head.

Q. What shouldn't I do after surgery?
A. You should avoid lifting heavy objects – no more than 5 pounds. Avoid all overhead lifting. Twisting, repetitive bending and tilting your head back to look overhead are also stressful to the neck. No driving while wearing a cervical collar or brace or taking narcotic pain medication or muscle relaxants. No sexual activity for two weeks and then when comfortable. If you are a smoker before surgery or are having a two or more level fusion, your surgeon may order a bone stimulator to assist in the healing process. If you are a smoker, you definitely should not smoke until your fusion is completely solid because it interferes with bone healing. It takes six to12 months for the fusion to heal. No baths, hot tubs or sauna for six weeks.

Q. Will I need to wear a neck brace?
A. Some patients will wear a type of neck brace after this surgery. The type of brace and length of time you need to wear the brace will be determined by your surgeon, IF NEEDED. For hard cervical collars, anticipate use for six weeks wearing at all times and may be removed for showering. Soft Cervical collars are worn for comfort only. You may remove them at any time and during showers.

Q. When can I go back to work?
A. That depends on the type of work you do. If a brace is required, you will not be able to drive until you no longer need the brace. For sedentary jobs, work may resume when you feel comfortable and when your surgeon releases your return to work. For jobs which require more strenuous physical exertion, a longer healing time may be required. Your surgeon will discuss this with you individually.

Q. What are the chances of being relieved of the pain?
A. 80-95 percent of the patients obtain relief from their arm pain. Relief of neck pain is less predictable.

Q. Will my neck be normal after surgery?
A. Most patients have excellent relief of arm pain after surgery, your neck may not be completely normal. While most patients with a one or two-level fusion will not notice significant loss of motion, the stiffened segment of your spine does put additional stresses on adjacent discs, which may already be abnormal to some extent. These other discs may cause symptoms. Although most patients can resume most of their normal activities after healing, you should take care of your neck. Your surgeon can discuss this with you in detail.

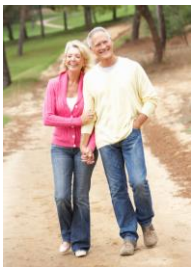
Q. What risks are there?
A. The risks of this operation include, but are not limited to, anesthesia, wound infection, bleeding, collection of blood clots in the wound or in the veins of the leg, pulmonary embolism (movement of a blood clot to the lungs) and heart attack. Death may rarely occur during or after any surgical procedure.

Q. Could I be paralyzed?
A. The chance of neurologic injury with spinal surgery is low, but not impossible. Injury to a nerve root with isolated numbness and/or weakness in the arm is possible.

Q. Could I have Difficulty Swallowing?
A. Most patients report mild discomfort with swallowing for a few days after surgery. Occasionally, swallowing difficulties may be more significant and last for longer periods of time. Rarely, it may be necessary to place a feeding tube while swallowing returns to normal. If swallowing difficulty persists longer, notify your physician.

Q. Will my voice be affected?
A. Some patients may be hoarse after anterior cervical spine surgery. Usually this goes away within a few days or weeks. Rarely, the hoarseness may be persistent for a longer period of time or even be permanent.

Q. Is the entire disk removed?
A. Yes.



Q. Could this happen to me again?
A. Unfortunately, yes. Similar conditions which led to the disc damage being treated now may have already started in one or more of the other discs, in your neck. A small percentage of fusions do not heal normally, which may require additional surgery. The chance of this happening increases if fusion is attempted at more than one level, which is why spine plates are sometimes used for multi-level fusions. Over 90 percent of patients do well. Less than 10 percent have some recurring problems.

Q. Should I avoid physical activity?
A. No. Exercise is good for you. You should get some sort of vigorous, low-impact aerobic exercise at least three times a week. Walking either outside or on a treadmill, using an exercise bike, and swimming are all examples of the type of exercise which is appropriate for spine patients once approved by your surgeon.

Q. Who performs this surgery?
A. Both Spine Fellowship trained Orthopedic Surgeons and Neurosurgeons are trained to do spinal surgery and both specialists may perform this surgery. It is important that your surgeon specialize in this type of procedure.

Frequently Asked Questions about Cervical Artificial Disk Replacement (Arthroplasty)

Q. What is wrong with my neck?
A. You have one or more damaged discs in your neck. Discs are rubbery shock absorbers between the vertebrae, and are close to the nerves which travel out to the arms. If the disc is damaged, part of it may bulge or even burst free into the spinal canal, putting pressure on the nerves and causing arm pain, numbness, weakness and/or pain in the neck or shoulder area. Occasionally, this pressure may affect the spinal cord and cause abnormalities in the legs or lower parts of the body. Bone spurs, usually the result of arthritis, can also put pressure on nerves or the spinal cord. Loss of the normal "shock absorber" function, or arthritis around the damaged disc, can also produce mechanical pain around the neck or shoulders with neck movement or awkward positions.

Q. What is required to fix the problem?
A. The best approach to your problem is to remove the damaged disc and any bone spurs from the front, or anterior part, of the neck and to perform a disk replacement. Certain conditions must be met for the surgeon to perform disc replacement.

Q. What is disk replacement?
A. The vertebrae are the blocks of bone which make up the bony part of the spine, much like a child's building blocks stacked on top of each other to make a tower. Normally each vertebra moves within certain limits in relationship to its neighbors. In spinal disease, the movement may become excessive and painful, or the vertebrae may become unstable and misaligned, putting pressure on the spinal nerves. In cases like this,

Q. How is the operation performed?
A. An incision, usually about one to two inches in length, is made across the front of the neck. The windpipe, esophagus (food pipe) and other tissues are temporarily pushed aside and the abnormal disc or discs are removed completely. The disk replacement implant is used to replace the disk sitting between the vertebrae.

Q. When is this operation necessary?
A. In most cases, the major indication for spine surgery is arm or neck pain. Weakness, numbness, clumsiness, and gait instability may also be an indication for surgery. Often nonsurgical measures can control the pain satisfactorily. If the pain persists and interferes with daily activities or if other neurologic problems develop, then surgery may be necessary to relieve the problem. In most cases, the patient makes the final decision about surgery because of pain. If neurologic damage is occurring, your doctors may strongly recommend that you proceed with the operation.

Q. How long will I be in the hospital?
A. For one level disk replacement, the hospital stay is generally one day. For a two level artificial disc replacement it may require a one to two day stay in the hospital.

Q. Will I need a blood transfusion?
A. Transfusions are rarely needed for this kind of surgery.

Q. What can I do after surgery?
A. Please refer to the Cervical Disk Replacement Discharge Instructions for details. You should try to walk and take care of yourself as much as you are able. You should try to exercise (walk) each day; climb stairs as needed. You may drive when allowed by your surgeon. Sleep on your back with pillows placed under knees or sleep on your side with pillows against your back. Use only one pillow under your head.

Q. What shouldn't I do after surgery?
A. You should avoid lifting heavy objects – no more than 10 pounds. Avoid all overhead lifting. No driving until allowed by your surgeon and you are not taking narcotic pain medication or muscle relaxants. No sexual activity for two weeks and then when comfortable. It takes six months for the implants to heal. No baths, hot tubs or sauna for six weeks.

Q. Will I need to wear a neck brace?
A. IF NEEDED, some patients will wear a type of neck brace, usually a soft collar for comfort only. The type of brace and length of time you need to wear the brace will be determined by your surgeon.

Q. When can I go back to work?
A. That depends on the type of work you do. For sedentary jobs, work may resume when you feel comfortable and when your surgeon releases your return to work. For jobs which require more strenuous physical exertion, a longer healing time may be required. Your surgeon will discuss this with you individually.

Q. What are the chances of being relieved of the pain?
A. 80-95 percent of the patients obtain relief from their arm pain. Relief of neck pain is less predictable.

Q. Will my neck be normal after surgery?
A. Most patients have excellent relief of arm pain after surgery. Although most patients can resume most of their normal activities after healing, you should take care of your neck. Your surgeon can discuss this with you in detail.

Q. What risks are there?
A. The risks of this operation include, but are not limited to, anesthesia, wound infection, bleeding, collection of blood clots in the wound or in the veins of the leg, pulmonary embolism (movement of a blood clot to the lungs) and heart attack. Death may rarely occur during or after any surgical procedure.

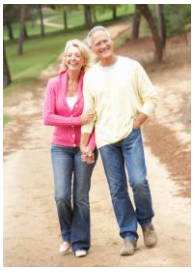
Q. Could I be paralyzed?
A. The chance of neurologic injury with spinal surgery is low, but not impossible. Injury to a nerve root with isolated numbness and/or weakness in the arm is possible.

Q. Could I have Difficulty Swallowing?
A. Most patients report mild discomfort with swallowing for a few days after surgery. Occasionally, swallowing difficulties may be more significant and last for longer periods of time. Rarely, it may be necessary to place a feeding tube while swallowing returns to normal. If swallowing difficulty persists longer, notify your physician.

Q. Will my voice be affected?
A. Some patients may be hoarse after anterior cervical spine surgery. Usually this goes away within a few days or weeks. Rarely, the hoarseness may be persistent for a longer period of time or even be permanent.

Q. Is the entire disk removed?
A. Yes.

Q. Could this happen to me again?
A. Unfortunately, yes. Similar conditions which led to the disc damage being treated now may have already started in one or more of the other discs, in your neck. A small percentage of artificial disc replacements do not heal normally,



which may require additional surgery. Over 90 percent of patients do well. Less than 10 percent have some recurring problems.

Q. Should I avoid physical activity?
A. No. Exercise is good for you. You should get some sort of vigorous, low-impact aerobic exercise at least three times a week. Walking either outside or on a treadmill, using an exercise bike, and swimming are all examples of the type of exercise which is appropriate for spine patients once approved by your surgeon.

Q. Who performs this surgery?
A. Both Spine Fellowship trained Orthopedic Surgeons and Neurosurgeons are trained to do spinal surgery and both specialists may perform this surgery. It is important that your surgeon specialize in this type of procedure.

Role of the Care Coordinator

The Care Coordinator is a nurse at the hospital who coordinates the care of each patient undergoing spine surgery. The Care Coordinator is available to answer any questions you may have about your surgery or the recovery process.

The Care Coordinator at **Edward Hospital** can be reached between the hours of 8 am - 4 pm Monday – Friday at (630) 527-3680.

The care coordinator will:

- Answer questions and direct you to specific resources within the hospital
- Answer questions and coordinate your hospital care with spine team members
- Act as your liaison throughout the course of treatment
- Assist to conduct a pre-operative class for patients undergoing spine surgery

Pre-op Spine Class
This class is ideally suited for patients who are undergoing multi-level cervical fusion or anterior/posterior cervical fusion as these surgeries generally require a longer hospital stay. However, all spine surgery patients are encouraged to attend. We encourage you to choose a coach to attend with you. See Appendix for class schedule and location.

Please bring your Coach and Guidebook with you to class

Section Two:

Pre-operative Preparation

Remember, this is just a guide. Your physician, physician assistant, nurse, or therapist may add to or change any of the recommendations. Always use their recommendations first and ask questions if you are unsure of any information. Keep your Guidebook as a handy reference for at least the first year after your surgery.

Start Pre-operative Exercises

Just as exercise is important in the rehabilitation process following spine surgery, it is important that you participate in a pre-operative exercise program as able. Exercising before surgery can help you build up the necessary strength and endurance for a more optimal recovery from spine surgery. To enhance your recovery from this surgery, try to incorporate aerobic exercise (walking, water aerobics and recumbent bicycle) into your daily routine. Our past patients have mentioned just how helpful it was to take the time to "strengthen" the muscles in their arms and legs prior to coming in for surgery.

NOTE: *Always consult your physician for any exercise restrictions.*

Four Weeks before Surgery

Contact Your Insurance Company

Before surgery, you will need to contact your insurance company. From them, you will need to find out if pre-authorization, pre-certification, a second opinion or a referral form (all HMO require) is required. It is very important to make this call, as failure to clarify these questions may result in a reduction of benefits or delay of surgery. This is especially important if your spine problem is due to an injury at work.

Billing for Service

After your procedure, you will receive separate bills from the anesthesiologist, the hospital and if applicable the surgical assistant, the radiology and pathology departments. If your insurance carrier has specific requirements regarding participation status, please contact your carrier.

