CASE REPORT

Inflammatory C2–3 subluxation: a Grisel’s syndrome variant

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The concurrence of non-traumatic atlanto-axial subluxation with inflammation of the adjacent neck tissues is known as Grisel’s syndrome. We report a 5 year old boy with recurring episodes of head tilt and painful and restricted neck movements that developed after repeated bouts of sinusitis. Radiographs showed a subluxation of the C2–3 joint. Medical treatment, with cervical collar, physiotherapy, and non-steroid anti-inflammatory agents, led to complete cure of the disease. We suggest that Grisel’s syndrome can occur in a location different from the classic atlanto-axial joint. To the best of our knowledge, this is the first report of a symptomatic case of Grisel’s syndrome occurring at the C2–3 segment.

CASE REPORT

A 5 year old boy was referred to our unit for assessment of recurring episodes of painful torticollis. Family and past histories were unremarkable; there was no traumatic antecedent. Since the age of 3 years, the child had suffered repeated bouts of sinusitis. During the previous year he had experienced three episodes of torticollis and painful cervical movements that closely followed each attack of sinusitis. Cervical symptoms in each episode lasted about two weeks. He had neither headaches nor diplopia. His neurological examination was normal, except for a head tilt and restricted and painful neck movements. Cervical spine radiographs showed a tilted head posture with a rotational component in the anteroposterior view (fig 1) and loss of the normal alignment of the spinolaminar line in the lateral projection (fig 2). Lateral flexion-extension radiographs of the child’s cervical spine showed that the subluxation did not modify in extension but that it markedly reduced in flexion. The child was managed conservatively for six weeks with mild physiotherapy, a soft collar, and non-steroidal anti-inflammatory agents with success. There have been no recurrences after one year follow up.

DISCUSSION

Grisel’s syndrome represents a subluxation of the atlanto-axial joint not associated with trauma or bone diseases and is primarily a disorder of childhood. Infrequently reported in the neurosurgical literature, the syndrome is apt to occur in association with any condition that results in hyperaemia and pathological relaxation of the transverse ligament of the atlanto-axial joint. It has been described in common otolaryngic entities such as tonsillitis, pharyngitis, otitis media, adenoiditis, parotitis, and tonsillar or cervical abscesses, or after common surgical procedures such as tonsillectomy, adenoidectomy, or mastoidectomy. The condition is thought to be caused by the spread of septic exudates through venous and lymphatic channels that connect the peripharyngeal space and the cervical venous plexus. Nasopharyngeal inflammation causes hyperaemia that may weaken the transverse and alar ligaments and the articular capsules resulting in atlantoaxial instability. Characteristically, the syndrome has almost exclusively been reported in children, although infrequent adult cases have also been documented. The predominance of the syndrome in children and adolescents may be explained by the hypertrophic status of the peripharyngeal lymphoid tissue in the first years of life. The
recently documented two children with midcervical (C3–4) joints of the cervical spine in children. Another peculiarity of horizontal disposition of the articular processes of the upper cervical vertebrae seen in children, which is caused by the marked hypermobility between the second and third cervical vertebrae, was caused by inflammation related hyperaemia together with abnormal laxity of the ligaments. The slippage is favoured by early management—consisting of cervical immobilisation, medical treatment, and computed tomography scans of the cervical spine require surgical fusion.

Differential diagnosis in our patient was made against cervical bone anomalies, tumours of the posterior fossa and spinal cord, cervical spine trauma, ocular and vestibular disorders, and dystonic torticollis associated with the untoward effects of drugs. We also took into account the peculiarities in mobility of the cervical spine of children, namely the physiological pseudosubluxation of the infantile cervical vertebrae. In this regard, a reliable sign consists of the misalignment of the involved vertebrae, which was assessed by drawing the spinolaminar line (fig 2).

Principles of management include: (a) bacteriological cure; (b) correction of the osseous deformity; and (c) prevention of neurological damage. We managed our patient according to the established treatment for treating Grisel's syndrome, namely anti-inflammatory agents, muscle relaxants, physiotherapy, and a cervical collar. Patients' management should be done in consultation with a paediatric neurosurgeon. Antibiotics must be used during the acute stages of the otolaryngic infectious process. The cervical spine must be immobilised with an external orthosis given the potential risk for spinal cord injury associated with a significant degree of ligamentous laxity. We have reported a symptomatic patient with a C2–3 subluxation resulting from the spread of paranasal sinus inflammation to the ligaments and joints of this cervical segment. The patient was managed with the currently used measures for treating Grisel's syndrome. We suggest that clinical and pathological manifestations in this child constitute a variant of Grisel's syndrome.

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