

Esophageal Perforation Following Anterior Cervical spine surgery: A Systematic Review of the Literature

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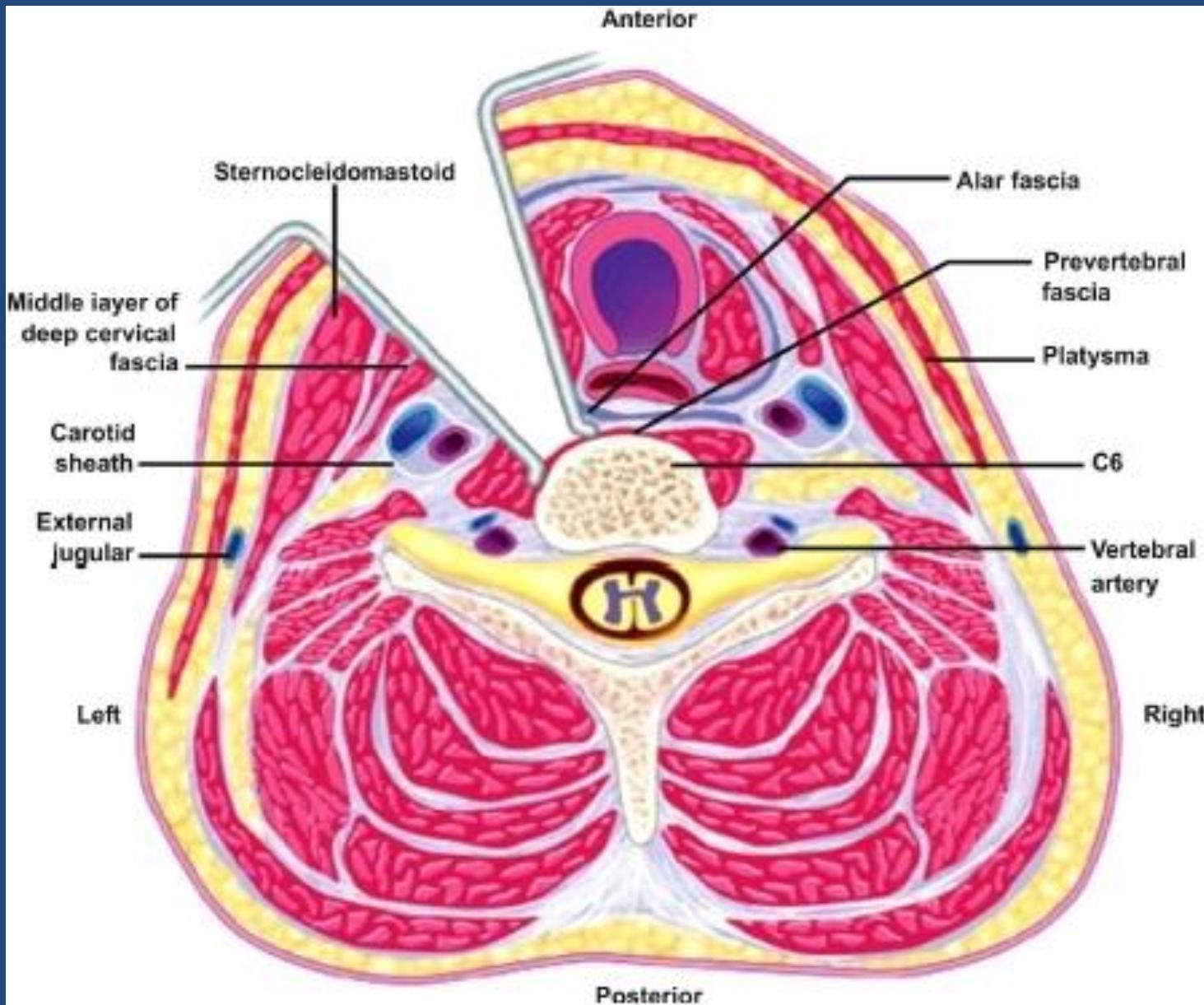
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Learning Objectives

By the end of this presentation, learners should be able to:

- 1.) Develop an understanding of etiology of esophageal perforations in anterior cervical spine surgery
- 2.) Identify the prognosis, outcomes, and methods of repair of esophageal perforations
- 3.) Appreciate the clinical manifestations of esophageal perforation in the post-operative period

Anterior Approach to the Cervical Spine



Source: Palumbo, M. A., et al. (2012). "Airway compromise due to wound hematoma following anterior cervical spine surgery." [Open Orthop J](#) 6: 108-113.

