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Osteoid osteoma: Contemporary management

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Abstract

Osteoid osteoma is a benign bone-forming tumor with hallmark of tumor cells directly forming mature bone. Osteoid osteoma accounts for around 5% of all bone tumors and 11% of benign bone tumors. Osteoid osteoma is the third most common biopsy analyzed benign bone tumor after osteochondroma and nonossifying fibroma. Two to 3% of excised primary bone tumors are osteoid osteomas. Males are more commonly affected with an approximate male/female ratio of 2 to 1. Adolescents and young adults are usually affected in the second decade of life, with most patients being under the age of 20 years. It is less likely to be seen in patients under 5 years of age or in adults greater than 40 years.

Localisation

Osteoid osteoma occurs predominantly in the appendicular skeleton. Spine is involved in one tenth of the cases. Flat bones with intramembranous formation in the body and skull are rarely affected. The lower extremity is more commonly affected than the upper extremity as shown in Figure 1. Commonly long bones particularly the femur and tibia are involved, followed far behind by bones of the feet, with a predilection for the talar neck. Common sites of femoral involvement are the juxta- or intra-articular regions of the femoral neck. In the upper extremity, phalanges of the hand are commonly affected.

Classification

In long bones, osteoid osteoma is more often situated in the cortico-diaphyseal or metaphyseal regions, but other localizations such as intramedullary, subperiosteal, epiphyseal or apophyseal have also been noted. It is very rare to have two osteoid ostomas in the same patient. According to Musculoskeletal Tumor Society staging system for benign tumors, osteoid osteoma is a stage-2 lesion. It is classified as cortical, cancellous, or subperiosteal. Cortical lesions are most common.

Clinical presentation

Pain is the most common symptom. Usually it is a dull ache, which is unremitting and starts off as mild and intermittent that gradually increases in intensity and persistence. The pain has a tendency to become increasingly severe at night and usually responds to salicylates and non-steroidal anti-inflammatory medications. If osteoid osteoma involves a bone in a subcutaneous location, then the patient usually presents with swelling, erythema and tenderness. If the proximal femur or pelvis is involved, the patient can present with referred pain in the knee. Lesions that are within the joint or juxta-articular can present with synovitis. If this continues to progress, the patient can present with joint pain, flexion contracture, decreased range of motion, and a limp or antalgic gait. Sometimes in children, a limp may be the only presenting symptom. If the lesion involves the open physis, it can result in limb length discrepancy with potential coronal and/or sagittal malalignment. Referred pain and muscle atrophy can result in misdiagnosis of a neurological disorder commonly seen in axial skeleton involvement with postural scoliosis due to paravertebral muscle spasm, which is reversible after treatment.

Pathogenesis

The exact pathogenesis of osteoid osteoma remains unknown. High levels of prostaglandin E2 and prostacyclin have been found within the nidus that is believed
to cause local inflammation and vasodilatation. A study by Mungo et al. revealed increased levels of cyclooxygenase-2 expression in nidus osteoblasts. Cyclooxygenase-2 inhibition is believed to be a mechanism by which NSAIDs provide symptomatic relief in osteoid osteomas. These inflammatory mediators may also contribute to perilesional sclerosis exhibited by most osteoid osteomas. In addition, high concentrations of intralesional unmyelinated nerve fibers have been implicated in the pathogenesis of the exquisite nocturnal pain. These processes probably function in parallel to produce the characteristic inflammatory symptoms.

Historically, there has been debate over the years about the precise nature of osteoid osteomas. Initially considered a neoplasm by Jaffe, other investigators proposed a reactive or reparative process citing its limited growth potential and its ability to spontaneously regress in some cases. Currently, most pathologists agree about the neoplastic nature of osteoid osteomas. The tumour’s histological similarity to osteoblastoma supports the belief that it is a benign tumour derived from the osteoblasts. There have been few cytogenetic studies that reported clonal cytogenetic abnormalities, including alterations involving chromosome 22q, a region which contains genes involved in cell proliferation that is commonly affected in a variety of other neoplasms.

**Gross features**

When removed intact, osteoid osteomas are usually small, and round to oval in shape. The cut surface is red to pink when fresh, and brown to granular after formalin fixation. They are well demarcated from the surrounding white sclerotic cortical bone. The nidus color is related to vascularity of intertrabecular areas. As osteoid osteomas are now treated by radiofrequency ablation, such intact specimens as described above are rarely received for histopathology.

**Microscopic features**

Histologically, the nidus is well circumscribed and composed of haphazardly interanastomosing trabeculae of variably mineralized woven bone. The trabeculae are usually thin and short, but can be sclerotic and broad and are rimmed by a single layer of osteoblasts. Scattered osteoclasts are also present on the surface of bony trabeculae (Figure 2). The osteoblasts are plump, uniform in size and shape and have eccentric nuclei with small nucleoli and open chromatin. Cytoplasm is usually amphophilic. No nuclear pleomorphism or increased mitotic activity is seen. The intertrabecular stroma is loose and fibrovascular (Figure 3). The reactive bone surrounding the nidus is dense cortical or trabecular bone and when the tumor grows closer to the bone surface, it becomes more pronounced. In medullary lesions, it is less pronounced.

