

**Clival osteoblastoma in a child**

**Case illustration**

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The authors present the case of a 12-year-old boy who harbored a clival lesion that was resected via a transoral approach. The patient presented with a 6-month history of retropharyngeal and upper-neck pain. On examination, there was no neurological deficit. A computerized tomography (CT) scan of the skull base and upper cervical spine revealed an expansive, sclerotic lesion located at the tip of the clivus (Fig. 1 *left and center*). A methylene diphosphonate (MDP) bone scan revealed intense tracer activity in the clivus with evidence of hyperemia (Fig. 1 *right*). The intense metabolic activity and hyperemia was suggestive of an osteoblastoma. The patient began a regimen of nonsteroidal antiinflammatory medication, which led to some improvement in his pain.

The patient underwent transoral curettage of the lesion with the aid of image guidance (ISG Viewing Wand; Surgical Navigation Network, Mississauga, ON, Canada). Pathological examination of the resected lesion confirmed the diagnosis of osteoblastoma (Fig. 2). Postoperatively, the patient was free from pain and a follow-up CT scan obtained 1 year postoperatively revealed that the bulk of the lesion had been removed (Fig. 3).

Osteoblastomas are common primary bone tumors within the bony spine. The present case represents the fourth case of clival osteoblastoma described in the literature.<sup>1-3</sup> The diagnosis is highly suggested by findings on CT scans in conjunction with those on MDP bone scans. The treatment of choice is curettage.

**References**

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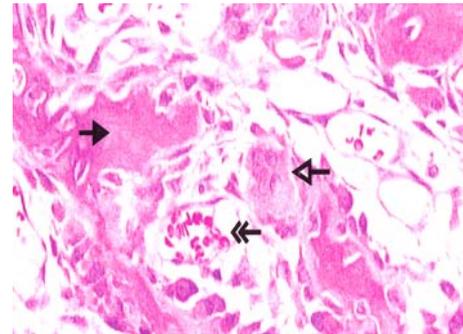


FIG. 2. Photomicrograph of a section of the clival tumor confirming the diagnosis of osteoblastoma. Osteoid formation (*solid arrow*), surrounding osteoblasts (*open arrow*), and a well-vascularized stroma (*double arrow*) are apparent. H & E, original magnification  $\times 200$ .



FIG. 3. Postoperative coronal CT reconstruction through the odontoid process and lower clivus demonstrating a small residual osteoblastoma superior to the odontoid process.

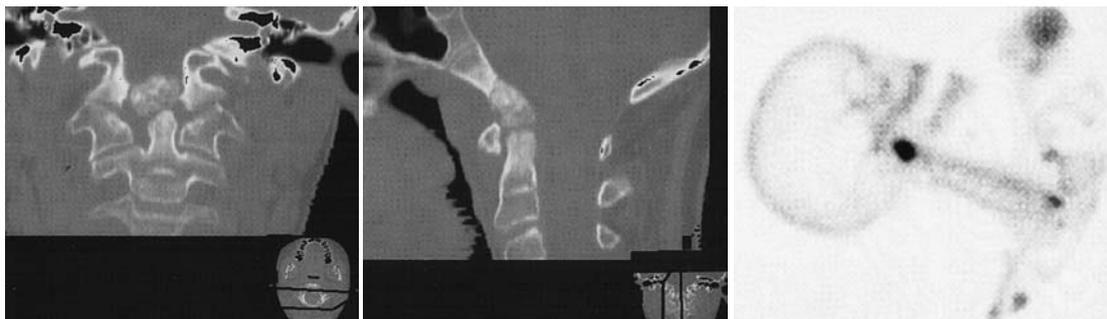


FIG. 1. Coronal (*left*) and sagittal (*center*) CT reconstructions demonstrating an expanded, sclerotic lesion of the lower clivus. An MDP bone scan of the head and neck (*right*) depicting areas of intense tracer activity in the clivus and upper cervical spine.

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