Invited Comments

The authors addressed an interesting and challenging entity: multisegmental OPLL. The study has a retrospective character. The numbers seem to be small, but were quite impressive when related to the incidence and prevalence of the disease. Several lessons can be learned from the study.

Although the pathology is located anterior to the spinal cord, OPLL is often closely adhered to the dura. Dissection is difficult, and the risk of CSF leakage and neurological deterioration is high. This is also shown in the present series. Furthermore, grafting with iliac crest over more than two levels has a significant risk of graft extrusion, subsidence, and especially pseudoarthrosis. These risks are even higher when instrumentation is not used. Although the authors did not mention whether they braced (halo?) the patients postoperatively, the complication rate related to the grafting is within the normal range for instrumented spondylodesis. Because the outcome seemed to be equal, complications directed the choice of the final treatment. In this case, laminectomy or laminoplasty clearly has less complications, and is therefore the treatment of choice. Although not investigated, one could argue whether in case of a straight or kyphotic cervical spine, a posterior decompression should be followed by an arthrodesis to prevent progression of the kyphotic deformity. Sometimes it is possible to reduce a straight or kyphotic spine in a lordotic spine. Personally, I prefer preoperative flexion and extension X-rays. If during extension a lordotic shape is seen, a posterior decompression is performed. The head of the patient is fixed in the Mayfield clamp, and under fluoroscopic guidance the neck is extended until a slightly lordotic shape is seen. Then the surgery is performed and an instrumented arthrodesis performed. This is extended to Th1 or Th2.

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