The pathologic evaluation of osteoid
osteoma has been affected by the increasing use of radiofrequency ablation (RFA) or other minimally invasive techniques. The techniques now used include core biopsy or biopsy obtained from a drill procedure. As compared to specimens received by traditional surgery, the yield of diagnostic tissue is lower and tissue findings are often obscured by heat or crushing artifacts. Consequently, pathologists may or may not be able to confirm the diagnosis on smaller, usually fragmented, and frequently distorted fragments of tissue. The techniques now used include core biopsy or biopsy obtained from a drill procedure. As compared to specimens received by traditional surgery, the yield of diagnostic tissue is lower and tissue findings are often obscured by heat or crushing artifacts. Consequently, pathologists may or may not be able to confirm the diagnosis on smaller, usually fragmented, and frequently distorted fragments of tissue. The techniques now used include core biopsy or biopsy obtained from a drill procedure. As compared to specimens received by traditional surgery, the yield of diagnostic tissue is lower and tissue findings are often obscured by heat or crushing artifacts. Consequently, pathologists may or may not be able to confirm the diagnosis on smaller, usually fragmented, and frequently distorted fragments of tissue. The techniques now used include core biopsy or biopsy obtained from a drill procedure. As compared to specimens received by traditional surgery, the yield of diagnostic tissue is lower and tissue findings are often obscured by heat or crushing artifacts. Consequently, pathologists may or may not be able to confirm the diagnosis on smaller, usually fragmented, and frequently distorted fragments of tissue. The techniques now used include core biopsy or biopsy obtained from a drill procedure. As compared to specimens received by traditional surgery, the yield of diagnostic tissue is lower and tissue findings are often obscured by heat or crushing artifacts. Consequently, pathologists may or may not be able to confirm the diagnosis on smaller, usually fragmented, and frequently distorted fragments of tissue. The techniques now used include core biopsy or biopsy obtained from a drill procedure. As compared to specimens received by traditional surgery, the yield of diagnostic tissue is lower and tissue findings are often obscured by heat or crushing artifacts. Consequently, pathologists may or may not be able to confirm the diagnosis on smaller, usually fragmented, and frequently distorted fragments of tissue. The techniques now used include core biopsy or biopsy obtained from a drill procedure. As compared to specimens received by traditional surgery, the yield of diagnostic tissue is lower and tissue findings are often obscured by heat or crushing artifacts. Consequently, pathologists may or may not be able to confirm the diagnosis on smaller, usually fragmented, and frequently distorted fragments of tissue. 

**Immunohistochemical features**

S100 and neurofilament show nerve fibers involving tumor. Osteoid osteomas also show strong nuclear expression for Runx2 and Osterix, which are regulatory transcription factors. This suggests that osteoid osteomas share common genetic pathways with normal skeletal development.

**Differential diagnosis**

Osteoid osteoma can be distinguished from other bone forming tumors based on the difference in size, location, pathology, and clinical symptoms. A small Brodie abscess with a radiolucent center and surrounding reactive sclerosis can mimic osteoid osteoma. With intracortical Brodie abscess the sequestrum is irregular in shape and the inner margin of the lucency is not smooth, whereas in osteoid osteoma, the inner margins are usually smooth. Tumors can also mimic osteoid osteomas. Chondroblastomas in epiphyseal locations of children with osteolytic lesions and extensive bone marrow edema and periosteal reaction can resemble osteoid osteoma. However the epiphyseal and intramedullary location is more characteristic for chondroblastomas, whereas osteoid osteomas are usually diaphyseal and intracortical. In the pediatric age group cortical lesions in the tibia caused by osteofibrous dysplasia, adamantinoma and stress fractures produce cortical thickening and proliferation that can be mistaken for osteoid osteomas. In stress fractures, the reactive woven bone network is well oriented around trabeculae of fractured bone. It is not haphazard and lacks the small irregular trabeculae seen in osteoid osteomas. Other lesions such as nonossifying fibromas, enchondromas, eosinophilic granulomas, Perthes disease, tuberculosis, neuromuscular conditions and malignant bone tumors can also be considered. In addition to clinical features, imaging techniques such as CT, bone and SPECT scans can assist in diagnosing the lesion.

**Imaging findings**

**Plain radiography**

Osteoid osteoma appears as an oval lytic lesion located within dense cortical bone in the diaphysis surrounded by fusiform cortical bone thickening and sclerosis. The cortical based lucency is less than 2 cm. Underlying lytic nidus may not always be visualized due to significant sclerosis. The sclerotic reactive bone often is seen distant from the lesion, in extra capsular location.

The tumor present at subperiosteal location is a rounded sclerotic focus that elevates the periosteum with limited sclerotic reaction. In intramedullary location, these tumors are well-circumscribed with a complete or partially calcified nidus. The surrounding reactive sclerosis can be minimal or absent (Figure 4A). In posterior elements of the spine, osteoid osteomas are difficult to localize. The nidus is not visualized on plain films but additional findings such as scoliosis with concavity at the side of the lesion is seen in these cases. A study done by PARK et al showed 28.6% of osteoid osteoma cases in their study had no plain radiography abnormality despite very typical clinical presentations. Radionuclide imaging was used to diagnose these cases. Therefore in cases where plain radiographs are not conclusive but clinical suspicion is high, further imaging workup should be requested.

**CT**

CT is the modality of choice for diagnosis and specifying location of lesion, i.e. cortical vs sub periosteal or medullary. CT shows well-defined nidus as round or oval with low attenuation (Figure 5). Nidus can show mineralization which may be puncate, amorphous or ring like. Surrounding reactive sclerosis can vary from mild sclerosis to extensive periosteal reaction and new bone formation, which may obscure the nidus.

For cases where nonoperative management is chosen as the treatment strategy, mineralization of the nidus is considered as a marker of age of the lesion. The mineralization ratio of osteoid osteoma increases significantly with pain duration. Touraine et al. showed that nidus mineralization ratio of osteoid osteoma is positively related to pain symptomatology.

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Figure 4. A 10 years old boy with humeral osteoid osteoma. A) AP radiograph shows radiolucent nidus arrow and surrounding sclerosis. B) Coronal STIR image shows hypointense nidus arrow and perilesional edema (small arrow). C) Axial T1-weighted and corresponding post contrast T1-weighted Fat sat images show hypointense nidus on pre contrast image with intense enhancement on post contrast images (long arrow). D) Technetium-99 bone scan, AP projection shows focal region of radiotracer uptake, corresponding to tumor nidus (Arrow).
duration and may be a marker of tumor age (P=0.007, hazard ratio=0.193). They however reported no association of nidus size with pain duration (P=0.092). In their study, diaphyseal osteoid osteomas displayed a lower ratio of nidus mineralization as compared to those in epiphyseal and metaphyseal locations.23

Dynamic contrast-enhanced CT helps in differentiating osteoid osteoma from bone cysts and chronic osteomyelitis, specifically Brodie abscess which are avascular. In these cases the tumor nidus shows rapid early arterial enhancement and appears hypervascular.24-26

Spinal osteoid osteoma is better characterized by CT. The nidus is visible as low-density area in posterior elements. Surrounding sclerosis of the ipsilateral pedicle, lamina, or transverse process may be present.