Two to Three Weeks before Surgery

Pre-Admission Nursing Assessment

For Edward Hospital: After your surgery has been scheduled, a nurse from Pre-Admission Testing (PAT) will call you to schedule your Pre-Admission Nursing Assessment (which is completed over the phone.) If we are unable to reach you and leave a message, please call PAT as soon as possible. Leave a message with a good time frame you would be available if we are not able to directly answer your call.

For Elmhurst Hospital: The Pre-Admission Testing (PAT) department will contact you to complete your pre-admission assessment by phone.

For your pre-admission assessment, you will need to have the following:

- Patient's full legal name and address, including county
- Home phone number and secure phone number to leave a message
- Marital status
- Social Security number
- Name of insurance holder, his or her address and phone number and his or her work address and work phone number
- Name of insurance company, mailing address, policy and group number
- Patient's employer, address, phone number and occupation
- Name, address and phone number of nearest relative
- Name, address and phone number of someone to notify in case of emergency. This can be the same as the nearest relative.
- Height and weight
- Medical and surgical history
- List of all medications (prescribed, OTC, vitamins, supplements, herbals) or have all bottles in front of you
- Calendar to schedule Pre-op testing, and Pre-op class

Obtain Medical and Anesthesia Clearance

When you were scheduled for surgery you should have received a medical clearance letter from your surgeon. This will tell you whether you need to see your primary-care physician and/or a specialist. You may get additional instructions from PAT directed by anesthesia requirements. Please follow the instructions.

Obtain Laboratory Tests

When you were scheduled for surgery, you should have received a laboratory-testing letter from your surgeon. Follow these instructions. Your primary care physician or specialist, along with PAT directed by Anesthesia, may order additional testing. PAT will set up the lab and X-ray testing appointments with you. If you have an HMO, you will need to contact your PCP and insurance on where to complete this testing and set up your appointments.

Review "Exercise Your Right"

The law requires that everyone being admitted to a medical facility have the opportunity to complete advance directives forms concerning future decisions regarding your medical care. To review information about Advance Directives or to find out how to get the necessary forms, please refer to the Appendix. Although Advance Directives are not required for hospital admission, we encourage

you to consider completing the forms for the directives you desire. If you do have advance directives, please bring copies to the hospital on the day of surgery.

Become Smoke Free

If you are a smoker, you should stop using tobacco products. The tar, nicotine and carbon monoxide found in tobacco products have serious adverse effects on your blood vessels and thus impair the healing of wounds and bone grafts. In addition, continued tobacco use damages the other discs in your spine, leading to disease at other levels. Finally, we have found that smokers experience a greater degree of pain than do non-smokers. Please read information about Smoking Cessation in the Appendix.

Read "Anesthesia and You" (Appendix)

Spinal surgery does require the use of general anesthesia. Please review "Anesthesia and You" (see Appendix) provided by our anesthesia department. If you have questions or want to request a particular anesthesiologist, please contact your surgeon's office.

Two weeks before Surgery

Medications to stop

Stop all herbals (such as Fish Oil), vitamins (especially E, and K) and appetite suppressants. (See List in Appendix.) Discuss NSAIDS, anticoagulants and anti-platelet medications (blood thinners). See list in Appendix. These may need to stop at this time or later as determined by your surgeon and prescribing physician.

Ten Days before Surgery

Pre-operative Visit to Surgeon

You should have an appointment in your surgeon's office one to two weeks prior to your surgery. This will serve as a final check-up and a time to ask any questions you might have. Some patients with acute disc herniations may have a shorter time between the visit and surgery.

At this time you should schedule your two week and six-week post-op visits with your surgeon, and a one week follow up visit with your Primary Care Physician.

Stop Medications that Increase Bleeding

- Ten days before surgery, stop all medications containing aspirin and anti-inflammatory medications, such as aspirin, Motrin, Naproxen, etc. (See List in Appendix). These medications may cause increased bleeding.

- If you are on blood thinners such as Coumadin, Xarelto, Plavix, Pradaxa, Effient, etc. (See List in Appendix) you will need special instructions on stopping this medication. Please contact the prescribing physician for these instructions AFTER DISCUSSING WITH YOUR SURGEON.

Planning Ahead to Ease Transition Back Home

Home

- De-clutter your home. Temporarily put away area rugs that may be a tripping hazard.
- Shop ahead! Have frozen dinners available to pop into the microwave and paper plates to limit washing. Also have plenty of liquids available. Pain medications can give you a very dry mouth.
- Complete needed yard work and mowing or arrange to have this done for you.
- Arrange for neighbors/family to collect mail and newspapers for a few days.
- Change your bed and have fresh linens prepared beginning with the night before your surgery.
- Strategically place nightlights in bedrooms, hallways and bathrooms you may need to access at night.
- Place essential and frequently used items at counter level in the kitchen. This may mean taking out the items from the lower or very upper cabinets out and storing them on the counter temporarily.
- Have current bills paid so you do not have to worry about these immediately after the surgery.
- Arrange for a ride home from the hospital.
- Have support lined up, especially if you live alone. Arrange for friends to call on certain days or stop by and make sure you don't need any extra assistance.
- No special chair is needed, but you want one that offers you support and comfort. One with side arms is best.

Pets

- Have help for the first few days to keep food and water available for pets.
- Have a dog walker planned for the first week at least. You will not want to chance losing your balance or being jerked by your excited canine friend!
- If you have cats, have the litter box up on a high table or counter so you don't have to bend down to clean it.

Points of Comfort

- You may want to bring extra pillows for the ride home to maximize your comfort.
- Bring comfortable, loose clothing to wear in the hospital and going home

Five Days before Surgery

Chlorhexidine Bathing

If your surgeon has instructed you to use Chlorhexidine (Hibiclens or Betasept) soap, please follow the instructions as provided. If you have not received this soap, please take a good "scrubbing" shower the evening before the surgery with a new bar of regular soap. Be sure to pay special attention to skin folds and area for surgery. Sleep on clean sheets and use clean clothing after bathing.

One to Two Days before Surgery

Find Out Your Arrival Time at the Hospital

The hospital will call you one to two days before surgery, or on Friday after 1 p.m., if your surgery is on Monday, to let you know what time your procedure is scheduled. We do not make these calls on the weekend. You will be asked to come to the hospital two hours before the scheduled surgery time to give the nursing staff sufficient time to start IVs, verify your information, complete any last minute testing, prepare the surgical site and answer questions. It is important to arrive on time because sometimes the surgical time is moved up at the last minute and your surgery could start earlier. If you are late, your surgery could be moved to a much later time.

The Night before Surgery

NPO - Do Not Eat or Drink

- Do not eat or drink anything, EVEN WATER, after 11PM unless otherwise instructed to do so.
- If you must take medication the morning of surgery, do so with a small sip of water.
- You may brush your teeth, rinse and spit.

SPECIAL INSTRUCTIONS:

You will be instructed by your physician and prescribing physician on diabetic medications, blood pressure or heart medications to take or omit the morning of surgery. PAT will also review this as advised by your physician and Anesthesia requirements for surgery.

What to Bring to the Hospital

- Patient Guidebook
- Advance directives and living will
- Insurance card and co-pay (if applicable)
- Personal hygiene items (toothbrush, powder, deodorant, razor, etc.)
- Shorts, tops, warm up suits and sweatpants, well-fitting slippers or flat shoes/gym shoes
- Loose-fitting warm-up suit for the ride home
- For safety reasons do NOT bring electrical items; battery-operated items are allowed
- A favorite pillow with a pillowcase in a pattern or color so it will not end up in the hospital laundry
- Any braces for your neck IF ORDERED
- Cane or walker if you already have one - have a family member bring these to the hospital room the day after surgery for proper adjustment, IF NEEDED
- Leave valuables at home
- No jewelry, make-up, or adhesives on dentures day of surgery

Section Three:

Hospital Care

Day of Surgery

Arrival

For Edward Hospital: Drive to the South parking garage. Free Valet parking is available during business hours. If you self-park, take the elevator from the garage to the first floor to enter the main hospital lobby. Wheelchairs are available if needed. Take the D elevator to the 2nd floor. Proceed to the Surgical and Endoscopy Check-In Desk. Here you and your family will be checked in and escorted to the Peri-op Area to be prepared for surgery. Up to two family members may wait with you until you are taken to surgery. Your family may then wait in the Surgical Waiting room until notified by the surgeon that the surgery has been completed. A receptionist will take down contact information so that your family may be easily reached to speak with the surgeon. Complimentary coffee is available for your family while in the Surgical Waiting room.

The cafeteria and gift shop are on the ground floor in the North area of the hospital and the coffee shop is in the South area of the hospital for your family's convenience

For Elmhurst Hospital: Park in the blue or green color-coded parking lots. Enter the hospital through the Main Entrance. Wheelchairs are available if needed. You will proceed to the main elevators that will take you to the Interventional Platform. Turn left when you get off the elevators and head to the Surgery Reception Desk. Here you and your family will be checked in and escorted to a preoperative room to be prepared for surgery. Up to two family members may wait with you until you are taken to surgery. Your family may then wait in the Surgical Waiting area until notified by the surgeon that the surgery has been completed. A volunteer will take down contact information so that your family may be easily reached when it's time to speak with the surgeon. Your family will be given a gift card for a complimentary coffee in the Wildflower Café. The Café, Starbucks, Walgreens, Wild Rose Floral & Gifts, and the Resource Center are located on the first floor.

What to Expect

In the preoperative room, you will be prepared for surgery. The team will be checking your vital signs, starting your IV, validating your medications, health history, lab results and any follow up for additional testing needed. At this time, they will obtain your consent for surgery and answer any questions you may still have. Your anesthesiologist and surgeon will see you and your family prior to your surgery. The surgeon will mark your surgical site. You will be escorted to the operating room by cart. Your family can wait in the surgical waiting room. Following surgery you will be taken to the Post Anesthesia Care Unit (PACU) where you will recover for approximately an hour. During this time, pain and nausea control will be established and your vital signs will be monitored frequently.

You will then be taken to the Spine Unit where our specialized staff will care for you. Friends and family can see you at this time.

For the rest of this day, you will begin with liquids advancing to soft foods. We encourage you to drink plenty of water. We will instruct you on breathing exercises, benefits of early ambulation, ankle pumps, compression stockings, and sequential compression devices (SCD's). Our staff will **assist** you out of bed to the chair or walking in the hallway. Initially, your pain will be managed with oral and IV medication. When able, the nurse will transition you to oral pain medication. There will be a dressing over your neck incision. You may have a catheter to your bladder that will be removed as soon as you are able to walk.

Post-op Routine through Discharge

An X-ray will be taken of your cervical spine after surgery. Your physician may have this done in surgery, in recovery, or on the Spine unit.

Each day starts with blood work obtained early in the morning with your vital signs. If your surgeon has ordered to have a Primary Care physician for your medical management additionally while you are in the hospital, a hospitalist may see you. A hospitalist is a physician who only sees patients while they are in the hospital. Most Primary Care physicians do not see their own patients while in the hospital anymore-hospitalists are used instead. If your physician does still see his or her own patients while in the hospital, then that will be the person contacted if ordered by your surgeon.

Understanding Pain Management

We realize that you will have some discomfort after your operation. It is our aim to make you as comfortable as possible after surgery. There are several factors that limit our ability to completely eliminate pain after surgery. The first is that pain medications have side effects. These include respiratory depression (decreased ability to breathe normally), hypotension (low blood pressure), nausea and constipation. Other less common side effects include itching, urinary retention (inability to urinate), and abdominal distention (collection of gas within the intestines). These side effects mean that the amount of medication will have to be reduced at times, to avoid creating dangerous or uncomfortable conditions. Another factor is tolerance. This is the body's tendency to become less responsive to the pain-reducing action of narcotics after being exposed to them for periods of time. In other words, your body can become used to having these drugs. Unfortunately, the side effects can still be present. Patients who have taken large doses of narcotics for months or years have a much harder time keeping comfortable after surgery. For this reason, it is **very important for you to provide accurate information to your surgeon about the amount of pain medication you have been taking. Inaccurate information could result in a**

needlessly painful and stressful post-operative course. It may be necessary to taper or discontinue your use of narcotics prior to surgery.

