Invited Comments

Ramani et al report their substantial experience with the management and outcome in 61 patients diagnosed with subaxial and cervicodorsal tuberculosis. Their strategy of ventral decompression of the neural elements and fusion with instrumentation has yielded good results in a large majority of their patients who experienced relief of the two main symptoms of pain and neurological dysfunction. Their series is unique for the high incidence (80%) of atypical radiological presentation (lack of involvement of the disc space) and the zero incidence of kyphotic deformity of the cervical spine. However, in some of the illustrations a mild kyphotic change is evident both at the involved segments and of the whole cervical spine. The authors do not mention whether any bone graft was used to fill in the defects created by the removal of the diseased bone and disc elements in their plated group of patients (40 patients). One would definitely consider using a bone graft to achieve early fusion and maintain cervical lordosis. To support the authors’ contention that none of their patients developed any “clinically significant” kyphotic change in the cervical spine curvature, they should have provided quantitative data in the form of Cobb angles of the involved segments on the preoperative and follow-up radiographs. The sagittal alignment of the cervical spine could also have been assessed (as lordotic, straight or kyphotic) on the preoperative and follow-up radiographs. It is also unfortunate that there are no illustrations of the sagittal alignment of the cervical spine in the plated group of patients. Ventral bony fusion of the cervical spine is almost always associated with some degree of settling of the bodies leading to a variable degree of change in the sagittal alignment of the cervical spine both segmentally and globally.\(^\text{[11]}\) Admittedly, this change in the cervical spine curvature is not clinically relevant in the short-term but may have a bearing on the long-term outcome of these patients in the form of adjacent segment spondylotic changes and neck pain. Results similar to those reported by the authors have been reported by us recently,\(^\text{[2]}\) albeit, in a smaller cohort of patients with subaxial cervical spine tuberculosis. Our surgical strategy, which was also directed ventrally, differed from that of the authors in the avoidance of instrumentation but in exchange for bed rest for 4 to 6 weeks following surgery. Use of a halo-vest following uninstrumented ventral decompression and fusion would be an alternative strategy. One of the major advantages of uninstrumented surgery is the ability to limit the vertical height of the corpectomy to only the involved parts of the vertebrae as even as little as a third of the normal vertebral body is adequate to create a mortice to accept the bone graft. Besides this, cost reduction is also a major consideration in this patient population which is generally from the economically deprived sections of society.

V. Rajshekhar

Christian Medical College, Vellore, Tamil Nadu, India

E-mail: rajshekhar@cmcvellore.ac.in

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