**Bone scintigraphy**

Technetium-99-labeled bone scintigraphy has high sensitivity for confirming diagnosis of osteoid osteoma. The sensitivity of skeletal scintigraphy for detection is 100%.27 On bone scan characteristic feature is very intense, round activity at nidus surrounded by less intensity of reactive bone. This is known as double density sign.28 The increased intensity of nidus is because of increased bone turn over. The less intense peripheral radiotracer uptake, represents the host bone tumor response (Figure 4) The sign is infrequently seen with spinal osteoid osteoma because of less peripheral sclerosis in vertebral bodies.29 A study done by PARK et al found out that all the patients in their study with or without conclusive appearance on plain radiography, were correctly identified on bone scintigraphy. They recommended that if the radionuclide imaging is positive, CT scans should be next imaging modality for further evaluation but in cases where radionuclide imaging is negative, MRI should be done for the diagnosis of other underlying bone pathologies.22

**PET**

PET may have role in initial diagnosis and post treatment follow-up. A study previously reported that tumor nidus exhibits 18FFDG-avid glucose metabolism, whereas the surrounding sclerosis does not. In follow up cases of radiofrequency ablation (RFA), hypermetabolic activity is absent. Some authors suggested role of PET specifically in cases of spinal osteoid osteoma. But this modality requires more research work to be done to prove its utility in diagnosis and follow up.30-33

In addition to FDGPET/CT, 68Ga-PSMA PET/CT, which is used in prostate cancer staging and restaging, has been used to detect a case of osteoid osteoma. This uptake was likely because of osteoblastic activity in osteoid osteoma but needs further evaluation to investigate its specific role and accuracy in diagnosis of osteoid osteoma.34,35

**MRI**

MRI is more sensitive than CT scan for detection of reactive changes in soft tissue. MRI is a reliable method of visualizing the nidus. The MRI appearance of nidus depends on its location in the cortex. The closer the lesion is to the medullary zone, the greater the role of MRI in recognizing the nidus compared to CT scan. However, compared to MRI, CT scan is more specific for identifying a nidus.36,37 The appearance of nidus on MRI is variable depending on mineralization and its vascularity. Nidus on MR T1 weighted sequence appears as round lesion, slightly hyper intense to intermediate signals to adjacent muscle and hyper intense to heterogeneous signals on T2 weighted and STIR sequences (Figure 4B and C). Nidus can be hypointense in all sequences, depending on vascularity and mineralization. Tumor enhancement is variable, can be diffuse or heterogeneous (Figure 4C). The surrounding osteosclerosis appears as low signal on both T1- and T2-weighted sequences.38,39 There is high potential of misdiagnosing osteoid osteoma as neoplastic lesion or oversight it when other modalities are not used for diagnosis. Small lesions may be hard to isolate on MRI as nidus signal is frequently similar to that of surrounding cortex.38,39 Although CT is the modality of choice in diagnosis of osteoid osteoma, but in patients with atypical clinical presentations, in whom the pain does not respond to NSAIDs and where no obvious abnormality on plain roentgenograms is reported, MRI is done to investigate the underlying cause. MRI is more sensitive than CT scan for detection of reactive changes in soft tissue and surrounding bone edema. Klontzas et al. reported that the half-moon sign of bone marrow edema was associated with the presence of osteoid osteoma in femoral neck. The half-moon sign is highly specific and sensitive for presence of osteoid osteoma in the femoral neck with 94.7% specificity and 100% sensitivity and positive and negative predictive values of 91.7% and 100%, respectively (D). But some authors have questioned this high specificity as the half-moon sign of bone marrow edema in femoral neck can be seen in intermediate-grade stress fractures of the femoral neck on MRI. It has therefore been recommended that if clinical features are suggestive of osteoid osteoma, then CT should be performed to determine the presence of a potentially occult nidus on MRI.35