It is important that patients taking Suboxone for chronic maintenance therapy inform their prescribing physician about their upcoming surgery. The physician who prescribed Suboxone can assist in modifying your maintenance therapy before surgery and provide advice on your pain management plan after surgery.

Once you have had your surgery, we will rely heavily on your own assessment of your pain, and work with you to relieve it. We will ask you to rate your pain on a scale of 1 – 10 with 10 being the highest pain imaginable. We will ask you this frequently. Most patients will receive oral pain medications along with intermittent low-doses of pain medication into their IV, which they either control with a small pump called a PCA (patient controlled analgesia) OR they will receive IV pain medication administered by a nurse for breakthrough pain. Generally, these oral pain medications are the same medications you will take at home once you are discharged from the hospital. Muscle relaxants may also be used to decrease muscle spasms. Throughout your hospital stay, your surgeon and your bedside nurses will assess your physical condition and look for signs of pain and side effects. Pain Service physicians and APN's are available when needed and consulted to help optimize your treatment program. Using this approach, most of our patients have very satisfactory pain control after surgery.

Discharge Plans and Expectations

The plan for your discharge begins with your decision to have surgery. Our goal is for you to optimize your recovery in the comfort of your own home.

You will be admitted to the hospital on the day of your surgery. The average hospital length of stay for spine surgical patients is 1 to 3 days. As early as the day of surgery, you will start physical therapy in the hospital. These sessions will help you prepare for discharge and your journey to wellness. Prior to discharge, patients should be ambulating and using the bathroom independently (with a walker IF NEEDED), eating and drinking well, and taking oral medication to control discomfort. If equipment (rolling walker) is needed, the Physical Therapist may assist you in obtaining one while in the hospital. We suggest that you have someone who can be your caregiver for the first two to three days at home. This can be a friend or family member who can change your dressing and help you with your compression stockings. This caregiver will also help out with meals and household activities.

You need to discuss your discharge options with your doctor and family PRIOR to your surgery. A representative from Case Management and nursing staff will collaborate with your surgeon for the

most appropriate discharge plan. While most patients go directly home, sometimes the services of home physical therapy or a sub-acute rehabilitation facility are needed. If so, the Social Worker will make these referrals for you and discuss them with you.

Patients who need to be discharged to sub-acute rehabilitation center prior to returning home must meet their insurance company's specific criteria before approval can be granted. If you do not meet these criteria, but strongly wish to pursue a sub-acute rehabilitation center, you have the option to pay privately for your stay. If you anticipate discharge to a rehab facility, it is strongly recommended to tour facilities prior to surgery, having a choice in mind to provide to the Social Worker at time of surgery.

Our team will also assist you in arranging the appropriate transportation (Medivan vs. ambulance) based on your needs. There is an out of pocket fee for transportation. You can discuss this further with the Social Worker.

Edward Hospital: The Orthopedic/Spine Case Manager or Social Worker can be reached at (630) 527-3569.

Elmhurst Hospital: The Case Management Department can be reached at (331) 221-1146.

Section Four:

Post-operative Care

Caring for Yourself at Home

When you go home there are several things you need to know to ensure your safety, steady recovery and comfort.

Control Your Discomfort

1.) Medication Management

- Take your pain medicine as prescribed especially at least 30 minutes before activity to control incisional pain.
- As your pain lessens gradually wean yourself from prescription medication to Tylenol.
- During the first three months after surgery (if you had cervical fusion), do not take over the counter anti-inflammatory (NSAIDS) medication such as Ibuprofen, Motrin, Advil, Aleve, etc. – See List in Appendix. This type of medication can interfere with bone healing and thus jeopardize the success of your surgery. If you have prescription non-steroidal anti-inflammatory (NSAIDS) medication at home, consult your surgeon before taking these or over-the counter non-steroidal anti-inflammatory medications (NSAIDS.)

2.) Use of Ice/Heat

- Use ice for pain control. Applying ice to your wound will decrease discomfort. Do not use ice for more than 30 minutes at a time each hour; do not place directly on skin.
- Apply heat to areas of muscle spasm only. **Do not use** heat around your incision; this will cause swelling.

3.) Positioning

- Change your position every 45 minutes throughout the day.
- Muscle strain and spasm can often be reduced by elevating the arms with pillows. Using positioning techniques along with pain medication will optimize your comfort. See Section 5 for pictures.

4.) Muscle Spasm

- If your doctor has prescribed a muscle relaxer, take this as needed to help relieve muscle spasms.
- Gentle stretching may ease muscle spasm. The idea is to “lengthen” the muscle that is in spasm. Remember to avoid the B.L.T.’s.(BENDING, LIFTING, TWISTING)
- Gentle massage applied to the muscle spasm may help to reduce discomfort.

5.) Breathing

- Take slow, controlled, deep breaths. Cough deeply and use your incentive spirometer (I.S.) several times each hour. This helps to expand your lungs after surgery and prevent pneumonia or respiratory complications. Deep breathing can also assist in relaxing your muscles and body. Breathing and relaxing while you move will help reduce muscle tension.

Body Changes

- Your appetite will be poor at first. Drink plenty of fluids to prevent dehydration and constipation. Your desire for solid food will return. Increase roughage with fresh fruits and vegetables and whole grains.
- You may have difficulty sleeping at night. This is not abnormal. Don't sleep or nap too much during the day.
- Your energy level will be decreased for the first month.
- Pain medications contain narcotics, which promote constipation. Use stool softeners like Colace while using narcotics. Add mild laxatives such as Milk of Magnesia, Senakot, or Miralax if necessary. Do not let constipation continue. If the stool softener or laxative does not relieve your discomfort, contact your pharmacist, family doctor, or surgeon for advice.

Caring for Your Incision

- Keep incision clean and dry at all times
- **Change dressing daily unless instructed differently**
- If allowed by your surgeon, you may shower (not tub bathe) once there is no drainage from the incision. Drainage usually stops within 3-4 days after surgery.
- Keep dressing in place while showering and cover with plastic to keep incision dry during shower.
- Position yourself so your incision faces away from the showerhead.
- After showering, remove old dressing, pat incision dry, and replace dressing as instructed.
- Do not use lotions or ointments on incision.
- No tub baths, hot tubs or saunas for 6 weeks
- Notify your surgeon if there is clear or increased drainage, redness, pain, odor or heat around the incision.
- Take your temperature twice a day; notify surgeon for a temperature above 101

Signs of Infection

- Increased swelling, redness at incision site
- Change in color, amount, and odor of drainage
- Increased pain around the incision
- Fever greater than 101 degrees

Prevention of Infection

- Take proper care of your incision as explained above.
- Keep incision clean and dry; sponge bathe until able to shower.
- No baths, hot tubs, or saunas for six weeks post op
- Good hand washing by visitors and yourself
- Clean bed linens and clothing
- Avoid people with colds and flu

Dressing Change Procedure

(Varies with surgeon)

This procedure is the same for the neck and hip bone graft incision

Dry Gauze Dressing

1. Wash hands.
2. Prepare all dressing change materials (open gauze pad and tape).
3. Remove old dressing.
4. Inspect incision for the following:
   - increased redness or swelling
   - increase in clear drainage
   - any yellow/green drainage
   - odor
   - surrounding skin is hot to touch
   - opening up of incision
5. Pick up gauze pad by one corner and lay over incision. Be careful not to touch the inside of the dressing that will lay over the incision.
6. Place the dressing over the incision and tape it in place.
7. Wash hands
8. No lotions or ointments to incision

Other Types of Dressing

Some types of dressings are only to be changed seven to 14 days after surgery.
Your nurse will instruct you on this if this is the case.

Skin glue

IF the incision has been treated with skin glue, please follow these instructions:

- If dressing remains dry, remove dressing on the second day after surgery. Carefully try to lift gauze from the incision. If the gauze adheres to the incision, do not pull it loose. Just trim away the loosened gauze as needed. After a few days the gauze should come free.
- If dressing becomes wet with a collection of fluid or blood, remove promptly and follow the dressing change instructions for "gauze dressing." Change dressing daily and as needed until incision remains dry.

Compression Stockings (TED Hose)

You may be asked to wear compression stockings while in the hospital. These stockings are used to help compress the veins and decrease the chance of blood clots. If ordered by your surgeon you will wear the stockings most of the day, taking them off for a few hours in the morning. You will continue to wear these stockings (if ordered) for two weeks after surgery until seen by your surgeon at your first post-op visit. If you have received other instructions from your surgeon, please follow those. Continue to wear your compression stockings until your doctor tells you to stop. They may be washed with gentle soap and air dried.
A home sequential compression device (SCD) may be ordered for use at home for the first two weeks after surgery when a patient is sedentary.

Blood Clots in Legs

Surgery may cause the flow of blood to slow and clot in the veins of your legs. If a clot develops, you may need to be admitted to the hospital to receive intravenous blood thinners. Prompt treatment usually prevents the more serious complication of pulmonary embolus. Moving around throughout the day, especially walking will reduce the chance of a blood clot.

Signs of Blood Clots in Legs

- Swelling in thigh, calf or ankle that does not go down with elevation of the legs
- Pain, tenderness in calf

These signs are not 100 percent certain, but are warnings. If they are present, promptly notify your surgeon.

Prevention of Blood Clots

- Frequent foot and ankle pumps
- Walking
- Compression stockings
- Elevating your feet/legs
- Home Sequential Compression Device (SCD)

Pulmonary Embolism

An unrecognized blood clot could break off in the vein and go to the lungs. ***This is an emergency and you should call 911 if suspected.***

Signs of an Embolism

- Sudden chest pain
- Difficult and/or rapid breathing
- Shortness of breath or anxiety with breathing
- Sweating
- Confusion

Prevention of Embolism

- Prevent blood clot in legs
- Walk and use your compression stockings as directed
- Recognize a blood clot in leg and call physician promptly

Section Five:

Post-operative Activity Guidelines

Remember, this is just a guide. Your physician, physician assistant, nurses, or therapist may add to or change any of the recommendations. Always use their recommendations first and ask questions if you are unsure of any information. Keep your Guidebook as a handy reference for at least the first year after your surgery.

Cervical Spinal Precautions: No "B.L.T."

Cervical Spine Precautions: No "B.L.T."

Check with surgeon or physical therapist for specific pre-operative precautions. General guidelines include:

No Bending

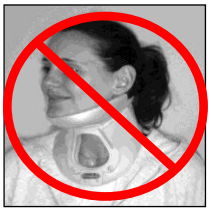
- Keep head straight and facing forward. Do not tilt head side-to-side, forward, or backward.
- Practice optimal body mechanics by keeping chest up, shoulders back, and abdominal muscles tight. This helps maintain neutral spine position and reduces stress on spine.

No Lifting

- Do not lift more than 5 pounds for one to two months after surgery.
- To lift an object, keep chest upright, bend at knees and hips, and hold object close to body.

No Twisting

- Keep ears and hips pointing in the same direction.
- To look behind you or to either side, turn entire body. Do not just turn your head.



Bed Positioning

Lying on Your Back

- Place a pillow under your knees or thighs, under your neck, and under your arms. This positioning reduces stress on your spine. You may also try a towel roll under your neck for support when lying flat on your back.
- When you change positions, tighten your abdominal muscles and log roll, keeping your hips, shoulders, and ears lined up together.

ADDITIONAL NOTES: To place a pillow behind your head, make sure it is supporting both your shoulders and head. Avoid large pillows as they can push your head and neck forward. The goal is to choose a pillow that will keep your neck straight, not bent forward, backward or to the side. Wear your cervical brace, if ordered, for support as directed by your doctor.

Lying on Your Side

- With your knees slightly bent up toward your chest, place a pillow between your knees and one under your neck.
- Remember to tighten the abdominal muscles and log roll when changing positions.
- Adding a pillow under your arm will also reduce stress on your neck and spine.

Lying on Your Stomach

- Avoid Sleeping on your stomach as this can strain your neck and back.

Transfers and Mobility

Getting Out of Bed

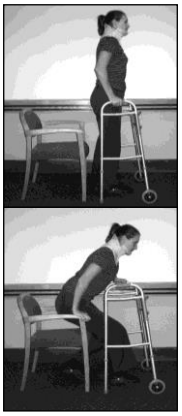
To move in and out of bed, "log roll" to prevent bending or twisting of spine. Start by bending knees up while lying on back. Now roll onto side keeping hips, shoulders, and ears moving together to avoid twisting (i.e., roll like a log).

