A pain in the neck

Dr A Hunningher,
Spr Anaesthesia, Central School of Anaesthesia

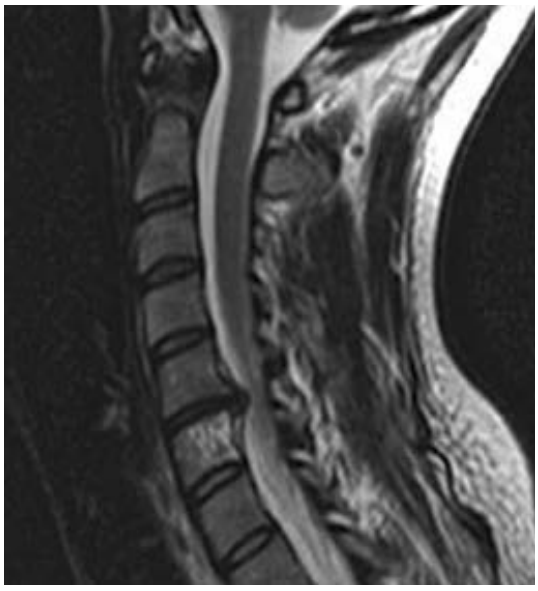
I have had neck pain and tingling in my thumb which I thought was caused, or at least exacerbated, by my work. Like many irritations, such as the exam or the credit crunch, I tried to ignore it in the hope it would go away. Then my rotation took me to Stanmore's sunny and green Royal National Orthopaedic Hospital (RNOH).

After a few weeks there it became clear to me that the ache and tingling in my C6 distribution were worse than some of our patients'. I had a chat with one of the consultant anaesthetists. This situation came as no surprise to her as she had come across many other anaesthetists with similar complaints. Before I knew it I had a hospital number and was lying in a scanner. Despite the text-book symptoms I assumed everything would be fine. But something was wrong. My scan clearly demonstrated the cause of my paraesthesiae.

It was a shock to see the results. A physical examination further revealed that I had muscle wasting and diminished reflexes in my dominant right arm.

Options and risks

My consultant arranged for me to see the surgeon in outpatients. My non-medical husband came for what was a full consultation including a discussion of the options available and the risks involved. This helped ensure the whole process was conducted on a professional basis and avoided corridor consultations. The surgeon recommended a C5/6 anterior cervical discectomy and fusion; a relatively routine procedure and with a good chance of success. He also encouraged me to get other opinions and so I rang some old friends at Queen Square, the National Hospital for Neurology and Neurosurgery. Ironically, I had written a CEACCP article on cervical spine disease and anaesthesia a few years before.



The pre-operative MRI

I had better be careful what I write about in the future!

Having thought long and hard and discussed the pros and cons at length with family, friends and colleagues, I went ahead with the surgery at the RNOH. The option of transfer to a different hospital was discussed but I felt reassured having the surgery at my place of work.

Post-operative weeks

I am pleased to say the operation was a success. Given the seriousness of the procedure, I was transferred to HDU for one night. This was a surreal experience as I had been the doctor three days before and now my colleagues were looking after me. It must have freaked out the long stay patients! I could not lie flat because my neck was swollen and I felt suffocated. The night was a blur thanks to my PCA until the morning when my arm started to develop itchy wheals and I insisted on being detached from the pump. Not the best night's sleep I've had.

Three days later I was at home but with instructions not to drive, lift anything for six weeks (including my 20-month-old son) or do any exercise for 12 weeks. Luckily, we have a nanny share so immediately post-op I arranged for her to come early and stay late. During her time off over Christmas and using my rota master experience, I divided the days into sessions and managed to ensure constant childcare cover.

I came back to work after six weeks with limited duties since I still could not lift patients and CPR was out of the question. It was fantastic to return to theatres as living proof of the good work they do! I left RNOH with scars to prove it. You might just see the anterior scar in the photo but it should fade into the skin crease due to my surgeon's handy work and my daily scar care.

I have now rotated to another hospital where I am back to full duties. As for the six weeks I missed, my training director suggests that what I'd learnt as a patient was invaluable as a trainee. I certainly feel older and wiser!

Good posture is vital

Look around any anaesthetic department and you will see poor posture. In every department I have worked in I have known anaesthetists who complain of back or neck pain. Other healthcare workers such as nurses and surgeons are known to be at increased risk of spinal problems, but the risk in anaesthetists is as yet unquantified and as a profession we are notorious for ignoring symptoms and avoiding occupational health departments. At the start of a rotation we just want to get on the payroll and get on with the job, but we are at risk. There are occupational hazards out. there which we should be taking more seriously. Do you always get the trolley height right for you? I didn't! Do you think of your posture at an arrest? Don't think so! Have you ever been taught manual handling? Um...maybe not. My experiences taught me to think ergonomically. I try to optimise the trolley height, position myself with a balanced arm level with the anaesthetic machine and kneel for cannulation. I ensure there is adequate help when transferring a patient and I don't pull patients up the bed single handed anymore.

A study by Walker showed that more experienced anaesthetists had a better posture for laryngoscopy.[1] I have recently completed a study of anaesthetists and have found that there was no link to experience, vision or height but rather that laryngoscopic posture comes in a connected pattern where, if you get close to the mannequin, the neck flexes significantly. We have a duty to teach anaesthetists good habits from the start of their careers. Like a piano teacher with their student, posture is an essential component to prowess in laryngoscopy. I'm also planning a survey of anaesthetists to assess the incidence of spinal symptoms and problems so that as a profession we can gain more information on spinal problems in anaesthetists. Physician, heal thyself!

I'll stop writing here! My neck is starting to hurt!

References

1 Walker JD. Posture used by anaesthetists during laryngoscopy *Br J Anaesth* 2002;**89**:772–774.