INSTITUTE FOR SPINE SURGERY

Understanding Your Spine

A patient guide to neck and back health, your treatment options, and knowing when to seek care.

FREE PATIENT GUIDE

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BEFORE YOU BEGIN

A note on how to use this guide.

This guide explains how the spine works, why it causes pain, and what your options are. Read it at your own pace. Bring your questions to your visit.

> **IMPORTANT**
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> This guide is for general education. It is not a diagnosis, and it is not a substitute for evaluation by a qualified clinician. No two spines are alike, and the same symptom can have very different causes from one person to the next. Use this as background, then let a specialist assess your individual situation.
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> **If you have any of the warning signs in Section 04, do not wait. Seek care right away.**

How your spine is built.

A column of bones, cushions, and joints that protects your nerves while letting you bend, twist, and stand tall.

Your spine is a stack of small bones called vertebrae, separated by soft cushions called discs. Behind the bones runs a protected channel that holds the spinal cord and the nerve roots that branch out to the rest of your body. Joints at the back of each level, the facet joints, guide movement and keep the spine stable.

The spine has three main regions. Understanding which region a problem sits in often explains where you feel your symptoms.

Cervical spine (neck)

Seven vertebrae that support the head and allow it to turn. Nerves here travel into the shoulders, arms, and hands, which is why a neck problem can be felt in the arm.

Thoracic spine (mid back)

Twelve vertebrae anchored to the ribs. This region is the most stable and is a less common source of nerve related pain.

Lumbar spine (lower back)

Five larger vertebrae that carry most of the body's weight. Nerves here travel into the hips, legs, and feet, which is why a low back problem can be felt down the leg.

The disc, simply explained

Each disc works like a small shock absorber. It has a firm outer ring and a softer center. Discs let the spine move and cushion the load with every step. Over the years discs naturally lose some water and height, which is a normal part of aging and does not always cause pain.

> **WORTH KNOWING**
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> Imaging often shows changes such as disc wear or mild bulging in people who have no pain at all. A finding on a scan only matters when it lines up with your symptoms and your exam. This is one reason a specialist looks at the whole picture, not the image alone.

Why the spine causes pain.

Pain is a signal, not a measurement. It tells you something needs attention. It does not always tell you how much damage is present.

Spine pain can come from several sources. The most common are muscle and soft tissue, the facet joints, the discs, and the nerves. Often more than one of these is involved at the same time, which is why two people with similar scans can feel very different.

Where the pain travels matters

Pain that stays local, in the neck or the low back, often points to muscle or joint. Pain that radiates, down an arm or down a leg, often points to a nerve being irritated or compressed. Doctors call radiating nerve pain radiculopathy. Sciatica is the familiar name for radiating leg pain from a lower back nerve.

Acute and chronic pain

Acute pain comes on suddenly, usually after a strain or injury, and tends to settle as the tissue heals. Pain that lasts longer than about three months is called chronic pain. Chronic pain can continue after the original problem has calmed down, because the nervous system itself can become more sensitive over time.

> **A REASSURING FACT**
>
> Most episodes of neck and back pain improve. Research and clinical experience both show that many flare ups settle within weeks with gentle activity and simple measures, without injections or surgery. Pain is also shaped by sleep, stress, and mood, so caring for the whole picture helps recovery.

Common conditions, in plain language.

These are the conditions we evaluate most often. Each one is described simply here. Your specialist will explain how it applies to you.

Disc herniation

A piece of disc material pushes out and presses on a nearby nerve. It can cause arm pain from the neck or leg pain from the lower back. Most symptomatic herniations improve on their own over time.

Radiculopathy (pinched nerve)

A compressed nerve root produces pain, numbness, tingling, or weakness that follows the path of that nerve into the arm or leg.

Spinal stenosis

A narrowing of the channel that carries the nerves. In the lower back it commonly causes leg symptoms when walking. In the neck it can affect the spinal cord itself.

Neurogenic claudication

A symptom of lower back stenosis. Pain or heaviness travels into both legs while walking or standing and eases with sitting or leaning forward.

Degeneration (spondylosis)

The gradual wear of discs and joints, a normal part of aging that usually appears after the age of forty. It can cause back pain, leg pain, or both, and often responds well to conservative care.

Spondylolisthesis

One vertebra slips slightly forward relative to the one below it, most often in the lower spine. It can cause back pain, leg pain, or both.