As you slide feet off bed, use arms to push up into sitting position. Scoot hips forward until feet are on floor and you feel stable. Using arms to help scoot typically helps minimize surgical pain. Scoot far enough forward so feet are flat on floor (heels included) to support lower back.

Returning to Bed

Reverse technique for returning to bed. Back up to bed until you feel bed at back of legs. Reach for bed with hands as you lower to sitting position on bed. Scoot hips back on bed. Further back you scoot; the easier it will be to lie down on your side. As you lean down on arm, bring feet up onto bed until you are lying down on side. Then, roll onto back keeping shoulders, hips and ears in alignment.

Getting Into a Chair



Back up to chair until it touches back of legs. With hands, reach behind to grasp armrests of chair. Using arms and legs, squat and lower yourself into chair.

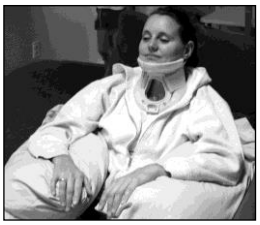
Special Instructions:

- Tighten stomach muscles to provide support for lower spine.
- Feet should be firmly resting on floor or foot stool. Do not let feet dangle as this will place additional stress on spine.

Getting Out of a Chair

Scoot forward until you are sitting near edge of chair. With hands on armrests push yourself up into standing position. Straighten legs and shift weight forward over feet. Bring hands to walker as you are moving into standing position.

Sitting Posture



Many patients choose to sleep in recliner chair for few days after neck surgery. Adjustable back position of recliner offers comfortable upright positioning for head and neck, as well as armrests that support arms. May be easier to stand up from chair instead of bed.

Position of Comfort

Immediately after surgery, patients complain of neck and shoulder pain and have trouble finding a comfortable resting position. Placing pillows under forearms and elbows may help to reduce pull on neck and shoulder muscles while sitting in recliner or lying in bed. Therapist may suggest gel ice-packs over shoulder muscles to reduce soreness.

Helpful Tips with Sitting

- Do not let your feet dangle when sitting. Have your feet firmly supported to prevent pulling at your back. You may use a pillow behind your back to keep you more forward in the chair, allowing your feet to touch and be supported by the floor.
- Protect your back by sitting in a chair with a back support. You can use a pillow or a towel as a lumbar roll.

Getting Into the Car

Back up to car seat until you feel it at back of legs. Reach hand behind you for back of seat and the other hand to secure spot either on frame or dashboard. (Door and walker are not secure options. If you need to use them, have someone hold the “unsteady” objects.) Lower slowly to sitting. Scoot hips back until you are securely on seat.

Leading with hips, bring one foot into car at a time until you are facing forward. Prevent twisting by keeping shoulders, hips, and ears pointing in same direction. May want to recline seat to increase ease of lifting legs. Keep seat slightly reclined while riding to support back from “bumps” in road.


Getting Out of the Car

When getting out of car bring legs out one at a time. Lead with hips and shoulders and do not twist back. Place one hand on back of seat and one hand on frame or dashboard. Push up to standing. Reach for walker when you are stable.

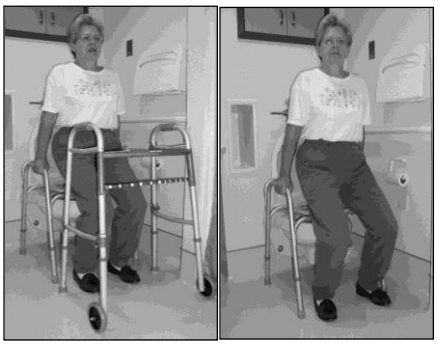
Helpful tips with car transfers:

- Have empty plastic bag on seat to help slide in/out.
- Have seat positioned all way back so you have maximum leg clearance.
- If you have to have one hand on walker for leverage, have someone hold walker down on front bar for stability.

Your surgeon will determine when you can return to driving. You need to have full neurologic function and minimal pain or discomfort before driving. You also need to discontinue taking medications that may affect your driving skills and safety.

Getting Onto the Commode

Back up to commode like you would chair. Without twisting to look, reach back for handles of commode or toilet seat and squat using arms to help slowly lower down to sitting position. Feet should be flat on floor for support while sitting.



Getting Off of the Commode

Use arms to lift body and scoot hips forward to edge of commode seat. With knees bent and feet placed underneath you, push up through legs and arms into standing position. As you stand, maintain support by reaching for walker one hand at a time.

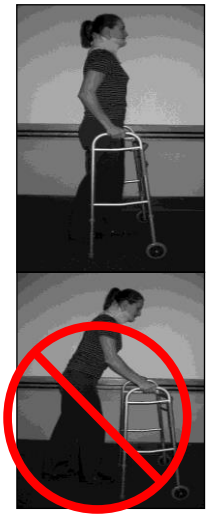
Bathing

Stepping in/out of tub:

- If shower is part of tub, hold onto front wall of shower and step in or out sideways versus stepping in forward. This side-step places much less stress and motion on lower spine.
- If a walk-in shower stall, step in as usual making sure not to twist as you turn to controls.
- May want to have a bathtub or shower seat available for first few days you shower. Borrow these items or buy them inexpensively. Small patio resin/plastic chair work for this. Small tub/shower benches can be purchased at most drug stores or medical supply stores.
- Your surgeon will provide clearance on taking a tub bath or swimming. Generally, these may not be resumed for at least six weeks following surgery.

Using a Walker

When using a walker, it is important to remember key rules.



- Push up from surface you are sitting on (e.g., bed or chair). Avoid pulling on walker to stand. Walker could easily tip backward and will not offer optimal support to stand.
- Easiest to stand up from chairs with armrests and from bedside commode with armrests. Armrests give better leverage and control to stand up and sit down safely.
- Walker takes pressure off your back. Push down through walker with arms as needed without raising shoulders or leaning too far forward.
- Keep feet near back of walker frame or rear legs. Don't be too close or too far from walker. Stay inside walker.
- Stand up straight when walking. Keep shoulders back, head up, chest up, and stomach muscles tight.
- If wheels on walker, no need to lift walker - just push walker forward as you walk or turn
- Each day increase frequency and distance. Go at own pace. Frequent walks are very important to keep you moving and decrease stiffness and pain. By six weeks, goal is to walk three miles unless otherwise instructed by physician or therapist.
- Taking smaller steps and walking slower does not necessarily make it easier to walk. May end up expending more energy than necessary. Move at own pace and comfort level.

Using Stairs

Negotiating Consecutive Steps

- Use handrail and/or cane for assistance.
- If one leg feels weaker than other, go up steps with stronger leg first and down steps with weaker leg first. Remember, "up with the good and down with the bad."
- If unsteady, take one step at time. This will make negotiating steps easier and safer.
- Concentrate on what you are doing. Do not hurry.
- Since you cannot bend neck to look down, feel step with feet.
- Have someone assist or spot you as you feel necessary or indicated by therapist. Person should stand behind and slightly to side when going up steps. When going down steps, person should be in front.

Helpful Stair Tips

- Keep steps clear of objects or loose items.
- Plan ahead. Right after surgery keep items in areas where you can limit stair use.
- Install one or two handrails. Two handrails will increase ease and safety with steps.

Negotiating Curb or One Single Platform Step

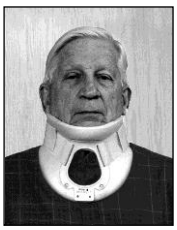
- Use rolling walker.
- Move close to step.
- Place entire walker over curb onto sidewalk. Make sure all four prongs/wheels are on curb.
- Push down through walker toward ground.
- Step up with stronger leg first, then follow with other leg.
- Reverse process for going down stairs. Place walker below step, then step down leading with weak leg first.

Neck Brace

Soft Collar

Least restrictive and least supportive of all cervical braces is the soft collar. Patients may be instructed to wear the soft collar at all times or only when out of bed. Soft collar is simple to put on and only requires fastening Velcro® strap at back of the neck. Chin should rest at a small divot in front of collar. Careful not to turn head side-to-side in this brace as it will not prevent you from performing this motion.

Philadelphia Cervical Collar®



A slightly more supportive brace is the Philadelphia® collar also referred to as the “Philly® collar.” This brace is made out of foam and has a rigid plastic support at the neck. The chin trough prevents you from turning head side-to-side. Some people call this your ‘shower brace’ because it is made of non-absorbing foam and can get wet (the straps will become wet, but can air dry). Collar is designed to give support and prevent motion that may be detrimental to healing or surgery. If you are told to wear this collar out of bed, please do so. The Philly® collar fastens on side with back portion sliding inside of front portion so Velcro straps can be fastened securely.

Miami J Collar®

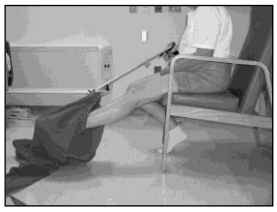
The Miami J Collar® is another firm brace that is sometimes used after surgery or after neck trauma to prevent motion and provide support. It is made of plastic with soft foam pads that Velcro to the plastic. The foam pads can be removed to launder and air dry. Chin should rest on chin trough at front and center of collar. Back portion should slide inside front and then the straps should be fastened securely. An orthotist, surgeon or therapist should make sure this brace is adjusted correctly to your size.

Aspen Collar®

The Aspen Collar® is a firm brace that is sometimes used after surgery or neck trauma for effective motion restriction. It spreads support across broad contact surfaces. This brace is made of plastic with soft foam pads that Velcro® to the plastic. The foam pads remove easily to hand wash and air dry. At the front and center of collar, the chin should rest on the chin trough. The back portion should rest outside the front and then fasten the straps securely.

Personal Care

Using a Reacher



Using a reacher limits amount of bending required to dress. Sit down in a chair with back supported. Use reacher to hold front of undergarments or pants. Bring garment over one foot at a time pulling underwear, then pants up to thighs. Stand up, squat to reach clothing and pull up both garments at same time. Reverse process to remove your clothing.

Using a Reacher to Pick Up Items

A reacher helps you obtain those items that fall while you are under "no bending" restrictions. Use it as an arm extension to reach to floor.

Using a Sock Aid

Sock aid helps you reach feet without bending. Sit supported in chair and hold sock aid between knees. Slide sock onto plastic cuff making sure to pull toes of sock all the way onto sock aid. Hold ropes and drop sock aid down to foot. Place foot into cuff and pull up on ropes as you point toes down until sock is on foot. Let go of one rope and pull cuff back onto your lap to don other sock.

Removing a Sock with the Reacher

Use black hook on reacher to push sock over back of heel. You continue pushing sock completely off foot or use jaw of reacher to pull sock completely off foot.

Note: *If you are able to raise your leg up to reach your feet while maintaining a neutral spine position, you will not need to use the reacher or sock aid for dressing.*

Section Six

Post-operative Exercise Guidelines

Remember, this is just a guide. Your physician, physician assistant, nurses, or therapist may add to or change any of the recommendations. Always use their recommendations first and ask questions if you are unsure of any information. Keep your Guidebook as a handy reference for at least the first year after your surgery.

Importance of Exercise

A post-operative exercise program is an important component of a successful spine surgery. Patients should work with their physical therapists to develop a maintenance program that is specific to their needs and is one that they enjoy. Check with your surgeon when you should begin physical therapy (generally 4-6 weeks after surgery). The ultimate goal for each patient is that strength, flexibility and mobility are restored through a progressive and safe exercise program. Consult with your surgeon or physical therapist before starting any exercise program.

- Exercises help to stabilize your spine and improve the strength and flexibility in your legs: thus optimize your surgical outcome and functional mobility.
- Whenever your surgeon releases you, you may start more vigorous low-impact exercises such as using a recumbent bike or walking on a treadmill. At six weeks, once your incision heals and your doctor approves, you may start water aerobics and swimming. These are good low-impact exercises for your entire body.
- Exercises are best done on a firm surface such as the floor or a firm bed. Protect your back. Keep good posture when exercising. Move slowly. Stop if you have excessive pain or discomfort.
- Listen to your body. If you notice increased discomfort or fatigue, recall what you did earlier that day or the day before. Chances are, you overdid things, and need to scale back until tolerated. Continue to slowly advance yourself as you tolerate the activity.
- Whenever you are performing an exercise, try to keep your abdominal muscles tight by "pulling your belly button in towards your spine". Make sure you are breathing continuously when performing the exercises. If you can't breathe comfortably as you perform the exercise, then you are tightening the muscles too much. Try counting out loud to keep from holding your breath.