**Pitfall of imaging**

The diagnosis of osteoid osteoma on imaging can be challenging in cases where there are severe associated inflammatory changes such as a prominent periosteal reaction, exaggerated synovial hypertrophy, joint effusion, extensive bone marrow and soft tissue edema. In cases of significant periosteal reaction and soft tissue edema in a young patient, the differential diagnoses of osteomyelitis or malignant bone tumor, such as Ewing sarcoma have to be considered. A small nidus obscured by extensive bone marrow and soft-tissue edema needs to be differentiated from traumatic injury or infection. For accurate and correct radiological diagnosis it is mandatory to identify the nidus.
<table>
<thead>
<tr>
<th>No.</th>
<th>Reference/ year</th>
<th>No. of patients</th>
<th>Age of patients (years)</th>
<th>Gender</th>
<th>Sites</th>
<th>Treatment</th>
<th>Duration of follow up</th>
<th>Outcome</th>
</tr>
</thead>
</table>
| 1   | Bousson et al.⁷⁰ 2018 | 23 | Range 8-44 | M 15  
Mean age 23.8 | F 8 | Cervical spine 5, Sacrum 3, Thoracic spine, Femoral neck, Femoral condyle and Tibia 2 cases each | Bisphosphonate therapy | Range 20-48 months  
(mean 36) | Recurrence of pain in 6 cases |
| 2   | Santiago et al.⁷⁰ 2018 | 21 | Range 17-54 | M 12  
Mean age 29.9 | F 9 | Femur 8, spine 5, talus 2, cuboid 2, humerus, tibia, fibula, and patella 1 case each | Percutaneous cryoablation | Range 6-40 (mean 21 months) | Recurrence in 1 case |
| 3   | Nijland et al.⁷¹ 2017 | 86 | Mean age 26.1 | M 59  
(±10.7) | F 27 | Femur 31, Tibia 29, Fibula 9, others 17 | CT-guided radiofrequency ablation | Mean 54.1 (±30.6) | Clinical success rate 81.4% |
| 4   | Wu et al.⁷² 2017 | 72++ | Range 3-16 | M 22  
(average, 10.5±4.6) | F 14 | Proximal femur 20, Tibia 6, Ilum 2, 1 case each in calcaneus and ischia | CT-guided radiofrequency ablation | 12 months | Recurrence in 1 case |
| 5   | Shields et al.⁷³ 2017 | 42 | Mean age 21.1 | M 14  
F 28 | Femur 8, Tibia/Fibula 21, humerus and forearm 2 cases each, Wrist/Hand, Foot and Spine/Pelvis 3 cases in each | Radiofrequency ablation | Range 21 to 127 months  
(mean 72.3 months) | Recurrence in 7 cases |
| 6   | Quraishi et al.⁷⁴ 2017 | 64 | Range 6.7-52.4 | M 65  
(mean 21.8±9.0) | F 19 | Thoracic spine 31, Cervical and lumbar spine 25 cases each, sacrum 3 | Surgical resection | Range 13 days-14.5  
(mean 2.7 years) | Recurrence in 6 patients |
| 7   | Erol et al.⁷⁵ 2017 | 47 | Range 4-19 years | M 29  
(mean 10.5 years) | F 18 | Femur 21, Tibia 7, Humerus 10, Tibia 7, Radius 2, ulna 1, Proximal phalanx 3, distal phalanx 1, talus 1, metatarsal 1 | Minimal invasive intraskeletal extended curettage | Range 12-136 months  
(59 months) | No local recurrence was observed after a minimum follow-up of 12 months |
| 8   | Garge et al.⁷⁶ 2017 | 30 | Range 4-20 years | M 25  
(mean 13.16 years) | F 5 | Femur 21, tibia 4, 4 near articular surface (one each at glenoid fossa of right scapula, head of right radius, talocalcaneal joint of right calcaneum, and left femoral head) and 1 in left sacrum | CT-guided percutaneous RFA | Average follow up 6 months | Recurrence in 1 patient |
| 9   | Karraguz et al.⁷⁷ 2016 | 18 | Range 10-27 years | M 12  
(mean 17.4 years) | F 6 | Femur 8, Tibia 7, ulna 1, foot 1, sacrum 1 | CT-guided radiofrequency ablation | Average 26.5 months | Recurrence in 1 patient |
| 10  | Miyazaki et al.⁷⁸ 2016 | 21 | Range 10-39 years | M 17  
(median 22 years) | F 4 | Femur 17, Tibia 2, Humerus 1, Rib 1 | Percutaneous radiofrequency ablation | Range 3-35 months  
(mean 15.3 months) | No recurrence |
| 11  | Masciocchi et al.⁷⁹ 2016 | 30 | Range 19.3-30; median 23 (MRgFUS group) Range 25-31; median 28 (RFA group) | M 18  
F 12 | Femur 15, Tibia 5, Talus 5, Humerus 4, Hip 1 | Magnetic resonance guided focused ultrasound surgery (MRgFUS) and radiofrequency ablation (RFA) | Average follow up 12 weeks | No recurrence in RFA group  
Recurrent in 1 patient in the MRgFUS group |
| 12  | Wallace et al.⁸⁰ 2016 | 18 | Range 5.5-58.2 years | M 13  
(mean 28.1±14.5 years) | F 2 | Femur 9, Tibia 4, cervical spine 2, calcaneus 1, iliac bone 1, fibula 1 | Navigational bipolar radiofrequency ablation | Range 34-91 days  
(median 56 days) | No recurrence |
| 13  | Ouiati et al.⁸¹ 2016 | 32 | Range 10 to 39 years | M 25  
F 7 | Femur 18, Tibia 7, humerus 2, 1 each in fibula, scapula, patella, lumbar vertebra, and acetabula | Radiofrequency ablation | Range 1 to 65 months  
(median 18 months) | Recurrence in 1 patient |
| 14  | Etemadifar et al.⁸² 2015 | 19 | Range 8-38 years | M 11  
mean age of 19.8 | F 8 | Lumbar spine 7, thoracic spine 6, cervical spine 5, sacrum 1 | Surgical intra-lesional curettage | Range 9-115 months  
(average 44.5 months) | No recurrence |

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Table 1. Continued from previous page.