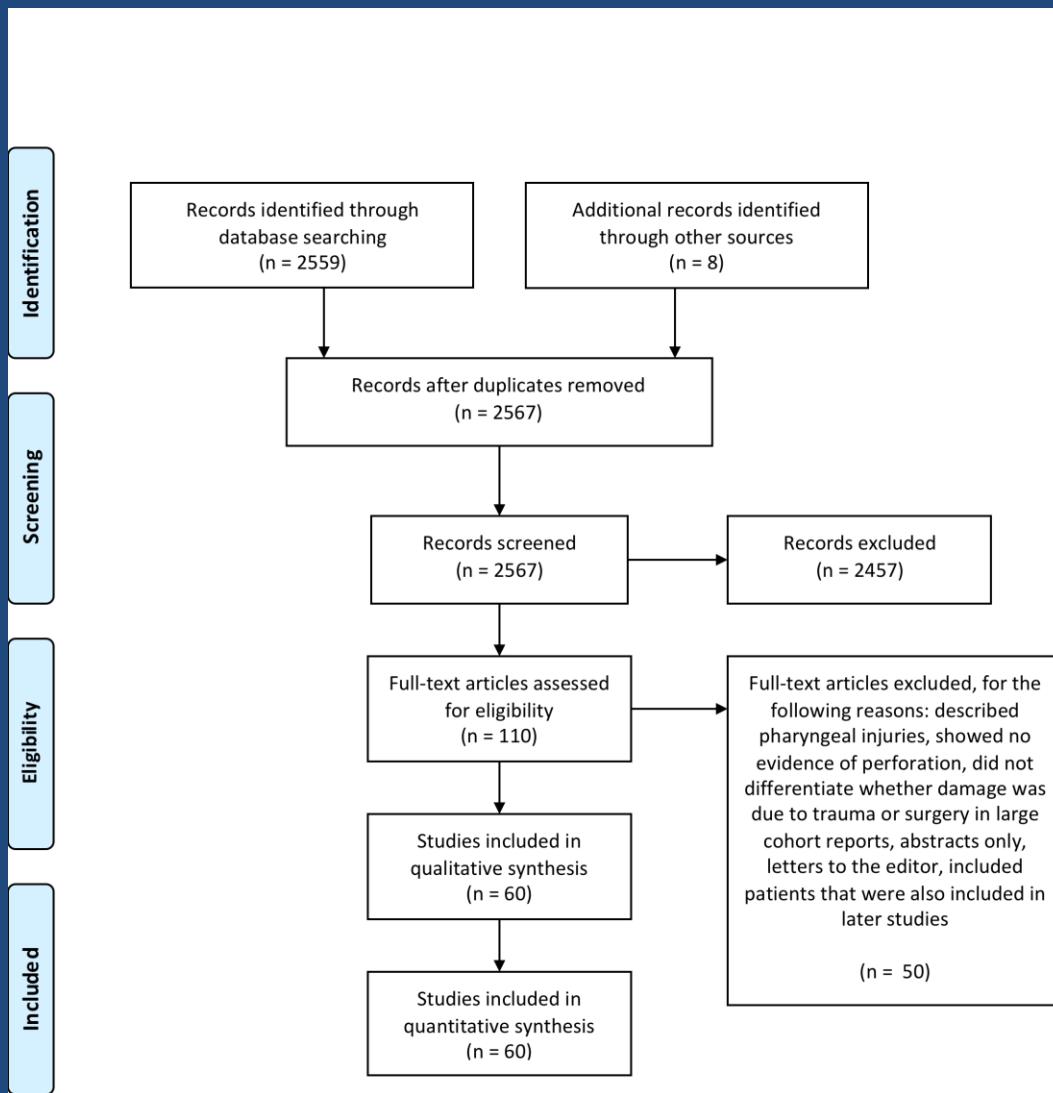


Source: Google Images
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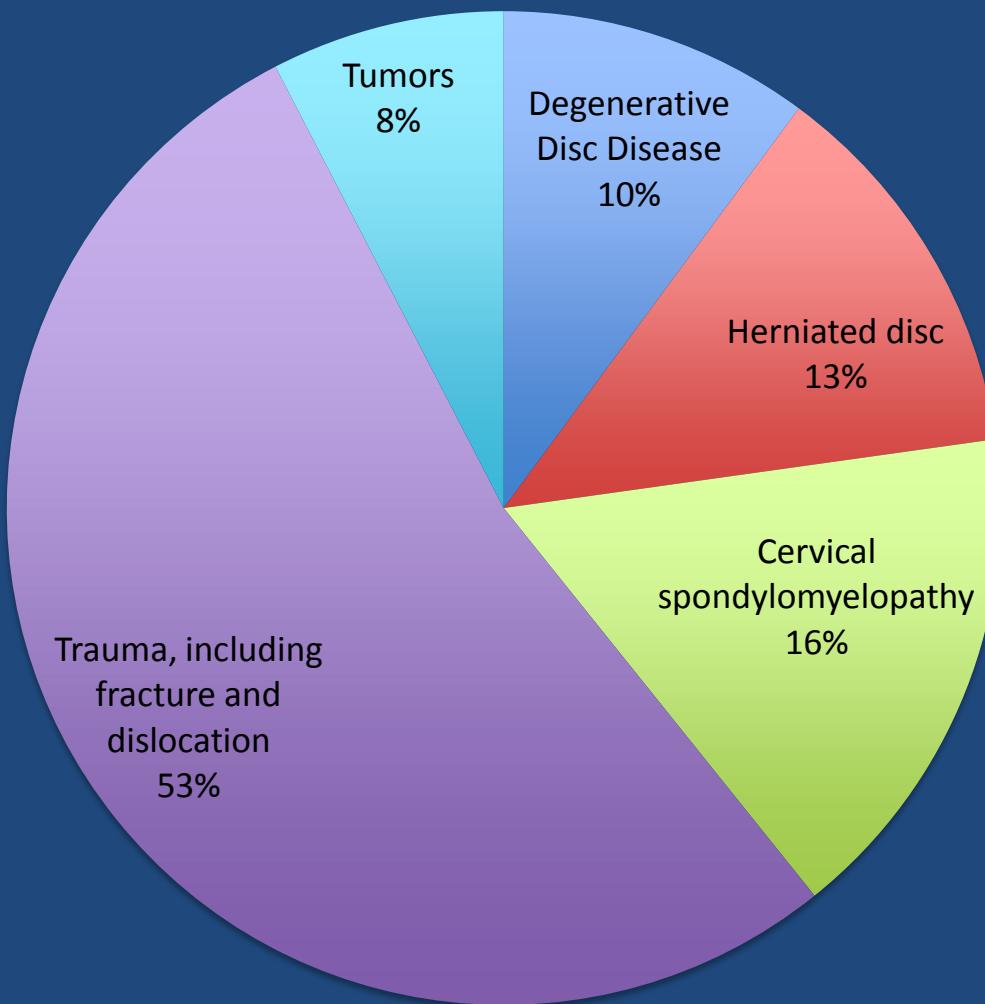
Methods

- PubMed database was searched using the following terms and parameters:
 - Full texts available
 - Published between January 1980 to Present
 - Last search performed on March 30th, 2015
 - “anterior cervical spine surgery” and
 - ‘esophageal’
 - ‘esophagus’
 - ‘complications’
 - ‘esophageal injury’
 - ‘dysphagia’
 - ‘esophageal perforation’
 - Articles were limited to the English language and humans were defined as the subjects for all studies.

