Repetitive Vertebral Fractures in Patients with Ankylosing Spinal Disorders: A Report of Two Cases

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Abstract:

Introduction: Vertebral fractures associated with ankylosing spinal disorders pose significant diagnostic and therapeutic challenges. Notably, the ankylosed spine remains in ankylosis after fracture treatment, and the underlying susceptibility to further fractures still remains. Nevertheless, information is scarce in the literature concerning patients with ankylosing spinal disorders who have multiple episodes of vertebral fractures.

Case Report: Case 1 involves an 83-year-old male patient with diffuse idiopathic skeletal hyperostosis (ankylosis from C2 to L4) who had three episodes of vertebral fractures. The first episode involved a C5-C6 extension-type fracture, which was treated with posterior segmental screw instrumentation. Five years later, the patient sustained a three-column fracture at the L1 vertebra following another fall. The fracture was managed with percutaneous segmental screw instrumentation. One year and two months postoperatively, the patient fell again and had a refracture of the healed L1 fracture. The patient was treated with a hard brace, and the fracture healed. Case 2 involves a 76-year-old female patient with ankylosing spondylitis (ankylosis from C7 to L2) who had two episodes. At the first episode, she suffered paraplegia due to a T8 vertebra fracture. The patient was treated with laminectomy and posterior segmental screw instrumentation. The patient recovered well and had all the hardware removed at 10 months postoperatively. Five years later, she had another fall and suffered a three-column fracture at L1. The patient underwent percutaneous segmental screw instrumentation. The patient required revision surgery with L1 laminectomy and L1 right pediclectomy for persistent right inguinal pain. At one-year follow-up, the patient recovered well, and the fracture healed.

Conclusions: The abovementioned cases show that an age older than 75 years and a long spinal ankylosis from the cervical spine to the lumbar spine may serve as risk factors for the repetition of vertebral fractures associated with ankylosed spinal disorders.

Keywords: Ankylosing spinal disorder, Diffuse idiopathic skeletal hyperostosis, Ankylosing spondylitis, Fracture

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Introduction

Ankylosing spinal disorders (ASDs) represent a group of conditions where multilevel spinal columns are continguously fused by either inflammatory (e.g., ankylosing spondylitis (AS)) or noninflammatory (e.g., diffuse idiopathic skeletal hyperostosis (DISH)) etiologies1-3. The clinical significance of an ankylosed spine includes reduced mobility and deformity of the trunk; however, more critical importance resides in its underlying susceptibility to unstable fractures4,5. Given their unusual (noncompression type) fracture configuration, preexisting pathologic osseous changes, and severe instability caused by long lever arms, vertebral fractures associated with ASD pose significant diagnostic and therapeutic challenges4,5,6. A delay in diagnosis was found to occur in approximately 20% of patients with ASD1,7. Complication rates are as high as 84% in the literature, with a one-year mortality of 32%2. Furthermore, the ankylosed spine re-
mains in ankylosis after fracture treatment, and the underly-
ing susceptibility to further fractures still remains. To date,
information is scarce in the literature concerning patients
with ASD who have multiple episodes of vertebral frac-
tures.

Case Report

Case 1

An 83-year-old male was presented to the clinic following
a ground-level fall with severe neck pain. Physical examina-
tion revealed no motor weakness or sensory disturbance.
Cervical computed tomography (CT) scans showed ossifi-
cation of the anterior longitudinal ligament (ALL), which was
fractured along the C6 vertebral body to the C5 spinal proc-
cess (Fig. 1A). The ossification of ALL was shown to con-
tinue from C2 to L4 to form an ankylosed spine, whereas
bilateral sacroiliac (SI) joints and facet joints remain un-
fused, thus indicating DISH. Short T1 inversion recovery
(STIR) MR images showed high signal in the C6 vertebra
contagious to the prevertebral space; this finding is consis-
tent with hemorrhage in an extension injury (Fig. 1B). The
patient was admitted and underwent posterior segmental
screw instrumentation and an autologous iliac bone graft
from C3 to T3 (Fig. 1C, 1D). The postoperative course was uneventful.

Five years later, the patient (88 years old) slipped from a
chair and was brought to the emergency room with severe
back pain. Upon physical examination, the patient was neu-
rologically intact. CT scans revealed a three-column fracture
of the L1 vertebra (Fig. 2A, 2B). Conservative treatment
with a hard brace failed to control his back pain. Percutane-
ous segmental screw instrumentation was performed from
T10 to L4 (Fig. 2C, 2D). CT scans at seven months postop-
eratively showed the formation of bridging callus over the
anterior wall of the L1 vertebral body.

