

SPONDYLECTOMY FOR SPINAL NEOPLASMS

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The results of treatment of 27 patients with tumors of various parts of the spine, who underwent two-stage surgical technology of spondylectomy, are presented. There were 12 males and 15 females aged 15 to 68 years. The proposed surgical methods of two-stage spondylectomy for cervical, thoracic, lumbar and sacral neoplasms can increase the rehabilitation potential, optimize the prognosis and improve the quality of life of a complex category of patients.

Key words: spine, neoplasms, surgical interventions, spondylectomy, surgical technologies.

Introduction

Radical surgical interventions performed for spinal neoplasms are among the most complex surgical technologies [1, 4]. It is necessary to take into account the localization, degree of damage to the vertebral bone structures, deformity of the spinal canal, morphological structure of the tumor, duration of the disease, and the presence of neurological disorders. Such operations as spondylectomy (SE) can be performed in specialized centers equipped with the necessary equipment, having qualified surgeons, anesthesiologists-resuscitators, etc. In recent decades, there have been works devoted to radical operations for spinal tumors, primarily benign and primary malignant, as well as in cases of single vertebral metastases. Anatomical and surgical classifications WBB (1997) and Totya (2001) have been proposed, which objectively demonstrate the possibility of radical removal of the tumor-affected vertebra even with total spread to the anterior and posterior structures [5, 8, 10]. First of all, this applies to neoplasms of the thoracic and lumbar spine. In recent years, there have been publications about successful spondylectomy of the cervical vertebrae at the C3-C7 level. Most authors divide the surgical intervention of SE into two stages, which can be performed simultaneously or sequentially [6, 7, 9].

Materials and methods

The results of treatment of 27 patients with spinal tumors operated on in the Republican Spinal Center of the State Institution of the Russian National Research Center for Spondylectomy in 1998-2007, who underwent two-stage surgical technology of spondylectomy, were analyzed. There were 12 males and 15 females. The patients ranged in age from 15 to 68 years. The median age was 45.2 years. Of these, there were 11 patients with cervical spine tumors; 8 patients with thoracic spine tumors; 7 patients with lumbar spine tumors; and one patient underwent two-stage tumor removal technology for sacral tumors [2, 3].

The structure of patients with spinal tumors by nosological forms is shown in Table 1.

As can be seen from Table 1, among the primary benign neoplasms, the most common were giant cell tumors (8 cases), osteoblastoma (3 cases). Solitary or multiple myeloma accounted for the majority of primary malignancies (7 cases).

Single vertebral metastases comprised 5 cases: 1-with a lesion of the thoracic vertebra, 4-with a lesion of the lumbar vertebrae.

Results and discussion

The diagnostic algorithm included performing an X-ray examination of the spine in two projections, магнитнорезонансной magnetic resonance imaging or computed X-ray tomography for all patients. When planning surgical interventions for cervical spine tumors, computer angiography of brachiocephalic vessels with the study of the state of vertebral arteries was mandatory. A significant paravertebral spread of the pathological process within the thoracic and lumbar regions was an indication for aortography and angiography of the iliac vessels. Osteoscintigraphy made it possible to determine the degree of neoplasm activity and exclude multiple lesions, especially when malignant tumors metastasize to the spine [1, 2, 4]. Spiral X-ray computed tomography (CRCT) is recognized as a highly informative method for diagnosing bone cancer. Thanks to the multiplanar reconstruction program, which provides simultaneous visualization of the studied object in three different planes, as well as the ability to measure density characteristics in absolute units on the Hounsfield scale Хаунсфилд, the SRCT method makes it possible to reliably assess the localization of the tumor process. The most important parameters at the stage of preoperative planning of the intervention are the prevalence of damage within the bone structures of the vertebra, as well as the presence and degree of involvement of surrounding паравертебральных, а также paravertebral and introvertebral formations. A prerequisite for preoperative planning of SE is the correlation of IPT data with the anatomical and surgical classifications WBB and Totca.