Principles of Exercises

When Standing

1. Keep your head level with your chin slightly tucked in.
2. Stand tall by looking forward and keeping your shoulders over your hips.
3. Relax your shoulders.
4. Tighten your stomach muscles by pulling in your stomach. This will relieve undue stress on your spine.

When Sitting

1. Keep your head level and chin up.
2. Place your buttocks all the way to the back of the chair. A rolled towel in the small of the back provides lumbar support. Do not slouch.
3. Keep your feet flat on the floor to support your back. When your feet dangle, it pulls at your lower back. (If your feet don't firmly touch the ground place your feet on a stool and put a pillow behind your back.).

When Lying

1. Use a firm mattress.
2. Lie on your side with your hips and knees slightly bent and with a pillow between your legs.
3. Lie on your back with a pillow under your head and one under your knees to take the strain off your lower back.
4. Avoid lying on your stomach.

When Lifting (5 pound weight limit until seen at follow-up appointment and surgeon allows)

1. Keep your head level and chin up.
2. Keep your back straight, bend your knees and hips and squat as low as possible, keeping your feet apart and chest up.
3. Lift with the strength of your legs.
4. Never twist or turn while lifting.
5. Hold objects close to your body.
6. Use a partner whenever necessary, especially if it is heavy or an awkward size.

When Walking

1. Your goal is to advance the distance you walk each day.
2. For the first few days at home, do multiple short walks throughout the day.
3. This approach is better for reducing stiffness. As you can tolerate it, advance your walking distance. Frequency is better than pushing you to walk a certain distance initially.
4. Keep your head up, chest up, shoulders back and relaxed, buttocks and stomach tucked in and use the walker as needed. Typically, people use the walker for distance ambulation to keep the pressure off the back. As you can tolerate, wean yourself off the walker unless otherwise indicated by your surgeon or therapist.

Home Exercise Program

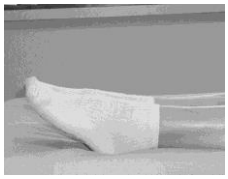
Weeks 1-2

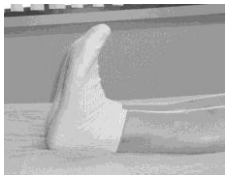
After one to two days, you will be ready for discharge from the hospital. During weeks one and two your recovery goals are to:

- Continue to walk using the walker as needed. The walker typically reduces the stress placed on your spine and can help with balance. As your pain and discomfort lessen, increase your walking distance, and wean yourself from the walker as you feel comfortable or as your physical therapist indicates.
- Walk frequently, slowly increasing your distance by 500-1000 ft as tolerated.
- Gradually resume daily activities and household tasks, keeping in mind to always adhere to your spinal precautions (no bending, lifting, twisting).
- Continue your ankle pumps and any exercises recommended by your surgeon and/or therapist.

Move ankles up and down as far as possible in each direction.

Perform this exercise while lying flat or sitting in a chair 15 to 20 repetitions every waking hour.





Weeks 3-12

The following are general goals for weeks three to 12:

- Continue to walk daily, steadily increasing your distance and endurance.
- Continue weaning yourself from the walker as indicated by your doctor or therapist.
- Walk frequently slowly increasing your distance one to three miles as tolerated.
- Gradually resume community tasks. Give yourself frequent rest breaks. Do not do ongoing activity for more than 30 minutes without resting.
- Always adhere to your spinal precautions (no bending, lifting, twisting).
- Do your home exercises as recommended by your surgeon and/or therapist.

Section Seven:

Body Mechanics

General Rules of Body Mechanics

This is a guide. Activities if allowed by surgeon.

This section will give general tips on how to practice and adapt safe body mechanics to everyday work activities. There are eight main sections (Standing, Sitting, Lifting, Turning, Reaching, Pushing vs. Pulling, Sleeping, and Do's & Don'ts). Under each section, there are general rules of thumb followed by more specific examples of activities you may perform. This is not an exhaustive list, but should help you learn to apply and practice optimal body mechanics when performing activities.

NOTE: There is not only one correct way to do a task. It depends on your abilities. You may need to alter ways of moving based on your strength, flexibility, pain level, and/or other medical conditions. Check with surgeon or physical therapist for details.

Standing

- Do not lock knees. Bent knee takes stress off lower back.
- Wear shoes that support feet. Helps to align spine.
- If you stand for long periods of time, raise one foot up slightly on a step or inside frame of cabinet. Resting foot on low shelf or stool can help reduce pressure and constant forces placed on spine. Shift feet often.
- While standing, keep shoulders back so they do not roll forward.
- Keep back as upright as possible; keep head and shoulders aligned with hips.

Lifting

- Lift body and load at same time. Let your legs do most of lifting.
- Squat to pick up heavy object and let leg muscles do work. Hold heavy objects close to body to keep back aligned. Lift objects only to chest height.
- Do not bend over at waist to lift anything or twist while lifting. Avoid trying to lift above shoulder level.

Kneeling Lift

- With awkward objects, kneel and move object onto one knee.
- Bring it close to body and stand up.

Lifting Object from Floor

- Stand with box between feet, grasping both handles while squatting. Keeping back straight, extend knees, and lift box.

Return to original position in same manner.

Sitting

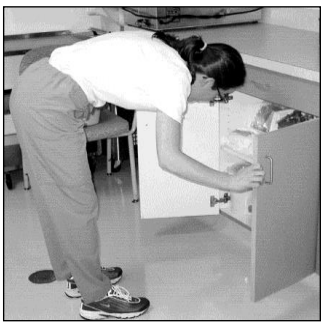
- Sit in chairs that support back. Keep ears in line with hips. If needed, support lumbar curve with rolled-up towel or lumbar roll.
- Knees should be level with hips. Feet should be well supported on floor to support spine. If needed, place feet up on footrest.
- Do not slouch. This puts back out of alignment and adds extra stress to lumbar curve. Don't sit too far away from steering wheel when you drive.
- Keep your shoulders back and head centered over hips.
- Do not let shoulders roll forward.

Computer Ergonomics

- Keep computer screen at eye level.
- Have lumbar support for chair.
- Armrests need to be placed at level that supports forearms and keeps them at waist level. Forearms should not be pushing up into shoulders.
- Adjust height of chair so keyboard is level with forearms.
- Maintain good upright sitting posture.
- Take frequent standing/rest breaks while working (every 20-30 minutes).

Lower Shelf

- When placing an object on low shelf, always bend down on one knee.
- Use other leg to support.
- Never bend over from waist to place item on shelf.



Childcare - Lift from Floor

- Do not bend over at back to pick up child. Instead, squat down, bring child close to chest and lift with legs.

Childcare - In/Out of Car

- When placing infant or child in car seat, always support yourself. Place knee on seat of car to unload the stress placed on back.
- Never bend over at waist.

Holding a Child

- To maintain good posture and decrease stress on back, hold baby/child to center of body, not propped on hip.

Carrying a Child

- Hold baby by cradling in arms.
- Keep baby close to body.
- Keep baby's head as upright as possible.

Turning

- Think of upper body as one straight unit, from shoulders to buttocks.
- Turn with feet, not back or knees. Point feet in direction you want to go. Step around and turn. Maintain spine's three curves.
- Do not keep feet and hips fixed in one position, and do not twist from back. Joints in back aren't designed for twisting; this kind of motion increases risk of injuring your discs and joints.

Unload Car Trunk

- Place leg on bumper and bring objects close to you.
- Bend at hips and lift object out of trunk.
- Keep abdominal muscles tight during entire process.

Carrying Luggage

- Carry bags on both sides of body instead of on one side. Try to keep weight equal on both sides.

Reaching

- Store commonly used items between shoulder and hip level.
- Get close to the item. Use a stool or special reaching tool, if you need to.
- Tighten your abdominal muscles to support your back. Use the muscles in your arms and legs (not your back) to lift the item.

Reaching Out

- When getting objects that are low, but not low enough to kneel or squat, brace yourself by placing hand on fixed object such as counter.

Overhead Cabinets

- Do not overreach to high positions.
- Step up on stool so overhead objects are lower.

Avoid Twisting

- Avoid twisting trunk to reach things.
- Step in direction of object you are trying to reach.

Pushing vs. Pulling

- Push rather than pull large or heavy objects.
- Make sure to lower hips and keep back stabilized by tightening abdominal muscles.

Moving Objects

- Keep elbows close at sides and use total body weight and legs to push or pull.

Sleeping

- Sleep on side or back. If you sleep on side, bend knees to take some pressure off back, put pillow between knees to keep curves aligned.
- Do not sleep on soft bed or couch. Takes three spinal curves out of alignment and adds extra stress to back. Avoid sleeping on stomach which can strain neck and back.

Around the House: Household Chores

Kitchen

- Do NOT get on knees to scrub floors. Use mop and long-handled brushes.
- Plan ahead! Gather all cooking supplies at one time. Sit to prepare meal.
- Place frequently-used cooking supplies and utensils where they can be reached without much bending or stretching.
- To provide better working height, use high stool, or put cushions on chair when preparing meals.

Bathroom

- Do NOT get on knees to scrub bathtub. Use mop or other long-handled brushes.
- ALWAYS use non-slip adhesive or rubber mats in tub.
- Attach soap-on-a-rope so it is within easy reach.

Vacuuming (Type of Pushing/Pulling Task)

- Use legs, not back, when vacuuming.
- Do not vacuum by reaching out away from body.
- Try to work for small intervals of time with frequent breaks.
- Keep vacuum close to body.
- Use a lightweight vacuum.

Sweeping/Mopping

- Use full length of broom to sweep.
- Do not hold broom handle close to floor.
- Try to keep spine as straight as possible.
- Sweep with motion coming from hips instead of shoulders.
- Do not get down on knees to scrub floors, instead use a mop.

Laundry - Loading Washer

- Place laundry basket so bending and twisting can be avoided.
- Place basket on top of washer or dryer instead of bending down with back.

Laundry - Unloading Washer

- To unload small items at bottom of washer, lift up one leg when reaching down into washer.
- Do not bend at waist to reach into washer when loading/unloading.

Laundry - Unloading Dryer

- Do not bend at lower back when removing laundry from dryer.
- Set basket on floor and squat/kneel next to basket when unloading dryer or front-load washer.
- Try "golfer's bend" to unload washer/dryer by supporting with one hand on unit and holding opposite leg straight out as you bend forward. This allows you to keep back straight and take some pressure off back with arm supporting you.

Lifting Laundry

- Pick up laundry basket by squatting near it. Do not bend over to lift.

Shaving

- Stay upright with one foot on ledge of cabinet under sink.

Showering

- When showering, try not to let head bend forward or backward (i.e., when washing hair). Squat down with knees or use tub bench and/or hand-held shower spout so neck remains straight.

Brushing Teeth

- While brushing teeth, stand up straight and keep knee bent with foot on cabinet lip.
- To avoid bending forward, spit into cup and use cup for rinsing mouth with water. Support back by leaning one arm on sink/counter as you spit into sink. Bend at knees, not back.

Ironing

- While ironing, keep ironing board waist level to avoid leaning forward at back.

Sink

- Keep one foot propped on lip of cabinet to reduce stress on back.

Refrigerator

- Bend at knees and hips to get things out of lower portion of refrigerator. It is better to squat or kneel instead of bending.

Dishwasher

- To get objects out of dishwasher, squat or kneel down by door.
- Try sitting on swiveling office chair to unload dishwasher. Place items up onto counter by pivoting around with feet. Then stand and put items into the cupboard.

Bathroom

- Do not overextend or get down on knees to scrub bathtub. Use mop or other long-handled brushes.
- Try to move lower by squatting and brace yourself with a fixed object.
- Always use non-slip adhesive or rubber mats in tub or "aqua/water shoes."

Making Bed

- Do not to bend over too far when making bed.
- Try to move sheet to corners and kneel or squat to pull them around mattress.

Dusting

- Use dusting implements that reach distances so you don't have to reach far or lean your head backward.

Cleaning

- To clean overhead or tall objects, use step stool so you don't have to overreach.

