Dysphasia caused by cervical diffuse idiopathic skeletal hyperostosis, a case report

Abstract
Diffuse idiopathic skeletal hyperostosis (DISH) is a systemic enthesopathy with involvement of ossification of anterior longitudinal ligament (OALL). Although DISH is usually associated with benign nature, cervical large OALL should be considered as a consideration in differential diagnosis of dysphasia. A 73-year-old-man presented with dysphasia and his radiographs showed massive OALL at C4/5. A filling defect was confirmed at the same level by video fluoroscopy. Followed by failure of conservative treatment, surgical treatment of symptomatic OALL due to DISH was performed. Satisfactory recovery of swallowing was obtained without radiographic recurrence of OALL one year after surgery.

Keywords: ossification of anterior longitudinal ligament, dysphasia, diffuse idiopathic skeletal hyperostosis

Introduction
Diffuse idiopathic skeletal hyperostosis (DISH) is a non-inflammatory enthesopathy of unknown etiology. It occurs primarily in men and the prevalence increases with age. DISH is defined as presence of ossification of anterior longitudinal ligament (OALL) at least four continuous vertebral bodies with spared disc space. Dysphagia is a common complaint especially among elderly people with the extremely broad causes. Frequency of dysphagia induced by DISH is relatively low, but this disorder can be an important consideration in differential diagnosis of dysphasia. Herein, we describe one case of successful treatment for dysphasia caused by DISH. This case report includes review of literature on pathology and treatment for dysphasia associated with DISH.

Case presentation
A 73-year-old man complained dysphasia over the past four months. This patient had a past medical history of atrial fibrillation and ischemic colitis. He complained neck stiffness without any neurological symptoms. His x-ray and Computed Tomography (CT) of cervical spine demonstrated a presence of continuous OALL from C3 to C6 with partial disruption. Video fluoroscopy (VF) revealed filling defect at C4/5, which is a level of most massive prominent of OALL, impaired epiglottic inversion and retention of contrast agent in pyriform sinus, epiglottic vallecula, and esophageal orifice due to OALL. Because 3 months of initial conservative therapy, such as anti-inflammatory medication and swallowing therapy, was unsuccessful, surgical treatment of symptomatic OALL due to DISH was performed. Satisfactory recovery of swallowing was obtained without radiographic recurrence of OALL one year after surgery.

Discussion
According to previous reports, severe dysphagia resulting from DISH seems to be a rare occurrence. Prevalence of DISH with the age of more than 40y/o is reported as 2.8% and only 0.1-6% of those will develop dysphagia. The pathogenesis of dysphasia caused by OALL has been argued in many studies. Mechanical obstruction, reaction in the surrounding tissues, or prevertebral edema are assumed as reason for dysphasia associated with DISH. The first treatment of patients with symptomatic OALL is conservative therapy, which includes anti-inflammatory medication, steroids, muscle relaxants, diet modification, and swallowing therapy. However, recent review article presented that conservative treatment was effective only for 35 of 169 (20.7%) cases. If conservative therapy is not effective, surgical treatment should be considered. Resection of symptomatic...
OALL alone by the anterior approach is commonly performed, and many studies have revealed the satisfactory results followed by this surgical procedure. However, some studies demonstrated that fusion surgery with resection of OALL is desirable for patients associated with segmental instability to prevent recurrence.

In this case report, the patient was treated with osteophytectomy alone for impairment of swallowing caused by DISH because severe segmental instability was not confirming edradiologically. Though careful observation is still necessary, the patient presented satisfactory recovery of swallowing without recurrence one year after surgery (Figure 1) (Figure 2).

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**Conflict of interest**

The author declares no conflict of interest.

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