<table>
<thead>
<tr>
<th>#</th>
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<th>Duration of follow up</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.</td>
<td>Petrelli et al. 15 2015</td>
<td>18</td>
<td>Range 10 to 34 years (mean 18 years)</td>
<td>M 15 F 3</td>
<td>Femur 7, tibia 6, humerus, ulna, ulnar, humerus 1, calcaneus and fibula 1 in each.</td>
<td>CT-guided percutaneous trephine resection</td>
<td>Range 6-60 months (median 29 months)</td>
<td>Recurrence in 1 patient</td>
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<td>16.</td>
<td>Kudsum et al. 16 2015</td>
<td>52</td>
<td>Range 4-62 years (mean 18.2 years)</td>
<td>M 34 F 18</td>
<td>Femur 28, Tibia 18, Humerus, ischium, fibula, calcaneus, cuboid, calcaneum 1 case each</td>
<td>CT-guided radiofrequency ablation (RFA)</td>
<td>NA</td>
<td>Recurrence in 1 patient</td>
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<td>17.</td>
<td>Hanan et al. 17 2015</td>
<td>17</td>
<td>Range 17-76 years (average 25 years)</td>
<td>M 7 F 10</td>
<td>Proximal phalanx 10, middle phalanx 4, metacarpal bone 3</td>
<td>Surgical resection and autograft bone grafting</td>
<td>6 months-9 years (average 4 years and 2 months)</td>
<td>No recurrence</td>
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<tr>
<td>18.</td>
<td>Sharma et al. 18 2014</td>
<td>31</td>
<td>Range: 5-59 (mean 26.6±13.2 years)</td>
<td>M 25 F 6</td>
<td>Femur 12, tibia 11, calcaneus 1, humerus 1. Vertebral (lumbar 1, cervical 1). No bony lesion could be identified on SPECT/CT in 4 patients</td>
<td>NA</td>
<td>Range 6-36 months</td>
<td>NA</td>
</tr>
<tr>
<td>19.</td>
<td>Bourgault et al. 19 2014</td>
<td>87</td>
<td>Range 5-19 (mean 23)</td>
<td>M 65 F 24</td>
<td>Femur 27, tibia 18, femoral neck 18, and talus in 6 cases. Greater trochanter 3, elbow, knee, humerus and scapula in 2 patients each; spine, fibula, lateral cuneiform, metatarsal, cuboid, calcaneus and pelvis in one patient each</td>
<td>Percutaneous CT guided radiofrequency thermocoagulation</td>
<td>Range 6-96 (mean 34 months)</td>
<td>Recurrence in 9 patients</td>
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<td>20.</td>
<td>Raux et al. 20 2014</td>
<td>44</td>
<td>Range 4-34 (average age 12.7 years)</td>
<td>M 24 F 20</td>
<td>Femoral neck 26, Lesser trochanter 18</td>
<td>CT-guided percutaneous bone resection and drilling (PBRD)</td>
<td>Range 12-56 (mean 12 months)</td>
<td>Recurrence in 7 out of 42 cases with follow up</td>
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<tr>
<td>21.</td>
<td>Rebnitz et al. 21 2013</td>
<td>72</td>
<td>Range 3-68 (median 18)</td>
<td>M 47 F 25</td>
<td>Femur 26, Tibia 24, Humerus 7, Spine 4, Hip 3, Radius, fibula, calcaneus 2 cases each, Scapula and talus 1 case each</td>
<td>CT-guided RFA</td>
<td>Range 2-109 months (mean, 51.2±31.2 months)</td>
<td>Recurrence in 1 patient</td>
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<tr>
<td>22.</td>
<td>Diomea et al. 22 2013</td>
<td>35</td>
<td>6 to 69 years (average 21.7 years)</td>
<td>M 27 F 8</td>
<td>Femur 19, tibia 7, patella 2, ulna, iliac bone, sacrum, calcaneus, neck of the talus, humerus and lateral cuneiform bone 1 case each</td>
<td>Interstitial laser photoablation</td>
<td>Range 3-122 months (mean 40 months)</td>
<td>Recurrence in 2 patients</td>
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<td>23.</td>
<td>Infanti et al. 23 2011</td>
<td>25</td>
<td>16 to 46 years (average 25.2±7.6 years)</td>
<td>M 21 F 4</td>
<td>Proximal phalanx 10, distal phalanx 5, metacarpal 4, scaphoid and capitate 2 in each, styloid of radius and trapezium 1 case each</td>
<td>Surgical excision 21, curettage and bone grafting 4</td>
<td>Range 3 months to 8 years (mean 36.4±6.9 months)</td>
<td>Recurrence in 5 patients</td>
</tr>
<tr>
<td>24.</td>
<td>Farhan et al. 24 2013</td>
<td>25</td>
<td>Range 12 to 48 years (mean 27.5±8.6)</td>
<td>M 12 F 13</td>
<td>Phalanx 16, metacarpal 4, carpal 4, distal radius 1</td>
<td>Surgical excision and curettage</td>
<td>Mean 98 months</td>
<td>Recurrence in 3 patients</td>
</tr>
<tr>
<td>25.</td>
<td>Reverté-Viñas et al. 25 2013</td>
<td>54</td>
<td>Range 10-47 years (mean 22.7 years)</td>
<td>M 46 F 8</td>
<td>Femur 28, tibia 15, humerus 5, fibula 2, talus 2, and ulnar 2</td>
<td>Percutaneous CT-guided resection</td>
<td>Range 6-28 months (mean 22 months)</td>
<td>Recurrence in 4 patients</td>
</tr>
<tr>
<td>26.</td>
<td>Ehrhart et al. 26 2013</td>
<td>21</td>
<td>Range 2.5-28.6 years (mean 11.4 years)</td>
<td>M 16 F 6</td>
<td>Proximal femur 10, tibial shaft 3, Femoral shaft 2, distal femur 2, distal tibia 2, distal humerus 1, calcaneus 1</td>
<td>Percutaneous radiofrequency ablation</td>
<td>Range 0.5-86.1 months (average 17.0 months)</td>
<td>No recurrence in 17 patients with follow up</td>
</tr>
<tr>
<td>27.</td>
<td>Villani et al. 27 2013</td>
<td>53</td>
<td>Mean age 7.2 years</td>
<td>M 40 F 13</td>
<td>Tibia 22, femur 14, pelvis 5, talus 3, humerus 2, sacrum 2, heel 1, radius 2, patella 1, rib 1</td>
<td>Radiofrequency ablation</td>
<td>Follow up at 6, 18 and 24 months</td>
<td>Recurrence in 1 patient</td>
</tr>
<tr>
<td>28.</td>
<td>Rebnitz et al. 28 2012</td>
<td>77*</td>
<td>Range 3-68 (mean 17)</td>
<td>M 52 F 25</td>
<td>Femur 27, Tibia 25, Humerus 8, Spine 6, Hip 3, Radius, Scapula, and Fibula 2 in each case; Calcaneus and Talus 1 in each case</td>
<td>CT-guided radiofrequency ablation</td>
<td>Range 3-92 months (mean 38.5 months)</td>
<td>Primary success rate was 74.77% (96.1%) of all patients. Retreatment with RFA in 3 patients</td>
</tr>
<tr>
<td>29.</td>
<td>Neumann et al. 29 2012</td>
<td>33</td>
<td>Range 5-50 years (mean 20 years)</td>
<td>M 22 F 11</td>
<td>NA</td>
<td>CT-guided percutaneous radiofrequency ablation</td>
<td>Range, 60-121 months (mean 92 months)</td>
<td>Recurrence in 1 patient</td>
</tr>
<tr>
<td>30.</td>
<td>Martí et al. 30 2011</td>
<td>19</td>
<td>All younger than 10 years. Average</td>
<td>M 13 F 6</td>
<td>Femur 10, Tibia 7, Fibula 1, Metatarsal 1</td>
<td>Fluoroscopic guided percutaneous excision 14,</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

Continued on the next page.
Table 1. Continued from previous page.