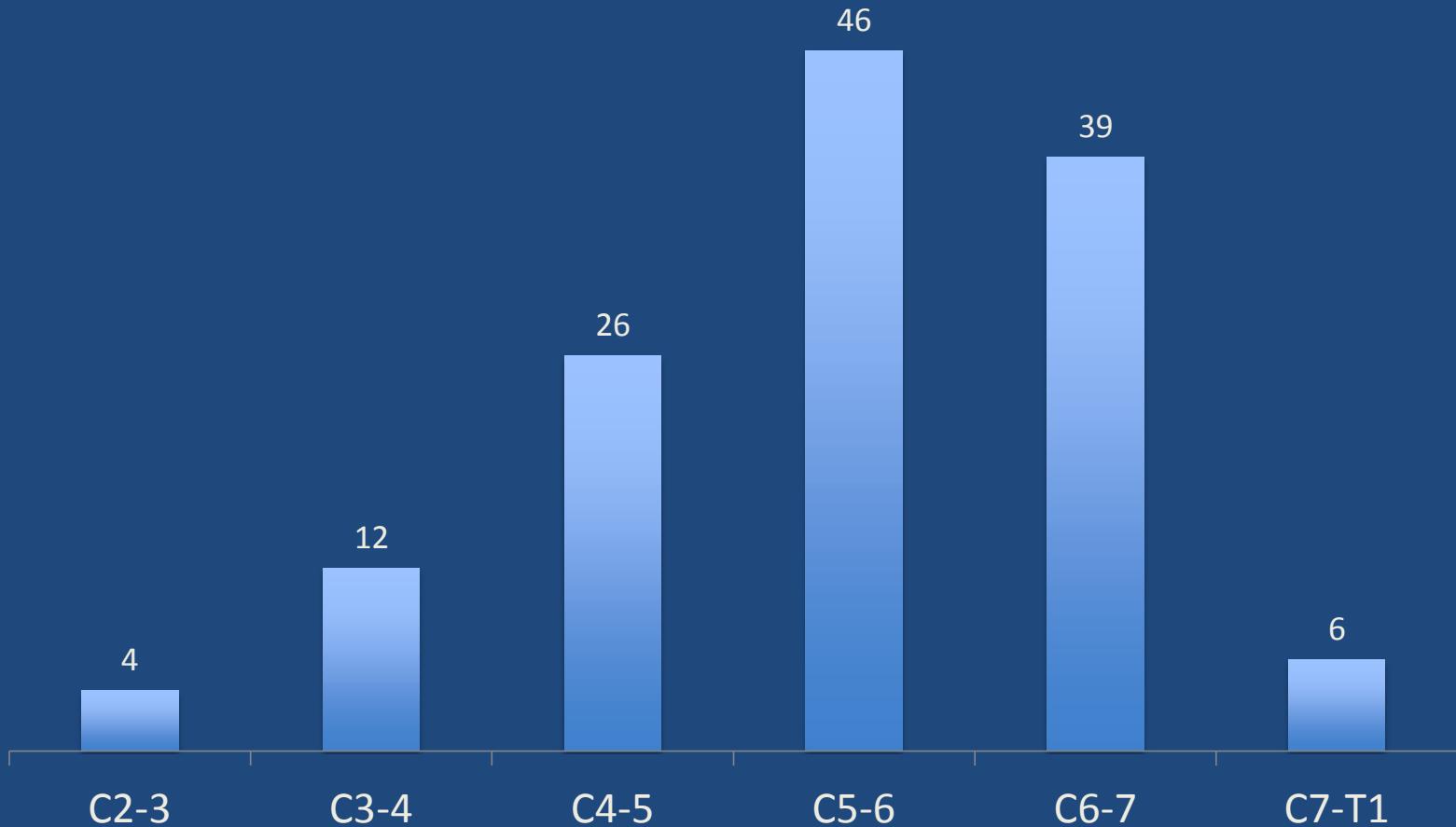
PRISMA Guidelines for Systematic Review



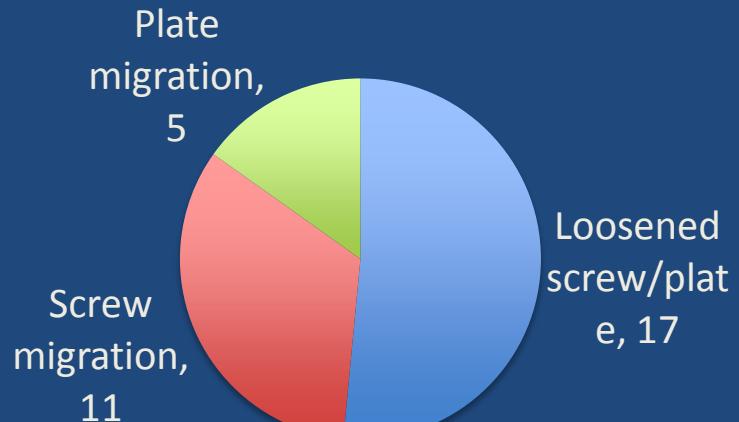
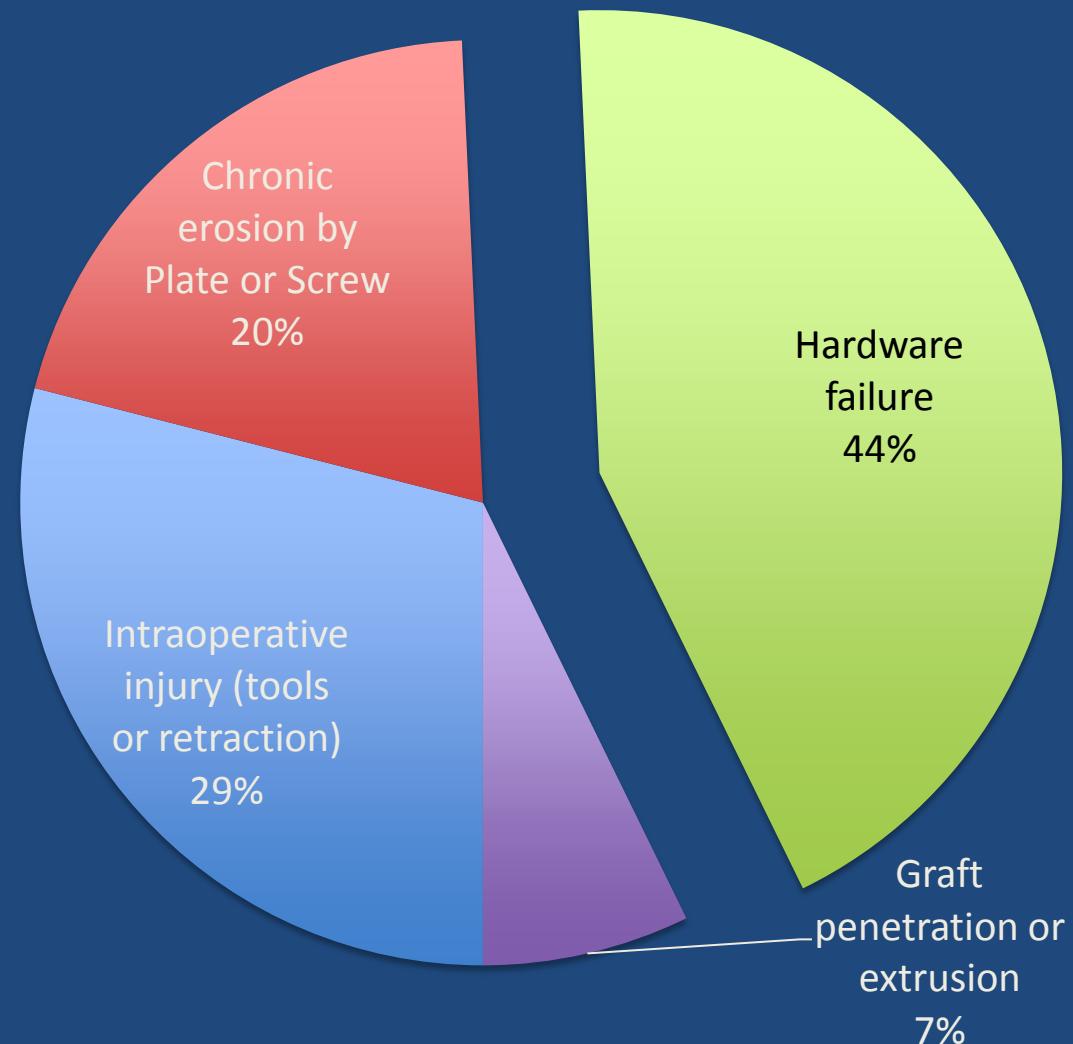
Meta-analysis: Indications for Anterior Spine Surgery



