We present a case report to remind surgeons of this unusual complication that can occur in any surgery, even posterior cervical spine surgery under general anesthesia and discuss its causes, treatment methods, and the follow-up results in the literature. The peripheral Tapia’s syndrome is a rare complication of anesthetic airway management. Main symptoms are hoarseness of voice and difficulty of tongue movement. Tapia’s syndrome after endotracheal general anesthesia is believed to be due to pressure neuropathy of the vagus nerve and the hypoglossal nerve caused by the endotracheal tube. To our knowledge, no report has been published or given an explanation for Tapia’s syndrome after posterior cervical spine surgery. Two patients who underwent posterior cervical surgery complained hoarseness and tongue palsy postoperatively. There is no direct anatomical relation between the operation, the vagus nerves and the hypoglossal nerves, and there is no record of displacement or malposition of the endotracheal tube. After several months, all symptoms are resolved. To avoid this problem in posterior cervical spine surgery, we suggest paying special attention to the position of the endotracheal tube to avoid excessive neck flexion before and during the positioning of the patient.

Key Words : Tapia’s syndrome · Posterior cervical spine surgery · Hypoglossal nerve · Vagus nerve.
no definitive lesion in postoperative brain magnetic resonance imaging. In laryngeal electromyography with 37 mm monopolar needle, there was no motor unit action potential on left thyroarytenoid muscle which is innervated by the recurrent laryngeal branch of the vagus nerve. Six months after surgery, symptoms were resolved.

The patient of second case is a 56-year-old man who presented gait disturbance. Fifteen years prior to admission, he had a cervical injury from a traffic accident and underwent C5/6 anterior cervical disectomy and fusion. On neurologic examination, ankle clonus was found. Magnetic resonance imaging and computed tomography revealed spinal stenosis on C2/3/4/5 and ossified yellow ligament in right C2/3 (Fig. 2). The patient was placed in the concord position under general endotracheal anesthesia and the head was secured in the Mayfield head clamp. He underwent right C2 hemilaminectomy and C3/4/5 laminoplasty under general anesthesia. Surgery was uneventful. Postoperatively, he complained of hoarseness, hypesthesia of left side tongue, and deviation of the tongue to the left during protrusion. On postoperative day 4, all symptoms except hoarseness were resolved. Two months later, hoarseness was also completely resolved.

**DISCUSSION**

Concomitant paralysis of the hypoglossal and recurrent laryngeal nerves can be caused by lesions affecting the lateral wall of the lower part of the oropharynx and the upper part of the hypopharynx where the hypoglossal and vagus nerves are in close proximity. There are many causes of Tapia’s syndrome, including general anesthesia (septorhinoplasty, coronary bypass, shoulder surgery), metastatic hemangiosarcoma, carotid artery aneurysm, fungal infection, neurofibroma of vagal and hypoglossal nerves. However, most of them are due to general anesthesia. Yavuzer et al. described a case of Tapia’s syndrome after septorhinoplasty as a consequence of nerve compression after inflation of the cuff within the larynx. Boisseau et al. reported a case of Tapia’s syndrome after general anesthesia following shoulder surgery. The syndrome, in their case, was believed to be due to a compression by the endotracheal tube, caused by the displacement of the head. Lykoudis et al. reported a case of Tapia’s syndrome after general anesthesia following rhinoplasty. They believed that throat packing, which is applied in hypopharynx and lower oropharynx, facilitated compression of the nerves upon the tracheal tube and the pharyngeal wall. To our knowledge, our cases are first reports of Tapia’s syndrome after posterior cervical spine surgery. The causes for our cases have not been confirmed. There was no direct anatomical relation between the operation, the vagus nerves and the hypoglossal nerves, and there was no record of displacement or malposition of the endotracheal tube. Considering the causes of aforementioned cases in the literatures, we hypothesize that additional neck flexion for surgical exposure may have caused the endotracheal tube to offend the lateral wall of oropharynx and hypopharynx where the two nerves are in close proximity. The more the neck is flexed, the more the endotracheal tube is bent within pharynx. So, when the neck is flexed excessively, convexity of the bent endotracheal tube may move freely in the pharynx. The middle convexity of the bent endotracheal tube may be entrapped amid the offending endotracheal tube, the ramus of mandible and transverse process of cervical vertebra (Fig. 4). Therefore, excessive neck flexion may facilitate compression of the nerves upon the
CONCLUSION

Tapia’s syndrome is a rare complication which every surgeon must nonetheless be aware of. To avoid this problem in posterior cervical spine surgery, we suggest paying special attention to the position of the endotracheal tube to avoid excessive neck flexion before and during the positioning of the patient.

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