Anterior Screw Fixation for Odontoid Fracture Using the Direct Approach at the C2-C3 Level: Case Report and Literature Review

Wuilker Knoner Campos* and Daniel dos Santos Sousa
Neuron – Institute of Neurosurgery, Baia Sul Medical Center, Florianopolis, Brazil

Abstract

Fractures of the odontoid process comprise 10–15% of all cervical fractures. Almost two thirds of all dens fractures are classified as type II according to Anderson and D’Alonso classification system, indicating that they involve the base of the odontoid process [3]. When these fractures are treated non-operatively, rates of non-union and pseudoarthrosis are high [4-6], besides infection and clinical complications associated to halo devices [7,8].

Presently, direct anterior odontoid screw fixation provides the best anatomical and functional results for type II odontoid process fractures with intact transverse ligament, and it is considered as treatment of choice for type II-B fractures [4,9-11]. The main advantage of this method is that preserves rotatory motion of the cervical spine with immediate stabilization of the spine through the well-known Smith-Robinson [12] or Cloward approach to access the prevertebral space. Routinely a transverse skin incision is made at the level of C4-C5 or C5-C6 to prepare a working corridor to C2 level [13].

However, these traditional approaches involve dissecting the longus colli muscles as well as for excessive retraction of the vascular structures, trachea, esophagus, and recurrent laryngeal nerve by retractor systems. This hard retraction can damage the surrounding soft tissue. We have advocated that the direct C2-C3 level approach could be a shorter and safer working corridor to the anterior odontoid screw fixation with less soft tissue retraction. Here we present a case report of a 62-year-old man who presented with Type II odontoid fracture and subsequently underwent a direct anterior odontoid screw fixation through a mini-open approach at the C2-C3 level. The literature available in the English language on related-approach complications of anterior odontoid screw fixation is reviewed.

Keywords: Odontoid fracture; Cervical spine fracture; Odontoid screw fixation; Minimally invasive spinal surgery

Introduction

Fractures of the odontoid process comprise 10–15% of all cervical fractures [1]. Almost two thirds of all dens fractures [2] are classified as type II using Anderson and D’Alonso classification system, indicating that they involve the base of the odontoid process [3]. Currently, the direct anterior odontoid screw fixation provides the best anatomical and functional results for this type of fracture and it is considered as the treatment of choice. Regarding the approach to the C2 vertebra, about 80% of authors usually make a skin incision at the lower cervical level (C4-C5 or C5-C6) for creating a working corridor. However, the required exposure and the relatively blind passage of the screw can damage the surrounding soft tissue. The direct approach at the C2-C3 level could be a shorter and safer working corridor to the odontoid screw fixation with less soft tissue retraction. Here we present a case report of a 62-year-old man who presented with Type II odontoid fracture and subsequently underwent a direct anterior odontoid screw fixation through a mini-open approach at the C2-C3 level. The literature available in the English language on related-approach complications of anterior odontoid screw fixation is reviewed.

Case Report

A 62-year-old healthy man was in a traffic accident. He presented with severe neck and occipital pain. He was initially evaluated at an outside emergency room and later transferred to our institution. His neurological examination was unremarkable (ASIA grade E). Cervical radiography and computerized tomography scanning demonstrated a Type II odontoid fracture (Figures 1A and 1B) according to the Anderson and D’Alonso classification [3]. Based on the direction of the fracture line extending from anterior-superior to posterior-inferior (Grauer Type II subclass) [14], this fracture still was classified as Type II-B (Figure 1C). MRI has also showed that atlantoaxial ligaments were undamaged.

The imaging findings were discussed with the patient as well as conservative and surgical options for treating his unstable odontoid fracture, and a direct anterior odontoid screw fixation was indicated. General endotracheal anesthesia was used and the patient was placed in a supine position with a folded sheet under the patient’s shoulders. A Mayfield head holder was used to fix the head on a radiolucent operating table with the mouth held open with a radiolucent bite block so that AP and lateral fluoroscopy was available throughout the operation (Figure 2). Anatomic reduction of the fragment was confirmed after gentle flexion and extension maneuvers of the head.

A 3.5-cm right transverse skin incision was placed at C2-C3.
of C2. The K-wire was placed in the desired direction under biplanar fluoroscopy (Figures 3A-C). A cannulated cancellous screw, 40 mm in length and 3.5 mm in diameter, was inserted through the prepared tract, across the fracture line, and to the tip of odontoid process (Figure 3D). Finally the K-wire was removed and we closed the platysma with absorbable sutures and the skin was closed with intradermal sutures.

Neurological examination was performed immediately after surgery and then daily until discharge. Postoperative radiographs (Figure 4) confirmed the good position of the odontoid screw and a Philadelphia neck collar was worn for at least two months. After three months, CT scans (Figure 5) were obtained showing satisfactory union of the fractured dens and therefore the collar was discontinued.

