Complications of cranioplasty following decompressive craniectomy: analysis of 62 cases

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Object. Decompressive craniectomy is a potentially life-saving procedure used in the treatment of medically refractory intracranial hypertension, most commonly in the setting of trauma or cerebral infarction. Once performed, surviving patients are obligated to undergo a second procedure for cranial reconstruction. The complications following cranial reconstruction are not well described in the literature and may very well be underreported. A review of the complications would suggest measures to improve the care of these patients.

Methods. A retrospective chart review was undertaken of all patients who had undergone cranioplasty during a 7-year period. Demographic data, indications for craniectomy, as well as preoperative, intraoperative, and postoperative parameters following cranioplasty, were recorded. Perioperative and postoperative complications were also recorded. Patients were classified as having no complications, any complications, and complications requiring reoperation. The groups were compared to identify risk factors predictive of poor outcomes.

Results. The authors identified 62 patients who had undergone cranioplasty. The immediate postoperative complication rate was 34%. Of these, 46 patients did not require reoperation and 16 did. Of those requiring reoperation, 7 were due to infection, 2 from wound breakdown, 2 from intracranial hemorrhage, 3 from bone resorption, and 1 from a sunken cranioplasty, and 1 patient’s cranioplasty procedure was prematurely ended due to intraoperative hypotension and bradycardia. The only factor statistically associated with need for reoperation was the presence of a bifrontal cranial defect (bifrontal: 8 [67%] of 12, requiring reoperation; unilateral: 8 [16%] of 49 requiring reoperation; p < 0.01)

Conclusions. Cranioplasty following decompressive craniectomy is associated with a high complication rate. Patients undergoing a bifrontal craniectomy are at significantly increased risk for postcranioplasty complications, including the need for reoperation. (DOI: 10.3171/2009.3.FOCUS9062)

Key Words • cranioplasty • craniectomy • cranial reconstruction • cerebral decompression • intracranial hypertension

Decompressive craniectomy is a potentially life-saving procedure used in the treatment of medically refractory intracranial hypertension, most commonly in the setting of trauma or large-vessel infarction and less frequently in the setting of aneurysmal subarachnoid hemorrhage, intraoperative brain swelling, and encephalitis. Decompressive craniectomy, however, remains controversial. Its efficacy is currently being investigated with respect to survival and quality of life in multicenter, prospective, randomized trials in the setting of traumatic brain injury and middle cerebral artery infarction.

Once patients undergo decompressive craniectomy, those who survive are obligated to undergo a second procedure for surgical cranial reconstruction, that is, cranioplasty. Much of the modern literature regarding cranioplasty following decompressive craniectomy is based on case series that emphasize the technical aspects of the procedure such as the use of materials, the use of techniques to store the bone flap prior to reconstruction, the timing of surgical intervention, or other specific modifications to either the craniectomy or cranioplasty procedure, which may influence the cranioplasty. There are relatively few modern-day large clinical series describing the clinical outcomes and perioperative complications of cranioplasties in the setting of nonpenetrating traumatic brain injury and large vessel infarction. Complications after cranial reconstruction, often viewed as a straightforward neurosurgical procedure, may very well be underreported. Furthermore, traditional neurosurgical dictums regarding certain aspects of cranioplasty such as timing of surgery may not be appropriate in the modern era of neurosurgical care. A review of the complications would suggest measures to improve the care of these patients.

In the current study, our goal was to provide a complete review of all perioperative complications, defined as any potentially adverse event within 30 days of surgery, as well as identify any risk factors that may be associated with the need for reoperation after a primary cranioplasty.
Methods

The study was approved by the institutional review board of Albany Medical Center, a Level 1 trauma, tertiary care, teaching hospital. After approval, the billing and discharge databases of the neurosurgical service were reviewed to identify all patients who had undergone cranioplasty following a decompressive craniectomy during a 7-year period (January 1, 2002–December 31, 2008). This series only included patients who underwent craniectomies for cerebral swelling and excluded those undergoing craniectomy for menigioma resection and craniosynostosis. Once identified, the available hospital charts and clinic records were reviewed retrospectively to abstract relevant data.

Abstracted data included age at time of cranioplasty (years), sex (male or female), medical comorbidities (hypertension, diabetes, and tobacco use), indications for craniectomy (trauma, stroke, infection, and intraoperative swelling), laterality of craniectomy (bilateral, unilateral, or bifrontal), time between craniectomy and cranioplasty (days), type of prosthesis if used (titanium, methylmethacrylate, or porex), storage of bone flap if used (subcutaneous or tissue bank), operative time (minutes), identification of intraoperative CSF leak (yes or no), estimated blood loss (ml), intraoperative fluid administration (ml), length of stay after cranioplasty (days), and disposition before and after the cranioplasty (home, hospital, or inpatient nursing facility).