One year and two months postoperatively, the patient (89
years old) had another fall. CT scans and MR images dem-
onstrated a refracture of the L1 vertebral body. The fracture
line was located lower in the vertebral body than the initial
fracture. There was no screw loosening or rod breakage.
The patient was treated with a hard brace, and the L1 fracture
healed.

Case 2

A 76-year-old female who sustained a T8 vertebral frac-
ture after a ground-level fall was transferred to our hospital
because of newly developed numbness and weakness in the
lower extremities at the 16th day after the injury. Physical
examination revealed an incomplete paraplegia (American
Spinal Injury Association Impairment Scale C). CT scans
showed ankylosis of the spine from C7 to L2 with ossifica-
tion of ALL and fusion of the facet joints. Furthermore, the
right SI joint was also fused, thus indicating AS. There was
a three-column vertebral fracture of T8 (Fig. 3A). MR im-
ages showed compression of the spinal cord (Fig. 3B). On
the second day after the transfer, the patient underwent
laminectomy from T7 to T9, posterior segmental screw in-
strumentation, and an autologous iliac bone graft from T5 to
T10 (Fig. 3C, 3D). The patient recovered from paraplegia
and was discharged with no assistive devices. Ten months
postoperatively, she requested hardware removal because of
persistent back pain due to metal irritation. Given that the
CT scans showed that the fracture had healed, all the hard-
ware was removed.
Five years later, the patient (81 years old) fell again and was transferred to our hospital with severe back pain and right inguinal pain. Physical examination disclosed no motor or sensory loss. CT scans revealed a healed T8 fracture.
Figure 4.
(A) A CT scan image showing a healed T8 fracture status postlaminectomy and hardware removal.
(B) A magnified CT scan image showing a three-column extension-type fracture of the L1 vertebra.
(C) Anterior-posterior and (D) lateral radiograph status postpercutaneous segmental screw instrumentation from T10 to L4.

Table 1.

<table>
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<th></th>
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<th>Location</th>
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<td>C3-T2</td>
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<td>T11-L3</td>
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*Parenthesis indicates area of ankylosed spine

Discussion

In this report, we presented two patients with ASD who suffered multiple episodes of vertebral fractures. Samartzis et al\(^4\) reported an 81-year-old male with AS who also sustained two episodes of vertebral fractures. To the best of our knowledge, there are no other reports of repetitive fractures of the ankylosed spine. The present two cases and the reported case share some clinical features, including an age older than 75 years old and ankylosis of the spine from the cervical spine to the lumbar spine (Table 1). These features may represent risk factors for the repetition of vertebral fractures associated with ASD.

In the literature, the mean age at the time of vertebral fracture is 59-62 years old in patients with AS and 68-70 years old in patients with DISH\(^2,7\). Although information is lacking in the literature regarding the number of ankylosed segments in patients with vertebral fracture without repetition, a long ankylosed spine (19 segments on average) seems to be a prerequisite for the development of a second fracture in the ankylosed spine.

The present two patients recovered well eventually. By contrast, the case reported by Samartzis et al\(^4\) had simultaneous fractures at C6-C7 and L2-L3 at the second episode, and the patient died following the fractures. The devastating outcome for this patient is likely more attributed to “the simultaneous double” nature of the spine fracture rather than “the repetitive” nature, as reported by Yagi et al\(^12\).
Repetitive vertebral fractures in patients with ASD may be more common than those reported in the literature. Attention needs to be paid to prevent subsequent vertebral fractures, particularly in patients who are older than 75 years old and have long spinal ankylosis from the cervical spine to the lumbar spine. For the prevention of the second fracture, it is important to be aware that a simple fall can cause fractures of the ankylosed spine. Therefore, fall precautions and fall prevention programs can help. Furthermore, despite the lack of guidelines for the screening and treatment of osteoporosis in ASD, medications such as teriparatide, which has recently been reported to be effective in the treatment of a vertebral fracture with ASD\textsuperscript{(13)}, may also be beneficial for the prevention of subsequent vertebral fractures.

**Conflicts of Interest:** The authors declare that there are no relevant conflicts of interest.

**Author Contributions:** Ryunosuke Fukushi, MD; Article drafting, Satoshi Kawaguchi, MD, PhD; Conception and design, Goichi Watanabe, MD, PhD; Data acquisition and analysis, Keiko Horigome, MD, PhD; Article revision, Hideki Yajima, MD; Data acquisition and analysis, Toshihiko Yamashita, MD, PhD; Final approval of the article to be submitted.

**References**


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