Wiping Lower Surfaces

- When wiping or dusting low objects, do not bend lower back.
- Try to kneel or squat next to object.

Mowing

- When pushing or pulling a mower, do not bend forward.
- Keep your back straight. Bend at your knees and hips. Push or pull with legs.

Raking

- When raking, keep back straight by bending at hip.
- Rake close to body using arms and shifting legs to perform rake motion.
- Take frequent breaks.

Shoveling

- Grab shovel close to end.
- Shovel by leaning forward and shifting weight.
- Use your legs, not your back.

Digging

- When digging, place blade end into soil with handle straight up and down.
- Step on top of blade then step off and angle shovel upward.

Planting

- When weeding or planting, do not bend over from standing position.
- Kneel or squat in area you are working. It is recommended you maintain squat position for only short period of time since this places stress on knees.
- Can also sit on chair or stool to reduce stress on knees instead of kneeling.

Safety Tips and Avoiding Falls

- Pick up throw rugs and tack down loose carpeting. Cover slippery surfaces with carpets that are firmly anchored to floor or have non-skid backs.
- Be aware of floor hazards such as pets, small objects, or uneven surfaces.
- Provide good lighting throughout. Install nightlights in bathrooms, bedrooms, and hallways.
- Keep extension cords and telephone cords out of pathways. Do NOT run wires under rugs — this is a fire hazard.
- Do NOT wear open-toe slippers or shoes without backs. They do not provide adequate support and can lead to slips and falls.
- Sit in chairs with arms. Makes it easier to get up.
- Rise slowly from either sitting or lying position to avoid getting light-headed.
- Do not lift heavy objects for first three months and then only with surgeon's permission.
- Stop and think and always use good judgment.

Dos and Don'ts for Rest of Your Life

Whether you have reached all recommended goals in three months, all spine surgery patients need to participate in a regular exercise program to maintain fitness and strength of muscles around their spine. With both your surgeon and primary care doctors' permission, you should be on a regular exercise program three to four times per week lasting 20-30 minutes. The aim of spine surgery is to return the patient to a full activity level, but conditions leading to spine surgery cannot be completely corrected by even the most successful operation, so certain precautions should be taken.

What to Do in General

- Avoid bending, lifting, and twisting as much as possible. It may be possible to return to strenuous physical activity, including heavy lifting, but discuss this with your surgeon.
- Maintain ideal body weight.
- DO NOT SMOKE!
- Maintain proper posture.
- When traveling, change positions every one to two hours to keep neck and back from tightening up.

Exercise - Do

- Choose low impact activity.
- Home program issued to you by your therapist.
- Regular one- to three-mile walks.
- Home treadmill and/or stationary bike.
- Regular exercise at fitness center.
- Low-impact sports such as golf, bowling, gardening, dancing, swimming, etc.
- Consult surgeon or physical therapist about specific sport activities.

Exercise – Don't

- Do not run or engage in high-impact activities or activities that require a lot of starts, stops, turns, and twisting motions.
- Do not participate in high-risk activities such as contact sports.
- Do not take up new sports requiring strength and agility until you discuss it with surgeon or physical therapist.

Section Eight:

Discharge Instructions

Cervical Decompression, Microdiscectomy and Laminectomy

1. **Immediate post-op to discharge from hospital:** You may get out of bed with assistance as soon as comfortable. Walk as desired. Keep wound clean and dry. Wear brace or collar as instructed if ordered.

2. **Discharge to first office visit:** If you were given a cervical collar, wear as directed. Continue to walk as desired. Gradually increase distance. You may shower when there is no drainage from your incision and allowed by your surgeon but do not tub bathe or swim. Keep the incision dry at all times. If you are not wearing a brace, you may drive short distances as soon as you are comfortable, allowed by your surgeon and not taking narcotics. Driving is not allowed while wearing a neck brace. You should plan to take it easy and rest for the next week at home, and then gradually increase your activity as tolerated.

3. **First visit (approximately two weeks) post-op:** Gradually increase activities. Remain on feet for longer periods of time and increase your walking distances. You may return to sedentary job in as little as two to three weeks. No bending, twisting or lifting more than 5 pounds.

4. **Six to 12 weeks:** You may return to light duty or physical labor if pain free and allowed by your surgeon. You may tub bathe and swim at six weeks when allowed by your surgeon. If allowed by your surgeon, you may lift up to 25 pounds but continue to avoid bending and twisting of the neck. At your six week visit, you may be shown specific exercises to strengthen your neck muscles.

5. **Twelve to twenty-four weeks:** Continue to avoid heavy lifting or repetitive bending and twisting of the neck. Continue these restrictions until advised further.

   Swimming: *refrain from pool activity that causes repetitive twisting of the head and neck. Even the simple activity of walking in the water can be therapeutic during this time of recovery.*

Cervical Fusion

1. **Immediate Post-op to discharge from hospital:** You may get up with assistance wearing a collar/brace if ordered.

2. **Discharge to first office visit:** Try to be up as much as possible, using a hard or soft collar as directed IF ORDERED. You may shower when there is no drainage and allowed by your surgeon, but do not tub bathe or swim. You should remove any dressings from the surgical sites after showering, pat dry, and replace if desired. You should avoid driving at this time. You may be a passenger. Avoid strenuous activity. You may walk as much as you feel comfortable with, but no other exercise is advisable for now.

3. **First visit (approximately two weeks):** Gradually increase activities using brace/collar if ordered. You may participate in low impact aerobic activity, such as walking, increasing your distance walked daily. You may return to work as instructed by your physician after your follow up appointment. Do not drive if you are still wearing a brace or taking narcotics. Continue to avoid lifting anything over 5 pounds.

4. **Six to twelve weeks:** You may be weaned from brace/collar depending upon your x-rays. You may tub bathe and swim when allowed by your surgeon. If out of brace, you may drive, otherwise continue as before. No running, contact sports or lifting of weights over 25 pounds. Use soft collar as desired for comfort.

5. **Twelve to twenty-four weeks:** Continue to avoid heavy lifting (over 25 pounds), repetitive bending and twisting of the neck. Continue these restrictions until your x-rays indicate that you are completely healed and your physician releases you to full activity.

Swimming: *refrain from pool activity that causes repetitive twisting of the head and neck. Even the simple activity of walking in the water can be therapeutic during this time of recovery.*

Cervical Artificial Disc Replacement (Disc Arthroplasty)

1. **Immediate post-op to discharge from hospital:** You may get out of bed with assistance as soon as comfortable. Walk as desired. Keep wound clean and dry. Wear collar as instructed if ordered. Usually free to move neck as tolerated.

2. **Discharge to first office visit:** If you were given a cervical collar, wear as directed. Continue to walk as desired. Gradually increase distance. You may shower when there is no drainage from your incision and allowed by your surgeon but do not tub bathe or swim. Keep the incision dry at all times. If you are not wearing a brace, you may drive short distances as soon as you are comfortable, allowed by your surgeon and not taking narcotics. Driving is not allowed while wearing a neck brace. You should plan to take it easy and rest for the next week at home, and then gradually increase your activity as tolerated.

3. **First visit (approximately two weeks) post-op:** Gradually increase activities. Remain on feet for longer periods of time and increase your walking distances. You may return to sedentary job in as little as two to three weeks. No bending, twisting or lifting more than 5 pounds.

4. **Six to 12 weeks:** You may return to light duty or physical labor if pain free and allowed by your surgeon. You may tub bathe and swim at six weeks when allowed by your surgeon. If allowed by your surgeon, you may lift up to 25 pounds but continue to avoid bending and twisting of the neck. At your six week visit, you may be shown specific exercises to strengthen your neck muscles.

5. **Twelve to twenty-four weeks:** Continue to avoid heavy lifting or repetitive bending and twisting of the neck. Continue these restrictions until advised further.

   Swimming: *refrain from pool activity that causes repetitive twisting of the head and neck. Even the simple activity of walking in the water can be therapeutic during this time of recovery.*

Appendix

Pre-op Spine Class: Edward Hospital

This class is held most Wednesdays from 4:00 p.m. - 5:00 p.m. in the Orthopedic Unit Conference Room located on the 3rd floor of the South Area of the Hospital. You may park in the South Lot or use Valet parking when available.

Address:
801 S. Washington
Naperville, IL 60540
Directions: Edward Hospital, South Entrance and Parking
Check-in at Outpatient Registration, South Entrance, 1st floor
Meet escort to class by Fish tank near Outpatient Registration

If unable to attend, please watch the spine class video on the new Edward Hospital intranet. It is approximately 20 minutes long. The link is: **www.eehealth.org/ortho-spine**

Pre-op Spine Class: Elmhurst Hospital

This class is held most Wednesday from 3:30 pm - 4:30 pm. Classes are held in the lower level conference area. To schedule your class call Elmhurst Hospital CareMatch at (331) 221-2273.

Address: Elmhurst Hospital
155 E. Brush Hill Road
Elmhurst, IL 60126
Directions: Park in the green lot and enter through the East Entrance. Take the east elevators to the lower level conference area.

Directions to Edward and Elmhurst hospitals can be found on our website:
www.eehealth.org/ortho-spine

Click on "Find a location" at the top, then choose and click Edward Hospital. Choose "directions"; you may enter your address to get specific directions to the hospital.

Please bring your Coach and Guidebook with you to class

Exercise Your Right

Put your Health-care Decisions in Writing

It is the policy of the Orthopedic Center to place patients' wishes and individual considerations at the forefront of their care and to respect and uphold those wishes.

What are advance medical directives?
Advance directives are a means of communicating to all caregivers the patient's wishes regarding health care. If a patient has a living will or has appointed a health-care agent, and is no longer able to express his or her wishes to the physician, family or hospital staff, the Hospital is committed to honoring the wishes of the patient as they are documented at the time the patient was able to make that determination.

There are different types of advance directives:

- Living wills are written instructions that explain your wishes for health care if you have a terminal condition or irreversible coma, and are unable to communicate.
- Appointment of a health-care agent (sometimes called a medical power of attorney) is a document that lets you name a person (your agent) to make medical decisions for you, if you become unable to do so.
- Health-care instructions are your specific choices regarding use of life-sustaining equipment, hydration and nutrition and use of pain medications.

On admission to the hospital, you will be asked if you have an advance directive. If you do, please bring copies of the documents to the hospital with you, so they can become part of your medical record. Advance directives are not a requirement for hospital admission. Advance directive forms are available upon request at the hospital.

Anesthesia and You

Who are the anesthesiologists?

The operating room, PACU (post-anesthesia care unit) and intensive care units are staffed by board-certified and board-eligible physician anesthesiologists. Each member of the service is an individual practitioner with privileges to practice at The Orthopedic Center.

What type of anesthesia will be used?

Spine surgery requires the use of general anesthesia, which provides loss of consciousness and requires the use of an endotracheal tube.

Will I have side effects?

Your anesthesiologist will discuss the risks and benefits associated with this anesthetic option, as well as any complications or side effects that may occur.

Nausea or vomiting may be related to anesthesia or the type of surgical procedure. Although less of a problem today because of improved anesthetic agents and techniques, these side effects continue to occur for some patients. Medications to treat nausea and vomiting will be given, if needed.

The amount of discomfort you experience will depend on several factors, especially the type of surgery. Your doctors and nurses can relieve pain with medications. Your discomfort should be tolerable, but do not expect to be totally pain-free. The staff will teach you the pain scale (0-10) to assess your pain level.

What will happen before my surgery?

You will meet your anesthesiologist immediately before your surgery.

Your anesthesiologist will review all information on the medical record to evaluate your general health. This will include your medical history, laboratory test results, allergies, and current medications. He or she will also answer any questions you may have.

You will also meet your surgical nurses. Intravenous (IV) fluids will be started and pre-operative medications may be given, as ordered. Once in the operating room, monitoring devices will be attached such as blood pressure cuff, EKG and other devices for your safety. At this point, you will be ready for anesthesia.

What does my anesthesiologist do during surgery?

Your anesthesiologist is responsible for your comfort and well-being before, during and immediately after your surgical procedure. In the operating room, the anesthesiologist will manage vital functions, including heart rate and rhythm, blood pressure, body temperature and breathing. The anesthesiologist is also responsible for fluid and blood replacement when necessary.

What can I expect after the operation?