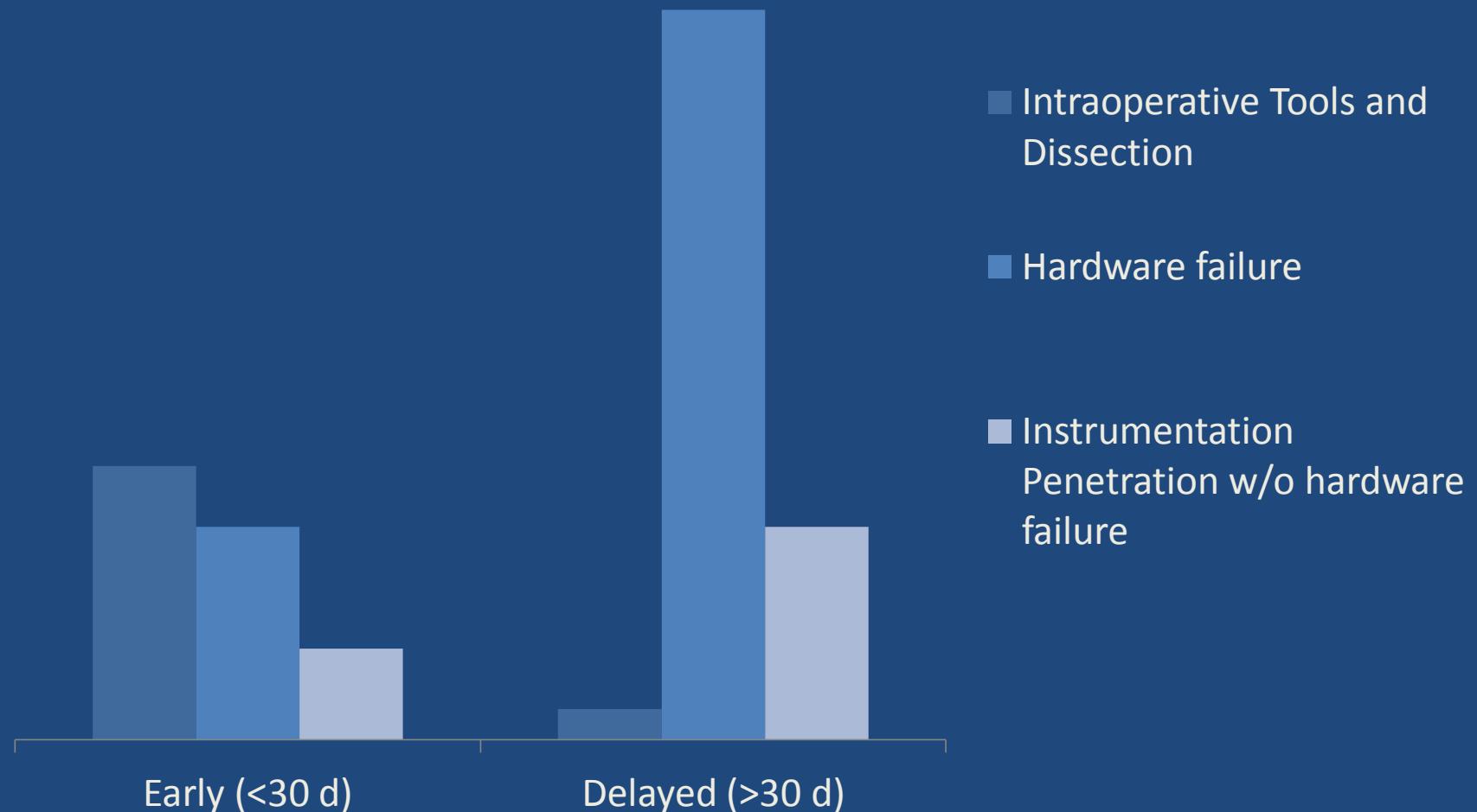
Meta-analysis: Spinal Level Operated On



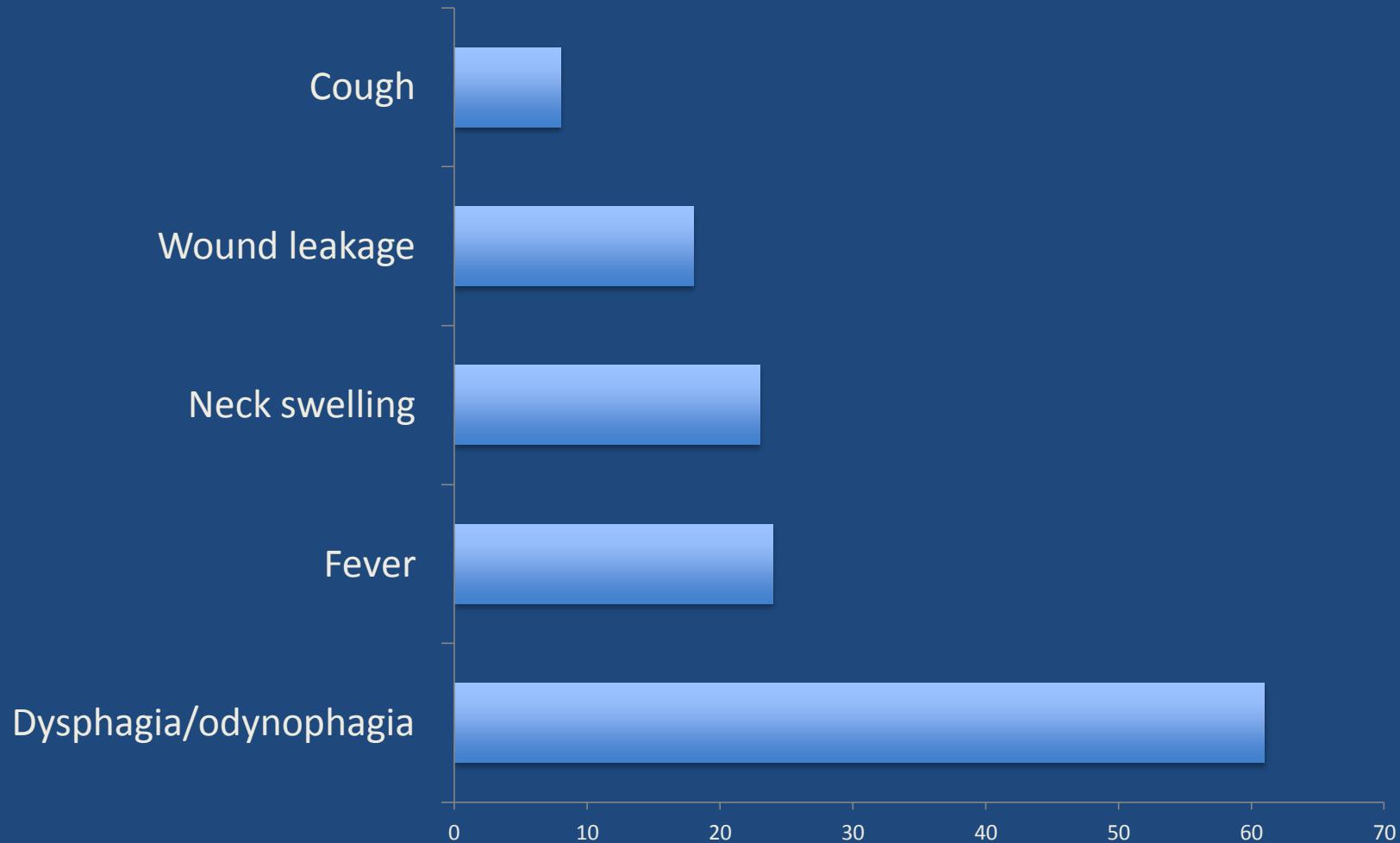
Causes of Esophageal Perforation



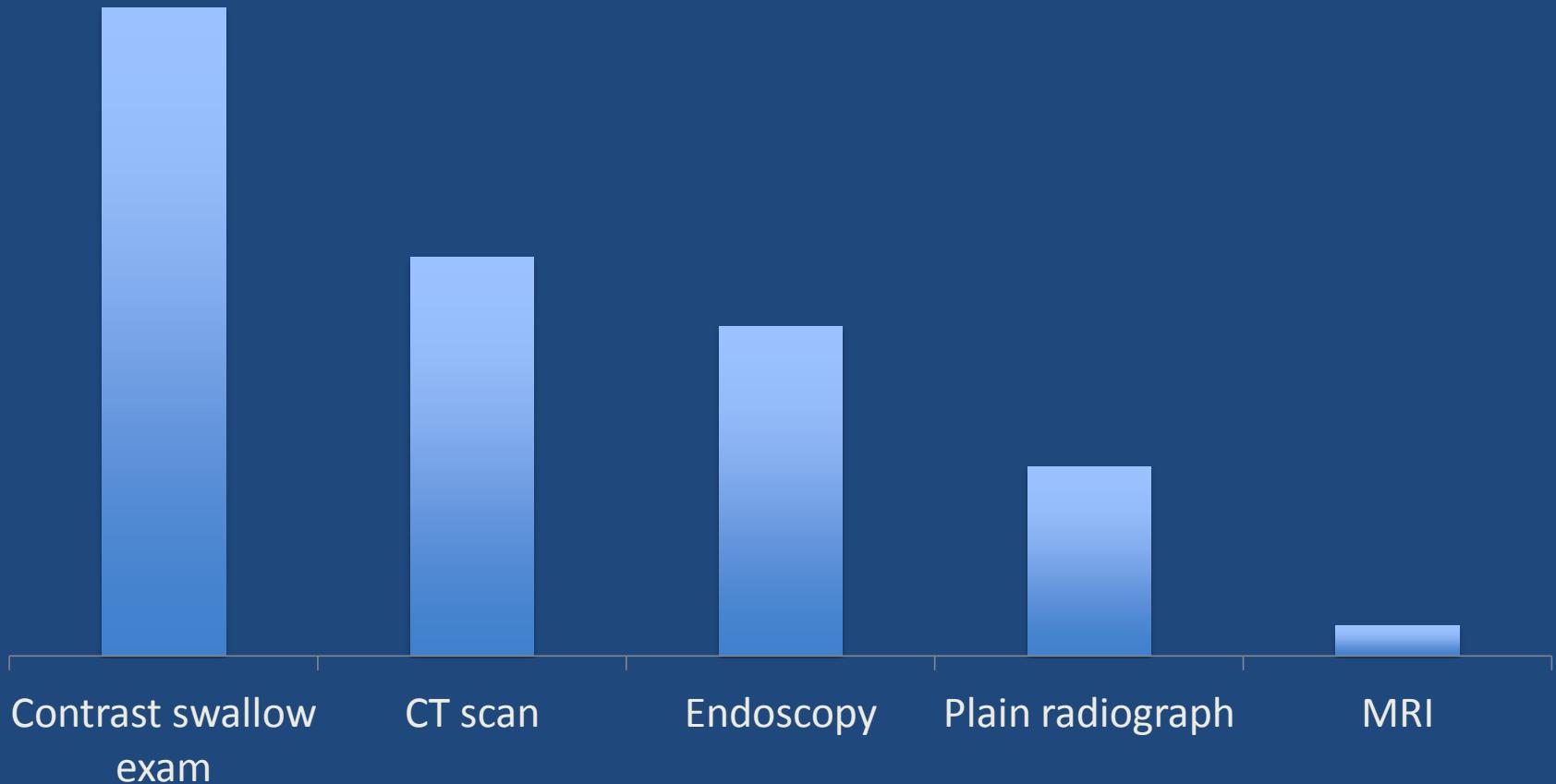
Stratification by Time to Diagnosis



Presenting Symptoms and Clinical Findings



Imaging Studies Used



Successful repair of esophageal perforation after anterior cervical fusion for cervical spine fracture

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Esophageal perforation related to anterior cervical spinal surgery