Foot drop

Difficulty lifting the front of the foot while walking, usually from compression of the L5 nerve. Because this is a sign of nerve involvement, it is evaluated promptly rather than watched.

Cervical myelopathy

Compression of the spinal cord in the neck. It can cause hand clumsiness, trouble with fine tasks like buttons, numbness, and balance changes. Early diagnosis matters, so it is taken seriously.

When to seek care right away.

Most spine pain is not an emergency. A small number of symptoms are. Knowing the difference, and acting in time, is the single most important thing in this guide.

GO TO THE EMERGENCY ROOM OR CALL 911 NOW

Seek emergency care immediately if you notice any of the following, especially in combination. These can signal a rare but serious compression of the lower spinal nerves called cauda equina syndrome, where a delay in treatment can lead to permanent loss of function.

- New loss of control of the bladder or bowels, or a new inability to pass urine
- Numbness in the saddle area: the groin, the buttocks, the inner thighs, or the genitals
- New or worsening weakness in both legs
- Sudden, severe weakness, such as a foot that drags, gives way, or cannot be lifted

Do not wait to see if these improve. Timing changes outcomes.

CALL YOUR DOCTOR PROMPTLY, THE SAME OR NEXT DAY

These signs do not always mean an emergency, but they should be checked soon rather than waited out.

- Back or neck pain with fever, chills, or a recent infection
- Back pain with a history of cancer, unexplained weight loss, or pain that wakes you at night
- Pain that begins after a significant fall, accident, or other trauma
- Progressive numbness, weakness, or new clumsiness in the hands or legs

When in doubt, get evaluated. It is always reasonable to have a new or changing symptom looked at by a professional.

What you can do at home.

For everyday neck and back pain without warning signs, simple measures help most people. These are general habits, not personalized medical advice.

Keep moving

Gentle activity usually helps more than rest. Long periods of bed rest tend to slow recovery and weaken the muscles that support the spine. Walking, light stretching, and a gradual return to normal activity are good starting points. If a movement sharply increases pain, ease off that movement rather than pushing through it.

Everyday habits that protect your spine

Lift with care

Bend at the knees, keep your back straight, and hold the object close to your body. Avoid twisting while lifting.

Mind your sitting

Change position often. Support your lower back and rest your feet flat. Stand and stretch through long stretches at a desk.

Sleep position

Lying on your side with the knees gently drawn up can ease pressure on the lower spine.

Stay strong

Regular low impact exercise that builds core and back strength helps prevent future flare ups.

Simple relief

For most neck and back pain, over the counter options such as acetaminophen, sold as Tylenol, and anti inflammatory medicines such as ibuprofen and naproxen, sold as Advil, Motrin, and Aleve, can reduce discomfort. Use them as directed on the label, and check with your doctor or pharmacist if you take other medicines or have health conditions. Heat or ice, whichever feels better, can also help.

> **TWO HABITS THAT MAKE A REAL DIFFERENCE**
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> **If you smoke, consider a plan to cut back or quit.** Smoking reduces blood flow to the spinal discs, which can speed wear and slow healing.
>
> **Do not let fear of movement take over.** It is natural to worry about reinjury, but avoiding all activity tends to make stiffness and weakness worse. A steady, gradual return to the things you enjoy supports recovery.

Non surgical care.

The great majority of spine conditions are managed without surgery. Care begins with conservative options and moves further only when it needs to.

When home measures are not enough, a specialist can build a plan around your specific condition. The aim is to relieve pain, restore movement, and protect the long term health of your spine.

Physical therapy

A personalized program to build strength, flexibility, and posture. For many people this is the foundation of recovery and the most important step.

Epidural steroid injections

A targeted injection that can reduce inflammation and nerve related pain from conditions such as a herniated disc or stenosis, often with minimal downtime.

Radiofrequency ablation

A minimally invasive procedure that interrupts pain signals from specific nerves, which can provide long lasting relief without surgery.

Chiropractic care and acupuncture

Considered alongside therapy and medication as part of a comprehensive plan. Acupuncture can help when muscle spasm is a major feature.

Coordinated pain management

For ongoing symptoms, a coordinated approach combines several of these tools to improve comfort and daily function.

> **A REALISTIC TIMELINE**
>
> Many people improve within a few weeks. A structured course of conservative care often runs about eight to twelve weeks before surgery is even discussed. The clear exception is when there is a neurological sign such as foot drop or progressive weakness, which is evaluated sooner rather than later.