<table>
<thead>
<tr>
<th>#</th>
<th>Reference/year</th>
<th>No. of patients</th>
<th>Age of patients (years)</th>
<th>Gender</th>
<th>Sites</th>
<th>Treatment</th>
<th>Duration of follow up</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>31.</td>
<td>Mahnken et al.</td>
<td>17</td>
<td>Range 9-40 years (mean 22.8 years)</td>
<td>M 12</td>
<td>Femur 11, tibia 4, fibula 1, cuboid bone 1</td>
<td>Excision by resection</td>
<td>Range 4 to 47 months (mean 29.9±14.8)</td>
<td>Recurrence in 3 patients</td>
</tr>
<tr>
<td>32.</td>
<td>Mylonas et al.</td>
<td>23</td>
<td>Range 15 to 38 years (mean age 28.8±6.7 years)</td>
<td>M 19</td>
<td>Femoral diaphysis 5, Tibial diaphysis 4, Inferior articular surface of femur 2, Anterior column of acetabulum 1, Sacrum 2, Vertebral arc 1, Transverse process 1, Great trochanter 2</td>
<td>CT-guided laser interstitial thermal therapy</td>
<td>Last follow up 12 months</td>
<td>Recurrence in 2 patients</td>
</tr>
<tr>
<td>33.</td>
<td>Akhlaghpour et al.</td>
<td>21</td>
<td>Range 10-30 years (mean 19.7 years)</td>
<td>M 17</td>
<td>Talus 8, Humerus 3, Acetabulum 3, Scapula (acromion) 1, Scapula (neck) 1, Ulna (radioulnar joint) 1, Third proximal phalanx 1, Cuneiform 1, Vertebral 2</td>
<td>Radiofrequency ablation</td>
<td>Range 12-37 months (mean 27.4 months)</td>
<td>No recurrence</td>
</tr>
<tr>
<td>34.</td>
<td>von Kalle et al.</td>
<td>54</td>
<td>Range 14.5-38.8 years (median 10.7 years)</td>
<td>M 35</td>
<td>Femur 28, tibia 15, pedicles of the thoracolumbar spine 5, Calcaneus 3, humerus 2, acetabulum 1</td>
<td>On bloc resection, open drill excision or curettage</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>35.</td>
<td>Sung et al.</td>
<td>28</td>
<td>Range 7-55 years (24.5 years)</td>
<td>M 21</td>
<td>Femur 18, Tibia 6, pelvic bone 2, 1 each in the humerus and the fibula</td>
<td>CT-guided percutaneous radiofrequency thermoaablative (PRT)</td>
<td>Range 24-66 months (mean 41.1 months)</td>
<td>Recurrence in 5 patients</td>
</tr>
<tr>
<td>36.</td>
<td>Peyer et al.</td>
<td>22</td>
<td>Range 3.5 to 18 years (mean 13.6 months)</td>
<td>M 15</td>
<td>Femur 15, Tibia 2, Humerus, talus, calcaneus, second metastasis, and sacrum 1 case each</td>
<td>CT-Guided RFA utilizing a water-cooled tip</td>
<td>Range 16-66 months (average 38.5 months)</td>
<td>Recurrence in 1 patient</td>
</tr>
<tr>
<td>37.</td>
<td>Blaszkiewicz et al.</td>
<td>20</td>
<td>Range 6-18 years (mean 13 years)</td>
<td>M 8</td>
<td>Cervical spine 7, thoracic spine 7, humerus 5, sacrum 1</td>
<td>Intracorporeal bone scas (IOBS) assisted resection</td>
<td>Range 8-18 months (average 15.6 months)</td>
<td>Recurrence in 1 patient</td>
</tr>
<tr>
<td>38.</td>
<td>Zampa et al.</td>
<td>19</td>
<td>Range 13-7 years (mean 29.8±12.2 years)</td>
<td>M 14</td>
<td>Femur 9, Tibia 3, Vertebral 3, Calcaneum 2, Acetabulum 1, Ilium 1</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>39.</td>
<td>Aschen et al.</td>
<td>25</td>
<td>Range 4 to 17 years (average 11.3 years)</td>
<td>M 15</td>
<td>Femur 12, tibia 9, acetabulum 2, ilium 1, talus 1</td>
<td>CT-guided laser thermoablation</td>
<td>Range 3 to 61 months (mean 26 months)</td>
<td>Recurrence in 1 patient</td>
</tr>
<tr>
<td>40.</td>
<td>Vandervschoren et al.</td>
<td>24</td>
<td>Range 6-18 years (mean 13.2 years)</td>
<td>M 16</td>
<td>Thoracic spine 10, Lumbar spine 7, Cervical spine 3, Sacrum 4</td>
<td>Radiofrequency ablation</td>
<td>Range 9-142 months (mean 72 months)</td>
<td>Recurrence in 5 patients</td>
</tr>
<tr>
<td>41.</td>
<td>Lee et al.</td>
<td>16</td>
<td>Range 13-51 years (mean age 23.2 years)</td>
<td>M 11</td>
<td>Femur 12, pelvis 2, tibia1, humerus 1</td>
<td>Percutaneous radiofrequency ablation</td>
<td>Range 2-17 months (mean 5.3 months)</td>
<td>Recurrence in 1 patient</td>
</tr>
<tr>
<td>42.</td>
<td>Akhlaghpour et al.</td>
<td>54</td>
<td>Range 3 to 26 years (mean 15.4±5.6 years)</td>
<td>M 43</td>
<td>Femoral shaft 25, femoral neck 17, tibia 10, fibula 1, L3 vertebral body 1</td>
<td>Combination of radiofrequency ablation and alcohol ablation</td>
<td>Range 13 to 48 months (28.2±4.7 months)</td>
<td>Recurrence in 2 patients</td>
</tr>
<tr>
<td>43.</td>
<td>Yang et al.</td>
<td>23</td>
<td>Range 6 to 39 years (mean 13.8 years)</td>
<td>M 11</td>
<td>Proximal femur 11, Femoral diaphysis 3, Distal femur 1, Proximal tibia 2, Tibial diaphysis 1, Distal tibia 1, Talar neck 1, Proximal humerus, distal radius and capitatis 1 case each</td>
<td>Conventional open excision 20 patients</td>
<td>Range 3 weeks to 142 months (mean 42.7 months)</td>
<td>Recurrence rate for conventional surgery 23%; CT-guided mini-incision surgery 0%</td>
</tr>
<tr>
<td>44.</td>
<td>Vandervschoren et al.</td>
<td>97</td>
<td>NA</td>
<td>NA</td>
<td>Femur 42, Tibia 14, Pelvis 8, Talus 5, Humerus 4, Ulna 4, Carpus 4, Metacarpal 3, Lumbar spine 3, Tarsal 3, Fibula 9, Cervical spine 7, Thoracic spine, Radius and Phalanx 1 case each</td>
<td>Thermocoagulation</td>
<td>Range 5-81 months (mean 41 months)</td>
<td>Unsuccessful treatment in 23 patients</td>
</tr>
<tr>
<td>45.</td>
<td>Gangi et al.</td>
<td>114</td>
<td>Range 5-56 years (mean 22.3 years)</td>
<td>M 69</td>
<td>Femur 48, tibia 19, humerus 8, fibula 2, spine 12, acetabulum 5, talus 4, calcaneus 3, ilium, navicular bone and metatarsal bone 2 cases each, ulna, coracoid process of scapula, acromion, lunate bone, hamate bone, cuneiform bone, and posterior sixth rib 1 case each</td>
<td>Percutaneous interstitial laser ablation</td>
<td>Range 13-130 months (mean 58.5 months)</td>
<td>Recurrence in 6 patients</td>
</tr>
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Table 1. Continued from previous page.

