

I was in agony - until the surgeon drilled a tunnel in my spine

By ANGELA BROOKS 15:17pm 15th August 2006



A flying recovery: Pilot Joanna Linton after surgery.

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Joanna Linton, 36, a 747 pilot from Horsham, West Sussex, is one of the 5,000 patients a year who have spinal fusion surgery for lower back pain, and she was the first in Britain to undergo a pioneering, minimally invasive form of the operation. Here, she talks about her operation and her surgeon explains the procedure. **THE PATIENT:** Even though I've always been pretty fit - I love riding, running, golf, gym and sailing - my back first started playing up occasionally when I was a teenager. Three years ago, the pain got much worse and I needed to see an osteopath for manipulation twice a week simply to maintain some quality of life. It felt as if I had a knife constantly stuck in my spine. I fly jumbo jets to Australia, Africa and America, and although sitting wasn't a problem, standing up and walking became harder and harder because of the pain. I had to take a lot of time off sick, and when I was able to work I had to get the cabin crew to carry my bags on to the plane because I was unable to lift anything. On a bad day, it was agonizing. I would struggle to maneuver myself around the house, leaning on furniture to try to take some of the load off my back. Four months ago, when I felt I couldn't take the pain any longer, my GP referred me to a spinal specialist, Mr. Quaile, at The Hampshire Clinic. After first trying me on cortisone injections, which failed, he then sent me for a discogram to establish the precise source of the pain. The discogram involved sticking needles into the lower-back discs under local anesthetic. It doesn't hurt when they stick a needle into a healthy disc, but when they push one into a damaged disc it's excruciating. Based on the findings from this, Mr. Quaile told me that one of my lower discs had degenerated and the best solution would be for me to have spinal fusion surgery, where two of the vertebrae are effectively bolted together. It wasn't until a few days before the operation that I learned I was going to be the first patient in the country to have it done in a remarkable new way. Instead of it being done through a large incision in the stomach or back, I would have it done via a small hole by my tailbone or coccyx. Through this hole they would feed a tube up to the degenerated disc and all the fusion work would be done through this. The great thing is that there are far fewer risks. There are no major blood vessels or nerves in the way, and recovery is faster. I was admitted to the hospital on the day of my operation, July 4, and I became nervous only once I was wheeled into the anesthetic room. The operation went to plan,

but I was kept in hospital for five days because I suffered from low blood pressure. A week after, however, I felt I'd turned the corner in my recovery. For the first time for a long time I could get around the house without a crutch and I'm feeling far less sore. It will take about six weeks before I'm ready to return to work, but I'm so pleased I've had this operation. Hopefully, I'm going to feel better than I've felt in years and get my life back. **THE SURGEON:** Mr. Andrew Quaile is orthopaedic surgeon at The Hampshire Clinic in Old Basing. He says: Conventional disc fusion is high-collateral surgery, but was the best tool we had for chronic lower back pain - until now. The new technique is minimally invasive and minimally traumatic and has been carried out in America for five years. It will take off rapidly here because it's a shorter operation with fewer serious risks. This procedure takes about 45 minutes compared to two-and-a-half hours for conventional surgery. With the patient anaesthetized and laying face down, we make a one-inch incision at the side of the coccyx between the buttocks. Under X-ray guidance, we push a blunt probe encased in a metal tube through the pad of fat just beneath the skin and guide it up to the junction where the tailbone links to the lowest lumbar vertebrae. This is slightly below the small of the back. It's the disc sandwiched between this lowest vertebrae and the one just above it that is most likely to have degenerated. The worn-out disc will be flat and hard and won't have any of the jelly-like properties a healthy disc provides, and because of this bone rubs on bone, frequently trapping nerves - the cause of the unremitting pain these patients complain of. Now we pull the blunt probe out of the tube and replace it with a drill, and with this we drill up through the two vertebrae. Having created this bony tunnel, we remove the drill and sweep out the bits of degenerated disc between the two vertebrae. We do this by feeding up a metal brush - almost like a miniature chimney sweep. By twizzling this around, the bits of faulty disc stick to the brush, which we then pull out. We then flush out any remaining bits of disc with water. Our next step is to make a compound to fill the empty disc space. We do this by mixing the bone shavings with a bone graft material which turns it into a paste which we squirt into the void. This prevents the vertebrae rubbing against each other. Finally, we feed a bolt through the tube. This is attached to a long handle, and by turning this we anchor the two vertebrae together with the bone paste which hardens in between. That done, we remove the surgical tools and sew up the small incision. In America, this is being done as day surgery, but I think there will be resistance to that here. This patient had a longer stay than the three nights anticipated because of her low blood pressure. I will see these patients for follow-up at regular intervals over the first year to make sure the fusion is sound. This operation is not available on the NHS. It costs around £8,500 privately.