Any potentially adverse medical or surgical events identified within 30 days of surgery were recorded as early complications. Late complications were unsatisfactory events directly related to the cranioplasty occurring > 30 days postoperation. Patients were classified as having no complication, any complication, and complication requiring reoperation. Specifically, our 2 outcomes of interest were complications after cranioplasty and the need for reoperation after cranioplasty. Both variables were dichotomized, and all patient- and surgery-related factors were assessed as risk factors for each of the 2 outcomes of interest via bivariate analysis. Chi-square analysis and the Fisher exact test were used to assess the association between the categorical risk factors and the outcomes. The Wilcoxon rank-sum test was used to assess if the distribution of the continuous variables was different among those who did and those who did not have the outcomes of interest. To assess complication rates associated with time to cranioplasty, patients were divided into quartiles, and ORs were calculated. All tests were 2-tailed. All associations were assessed at a level of 0.05 of statistical significance. Statistical analysis was performed using STATA 10 software (StataCorp LP).

Results

We identified 109 patients who had undergone a cranioplasty following cerebral decompression via craniectomy. Of these, 23 charts were incomplete for the purpose of this study, and 24 patients were lost to follow-up in the early postoperative period. As a result, 62 patients were identified who had undergone a decompressive craniectomy and subsequent cranioplasty with a minimum of 4 months of follow-up. Even among this population, some variables could not be reliably extracted from the medical records including medical comorbidities, disposition before and after cranioplasty, and intraoperative CSF leakage. The baseline patient characteristics and perioperative factors are shown in Table 1. The majority of the patients in this review were male (34 [55%]), and the most common indication for craniectomy was trauma (41 [66%]). Other reasons for decompressive craniectomy included stroke, infection, and intraoperative swelling. Most craniectomies were unilateral (49 [79%]). In addition, 12 patients (19%) underwent a bifrontal craniectomy, and 1 (2%) underwent a bilateral decompression. Regarding the cranioplasty procedure, the overwhelming majority of repairs used autologous bone (57 [92%]), and all autologous bone was stored in a tissue bank. Titanium and methylmethacrylate repairs were performed much less frequently (2 [3%] and 3 [5%] cases, respectively).

Surgical Complications

Perioperative and postoperative complications are summarized in Table 2. Of the 62 patients undergoing

### Table 1: Demographic and operative details in 62 patients undergoing craniectomy and cranioplasty

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>No. of Patients (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>no. of patients</td>
<td>62</td>
</tr>
<tr>
<td>male</td>
<td>34 (55)</td>
</tr>
<tr>
<td>female</td>
<td>28 (45)</td>
</tr>
<tr>
<td>craniectomy</td>
<td></td>
</tr>
<tr>
<td>mean age (yrs)</td>
<td>31.5 ± 2.4</td>
</tr>
<tr>
<td>indication</td>
<td></td>
</tr>
<tr>
<td>trauma</td>
<td>41 (66)</td>
</tr>
<tr>
<td>stroke</td>
<td>15 (24)</td>
</tr>
<tr>
<td>infection</td>
<td>2 (3)</td>
</tr>
<tr>
<td>intraop swelling</td>
<td>4 (6)</td>
</tr>
<tr>
<td>type</td>
<td></td>
</tr>
<tr>
<td>unilat</td>
<td>49 (79)</td>
</tr>
<tr>
<td>bifrontal</td>
<td>12 (19)</td>
</tr>
<tr>
<td>bilat</td>
<td>1 (2)</td>
</tr>
<tr>
<td>cranioplasty</td>
<td></td>
</tr>
<tr>
<td>mean age (yrs)</td>
<td>31.9 ± 2.4</td>
</tr>
<tr>
<td>type of prosthesis</td>
<td></td>
</tr>
<tr>
<td>autologous</td>
<td>57 (92)</td>
</tr>
<tr>
<td>titanium</td>
<td>2 (3)</td>
</tr>
<tr>
<td>methylmethacrylate</td>
<td>3 (5)</td>
</tr>
<tr>
<td>mean no. of days btwn craniectomy &amp; cranioplasty</td>
<td>133 ± 18.2</td>
</tr>
<tr>
<td>mean op room time (min)</td>
<td>173 ± 10</td>
</tr>
<tr>
<td>mean estimated blood loss (ml)</td>
<td>238 ± 28</td>
</tr>
<tr>
<td>mean intraop intravenous fluids (ml)</td>
<td>1881 ± 138</td>
</tr>
<tr>
<td>mean length of stay (days)</td>
<td>11 ± 2.1</td>
</tr>
</tbody>
</table>