When surgery is considered.

Surgery is a tool for specific situations, not a default. It is considered when the picture points clearly to a problem that surgery can fix.

A surgical conversation usually begins when three things line up: persistent or progressive symptoms, an imaging finding that matches those symptoms, and limited improvement after a fair course of non surgical care. A neurological deficit, such as weakness or foot drop, or signs of spinal cord compression, can move that conversation earlier.

Modern approaches

Where it is appropriate, minimally invasive techniques use smaller incisions, which can mean less pain after surgery and a quicker recovery. Depending on the condition, a procedure may relieve pressure on a nerve, stabilize a segment with a fusion, or preserve motion with a disc replacement. The right approach depends entirely on your anatomy and your goals.

Decompression

Removing what is pressing on a nerve or the spinal cord to relieve pain and protect function.

Spinal fusion

Joining two or more vertebrae to stabilize the spine and relieve pain from movement at an unstable segment.

Motion preserving surgery

In selected cases, an artificial disc can relieve pressure while keeping natural movement at that level.

> **WHAT TO EXPECT**
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> Recovery varies by procedure and by person. A good surgical plan is personalized, explains the goals clearly, and sets realistic expectations before anything is scheduled. The point of surgery is to restore function and quality of life, not simply to operate.

Preparing for your visit.

A little preparation helps your specialist understand your situation quickly and makes your time together more useful.

Bring with you

- ☐ A short summary of your symptoms: where they are, how long you have had them, and what makes them better or worse
- ☐ Any prior imaging, such as MRI, CT, or x ray studies, ideally on a disc or through your patient portal
- ☐ A current list of your medications, including over the counter ones
- ☐ A note of treatments you have already tried, such as therapy, injections, or medication, and how they helped

Good questions to ask

- What is most likely causing my symptoms?
- What are my non surgical options, and where should we start?
- Do I need imaging now, or can we wait?
- What warning signs should send me back to you sooner?
- What can I do at home to help my recovery?

> **A SMALL TIP**
>
> Write your questions down before the visit and bring someone with you if you can. It is easy to forget a question in the moment, and a second set of ears helps you remember the answers later.

Questions patients ask most.

Do I need surgery for my spine condition?

Most people do not. The majority of spine conditions improve with conservative care. Surgery is reserved for specific situations, such as a clear neurological deficit or symptoms that persist despite a fair course of non surgical treatment.

I have neck or back pain. Do I need an MRI?

Often not right away. Most new pain improves with simple measures over a few weeks. Imaging becomes important when pain persists, or when there is numbness, weakness, or another warning sign, which should be evaluated regardless of the pain level.

What is minimally invasive spine surgery?

It refers to techniques that use smaller incisions and spare more of the surrounding tissue. For suitable patients this can mean less pain after surgery and a faster recovery compared with traditional open approaches.

How long is recovery after spine surgery?

It depends on the procedure and the person. Minimally invasive procedures often allow a quicker return to activity, while a fusion takes longer to heal fully. Your surgeon will give you a timeline based on your specific operation.

Will I need a second surgery?

Most patients do not. A thoughtful first plan is built to address the underlying problem and reduce the chance of returning to the operating room. Long term spine health also depends on staying active and caring for your overall health.

Should I try physical therapy or an injection first?

For many conditions, physical therapy is the foundation. Injections such as an epidural can be added when nerve related pain needs more targeted relief. Your specialist will recommend the right order for your situation.

NEXT STEPS

Talk with a spine specialist.

If your symptoms are limiting your life, or you simply want answers, an evaluation is the clearest next step. There is no need to live with uncertainty.

THE INSTITUTE FOR SPINE SURGERY

Request an appointment.

Our team reviews your situation and recommends the right path, surgical or non surgical. Typical callback within one business day.

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Sources and further reading

National Institute of Neurological Disorders and Stroke. Low Back Pain and Pain fact sheets. ninds.nih.gov

American Association of Neurological Surgeons. Herniated Disc and Cauda Equina Syndrome. aans.org

MedlinePlus, U.S. National Library of Medicine. Herniated disk and Cervical spondylosis. medlineplus.gov

Medically reviewed by John M. Abrahams, MD, board certified neurosurgeon and Fellow of the American Association of Neurological Surgeons. Reviewed May 2026.