

## Unsuspected cervical osteophytes and complex endoscopy: there is cause for concern!

Cervical osteophytes are a common disorder in elderly people [1]. The most common warning sign that cervical osteophytes may be present is dysphagia [2, 3]; however, the condition is often asymptomatic. During complex endoscopic procedures they can cause major difficulties in both airway management and the insertion and positioning of large endoscopes. We report our experience with an 80-year-old man with no swallowing or respiratory impairment, who was scheduled to undergo endoscopic retrograde cholangiopancreatography (ERCP) for ultrasonographically suspected common bile duct stones.

After induction of general anesthesia, intubation was complicated by an unexpected difficulty. The laryngeal aditus was clearly visualized with the aid of an Airtraq device (Prodol Meditec, Vizcaya, Spain) but nevertheless introduction of a standard endotracheal tube (diameter 6.5 mm) was not possible because of an obstruction at the subglottal level. We reduced the size of the endotracheal tube until a 5-mm tube was inserted smoothly in the trachea. Using a 13.7-mm duodenoscope, the endoscopist had the same difficulty crossing the upper esophageal sphincter. Use of a 5.9-mm nasal gastroscope also failed. In the absence of ongoing cholangitis the procedure was aborted, and a policy of waiting was adopted. Because of severe laryngeal edema, the sedated and intubated patient was transferred to the postoperative intensive care unit until wean-



**Fig. 1** Cervical computed tomography scan showing a large anterior osteophyte in an 80-year-old man (arrow).

ing from mechanical ventilation and extubation were possible.

A postoperative cervical computed tomography scan (Fig. 1) showed a large anterior cervical osteophyte at C6–C7. Our experience focuses attention on a concern that is not usually considered. In the time since an old report in 1998 [4], the possibility of undiagnosed osteophytes has not been adequately investigated. We need to consider whether the aging of the patient population and the increased demand for complex endoscopic procedures necessitates a specific assessment for this underestimated but insidious risk factor.

Endoscopy\_UCTN\_Code\_CCL\_1AB\_2AC

**Competing interests:** None

**Fabio Sbaraglia<sup>1</sup>, Giorgia Spinazzola<sup>1</sup>, Guido Costamagna<sup>2</sup>, Maria Sammartino<sup>1</sup>**

<sup>1</sup> Department of Anesthesia and Intensive Care, Catholic University of the Sacred Heart, Rome, Italy

<sup>2</sup> Digestive Endoscopic Unit, Catholic University of the Sacred Heart, Rome, Italy

### References

- 1 *Ranasinghe DN, Calder I.* Large cervical osteophyte – another cause of difficult flexible fiberoptic intubation. *Anaesthesia* 1994; 49: 512–514
- 2 *Kilincalp S, Akinci H, Isak ÖA et al.* A rare cause of dysphagia: compression of esophagus by a giant thoracic spine osteophyte. *Endoscopy* 2015; 47 (Suppl. 01) UCTN: E1. doi: 10.1055/s-0034-1365795
- 3 *Lin HW, Quesnel AM, Holman AS et al.* Hypertrophic anterior cervical osteophytes causing dysphagia and airways obstruction. *Ann Otol Rhinol Laryngol* 2009; 118: 703–707
- 4 *Thomson A, Fleischer DE, Epstein B.* Submucosal hemorrhage of the esophagus associated with endoscopy in a patient with cervical osteophytes. *J Clin Gastroenterol* 1998; 27: 267–268

### Bibliography

**DOI** <http://dx.doi.org/10.1055/s-0042-112972>  
*Endoscopy* 2016; 48: E265  
 © Georg Thieme Verlag KG  
 Stuttgart · New York  
 ISSN 0013-726X

### Corresponding author

**Fabio Sbaraglia, MD**

Institute of Anesthesia and Intensive Care  
 Largo A Gemelli 1  
 00135 Rome  
 Italy  
 Fax: +39-06-3013-450  
 fabiosbaraglia@hotmail.com