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1. Clinical Image
We are presenting an interesting case of a 23-year-old healthy male patient transferred to our emergency department after involvement in a motor vehicle accident with severe kinematics. According to Emergency Medical Services he was found fully conscious and lying supine outside the car.

Upon arrival he presented in a cervical collar, hemodynamically stable and neurologically fully conscious and oriented. Focused Assessment with Sonography for Trauma (FAST) scored negative, Glasgow Coma Scale (GCS) scored 15, American Spinal Injury Association (ASIA) Impairment Scale graded A at level C5 with priapism and absent bulbo-cavernous reflex.

Computed Tomography (CT) trauma protocol scan of the thoracic region showed minor irregularity of the descending aorta (very minor finding) and spinal imaging showed C5-C6 burst fractures with C5 posterior dislocation and spinal canal obliteration (Figure 1A and 1B). CT revealed no cranial or abdominal findings. Computed tomographic angiography showed significant bilateral irregularity of the vertebral arteries with obliteration sites from C5-C6 and normal filling distal to C3.

Figure 1A: Sagittal
Figure 1B: Axial