**Figure 2.** Double image intensifier to have lateral and open mouth view of the dens simultaneously available.

**Figure 3:** Intra-operative fluoroscopic image (lateral view). (A) the initial groove preparing the bed for the screw head; (B) The guide K-wire was advanced into the odontoid with a power drill until the tip of fractured odontoid process; (C) The protection tube over the guide tube was inserted into the C2 body; (D) the cannulated screw was advanced into the odontoid process.

**Figure 4:** Postoperative (A) lateral and (B) open mouth radiographs demonstrating excellent reduction and fixation of the Type II odontoid fracture with a single titanium cannulated lag screw.

**Figure 5:** (A, B) Sagittal reconstructed CT scan showing adequate placement of the odontoid screw. (C, D) 3D-sagittal reconstruction view 90 days after the operation.
Discussion

Direct fixation of the odontoid process has been viewed as a method to provide direct fixation of the fracture fragment, eliminating the need for more extensive C1–C2 arthrodesis techniques and allows rapid return to normal lifestyle [15]. This procedure is associated with excellent clinical results [4]. The fusion rate is about 90% when the surgery is performed within the first 6 months of injury, but drops to 25% for remote fractures [4,9]. Curiously, this procedure was first reported independently by Nakanishi in 1980 [16] and Bohler in 1982 [17].

The complications associated with anterior screw fixation are principally related to either hardware failure (biomechanical problems of the screw fixation) or due to the technical demands of the procedure. A 10% hardware complication rate is reported in the literature and the most common complication was screw pullout of the body of C2 [9]. In our case, there are no complications related to hardware failure. The postoperative images also showed precise positioning of the odontoid screw (Figures 4 and 5). Our patient did not have any complications during his admission or follow-up.

On the other hand, the Literature is unclear regarding the approach-related complications. Authors have reported them occur more frequently in the elderly and include postoperative hematoma, dysphagia, esophageal or pharyngeal perforation, airway problems and hoarseness [9,18]. Dysphagia after anterior cervical surgery is common in the initial postoperative period and decreases with time, though most authors neglect it as a transitory complication in their reports. Daylei et al. revealed an incidence of dysphagia of 35% in elderly, with 25% of patients requiring a temporary feeding tube for 4 months or longer [19]. Postoperative airway complications are also reported as an important problem. They include vocal cord dysfunction, tracheostomy, prolonged or repeated intubation, respiratory distress, airway edema, prolonged ventilator use, and aspiration pneumonia [20]. The risk of aspiration pneumonia has been reported to be as high as 19% in elderly patients, increases in these patients with dysphagia [19].

All information above-mentioned about related-approach complications testifies the importance of a softer working corridor during the direct anterior odontoid screw fixation. Nowadays careful attention to surgical detail is essential to avoid potential injury of surrounding soft tissue during anterior cervical approach. Therefore, when a skin incision is made at the lower cervical level (C4–C5 or C5–C6), the required exposure and the relatively blind passage of the screw may be the greatest sources of complications [9]. According to Literature review [4,10,11,21-38], about 80% of authors used these levels as entry point to achieve a work corridor to the odontoid fracture (Table 1). Another 20% of authors reported a higher level of cervical approach (C2–C3 or C3–C4). Like our surgical practice, Lee and Sung [33] first started at the C5-C6 level, then changed to C4–C5 and finally at C3–C4 level. Likewise, we agreed with them about this approach made the working distance up to C2–C3 level much shorter, and the procedure became more convenient. However, there are no studies comparing approach-related complications with cervical levels approach so far.

Besides a shorter working corridor has been achieved in present case, our patient also had a good cosmetic result. He had a 3.5-cm transversal skin incision, compared with the traditional skin incision at C5-C6 level which is 6–7 cm in length [39]. The neck incision was smaller than that in the traditional procedure because the exposure did not need to accommodate a three- or four-blade retractor system, only a specular retractor. Our cosmetic result was comparable to authors that used the anterior screw fixation through the endoscopically assisted system [40]. Regarding the percutaneous anterior odontoid screw fixation [26], a better cosmetic result is achieved. However, the major criticism may be that this technique uses a blind passage of the screw, which can result in damage of the surrounding soft tissue.

Finally, we believe that the direct at the C2–C3 level approach to perform an anterior odontoid screw fixation has good advantages. First, it is less invasive than conventional approach because provides a smaller working corridor through the mini-open approach. The use of a smaller working corridor may reduce the incidence of injury to the surrounding soft tissue and consequently approach-related complications. Second, it allows the direct view and access to the C2 body with the possibility of the direct reduction of the odontoid process fracture during the screw fixation. Third, this approach might help to relieve some of the technical demands of preserving the appropriate screw trajectory, especially in patients with barrel chested or obesity. Minimally invasive techniques are becoming more widespread in the surgical specialties. Present mini-open approach to the C2–C3 level might be a safe and feasible option for the traditional approach to treat Type II-B odontoid fracture [41,42].

References