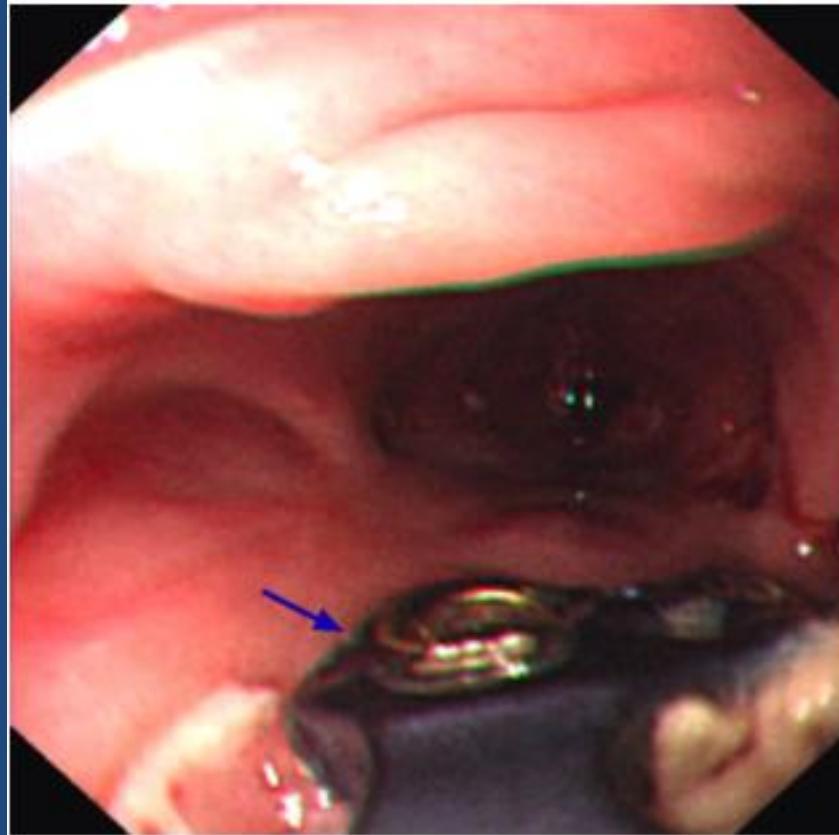


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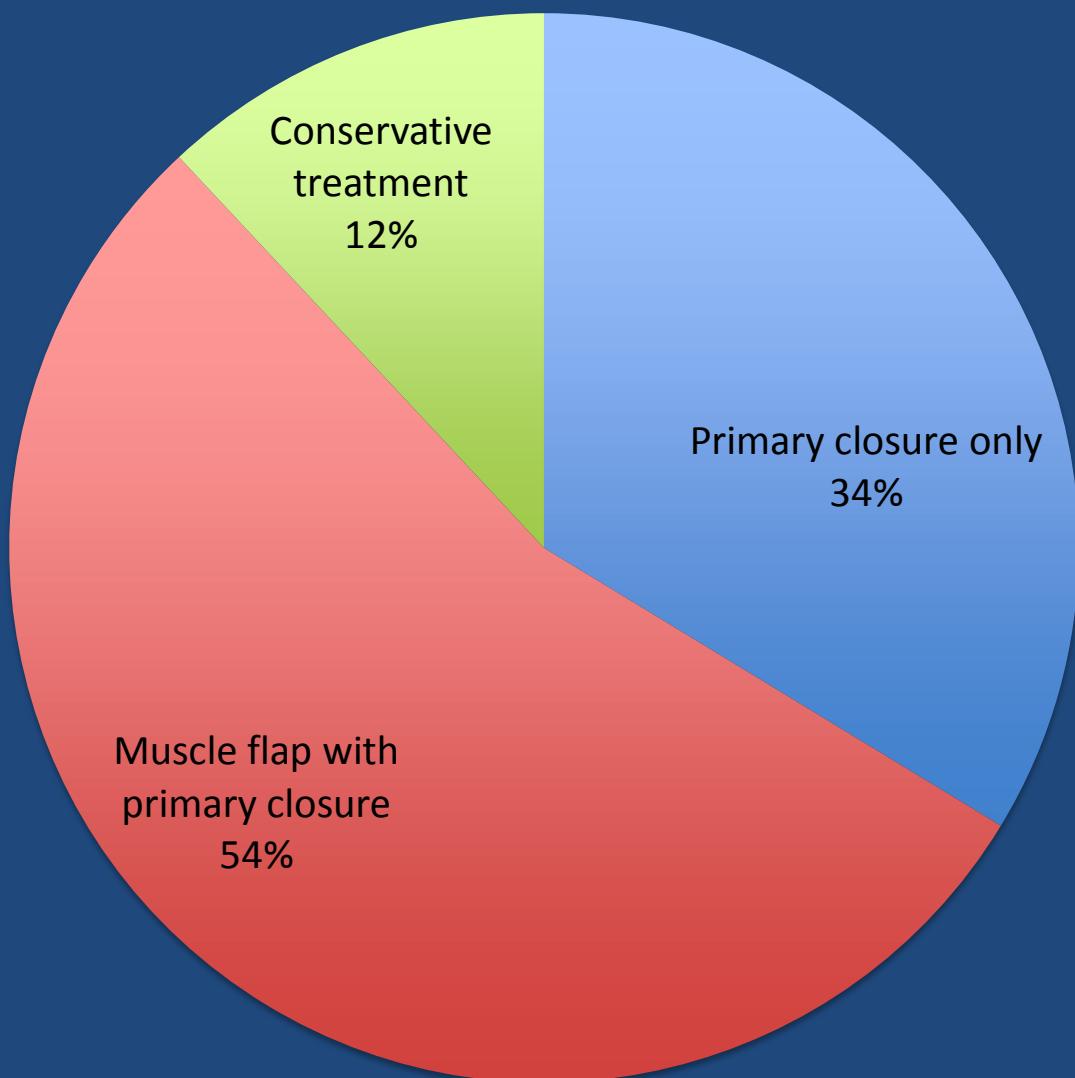
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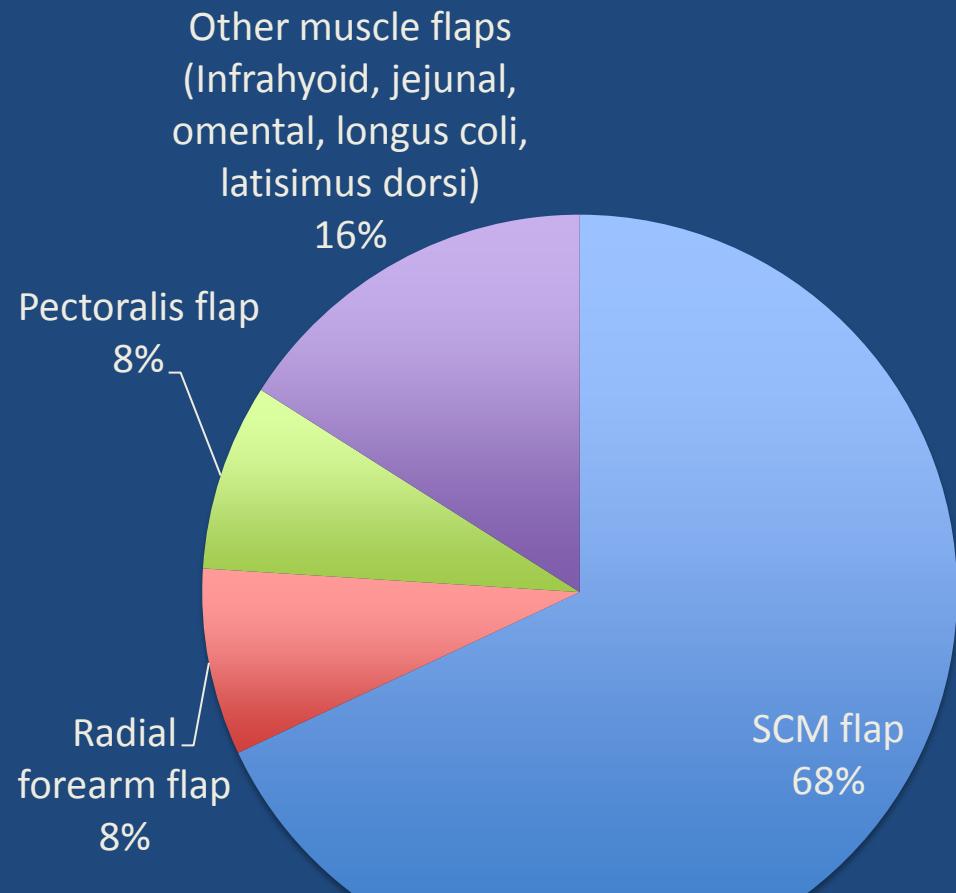
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Method of Esophageal Repair



Types of Muscle Flaps



Complications following Esophageal Perforation

- Secondary Complications (Incidence = 15.6%)
 - Pneumonia (n = 6)
 - Mediastinitis (n = 4)
 - Osteomyelitis (n =3)
 - Sepsis (n = 3)
 - ARDS (n = 2)
 - Recurrent Laryngeal nerve damage (n = 1)

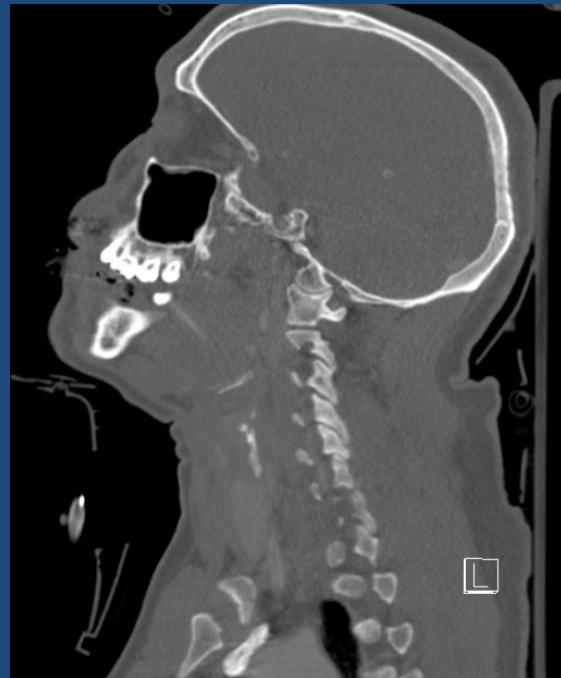
Outcomes

- Average time to oral intake = 30.43 days (range 4-188)
 - Primary repair alone: mean = 28.3 days (range 7-188)
 - SCM Flap: mean = 27.3 days (range = 6-113)
 - Conservative treatment: mean = 68 days (range = 7-135)
- Average repairs attempted= 1.57 (n = 94); range 1-9 repairs
 - 29 patients required >1 repair
 - 21 achieved complete resolution only AFTER instrumentation was removed
- Mortality incidence = 4.08% (n = 6)

Case Example

- 40-year-old Male, MVA
- C6-C7 bilateral facet perched with incomplete spinal cord injury
- CT- C6-C7 bilateral facet fracture /perch with about a 20% to 25% listhesis.
- MRI- cord compression at C6-7 due to the anterolisthesis.