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<tr>
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<th>Duration of follow up</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>46.</td>
<td>Peyser et al.104 2007</td>
<td>51</td>
<td>Range 3.5-57 years (mean 20 years)</td>
<td>M 36 F 15</td>
<td>Femur (29), tibia (10), calcaneus (2), talus (2), metatarsus (2), humerus (1), sacrum (1), scapula (1), olecranon (1), patella (1) and thoracic vertebra (1)</td>
<td>CT-guided RFA using the water-cooled probe</td>
<td>Range 9-51 months (mean 2 years)</td>
<td>Recurrence in 1 patient</td>
</tr>
<tr>
<td>47.</td>
<td>Ferreloch et al.105 2006</td>
<td>18</td>
<td>Range 11 to 35 years (mean 18 years)</td>
<td>M 4 F 14</td>
<td>Proximal femur 7, femoral shaft 3, tibia 5, iliac bone 1, sacrum 1, acetalular roof 1</td>
<td>Percutaneous CT-guided curettage</td>
<td>Range 12 to 42 months (average 29 months)</td>
<td>Recurrence in 2 patients</td>
</tr>
<tr>
<td>48.</td>
<td>Sierre et al.106 2006</td>
<td>18</td>
<td>Range 6-17 years (mean 11.6 years)</td>
<td>M 11 F 7</td>
<td>Femur 10, tibia 5, humerus 2, vertebral body 1</td>
<td>CT-guided drilling resection</td>
<td>Range 2-56 months (mean 19.4 months)</td>
<td>Recurrence in 1 patient</td>
</tr>
<tr>
<td>49.</td>
<td>Kjar et al.107 2006</td>
<td>24</td>
<td>Range 10-51 years (median 20 years)</td>
<td>M 18 F 6</td>
<td>Femur 12, tibia 10, 1 each in the humerus and fibula</td>
<td>Percutaneous radiofrequency ablation</td>
<td>Range 2-56 months (median 26 months)</td>
<td>Recurrence in 1 patient</td>
</tr>
<tr>
<td>50.</td>
<td>Cribb et al.108 2005</td>
<td>45</td>
<td>Average age 21 years</td>
<td>M 32 F 13</td>
<td>Femoral neck 12, femoral diaphysis 8, proximal femur 4, tibial diaphysis 11, distal tibia 1, proximal humerus 1, ulna diaphysis 2, index finger proximal phalanx diaphysis 1, talus 2, calcaneum 1, acetabulum 1, base in S1</td>
<td>CT-guided percutaneous radiofrequency thermocoagulation</td>
<td>Range 12-48 months (mean 26 months)</td>
<td>Recurrence in 7 patients</td>
</tr>
<tr>
<td>51.</td>
<td>Martel et al.109 2005</td>
<td>41</td>
<td>Range 5-43 years (mean 18.7 years)</td>
<td>M 27 F 14</td>
<td>Femur 14, tibia 5, foot 5, spine 5, fibula 3, acetabulum 2, humerus 2, clavicle, hand, atragulhus, iliacus and scapula 1 in each</td>
<td>CT-guided percutaneous RFA 38 patients</td>
<td>Range 3 months to 2 years</td>
<td>Recurrence in 4 patients</td>
</tr>
<tr>
<td>52.</td>
<td>Rimbaldi et al.110 2005</td>
<td>97</td>
<td>Range 4-47 years (mean 20 years)</td>
<td>M 61 F 36</td>
<td>Femur 44, tibia 21, humerus 3, acetabulum 5, ulna 4, radius 3, fibula 2, ankle 1, patella 1, ischium 1, cuneiforms 1, tarsal scaffold 1</td>
<td>Radiofrequency ablation</td>
<td>1 year for 74 patients, 6 months for 16 patients, and 3 months for 7 patients</td>
<td>Recurrence in 15 patients</td>
</tr>
<tr>
<td>53.</td>
<td>Cioni et al.111 2004</td>
<td>38</td>
<td>Range 4-46 years (mean 23±11.9 years)</td>
<td>M 31 F 7</td>
<td>Femur head 4, femur neck 9, trochanter minor 6, femur diaphysis 6, tibia 7, radius 3, fibula 1, calcaneus 2, ilium bone 1</td>
<td>CT-guided percutaneous RFA</td>
<td>Range 12-66 months (mean 35.5±7.5 months)</td>
<td>Recurrence in 8 patients</td>
</tr>
<tr>
<td>54.</td>
<td>Bari et al.112 2004</td>
<td>38</td>
<td>Range 19-30 years (mean 21.5 years)</td>
<td>All males</td>
<td>Lower limb bone 32, upper limb 2, spinal 4</td>
<td>Open wide excision</td>
<td>Range 1.5-5.5 years (mean 2.2 years)</td>
<td>Recurrence in 1 patient</td>
</tr>
<tr>
<td>55.</td>
<td>Albright et al.113 2004</td>
<td>183</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>Radiofrequency thermal ablation</td>
<td>Range 1-40 months</td>
<td>Recurrence in 2 patients</td>
</tr>
<tr>
<td>56.</td>
<td>Woertler et al.114 2001</td>
<td>47</td>
<td>Range 8-41 years (mean 19.6 years)</td>
<td>M 34 F 13</td>
<td>Femur 25, tibia 15, pelvis 2, humerus 1, ulna 1, tibia 1, calcaneus 5, vertebral body 5</td>
<td>CT-guided radiofrequency ablation</td>
<td>Range 8-39 months (mean 22 months)</td>
<td>Recurrence in 3 patients</td>
</tr>
<tr>
<td>57.</td>
<td>Sana et al.115 1999</td>
<td>38</td>
<td>Range 5-64 years (mean 25.4 years)</td>
<td>M 20 F 9</td>
<td>Femur 17, tibia 12, fibula, acetabulum, talus, patella, iliac wing 1 case each, spine 2, ulna 1, radius 1</td>
<td>CT-guided percutaneous resection</td>
<td>Mean follow up 2.7 years</td>
<td>Recurrence in 6 patients</td>
</tr>
<tr>
<td>58.</td>
<td>Rosenthal et al.116 1998</td>
<td>125</td>
<td>Average age 22 and 23 years for operative and ablation group respectively</td>
<td>M 88 F 37</td>
<td>NA</td>
<td>Radiofrequency Coagulation 38 Operative excision 87</td>
<td>NA</td>
<td>Recurrence in 11 patients overall</td>
</tr>
<tr>
<td>59.</td>
<td>Nogués et al.117 1998</td>
<td>28</td>
<td>Range 7-39 years (mean 19.4 years)</td>
<td>M 19 F 9</td>
<td>Femur 12, tibia 6, fibula, talus, humerus 2 cases each, 1 case in the patella, sacrum, a dorsal vertebra, and 1 tarsal scaphoid</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>60.</td>
<td>Leizaga et al.118 1993</td>
<td>73</td>
<td>Range 2 to 51 years (mean 12 years)</td>
<td>M 46 F 27</td>
<td>Long bones of lower extremities 51.5%, Foot 15.6%, Hand 17%, Upper extremities 6.3%, Vertebral column 6.2%, Thorax 3.2%, Lower extremities 88.5%, Foot and hand 32.62%, Four extremities 93%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>
Treatment

