CASE REPORT

Oral Extrusion of a Cervical Screw 15 Months after Anterior Cervical Spine Plating

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ABSTRACT
Oesophageal perforation following anterior cervical fusion procedures is a rare complication. This report describes a case of oral extrusion of an implant screw that resulted in a benign course in a 64-year-old Chinese man. Oesophageal perforation probably closed spontaneously in this patient. A literature review of the causes of implant failure was performed. The reasons behind extrusion of such a well-placed expansion lock screw are discussed.

Key Words: Bone screws, Cervical vertebrae, Esophageal perforation, Prosthesis failure

INTRODUCTION
Anterior cervical spine fusion and stabilisation is a well-established procedure for managing trauma, degenerative spondylosis, cervical myelopathy, and radiculopathy. However, it is not free of complications. Problems can be graft-related or implant-related. In this report, a rare but potentially life-threatening complication of screw extrusion in which the screw was eventually coughed out by the patient is described.

CASE REPORT
A 64-year-old Chinese man was admitted to the Department of Orthopaedic Surgery at the National University Hospital, Singapore, in November 2001 for anterior cervical discectomies and fusion at the C4-5 and C5-6 levels to manage cervical myelopathy. The preoperative diagnosis was intervertebral disc herniation at both levels that was causing significant spinal cord compression. Tricortical-cancellous autogenous bone grafts were harvested from the iliac crest and placed in the intervening disc spaces after completion of the discectomies. Anterior cervical plating was performed with the Window Cervical Dynamic Plate System (Advanced Spine Technology Inc, Oakland, USA). This construct had unicortical locking screw anchorage and offered dynamic subsidence of up to 4 mm. Two screws were placed at each end of the plate and 1 screw was placed into each autograft at the disc spaces.

Postoperative recovery was unremarkable. After 5 days, a soft cervical collar was fitted and the patient was discharged from hospital. Postoperative X-rays showed good positioning of the bone graft and implants, as well as restoration of cervical lordosis (Figure 1). The patient had no dysphagia or sore throat on follow-up, and the preoperative symptoms of unsteady gait and limb weakness gradually subsided.