After surgery you will be taken to the post-anesthesia care unit (PACU). You will be watched closely by specially trained nurses. During this period, you may be given extra oxygen and your breathing and heart functions will be closely observed. Your pain level will be assessed and medication will be given to obtain an acceptable level of comfort and relieve any nausea. An anesthesiologist is available to provide care as needed for your safe recovery.

May I request an anesthesiologist?

Although most patients are assigned an anesthesiologist, you may request one based on personal preference. If you have questions about your insurance coverage or medical plan participation by the anesthesiologist, please contact your insurance company for guidance.

Requests for specific anesthesiologists should be submitted in advance through your surgeon's office for coordination with the surgeon's availability.

Smoking Cessation Programs

Did you know:

- Within 24 hours of quitting your risk for heart attack decreases?
- Within 48 hours your lung function can increase up to 30 percent?
- Within one month nicotine is no longer in your body?
- The benefits of stopping tobacco use never end?

The good news is that it can be done! Thousands of people have walked away from tobacco. The bad news is that many well-intentioned people fail. Nicotine is the most addictive drug known. Staying away means breaking the addiction and adopting new habits. It can mean lifestyle changes. Statistics show that smokers attempting to quit on their own succeed only 7 percent of the time. A minimum of 4-6 weeks of smoking cessation is required to reduce your risk closer to a standard patient that does not smoke.

Smoking Cessation Programs

Leading a healthier, happier life takes more than good intentions. It takes action. And it's easier to take action when you're supported by like-minded individuals with similar goals. **Freedom From Smoking** is a smoking cessation program offered at Edward-Elmhurst Health in affiliation with the American Lung Association. Edward-Elmhurst Health offers both group smoking cessation classes call - (630) 527-6363, as well as one-on-one hypnosis and counseling sessions to aid in smoking cessation - call (331) 221-6135 for an appointment.

The Illinois Department of Public Health funds the **Illinois Tobacco Quitline**, which is operated by the American Lung Association. This partnership was formed in 2001 to provide tobacco cessation services to the citizens of Illinois. There is no cost for the counseling services. Hours of operation are from 7 a.m. to 11 p.m., Sunday through Saturday. For more information, call (866) QUIT-YES or (866) 784-8937.

MEDICATIONS TO STOP BEFORE SURGERY AS DIRECTED BY YOUR SURGEON AND PRESCRIBING PHYSICIAN

Anticoagulants and Antiplatelets (Blood thinners)

- Plavix (Clopidogrel)
- Prasugrel (Effient)
- Warfarin (Coumadin)
- Dabigatran (Pradaxa)
- Rivaroxaban (Xarelto)
- Anagrelide (Agrylin)
- Aspirin
- Dipyridamole (Persantine)
- Cilostazol (Pletal)
- Ticagrelor (Brilinta)
- Ticlopidine (Ticlid)
- Vorapaxar (Zontivity)
- Apixaban (Eliquis)
- Acenocoumarol

NSAIDS (Nonsteroidal anti-inflammatory drugs)

- Ibuprofen (Advil, Motrin, Midol, Nuprin, Pamprin)
- Naproxen (Aleve, Naprosyn, Anaprox)
- Oxaprozin (Daypro)
- Aspirin (Bufferin, Ecotrin, Bayer, ASA)
- Declofenac (Cataflam, Voltaren, Arthrotec)
- Ketorolac (Toradol)
- Etodolac (Lodine)
- Nabumetone (Relafen)
- Indomethacin (Indocin)
- Piroxicam (Feldene)
- Meloxicam (Mobic)
- Diflusinal
- Fenoprofen (Naflon)
- Floctafenine

- Flurbiprofen (Alti-Flurbiprofen, Ansaid, Apo-Flurbiprofen, Froben)
- Froben-SR, Novo-Flurprofen, Nu-Flurprofen)
- Ketoprofen (Active-Ketoprofen)
- Meclofenamate (Meclomen)
- Mefenamic Acid (Ponstel)
- Sulindac
- Tiaprofenic Acid
- Tolmetin

Anorectics – Appetite suppressants

- Phentermine (*Adipex, Duromine, Fastin, Ionamin, Metermine*, etc.)
- Diethylpropion (*Tenuate)*
- Rimonavant (*Acomplia)*
- Sibutramine (*Meridia, Reductil*)
- Oxymetazoline (*Afrin*)

Opioid agonist-antagonist

- Suboxone

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Glossary of Terms

Annulus – The outer rings of rigid fibrous tissue surrounding the nucleus in the disc.

Anterior – A relative term indicating the front of the body.

Bone Spur – An abnormal growth of bone, usually present in degenerative arthritis or degenerative disk disease.

Bone Growth Stimulator - Portable battery powered non-invasive device that provides electromagnetic supplemental treatment. This may help to promote bone growth and healing after spinal fusion. Used only when indicated and arranged by your surgeon's office.

Cartilage – A smooth material that covers bone ends of a joint to cushion the bone and allow the joint to move easily without pain.

Computed tomography scan (also called a CT or CAT scan) – A diagnostic imaging procedure that uses a combination of x-rays and computer technology to produce cross-sectional images, both horizontally and vertically, of the body. A CT scan shows detailed images of any part of the body, including the bones, muscles, fat and organs. CT scans are more detailed than general x-rays.

Congenital – Present at birth.

Contusion – A bruise.

Cervical Spine – The part of the spine that is made up of seven vertebrae and forms the flexible part of the spinal column. The cervical spine is often referred to as the neck.

Corticosteriods – Potent anti-inflammatory hormones that are made naturally in the body or synthetically for use as drugs; most commonly prescribed drug of this type is prednisone.

Degenerative Arthritis – The inflammatory process that causes gradual impairment and loss of use of a joint.

Degenerative Disc Disease – The loss of water from the discs that reduces elasticity and causes flattening of the disks.

Disc – The complex of fibrous and gelatinous connective tissues that separate the vertebrae in the spine. They act as shock absorbers to limit trauma to the bony vertebrae.

Disc Arthroplasty - Cervical disc arthroplasty is a safe and effective surgical treatment of some forms of symptomatic cervical degenerative disc disease that aims to relieve radicular pain while preserving functional motion between vertebrae. Also known as Artificial Disc Replacement or ADR.

Discectomy – The complete or partial removal of the ruptured disc.

Dura – The outer covering of the spinal cord.

Dural Tear – A laceration or tear of the dura that can occur during surgery. Leakage of spinal fluid occurs at this site. This is often treated with bed rest for 24-48 hours thus allowing the tear to heal.

Facet – The small plane of bone located on the vertebra or knuckle that pops when self-adjusting.

Foramina – Plural form of foramen (a natural opening or passage through a bone).

Foraminotomy – The surgical procedure that opens up the foramen. This is done for relief of nerve root compression.

Fracture – A break in a bone.

Fusion – The surgical procedure that joins or “fuses” two or more vertebrae together to reduce movement at this joint space.

Herniated Disc – The abnormal protrusion of soft disc material that may impinge on nerve roots. Also referred to as a ruptured or protruding disc.

Inflammation – A normal reaction to injury or disease which results in swelling, pain and stiffness.

Joint – Where the ends of two or more bones meet.

Lamina – The bone that lies posterior to the vertebrae.

Laminectomy – The removal of the entire lamina.

Ligaments – Flexible band of fibrous tissue that binds joints together and connects various bones.

Lumbar Spine – The portion of the spine lying below the thoracic spine and above the pelvis. This part of the spine is made up of 5 vertebrae. Also called the lower back.

Magnetic Resonance Imaging (MRI) – A diagnostic procedure that uses a combination of large magnets, radiofrequencies, and a computer to produce detailed images of organs and structures within the body.

Myelopathy – A condition that is characterized by functional disturbances due to any process affecting the spinal cord.

NSAID – An abbreviation for non-steroidal anti-inflammatory drugs, which do not contain corticosteroids and are used to reduce pain and inflammation; aspirin and ibuprofen are two types of NSAIDs.

Nerve Root – The portion of a spinal nerve that lies closest to its origin from the spinal cord.

Neuropathy – A functional disturbance of a peripheral nerve.

Nucleus Pulposis or Nucleus – The relatively soft center of the disc that is protected by the rigid fibrous outer rings.

Osteoporosis – A condition that develops when bond is no longer replaced as quickly as it is removed.

Osteophyte – A bony outgrowth.

Pain – An unpleasant sensory or emotional experience primarily associated with tissue damage.

Pain Threshold – The least experience of pain that a person can recognize.

Pain Tolerance Level – The greatest level of pain that a person is prepared to tolerate.

Paresthesia – An abnormal touch sensation, such as burning or tingling.

PCA pump – Patient controlled analgesia pump (Pain medicine tool that the patient controls)

PCT – Patient Care Technician (nursing assistance)

Posterior – A relative term indicating that an object is to the rear of or behind the body.

Radiculopathy – A condition involving the nerve root that can be described as numbness, tingling or pain that travels along the course of a nerve.

Sacral Spine – The last section of the spinal column located below the lumbar spine. It is made up of several semi-fused pieces of bone.

Sequential Compression Device (SCD) – intermittent compression device placed on legs to prevent blood clots.

Sciatica (also called lumbar radiculopathy) – A pain that originates along the sciatic nerve.

Scoliosis – A lateral, or sideways, curvature and rotation of the back bones (vertebrae), giving the appearance that the person is leaning to one side.

Soft tissues – The ligaments, tendons, and muscles in the musculoskeletal system.

Spinal Stenosis – A narrowing of the vertebral canal, nerve root canals, or intervertebral foramina of the spine caused by encroachment of bone upon the space. Foraminal stenosis symptoms are caused by compression of the nerves and include pain, numbness and/or tingling,

Spine –Series of stacked bones (vertebrae), discs and ligaments extending from the base of the skull to the small of the back that surround and protect the spinal cord and provide support to the upper body, chest, stomach and back. The cervical, thoracic and lumbar regions of the spine are composed of 24 articulating/flexible vertebrae.

Spinous Process – The part of the vertebrae that you can feel through your skin.

Spondylosis (spinal osteoarthritis) – A degenerative disorder that may cause loss of normal spinal structure and function. Although aging is the primary cause, the location and rate of degeneration is individual. The degenerative process of spondylosis may impact the entire spine creating over growth of bone and affecting the intervertebral discs and facet joints.

Spondylolisthesis – A displacement of one vertebra over another.

Sprain – A partial tear of a ligament.

Strain – A partial tear of a muscle of tendon.

Stress fracture – A bone injury caused by overuse.

Tendon – The tough cords of tissue that connect muscles to bones.

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Thoracic Spine – The portion of the spine lying below the cervical spine and above the lumbar spine. This part of the spine is made up of 12 vertebrae.

Torticollis (also called wryneck) – A twisting of the neck that causes the head to rotate and tilt on an angle.

Transverse Process – The wing of bone on either side of each vertebra.

Trigger Point – Hypersensitive area of muscle or connective tissue, usually associated with myofascial pain syndromes.

Ultrasound – A diagnostic technique which uses high-frequency sound waves to create an image on the internal organs.

Vertebra (e) – The bone or bones that form the spine.

X-ray – A diagnostic test which uses invisible electromagnetic energy beams to produce images of internal tissues, bones and organs onto film.

Healthy Driven
Edward-Elmhurst HEALTH

Call Don't Fall

Fall Prevention at the Hospital

While you're at Edward, your safety is our priority. Please speak up when you need help.

Your doctor and/or nurse will let you know when you are able to walk without assistance. Before this time, please "Call don't fall!" Even if you feel capable, call your nurse or patient care tech for help when getting out of bed, going to and from the bathroom or walking.

- Call for help when getting out of bed.
- Take your time. Be sure you are not feeling weak or dizzy.
- Wear non-skid footwear.
- Use canes, walkers and assist devices as instructed.

Dec. 2015

Healthy Driven
Edward-Elmhurst HEALTH

Fall Prevention at Home

Each year, thousands of Americans fall at home. Many of them are seriously injured, and some are disabled. All age groups are affected, with adults over age 60 ranking highest for these injuries.

The points below address hazards found in your home that have been associated with falls. Attention to these hazards now may prevent a fall in the future.

