PROCEDURE

Diskectomy

Diskectomy is surgery to remove spinal disk tissue that is pressing on a nerve.

PURPOSE
Relieve nerve pressure caused by a damaged spinal disk

PROCEDURE TYPE
Therapeutic surgery, open or minimally invasive

WHERE IT IS DONE
Operating theatre

ANAESTHESIA
General

HOW LONG IT TAKES
Usually 1 to 2 hours

PREPARATION
Fasting; medication review; planned blood thinner changes

RECOVERY
Home same day or overnight; no driving while impaired

MAIN RISKS
Infection, dural tear, nerve injury, recurrent disk herniation

RESULTS
Pain relief may begin immediately or over several weeks

Overview

A diskectomy removes spinal disk tissue pressing on a nerve. Spinal disks are soft cushions between the bones of the spine. If a disk's outer covering tears, softer material can push outward, causing a herniated disk.

The procedure is most often performed in the lower back for pain that travels into a leg, commonly called sciatica. It may also treat a neck disk pressing on a nerve supplying an arm.

The surgeon usually removes only the loose or bulging material. A microdiskectomy uses magnification and a small incision, while an endoscopic diskectomy uses a narrow tube and camera. Some operations require a larger incision or removal of nearby bone.

Diskectomy mainly treats nerve-related arm or leg symptoms. It may not relieve back or neck pain caused by arthritis, muscle problems, or general disk wear.

Why the procedure is performed

Diskectomy may be considered when a herniated disk clearly matches your symptoms, examination, and imaging, usually an MRI scan.

Reasons for surgery include:

Loss of bladder or bowel control, numbness around the genitals or buttocks, or rapidly worsening leg weakness can indicate compression of the nerves at the bottom of the spine. This requires emergency assessment and may require urgent surgery.

- Disabling arm or leg pain despite nonsurgical treatment
- Numbness or weakness caused by pressure on a spinal nerve
- Difficulty standing, walking, sleeping, or working
- Worsening muscle weakness
- Loss of bladder or bowel control from severe nerve compression

Who should and should not have it

Diskectomy may be suitable when symptoms, examination findings, and imaging identify the same compressed nerve. It is often offered after activity changes, pain medicine, or physical therapy have not provided enough relief.

Surgery may not help if imaging does not show nerve pressure that explains the symptoms. It is also less likely to relieve pain limited to the back or neck without clear nerve involvement.

A planned operation may be delayed for an active infection, an uncontrolled medical condition, or a blood-clotting risk that cannot yet be managed safely. Smoking, poorly controlled diabetes, and some heart or lung conditions increase surgical or healing risks and may affect timing or approach.

Improving symptoms may support continued nonsurgical care, while severe or worsening weakness may make waiting less appropriate. Ask why surgery is recommended now and what may happen without it.

How to prepare

Follow the treating facility's instructions, which take priority over general information.

Tell the surgical team about all prescription medicines, over-the-counter products, vitamins,

and supplements. Blood thinners and medicines affecting clotting require a specific plan. Do not stop them unless the clinician responsible for your procedure tells you to.

Follow instructions about when to stop eating and drinking before anaesthesia. Ask how to manage diabetes medicines and medicines normally taken with food.

Arrange for an adult to take you home. You may also need someone to stay with you the first night, depending on your health, procedure, and home support.

Before surgery, the team may confirm the spinal level using your examination and imaging. Report changed symptoms, illness, fever, or a skin infection.

What happens during the procedure

You will usually receive general anaesthesia, so you are unconscious during the operation. The team positions you according to the part of the spine being treated.

For a lower-back diskectomy, the surgeon makes an incision, moves the muscles aside, and may remove a small amount of bone or ligament to reach the nerve. The nerve is protected while the compressing disk fragments are removed.

Microdiskectomy uses magnification through a smaller opening. Endoscopic surgery uses a camera and instruments passed through a narrow tube. These approaches are not suitable for every herniation.

For neck surgery, the surgeon may approach from the front or back. Disk removal may be combined with fusion or disk replacement if the whole disk is removed or the spine needs support.