Non-operative

Non-operative treatment can be considered as an option since the natural history of osteoid osteoma is that of spontaneous healing.40 Moberg40 and Golding41 reported resolution of symptoms with conservative management in osteoid osteoma within 6 to 15 years. Use of aspirin or other non-steroidal anti-inflammatory medications (NSAIDs) decreases this time to 2 to 3 years.52,43 Use of this nonoperative treatment option risks the potential side effects of protracted NSAID treatment. In anatomical areas where osteoid osteoma is not easily accessible surgically, this may be a viable treatment option. However caution should be exercised with this option, as there are some reports that these tumors progress to osteoblastoma with prolonged NSAID treatment.44

Surgical management

Surgical treatment is an option for patients with severe pain and those not responding to NSAIDs. This option should also be considered for those patients not willing to tolerate pain and those at particular risk of long-term renal and gastrointestinal complications of NSAIDs. Moreover in children with open physes, continued presence of these tumors can lead to growth disturbances like limb length discrepancies, scoliosis and osteoarthritis.54 Available procedures include CT-guided thermocoagulation, en bloc resection, and CT-guided percutaneous excision.

En bloc resection

For symptomatic relief, the entire nidus has to be excised. Complete removal of the sclerotic reactive bone however, is not required. Preoperative roentgenograms and CT scans delineate the location of the nidus. This resection has the drawback of an open surgical approach with excision of sclerotic bone leaving behind a bone defect which may require bone grafting and internal fixation with consequent restrictions on postoperative activities and weight bearing. With this approach, intraoperative localization of the tumor may be challenging leading to partial removal and potential recurrence. For structurally critical anatomical sites like the femoral neck, one can consider deroofing and curettage. For intra-articular locations of the tumor, arthroscopic excision is a possible option.46

CT guided percutaneous techniques

Over the years, to reduce the surgical morbidity of open procedures, several percutaneous techniques using CT guidance have been used. These include trephine excision, cryoablation, radiofrequency ablation and laser thermocoagulation.45-51 Fine drills, bone trephine, Tru-Cut needles, and cannulated curettes have been used with percutaneous CT guided techniques performed in the outpatient setting. Using percutaneous CT guided resection, Sans and colleagues52 showed a cure rate of 84% at 3.7 years with two complications of femoral fractures at 2 months. For osteoid osteomas of the hip Muscolo and colleagues53 showed superior results of percutaneous resection guided by CT.

Roqueplan and colleagues54 reported percutaneous CT guided trephine resection success rate of 95% at 2 years. Two patients got skin burns and one had meralgia. The same authors reported 94% success rate with interstitial laser ablation at 2 years and complications of infection, tendinitis, hematoma, and common peroneal nerve injury. Percutaneous thermocoagulation of osteoid osteoma was reported by de Berg and colleagues55 successfully in 17 patients. Hoffman et al.56 reported 5-year results of radiofrequency ablation with confirmed cure in 38 of 39 patients. Complications in this series included one broken drill and one case of infection. Papatheanassiou et al.57 in their series of 21 patients over 5 years reported a primary cure rate of 89.6% that increased to 93% if a second treatment was required. Rosenthal and colleagues58 reported their results of CT guided RF ablation in 263 patients. A total of 271 procedures were performed of which 249 were for initial tumor treatment, 14 for recurrence after open excision, and 8 for recurrence after prior RF ablation. They reported 2 minor complications and recommended RF ablation as the treatment of choice with 91% clinical success, brief recovery and low complication rate.

It is important to note that irrespective of the technique used, a biopsy is required to confirm the diagnosis. In order to evaluate complete removal of the nidus, several techniques have been used which include roentgenograms, CT scans, and microradiography of specimens. Table 199-118 is a synopsis of the published literature referencing all case series with more than 15 patients listing the treatment and outcomes.

Conclusions

Osteoid osteoma is a distinct benign bone-producing tumor. Nonoperative treatment with NSAIDs is an appropriate option for pain control. Surgical options should be considered when conservative treatment fails or is not indicated for or not opted for by the patient. Minimally invasive methods including CT-guided excision and RF ablation have shown promise with highly successful outcomes.

References

Radiofrequency Ablation of Osteoid Osteoma: Initial Experience and Review of the Literature


94. Wallace AN, Tomasian A, Chang RO, Jennings JW. Treatment of osteoid osteomas using a navigational bipolar radiofrequency ablation system.


