

## Thoracic disc: Current scenario

Thoracic disc herniation (TDH) is rare and mainly occurs between T8 and L1, with an estimated frequency of 1 per 1,000,000 people. TDHs have a particular mode of revelation and progression, dominated by the risk of medullary compression. The herniated disc can be very large in volume and predominantly calcified, which herniation increases the risk of intradural extension due to erosion and progressive thinning of the dura. TDH is labeled as giant when it occupies more than 40% of the medullary canal on computed tomography scan or magnetic resonance imaging. TDH is most common in adults 30–50 years of age, with equal distribution between the two genders. In 75% of cases, the TDH is located below the T7–T8 disc. The T11–T12 disc is the most vulnerable because of greater mobility and posterior longitudinal ligament weakness at this level.

TDH presents with axial pain in the mid- to lower-thoracic spine associated with radicular pain, which occurs in dermatomal distribution, and thoracic myelopathy with weakness and impaired balance.

Conservative treatment is appropriate for most cases which may include activity modification, analgesics, Non-steroidal anti inflammatory Drugs, and physical therapy. In the acute phase, passive modalities may be used, but after that, the focus should switch to active rehabilitation, including aerobic activity, range of motion, and strengthening with emphasis on extension exercise.

Surgical treatment is reserved for progressive myelopathy, myelopathy with significant functional deficit, and radicular pain that is not improving. Posterolateral approaches are recommended for soft lateral herniation. Transthoracic approaches are not only safer for giant herniation but also generate more complications.

Minimally invasive transtubular approaches are feasible and reduce morbidity. Progress in the treatment methods will come from the use of computer navigation and minimally invasive approaches.

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