General

- Keep pathways clear and free of clutter.
- Remove throw rugs or use double-sided tape or a non-slip backing so the rugs won't slip.
- Coil or tape wires next to the wall to avoid tripping over them.
- Keep objects off the stairs.
- Be sure carpet on stairways is firmly attached. Apply non-slip rubber treads to the stairs if there is no carpet.
- Fix loose or uneven steps.
- Fix loose handrails.
- Maintain adequate lighting.

Kitchen

- Keep things you use often on the lower shelves.
- Use a sturdy step stool when climbing. Do not use a chair.

Bathroom

- Use a non-skid mat or adhesive strips in the bathtub or shower.
- Install grab bars in the tub, shower and toilet area.

Bedroom

- Place a lamp close to the bed where it is easy to reach.
- Use a night light so you can see where you're walking.

Other

- Exercise regularly if not contraindicated by your physician. Exercise makes you stronger and improves your balance and coordination.
- Review your medications with your Doctor. Some medicines can make you sleepy or dizzy.
- Have your vision checked. Poor vision can increase your risk of falling.
- Get up slowly after you sit or lie down.
- Wear shoes both inside and outside the house.
- Keep emergency numbers near each phone.
- Consider wearing an alarm device that will bring help in case you fall and can't get up.

Directions and Contacts - Edward Hospital

Directions for both hospitals

Hospital website: https://www.eehealth.org/ortho-spine

Click on "Find a location" at the top, then choose and click Edward or Elmhurst Hospital. Choose directions; you may enter your address to get specific directions to the hospital.

Contacts for Edward Hospital

___ **Preadmission Testing (PAT)**
Phone: (630)527-3325
FAX: (630) 527-3334

___ Ambulatory Surgery Care Center (ASCC)
Phone: (630) 646-8129

___ **Care Coordinator (CC)**
Phone: (630) 527-3680
Email: karen.murphy@EEHealth.org

___ **Discharge Planning**
Case Manager or Social Worker
Phone: (630) 527-3569

___ **Edward Orthopedic Center**
Phone: (630) 527-3250

___**Outpatient Rehab Services**
Phone: (630) 527-3375

___**Inpatient Rehab Services**
Phone: (630) 527-5371

Visit our website at: www.eehealth.org/ortho-spine

Directions and Contacts – Elmhurst Hospital

Directions for both hospitals

Hospital website: https://www.eehealth.org/ortho-spine

Click on "Find a location" at the top, then choose and click Edward or Elmhurst Hospital. Choose directions; you may enter your address to get specific directions to the hospital.

Contacts for Elmhurst Hospital

___**Pre-admission Testing (PAT)**
Phone: (331) 221-3920
FAX: (331) 221-3885

___ **Pre-op and Recovery Unit**
Phone: (331) 221-1072

___ **Surgery Reception Desk**
Phone: (331) 221-0490

___**Discharge Planning Case Manager or Social Worker**
Phone: (331) 221-1146

Outpatient Rehab Services
Center for Health Phone: (331) 221-6044
Lombard Center for Health Phone: (331) 221-5820

___**Inpatient Rehab Services**
Phone: (331) 221-0590

Discharge Education

Patient Education

Narcotic Pain Medicines

Names of medicines: Norco, Vicodin, Oxycodone IR, Oxycontin SR

What are narcotic pain medicines? – Narcotic pain medicines are a group of medicines that relieve pain.

Narcotics come in lots of different forms, including:

- Pills and liquids that you swallow
- Patches that you wear on your skin
- Liquids that are given as a shot

When are narcotics used? – Narcotics are used to treat severe pain caused by all sorts of medical problems and injuries. They are also used to manage pain after surgery.

Are all narcotics the same? – Yes and no. All narcotics work on the same chemical process in the body, but they do it in different ways. Some narcotics need to be taken more often during the day than others to work for certain kinds of pain. And some are more likely than others to cause certain side effects. Plus, the effects of narcotics are different depending on whether they come in a pill, a patch, a shot, or in some other way.

Are narcotics safe for everyone? – Narcotics are safe for most people who need them for severe pain. If you take these medicines, take **ONLY** the amount prescribed and only as often as prescribed. Do not chew, cut, or crush pills or capsules that release medicine slowly.

What side effects can narcotics cause? -- Narcotics can cause some side effects that are just bothersome and some that are dangerous.

Call for an ambulance or go to the hospital if you (or someone close to you):

- Can't seem to wake up
- Become very confused
- Appear to be drowsy and breathing very slowly
- Pass out or have seizures
- Become unable to urinate

Talk to your doctor or nurse if you have any of these *side effects* and they bother you:

- **Constipation** – Your doctor or nurse might suggest you take medicines to prevent or treat constipation. It's also important to drink plenty of water

- Nausea, vomiting, or itchiness – If you have any of these problems, your doctor might be able to switch you to a different narcotic

- Dry mouth
- Feel dizzy, sleepy, or have trouble thinking clearly
- Vision problems
- Feel clumsy or fall down

What happens if I take more than the recommended dose? -- Taking more than the recommended dose of a narcotic or combining narcotics with other medicines without a doctor's OK can cause serious problems. For example, it can make you pass out or stop breathing.

Anybody who takes too much of any medicine at once should call a doctor or the Poison Control Hotline (1-800-222-1222). If the person is not breathing or is not conscious, call for an ambulance (in the US and Canada, dial 9-1-1)

Should I worry about addiction? – Taking narcotics to manage pain or other symptoms does not lead to addiction in most people. But it can be a problem for people who have problems with drug or alcohol use.

To reduce the changes of addiction, you should:

- Never take narcotics that were not prescribed to you
- Take narcotics only for as long as your doctor or nurse prescribes, and only at the dose he or she recommends
- If the problem for which the narcotics were prescribed gets better, throw away any leftover narcotics. Do not keep old narcotics around the house
- Tell your doctor or nurse if the narcotics seem to stop working

Reference: http://online.lexi.com/lco/action/pcm/print/leaflet/3852328

Healthy Driven
Edward-Elmhurst HEALTH

Drop Boxes for Prescriptions

- Bring over-the-counter, unused, unwanted, expired, and household medications
- Cross off personal information on the label OR put pills in a plastic bag
- NO sharp needles, or EPI pens allowed
- NO radioactive medicines
- NO household chemical waste

Addison
Addison Police Department
3 Friendship Plaza

Aurora
Aurora Police Department
1200 E. Indian Trail

Bensenville
Bensenville Police Department
345 E. Green Street

Bloomingdale
Bloomingdale Police Department
201 S. Bloomingdale Road

Burr Ridge
Burr Ridge Village Hall
7700 S. County Line Road

Clarendon Hills
Clarendon Hills Police Department
448 Park Avenue

Downers Grove
Walgreens
1000 Ogden Avenue

Elmhurst
Elmhurst Hospital
Door 28 near ER
155 E. Brush Hill Road

Elmhurst Police Department
125 E. 1st Street

Naperville
Edward Hospital
South Lobby
801 S. Washington Street

Fire Station No. 1
964 East Chicago Avenue

Fire Station No. 2
601 E. Bailey Road

Fire Station No. 3
1803 N. Washington Street

Fire Station No. 4 & Training Facility
1971 Brookdale Road

Fire Station No. 5
2191 Plainfield/Naperville Road

Fire Station No. 6
2808 103rd Street

Fire Station No. 7 &
Administration Building
1380 Aurora Avenue

Fire Station No. 8
1320 Modaff Road

Fire Station No. 9
1144 W. Ogden Avenue

Fire Station No. 10
3201 95th Street

Naperville Police Department
1350 Aurora Avenue

Walgreens
63 W. 87th Street

Glendale Heights
Glendale Heights Police Department
300 Civic Plaza

Glen Ellyn
Glen Ellyn Police Department
535 Duane Street

Hanover Park
Hanover Park Police Department
2011 W. Lake Street

Itasca
Itasca Police Department
540 W. Irving Park Road

Lisle
Lisle Police Department
5040 Lincoln Avenue

Plainfield
Plainfield Police Department
14300 S. Coil Plus Drive

Roselle
Roselle Police Department
103 S. Prospect Street

Schaumburg
Schaumburg Police Department
1000 W. Schaumburg Road

Westmont
Farland Pharmacy, Inc
2 North Cass Avenue

Westmont Police Department
500 N. Cass Avenue

Wheaton
DuPage County Sheriff
501 N. County Farm Road

Wood Dale
Wood Dale Police Department
404 N. Wood Dale Road

Woodridge
Woodridge Police Department
1 Plaza Drive

For additional locations in and outside of DuPage County, visit **http://gis.dupageco.org/rxboxlocations/**

Need help?

If you're struggling with addiction or are having trouble controlling your use of painkillers, please call **Linden Oaks Behavioral Health** at (630) 305-5027.

Pain Management with Opiates

(Narcotics is a term used outside of healthcare to describe certain medications that include opiates.)

Why opiates?

- Opiates are pain medications used to treat moderate or severe pain. These medicines are often necessary for acute pain and can be part of a plan that combines medication and non-medication options to better manage your pain.
- The goal of therapy is to increase function and recovery.
    - Some pain is normal, and it is not realistic to completely eliminate pain.
- Opiates are safe for most people if taken as directed for moderate to severe pain.

How do I manage my pain with opiates?

- Try non-medication options to manage your pain like ice, positioning, exercise, relaxation, and thoughts or activities to take your mind off your pain.
- Discuss with your doctor if Tylenol and/or Motrin (Ibuprofen, Advil, and Aleve) are safe for you to take to manage your pain with opiates or to minimize the need for opiates. Some opiates have Tylenol in them.
- Only take opiates when you need them for moderate or severe pain that is not relieved with the options above, when approved by your doctor
- Take the medication as prescribed and never take more than prescribed.

Side effects and risks

- Suspected allergic reaction with rash or shortness of breath or decreased ability to breathe normally/respiratory depression - **Call 911**
- Sleepiness or dizziness: do not drive, use machinery, or any activity requiring mental alertness until you know how this medicine affects you. **Notify your doctor if you are too drowsy or dizzy.**
- Avoid alcoholic drinks and medications that make you drowsy such as sleep aids, medications for anxiety unless prescribed by your physician.
- If you have sleep apnea, opiates can make apnea worse.
- Nausea, constipation, dry mouth: **If you are unable to eat due to nausea or if constipation persists for more than 3 days**, call your doctor
- Confusion: **stop medication and call your physician.**

Weaning the medication

- As you recover, your pain should improve and you will require less opiate. As your pain improves, you will take fewer pills per day and will take the opiate less frequently.
- You may develop tolerance to the medicine. Tolerance means that you will need a higher dose of the medicine for pain relief. Tolerance is normal and is expected if you take the medication for a long time.
- Do not <u>suddenly</u> stop taking your medicine because you may develop a severe reaction. Your body becomes used to the medicine over time, and you should discontinue the medication slowly. If you received instructions from your physician about tapering/weaning the opiate you are taking, follow those instructions.
- You should wean off the opiate and eventually not need to take the opiate for pain.
- Use of opiates carries the risk of developing a substance use disorder (addiction), and potentially overdose with high doses and prolonged use. Substance use disorders are treatable, but it is important to talk to your doctor right away if you feel your use of your medication is becoming excessive or problematic. Signs that this may be the case include using more medication than prescribed, using the medication to feel better emotionally (rather than for treating pain), taking additional pain medication provided to you by others.

Safe storage and disposal

- Keep opiates in a secured place (locked cabinet, drawer) out of reach of visitors and children.
- Dispose of your unused opiate.
    - See Drop Box locations at http://rxdrugdropbox.org/
    - Mix medicines (do not crush tablets or capsules) with an unpalatable substance such as dirt, kitty litter, or used coffee grounds and place in a plastic ziplock bag – then throw into household trash.

Healthy Driven
Edward-Elmhurst HEALTH

Medication Take-Back Program

Protect your family, friends and the environment by disposing of dangerous medications.

Simply drop your **unused, unwanted or expired controlled medications** in one of our handy collection bins 24/7/365.

Restricted items include

- Needles/syringes
- Liquids
- Aerosols
- Inhalers
- Thermometers
- Illegal drugs

BIN LOCATIONS

Edward Hospital – 801 S. Washington Street, Naperville
Hallway between the south parking garage and south lobby off of Osler Drive

Elmhurst Hospital – 155 E. Brush Hill Road, Elmhurst
Vestibule of Door 28 near the Emergency Department (Door just to the right of the main ED Entrance)

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