Case Report

Occipito-cervical fusion in Cranio-Vertebral anomalies with basilar invagination

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ABSTRACT

Basilar invagination are uncommon syndrome that occurs when the superior part of the odontoid (part of the C2 vertebrae) migrates upward through foramen magnum and that causes bulbomedullary compression. Basilar invagination are divided on bases of that causation in traumatic and other one is developmental. Mostly seen basilar invagination are developmental. Here with describe a case of 13yr old female with developmental craniovertebral junction abnormality in form of congenital atlanto axial dislocation with Platiebasia with basilar invagination which is treated with decompression and occipital plate and screw based posterior fixation with its clinical as well as radiological outcome.

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1. Introduction

Basilar invagination has several etiologies it should be considered a radiographic finding and the underlying etiology should be identified. Basilar invaginations are classified as developmental and traumatic. Among the reported etiologies of developmental basilar invagination are clival hypoplasia, condylar hypoplasia, hypoplasia of the atlas, incomplete ring of atlas with spreading of the lateral masses, achondroplasia, and atlanto-occipital assimilation. “Basilar impression” is the term used to describe the acquired form of basilar invagination, which results from softening of the bone at the base of the skull. Common conditions leading to basilar impression are Paget’s disease, rheumatoid arthritis, osteomalacia, hyperparathyroidism, osteogenesis imperfecta, Hurler syndrome, rickets, and skull base infection.

The Chamberlain line- from the dorsal lip of foramen magnum (opisthion) to the posterior portion of the hard palate. The superior tip of odontoid usually does not exceed beyond this line, extension beyond 5 mm is typically considered abnormal.

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McRae line delineates the foramen magnum from anterior margin to the posterior border, for which the odontoid tip should not cross.

McGregor described a modification of the Chamberlain line from the posterior portion of the hard palate to the lowest edge of the midline occipital surface.

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McGregor described a modification of the Chamberlain line from the posterior portion of the hard palate to the lowest edge of the midline occipital surface.

Goel’s classification of atlanto axial instability
Type 1- Anterior atlanto axial facet dislocation
  Most common as well as most symptomatic type
Type 2- Posterior atlanto axial facet dislocation
Type 3- Central atlanto axial facet dislocation
  Generally type 2 and type-3 predental space is not affected and they are generally less symptomatic. Generally they become symptomatic after trauma.

1.3. Case description
13yr old female with complain of neck pain and b/l upper limb and lower limb weakness since 15 days which is progressive and patient became unable to walk or even stand and since last 4 days with normal bowel and bladder function without any history of trauma or any clinical complain like fever, cough etc. So patient brought to Rajkot civil for treatment where all radiological investigation done and in MRI and CT scan patient found to have predental space of 6.5mm which is suggestive of atlanto-axial dislocation and tip of dens is 11mm above level of chamberlain line which suggestive of basilar invagination with Patiebasia which cause compression over brainstem due which pateint has weakness in b/l upper and b/l lower limb. When patient came to CHA tong insertion done and traction given then traction CT scan done for checking stability of Atlanto axial joint and patient was operated oc fusion with plate and screw fixation with posterior approach and after 2 days of surgery patient’s neurology got improved and post operative ct scan done.

2. Discussion
Cervical instability due to trauma or congenital pathologies are the most common indications leading to instrumented spinal fusions in children. I Zehan et al shows fusion gives significantly better clinical outcome with low morbidity if performed with skilled surgeon who has impwerative knowledge about anatomy of
cranio-vertebral junction. M. lastikka shows better outcome of it in children with skeletal dysplasia.

The main indications for instrumented cervical spinal fusions in the current case was instability due to developmental atlanto-axial dislocation with basilar invaginations with platybasia. Fusion is sometimes necessary to treat and/or prevent neurologic deficits in developmental anomalies of craniovertebral junction. Occipito-cervical fusion can be done with two different techniques. 1) Rigid internal fixation with screws and 2) semi rigid wiring techniques and in which first has been documented to be superior in terms of lower complication rates and higher fusion rates. The biomechanical stability of C1 to C2 fusion has also been found to be in favour of a screw system over wiring techniques in studies. It is also thought that rigid internal fixation will diminish the need and duration of long post operative external stabilisation devices. Screw/rod implants offer rigid skeletal fixation for occipito-cervical stabilization. Rigid cervical fixation is advantageous in that it minimizes axial rotation. Such fixation is attained through C1-2 transarticular screw fixation or through C1 lateral mass fixation coupled with C2 pars interarticularis, pedicle, or laminar fixation. Occipital plate is connected with rods to C1 lateral mass screws and C2 translaminar screws. Note the large surface area covered by the plate. The first step is to achieve fixation in the upper cervical spine by using techniques described previously. The next step is to bend the rods to match the anatomical configuration of the Cranio vertebral junction. Low-profile connectors allow the rods to be secured to the occiput with cortical bone screws. This avoids the use of polyaxial screws that have large heads and are therefore prone to break through skin because of inadequate soft tissue in the occiput. Alternatively, rods can also be secured to an occipital keel plate. Occipital keel plates are available in various configurations. They cover more surface of the occiput than low-profile connectors. This may hinder occipital graft placement. Bone thickness should be assessed through preoperative axial imaging studies. Ideal occipital fixation is achieved in the midline because the thin, squamous portion of the occiput does not allow sufficient screw purchase. The midline bone usually can accept a 10 mm screw. Often 12 or 14 mm screws can be placed into this structure. Rigid fixation should be achieved through at least four bicortical occipital screws. Six screws are optimal, but the patient’s anatomy may not allow for this many to be implanted. Drilling is performed with a high-speed drill, and the drill holes should begin lateral to the midline and below the superior nuchal line. A midline screw may be utilized in certain occipital plate designs once the skull is sculpted with a burr to allow the plate to sit
flat below the superior nuchal line. The drill should be advanced very slowly. A probe is helpful for determining when the hole is bicortical. After the drill holes have been made, tapping is necessary before placing the fixation screws. Bleeding is often encountered from the bone but is usually self-limited following screw placement. Occipito-cervical fusion with lateral mass screws in C1 and pars interarticularis screws in C2. Here patient is operated for occipitocervical fixation through posterior approach without odontoidectomy. Immediate post operatively forepost collar givrn to patient for stabilization. Post operatively patient’s improved drastically from 4/5 power in b/l lower limb and 3/5 power in b/l lower limb to 5/5 power in b/l lower limb and 4+ power in b/l upper limb so that patient improved to neurick grade-1 from Neurick grade-3 and in post op CT scan tip of dens is at the level of chamber lands line before surgery which is 11 mm away from the line which is significant for basilar invagination in predental space there is no significant change due partial assimilation of atlas to oociput. Many complications of occipito cervical fusion are neurological deficit, non fusion, perforation in skull, infection, abnormal motions of fused segment. For better understanding of clinical course of patient advised for regular follow up.

3. Conclusion

Here by, this is concluded that OC fusion with posterior screw and plate fixation is a treatment option in patient with developmental atlanto-axial dislocation with basilar invagination. Patient shows significant improvement clinically as well as radiologically without any significant increasing chances of immediate and early post operative complications.

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None.

5. Conflict of Interest

None.

6. References


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