The initial symptoms of the tumor may be non-specific neck or back pain which often goes undiagnosed. When it affects the vertebral column, the posterior elements are more commonly involved. Long bones like tibia and femur are also commonly involved. Osteoblastoma is histologically similar to osteoid osteoma. Some people would like to distinguish the two by size alone; with lesions less than 1.5 cm diagnosed as osteoid osteoma.

Osteoblastoma has the propensity for spine, is more aggressive, doesn’t have a nidus, doesn’t cause a severe night pain and neither does it improve with aspirin unlike in osteoid osteoma.

Case Report

An 18 year old patient presented to the outpatient with history of neck pain for duration of 6 months and left upper limb radiculopathy for 2 months. The pain was excruciating and he was unable to move his neck in either direction.
but had residual neck pain which improved over a week. Plan is to perform an annual CT spine to see any recurrence.

The histopathology revealed haphazardly arranged woven bone with areas of hyaline cartilage. Bony trabeculae lined with osteoblastic cells were also seen. (Figure 3)

**Discussion**

Osteoblastoma occurs predominately during the first two decades, in accordance with our case. Most of these lesions arise within the posterior elements of the spine. Vertebral body involvement rarely occurs alone but may be involved via tumor extension through the pedicle. 

The most important symptoms in patients with osteoid osteoma and osteoblastoma are a resistant localized neck or back pain and stiffness in the spine. These general symptoms are often present for longer than 12 months prior to diagnosis. Delayed diagnosis occurs because initial symptoms are often nonspecific and osteoblastoma accounts for less than 1% of all bone tumors.

Imaging modalities used to diagnose osteoid osteoma and osteoblastoma are primarily CT and MRI. Plain X-rays are more useful in the detection of osteoblastomas, but may miss small neoplasms. Since osteoblastoma is a vascular tumor, pre op embolization has been suggested to decrease blood loss and facilitate total excision.

The aim of surgical treatment is to have a complete excision with free margins, decompression of neural tissue and fixation of the spine when deemed necessary.

Despite complete surgical excision, recurrence occurs in around 10%. 

Vertebral artery injury during surgical excision of a C3-C4 osteoblastoma has been reported from China.

Radiotherapy is limited to tumors where complete excision is not possible or the tumor continues to grow despite excision. However, malignant transformation after radiation therapy is reported.

**Conclusion**

Persistent neck pain in a young patient can be because of spinal tumors. Proper investigation and surgery can lead to a successful outcome.

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References