Pre-operative Imaging



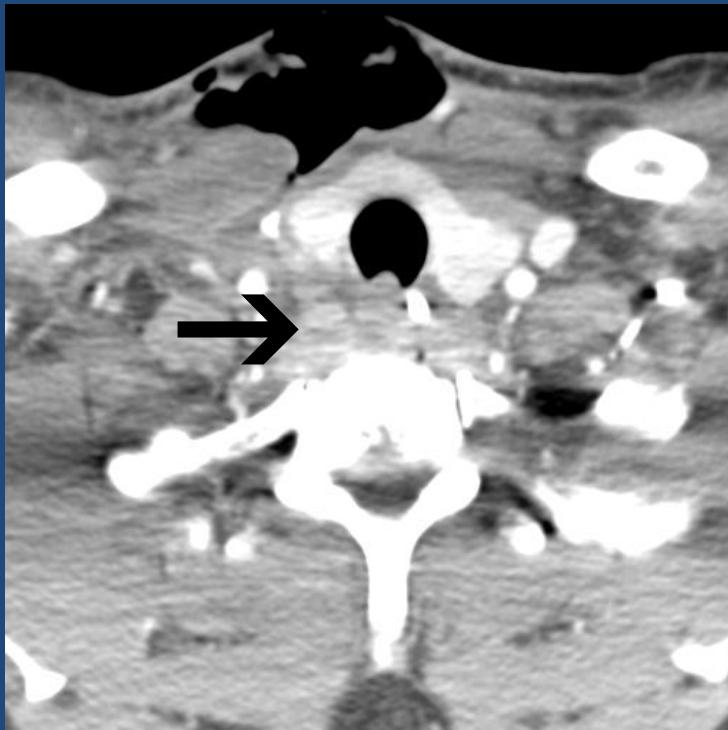
Surgery

- C6-7 ACDF with fibular strut
- No complications
- Discharged in few days



Few days later

- Subcutaneous emphysema
- Right vocal cord paralysis
- ?wound infection
- CT with oral/IV contrast

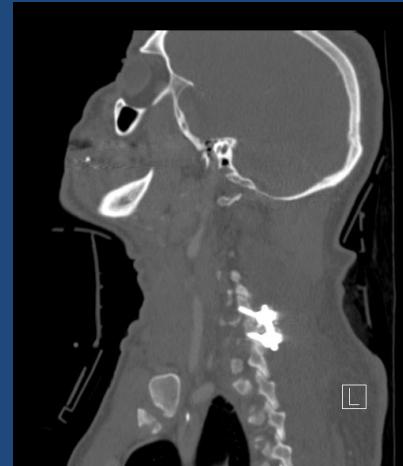


Original Article
Thyroid Abscess Secondary to Perforated Carcinoma of the Oesophagus: A Rare Presentation
G Gole, R Desai, K Raghu, S Gole

Surgery for repair with ENT

- Posterior C6-7 instrumentation fusion first
- Then Rigid Esophagoscopy in OR- saw the defect
- Removal of hardware
- Esophageal defect clearly seen- Dubhoff visualized
- Esophageal repair with inf based SCM flap

Post-Operative Imaging



The Role of the Sternocleidomastoid Muscle Flap for Esophageal Fistula Repair in Anterior Cervical Spine Surgery

Ramon Navarro, MD,* Ramin Javahery, MD,* Frank Eismont, MD,‡ David J. Arnold, MD,† Nitin N. Bhatia, MD,* Steve Vanni, DO,* and Allan D. Levi, MD, PhD*

- The muscle functions as a bolster for repair
- Provides a layer of separation between the esophagus and the graft/ instrumentation
- Increases the antibiotic delivery due to its vascularized nature.



Figure 2. Evidence of abscess formation in the prevertebral space in patient 5.

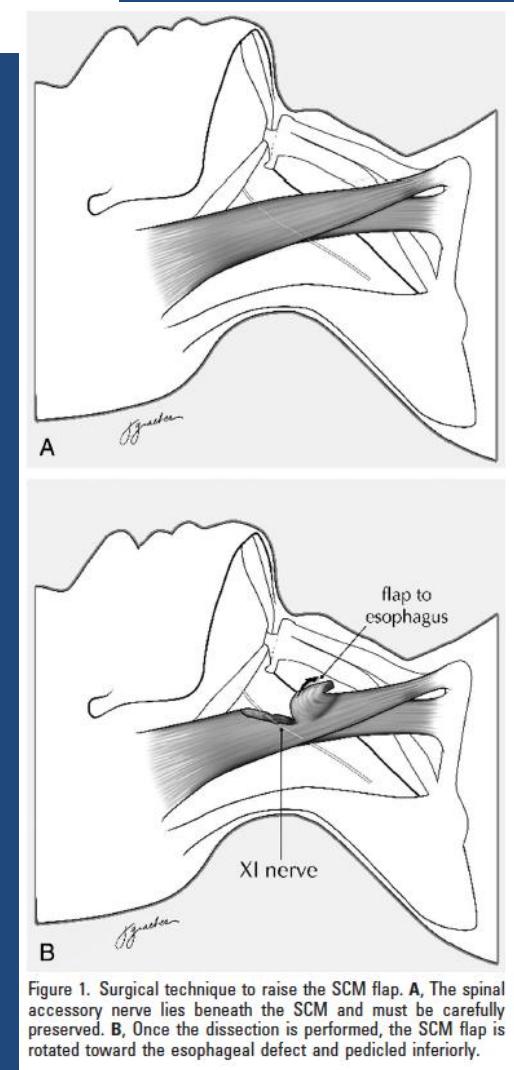


Figure 1. Surgical technique to raise the SCM flap. A, The spinal accessory nerve lies beneath the SCM and must be carefully preserved. B, Once the dissection is performed, the SCM flap is rotated toward the esophageal defect and pedicled inferiorly.

Conclusion

- Most common presenting sx = Dysphagia
- Intra-operative damage and hardware failure are the two most common causes of esophageal perforation
- Perforations are most commonly identified using contrast swallow studies
- Perforation repair is most commonly achieved using SCM flap with primary closure
- There is a high morbidity and mortality associated with esophageal perforations

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