The wound is closed, and you move to a recovery area as the anaesthetic wears off.

Recovery and what to expect afterward

Incision soreness, muscle tightness, or spasms are common. Arm or leg pain may improve quickly, but numbness, tingling, or weakness can take longer because nerves recover gradually.

You can usually eat and drink once awake and not feeling sick. Walking is generally encouraged soon after surgery. Increase activity gradually and follow instructions for lifting, bending, twisting, exercise, and wound care.

Some people go home the same day; others stay overnight or longer. Do not drive home. Avoid driving while taking sedating medicines or while pain or limited movement prevents safe

vehicle control. Your team will advise when you can resume.

Return-to-work timing depends on recovery and job demands. Physical work involving lifting, bending, climbing, or machinery generally requires more time than desk work.

Risks and possible complications

Diskectomy cannot guarantee complete or permanent relief. Possible complications include:

Neck surgery may cause temporary swallowing difficulty or voice changes. Less commonly, the spinal cord, airway, food pipe, nerves, or blood vessels may be injured.

Risk varies with the spinal level, surgical approach, previous operations, and general health.

- Bleeding, infection, or an anaesthetic reaction
- Nerve root injury causing new pain, numbness, or weakness
- A tear in the nerve covering with spinal fluid leakage
- Continued symptoms from an irritated or damaged nerve
- Another herniation at the operated disk
- Scar tissue around a nerve
- Blood clots
- Spinal instability or another operation

Results and follow up

Pain caused by nerve pressure may improve soon after surgery. Numbness and weakness can recover over weeks or months and may not disappear completely if the nerve has lasting damage.

Follow-up checks the wound, strength, sensation, pain control, activity, and readiness to work. Keep these appointments even if recovery seems straightforward. Contact the team between visits if symptoms are not improving as expected.

Alternatives

For stable or improving symptoms, options include guided activity, pain medicines, and physical therapy. These may reduce symptoms and improve movement but do not remove

disk material or reliably reverse worsening weakness.

An epidural steroid injection may temporarily reduce inflammation around the nerve and postpone surgery, but it does not repair the disk and may not help everyone.

Spinal instability, narrowing caused by bone changes, or disease involving several structures may require wider decompression, fusion, or disk replacement.

Choosing no surgery remains an option unless nerve compression requires urgent treatment. Ask how waiting could affect pain, strength, bladder or bowel function, and the chance of nerve recovery.

When to call your healthcare team

Seek emergency care for:

Contact your surgical team promptly for increasing wound redness, swelling, drainage, or opening; fever; suddenly worse or uncontrolled pain; a swollen or painful calf; or new numbness or weakness.

Mild soreness, tiredness, and gradual changes in tingling may occur during recovery. Mention them at follow-up, or call sooner if they worsen or concern you.

- New loss of bladder or bowel control
- New numbness around the genitals, inner thighs, or buttocks
- Rapidly worsening arm or leg weakness
- Severe breathing difficulty, chest pain, or collapse

Common questions

Will I be asleep?

Usually. Most diskectomies use general anaesthesia.

Can I drive home?

No. Arrange a ride and resume driving only when your team agrees, you can move safely, and you are not taking sedating medicine.

How painful is it?

Incision and muscle soreness are common. Nerve pain may improve quickly, although tingling or aching can continue during recovery.

When will I know if it worked?

Some people notice improvement immediately; for others, it becomes clearer over days or weeks. Numbness and weakness often take longer.

Can the disk herniate again?

Yes. The same or another disk can herniate, although repeat surgery is not always needed.

Will I need a spinal fusion?

Most straightforward lower-back microdiskectomies do not include fusion. It may be considered for instability or complete removal of a neck disk.

Sources

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- American Association of Neurological Surgeons: Herniated Disc , patient information
- NHS: Lumbar decompression surgery , overview, recovery, and risks
- National Institute for Health and Care Excellence: Low back pain and sciatica in over 16s , guideline NG59
- North American Spine Society: Diagnosis and Treatment of Lumbar Disc Herniation with Radiculopathy , evidence-based clinical guideline