* Unless otherwise indicated, mean values are presented as the means ± SEMs.
Complications of cranioplasty after decompressive craniectomy

Complications in 62 patients undergoing craniectomy and cranioplasty

<table>
<thead>
<tr>
<th>Complication</th>
<th>Early (≤30 days postop)</th>
<th>Late (&gt;30 days postop)</th>
<th>No. Requiring Reop</th>
</tr>
</thead>
<tbody>
<tr>
<td>wound</td>
<td>3 (4.8)</td>
<td>6 (9.7)</td>
<td>9</td>
</tr>
<tr>
<td>infection</td>
<td>2 (3.2)</td>
<td>5 (8.1)</td>
<td>7</td>
</tr>
<tr>
<td>dehiscence</td>
<td>1 (1.6)</td>
<td>1 (1.6)</td>
<td>2</td>
</tr>
<tr>
<td>epidural</td>
<td>2 (3.2)</td>
<td>1 (1.6)</td>
<td>3</td>
</tr>
<tr>
<td>subdural</td>
<td>1 (1.6)</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>bone resorption</td>
<td>0</td>
<td>4 (6.5)</td>
<td>3</td>
</tr>
<tr>
<td>sunken bone plate</td>
<td>0</td>
<td>1 (1.6)</td>
<td>1</td>
</tr>
<tr>
<td>intrap hemodynamic instability</td>
<td>1 (1.6)</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>status epilepticus</td>
<td>1 (1.6)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>hydrocephalus</td>
<td>1 (1.6)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>deep vein thrombosis</td>
<td>2 (3.2)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>upper extremity</td>
<td>1 (1.6)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>lower extremity</td>
<td>1 (1.6)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>total</td>
<td>10 (16.1)</td>
<td>11 (17.7)</td>
<td>16/21 (76.2)</td>
</tr>
</tbody>
</table>

* Of 62 patients, 21 (33.8%) had some complication and 16 (25.8%) required a reoperation.

Complications Requiring Reoperation

- Eight patients (13%) had complications that required reoperation. Complications included infection (7), wound dehiscence (2), epidural hematoma (1), subdural hematoma (1), bone resorption (4), and sunken bone plate. In 1 patient, the initial procedure was aborted midoperation due to hemodynamic instability. After statistical analysis, the only variable found to be significantly associated with a need for reoperation was the presence of a bifrontal cranial defect (bifrontal: 8 [67%] of 12 requiring reoperation; unilateral: 8 [16%] of 49 requiring reoperation; p < 0.01) (Table 3).

Time to Cranioplasty

The 62 patients who underwent cranioplasty were divided into 4 groups, each containing approximately the same number of patients, based on duration of time between craniectomy and cranioplasty. Odds ratios calculating the likelihood of complications and complications requiring reoperation with respect to timing of cranioplasty are presented in Table 4. For complications and complications requiring reoperation, ORs were highest in the 100- to 136-day group (OR 1.67 and 3, respectively).

Discussion

Cranioplasty following decompressive craniectomy is a conceptually intuitive procedure from the perspective of safety and cosmesis. More recent reports have suggested that the procedure may help optimize neurological recovery, both physiologically and/or clinically.1,4,11,13,15,23,31,32,44-46,57,58,61,64,65,69 However, there is no specific technique or material that has consistently stood alone as superior, and postoperative complication rates vary widely.22 In the modern era, most reports in the literature regarding cranioplasty have focused on technical aspects of the procedure and have not emphasized overall surgical complications.2,3,9,10,12,14,20,26,28,30,33-36,38,41,50-52,54,55,60,63,67,68,70,71 Because decompressive craniectomy is now being reevaluated in large, prospective, randomized trials,22,27,46 an analysis of complications for cranioplasty is particularly important. As almost all patients surviving a decompressive craniectomy will require cranioplasty, the complications of this second operative intervention should be acknowledged.

Complications Following Cranioplasty

The current report suggests that cranioplasty following decompressive craniectomy is associated with a high complication rate (33.8%). Of those patients who did experience complications, 5 (24%) of the 21 did not require

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a subsequent operation. However, these complications could not all be classified as “minor.” Specifically, one such patient was found to be in status epilepticus immediately postoperatively. Of the patients with complications, 76% required another operation to address their previous cranioplasty. Such complications included infection, bone resorption, wound dehiscence, sunken bone flap, hematoma, and intraoperative hemodynamic instability necessitating a premature end to the primary cranioplasty procedure. Of note, our infection rate (11.3%) appears to be similar to that previously reported in large series of patients undergoing cranioplasty.2,29,40,42

Complications Requiring Reoperation Following Cranioplasty

In the current analysis, complications requiring reoperation occurred in 16 patients (26%) and in 76% of those who had any complication (16 of 21). This overall reoperative complication rate is surprisingly high, considering the perceived straightforward nature of this procedure.