The morphological diagnosis was verified both by preliminary biopsy data and by the results of examination of tumor tissues removed during surgery [2, 3].

The developed and implemented methods of surgical interventions with спондилоэктомии spondylectomy in 27 patients are shown in Table 2.

In case of localization of neoplasms in the cervical spine, a one - stage two-stage spondylectomy was performed in one case. After removal of the giant cell tumor of the C5 vertebra, bone grafting with an autograft and interbody fusion with a titanium plate were performed. Separate two-stage SE in combination with bone grafting and metal osteosynthesis was used in three patients. остеобластоме Bone grafting was performed for NW osteoblastомасолитарной мие-ломе, and two patients underwent spinal fusion with a porous titanium implant and a titanium plate for solitary fibroblastoma. Ини the first cases of extensive resections of the cervical vertebral bodies, we proposed combined fusion with bone grafts or implants in combination with extra-focal stabilization of the cervical spine with a halo device.

On the thoracic spine, 4 patients underwent separate two-stage removal of the neoplasm with bone grafting and metal osteosynthesis. Surgical defects in the thoracic vertebral bodies were replaced with bone grafts or implants made of porous titanium in combination with posterior fusion with a universal transpedicular fixator.

One patient with prostate cancer metastasis in the body of the Th1 vertebra underwent combined fusion with fixation in a halo device.

Two-stage spondylectomy was performed simultaneously for one patient in the lumbar spine осуществлена одномоментно, а б-, and separately for two patients. The first stage was performed from the posterior surgical approach, the second—from the anterior or anterolateral one. Surgical defects in the lumbar vertebral bodies were replaced with bone grafts or implants made of porous titanium in combination with interbody спондило-дезом fusion with titanium plates and mandatory transpedicular fixation of adjacent vertebral-моторных segments.

One patient with giant нейрофибромой sacral neurofibroma in segments S1-S2 underwent two-stage separate removal of the neoplasm with metal osteosynthesis of the lumbosacral region. A variant of transpedicular insertion of screws into the lower lumbar vertebrae and into the lateral masses of the sacrum at the level of S1-S2 was used.

The results of treatment were tracked over a period of 2 to 5 years. In all cases, complete spinal fusion of the operated vertebral-motor segments was formed. Loss of correction with the development of kyphotic deformity in the surgical area without pronounced clinical manifestations was observed in three patients. In two cases, at the request of patients, the transpedicular fixator was removed three years after the operation.

Conclusions

1. Timely establishment of a morphological diagnosis, study of the structure and nature of a spinal tumor allows predicting the course of the postoperative period, planning the timing and sequence of radiation and chemotherapy.
2. Indications for the surgical stage of treatment of primary malignant and metastatic spinal tumors are determined after a comprehensive examination in an oncological hospital, morphological verification of the neoplasm is mandatory.
3. In the preoperative planning of spondylectomy, the most important factors are the degree of tumor prevalence in the vertebral tissues, the involvement of paravertebral and intracanal spaces, the degree of involvement of the spinal cord and its elements, large vascular trunks in the pathological process, and confirmation of a single lesion in spinal metastases. These data should be correlated with the developed anatomical and surgical systems WBB, Tomita.
4. Comprehensive examination of patients with spinal neoplasms allows us to determine the possibility of radical removal of the tumor using two-stage spondylectomy technology спондилэктомии.
5. In the postoperative period, patients should be monitored by an oncologist, orthopedic traumatologist, neurosurgeon, and, if necessary, receive combined or complex treatment in cancer hospitals.

Thus, the two-stage methods of spondylectomy for cervical, thoracic, lumbar and sacral neoplasms developed and performed at the Republican Center for Spine Surgery of the Russian National Research Center of Traumatology and Orthopedics make it possible to increase the rehabilitation potential, optimize the prognosis and improve the quality of life of a complex category of patients.

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