INTRODUCTION
Intracranial migration of odontoid screws is a rare but serious complication of anterior odontoid screw fixation not often reported in literature. Here, we describe the second case in literature of intracranial migration of an odontoid screw.

CASE DESCRIPTION
64-year-old neurologically intact patient with a type II odontoid fracture secondary to trauma underwent anterior odontoid screw fixation without any intraoperative complications. He tolerated the procedure well, and postoperative imaging demonstrated near anatomic correction of the fracture with satisfactory placement of the lag screw. Unfortunately, the patient was subsequently lost to follow up and he presented 7 months later for a routine outpatient computed tomography (CT) of the cervical spine, which demonstrated upward migration of the screw into the intracranial cavity abutting the medulla, with CT angiography of the neck also confirming the screw lying between the two vertebral arteries. Magnetic resonance imaging of the cervical spine also demonstrated the odontoid screw lying within close proximity to the ventral cervicomedullary junction, margination the left vertebral artery. Subsequently, the patient was managed with removal of the odontoid screw and posterior cervical arthrodesis and instrumented fusion.

REFERENCES

DISCUSSION
C2 odontoid process fractures are a common cervical spine injury.1-3 While there is no current consensus on the best surgical treatment of type II odontoid fractures, AOSF has become popular due to its minimal invasive nature, immediate stabilization, preservation of the atlantoaxial joint movement, and high fusion rates.4-6 Since our patient was elderly and deemed healthy to undergo surgery, we chose to perform an AOSF due to higher success rates of fusion with AOSF as compared to a stabilization by a cervical collar7 and for immediate and robust stability of the fracture without compromising the normal atlantoaxial rotation.8 Post-op migration of odontoid screws is rarely reported in literature. Our patient initially underwent AOSF with near anatomic correction of the type II odontoid fracture. Follow-up imaging 7 months later demonstrated upward migration of the odontoid screw, which necessitated anterior screw removal with PCIF and C1-4 instrumented fusion.

CONCLUSION
Intracranial migration of odontoid screws is a rare but serious complication of AOSF. Here, we report the second case in literature of intracranial migration of an odontoid screw in a neurologically intact patient, managed with subsequent removal and PCIF. Our case demonstrates the rare but serious complication of intracranial odontoid screw migration, which we bring to the attention of the neurosurgical community.