In our series, all patients who experienced wound complications as defined by infection and wound dehiscence required reoperation. Three of these patients initially presented with wound dehiscence without gross evidence of infection. All 3 were treated with primary closure. Two of the patients received scalp tissue expanders prior to this procedure. The third patient underwent uneventful revision of his scalp flap, but bacterial cultures taken from the operating room eventually revealed methicillin-resistant *Staphylococcus aureus*. He was subsequently treated with intravenous antibiotics. None of these patients was treated by removal of the bone plate. Our review demonstrated that patients undergoing a bifrontal cranioplasty were significantly more likely to have complications. The complications in this group included infection (in 4 patients), wound dehiscence (in 1), sunken bone plate (in 1), resorption (in 1), and hemodynamic instability during cranioplasty (in 1). All complications for these patients led to reoperation. Several factors may have contributed to this observation, including a longer incision in the case of a bifrontal defect, less available temporalis muscle to provide soft-tissue coverage, possible violation of the frontal sinus, and perhaps a longer operative time. Of these, violation of the frontal sinus has previously been described as a definitive risk factor for infection after cranioplasty.5,39 Unfortunately, because of the retrospective nature of this study we were unable to reliably quantify any of these potentially contributing variables.

Time to Cranioplasty

According to traditional neurosurgical dictum, a shorter time from craniectomy to cranioplasty is associated with poor outcome.17,53,62 While often recommended in neurosurgical texts, the basis of this recommendation is not well cited. The rationale for this waiting period is most likely based on the large series of patients reported by Rish and colleagues56 in 1979. This group found that cranioplasties taking place 1–6 months after craniectomy had the highest complication rate (7.9%) and those performed 12–18 months after craniectomy had the lowest complication rate (4.5%). The purported advantage of this waiting period includes avoidance of operating on a potentially contaminated wound.56 However, because this study included only patients with penetrating head injuries, the results may not apply to patients who have undergone decompressive craniectomy in the setting of nonpenetrating injury. Recently Carvi et al.6 and Liang et al.37 have suggested that cranioplasty following decompressive craniectomy for blunt injury can be performed sooner than previously suggested. The possible advantages of performing cranioplasty in a more timely fashion may include easier dissection of tissue planes, as well as prevention of negative postcraniectomy sequelae including posttraumatic hydrocephalus,8 syndrome of the trephined,31,46 or other neurological complications.32,9,44

Our analysis in regard to time between craniectomy and cranioplasty revealed a higher risk of both postoperative complications and need for reoperation in those patients treated between 100 and 136 days. It is difficult to rectify this point clinically, and our small number of events in each group limits the strength of any conclusions to be made regarding these data. Most significant may be the fact that those patients treated early (0–48 days) or those treated late (≥137 days) did not have a significantly increased risk. This finding, along with the reports by Carvi et al.6 and Liang et al.37 may negate previous dictum suggesting cranioplasty needing to be performed during a certain time point postcraniectomy. Again, this conclusion is limited and requires further analysis in a prospective study.

Critique of the Current Study

The current study is a retrospective analysis of the complications of cranioplasty following decompressive craniectomy. Accordingly, the study suffers from all the anticipated deficiencies of a retrospective analysis including loss of patient information, poor follow-up, inconsis-
Complications of cranioplasty after decompressive craniectomy

tent operative indications for craniectomy, and inconsistent
techniques for cranioplasty. These deficiencies may
lead to an inaccurate estimation of the true complication
rate.

In an effort to accurately estimate the complication
rate, any potential adverse event in this series was iden-
tified as a complication. This method may have falsely
inflated the observed complication rate. On the other hand,
in a review of cranioplasties in 75 children, Blum et al., did not identify any complications until 2.5 years postop-
eratively. Given that our patients were included with only
a minimal follow-up of 4 months, it is possible we may
actually be underreporting the total number of complica-
tions. Despite these limitations, the current study is im-
portant as it highlights the fact that a significant number
of complications that may necessitate reoperation.

Conclusions

Patients undergoing decompressive craniectomy are
obligated to undergo a second procedure for cranial re-
construction. This second surgery has a remarkably high
rate of complications. Additionally, patients undergoing
bifrontal craniectomies are at a significantly increased
risk for postcranioplasty complications including the need
for an additional operation. The time between cranie-
tomy and cranioplasty does not appear to be associated
with complications; however, our data are too limited to
make definitive conclusions as to this point. Prospective
studies are needed to further evaluate cranioplasty com-
pliances.

Disclaimer

The authors report no conflict of interest concerning the mate-
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paper.

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Complications of cranioplasty after decompressive craniectomy


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