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Full Length Research Paper

Umbilical cord torsion leading to intrauterine fetal death

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The umbilical cord is the critical organ that links the placenta and fetus. The intrauterine conditions and fetal activity influences the umbilical cord length. The normal umbilical cord is spiraled. By ultrasound, the spiral nature of the umbilical cord can be demonstrated early in the first trimester. Most of the adverse pregnancy and perinatal outcomes are related to abnormal Umbilical Cord coiling Index (UCI). A 23 year booked G_2P^1+0 of about 4/12 pregnant is presented. She presented 4 h history of colicky lower abdominal pain and 1 h history of vaginal bleeding; there were passage of blood clot but no fleshy materials or vesicles. No history of urinary symptoms or trauma, she is not a known Diabetics, hypertensive or sickle cell diseases patient. On examination, was not in painful distress, not pale, afibrile (36.9°C), anecteric and no fedal edema. Other parameters were within normal limit. Pelvic examination reveals a vulva smeared with blood, the fetal membrane were bulging into the vagina, this rupture spontaneously, and the cervix was fully dilated. She was managed for inevitable abortion; she subsequently expelled a female abortus. The abortus and the placenta were taken for histology which shows ischemic infarction on the placental tissue and hyper coiling of the umbilical cord. She was placed on anti-malaria, antibiotics and heamatenics, and was discharged home for follow-up. Modern imaging techniques are useful in the evaluation of Umbilical Cord coiling Index especially during the second trimester. To predict the adverse prenatal and pregnancy outcomes with view of instituting appropriate measures to obviate them, therefore routine screening for the high index cases is suggested.

Keywords: Umbilical cord, coiling index, torsion, intrauterine fetal death (IUFD).

INTRODUCTION

The connecting stalk of the fetus develops blood vessels and fuses with the omphalomesenteric duct to become the umbilical cord approximately 7 to 8 weeks after conception (Moshiri et al., 2014). Between 12 and 16 weeks of gestation, the allantoids or urachus develops as a second out pouching from the primitive gut and projects into the connecting stalk, and its blood vessels develop into the umbilical cord vasculature (Moshiri et al., 2014). The umbilical cord grows until the end of the second trimester to a length of 50 to 60 cm and The normal umbilical cord is spiraled (Frederick et al., 2002), usually counterclockwise (counterclockwise/clockwise = 7:1)

(Frederick et al., 2002), and the average number of coils is 0.2 coil/cm (Frederick et al., 2002). The coiling is thought to be due to the distribution of the helical muscle fibers in the umbilical cord vessels (de Laat et al., 2005). Coiling is thought to protect the cord by adding strength and resisting compression of the vessels. The cord length and twists depend on the tensile forces placed on the cord by fetal movements (de Laat et al., 2005). One of the most important parameter to be taken accurately and promptly before taking samples for other special studies is the length of the umbilical cord; this is due to the fact that during few hours after delivery the umbilical cord length decreases by as much as 7 cm (Frederick et al., 2002). Standards for cord length relative to gestational age have been established (Kraus et al., 2004). The mean cord length at term is about 55 to 60 cm (Glanfield and Watson, 1986). Many factors influence the growth of the umbilical cord, reflects it length, which are mainly tensile forces related to activities of the fetus and intrauterine conditions affecting fetal movement. Due to decrease in fetal movement during the third trimester the growth of the umbilical cord is slows, although some cord growth occurs normally until term. Relatively short cords are associated with amniotic bands, oligohydramnios, crowding (multiple pregnancies) and Down's syndrome. This is because these conditions restrict fetal mobility. Adverse prenatal and pregnancy outcomes are associated with extremes of umbilical cord length. Therefore some consideration of relative as well as absolute cord length is appropriate. Excessive torsion may be associated with interruption of fetal blood flow and fetal death (Glanfield and Watson, 1986). Long cords are associated with excessive torsion and at the fetal end of the cord, where it is sometimes associated with stricture. Strictures are usually single, sharply defined, short segments of the cord, most frequently occurring at the fetal end, with contracted vessels, a loss of Wharton jelly, or fibrosis. Associated venous congestion, edema, and thrombi provide evidence that the lesion is not a postmortem artifact (Hallak et al., 1994; Sun et al., 1995).

CASE REPORT

A 23 year booked G2P1+0 whose Last Child Birth was 10 months ago and was about 4/12 pregnant was presented. She presented 4 h history of colicky lower abdominal pain and 1 h history of vaginal bleeding; there were passage of blood clot but no fleshy materials or vesicles. No history of urinary symptoms or trauma prior to the onset of her problems. The index pregnancy was spontaneously conceived and booked 2/12 prior to onset of her problems.

Her 1st pregnancy was in 2014. It was carried to term and she had unsupervised home delivery of a severely asphyxiated male baby boy who died few hours after birth. She is not a known diabetics, hypertensive or sickle cell diseases patient. Not in painful distress, not pale, afibrile (36.9°C), anecteric no fedal edema.

PR was 72 B/P, BP was 116/70 mmHg, RR was 20C/P and Chest clinically clear. There was abdomen full moves with respiration; she had supra pubic tenderness; liver, spleen and kidney were not palpably enlarged and the uterus was about 18/52 size.

For pelvic examination the vulva was smeared with blood, the fetal membrane were bulging into the vagina, this rupture spontaneously, the cervix was fully dilated. She was managed for inevitable abortion and had oxytocin infusion 10IU in 1 L of normal saline; she subsequently expelled a female abortus, which was well developed, the placenta was also delivered completely and she subsequently had a check manual vacuum aspiration. The abortus and the placenta was taken for histology result of investigations: MP +, PCV=25%, FBS= 4.2 mmol/L, Blood group was B+, Hb genotype was AS, urinalysis (Blood ++, Ketenes +).

She was treated for malaria, and also was placed on ciprofloxacin and metronidazole and heamatenics; she was discharged home for follow-up to clinics in three week's time; she came back and had no complain.

DISCUSSION

The umbilical cord is the critical organ that linked the placenta and fetus. The intrauterine conditions and fetal activity influences the umbilical cord length. Diminished blood flow from the umbilical cord result into severe or increase risk of fetal compromise (IUGR or Neurologic injury) or death (IUFD). Many factors leads to umbilical cord flow compromised among which are, mechanical factors (compression), damage to blood vessels (trauma, inflammation or meconium) or thrombosis. Abnormalities of the umbilical cord with the potential for blood flow obstructions like abnormal coiling, stricture, true knots, abnormal length, prolapse,velamentous insertion or entanglements (Baergen, 2007; Baergen et al., 2001). Many of these conditions are related; true knots and excessive coiling commonly occur in long cords, and stricture almost always occurs in a hyper coiled cord (Parast et al., 2008) vascular channels dilatations and thrombosis, chorionic, intimae fibrin cushions, and /or villous alteration reflecting fetal vascular occlusion (villous stroma -vascular karyorrhexis) are evidence of chronic partial or intermittent blood flow obstruction (Parast et al., 2008). Based on these findings, more than half of the unexplained intrauterine fetal deaths resulted from non-acute umbilical cord compression. Acute flow obstruction may supervene when a knot or entanglement tightens during delivery or there is cord prolapse. Umbilical cord obstruction and compression have been confirmed by

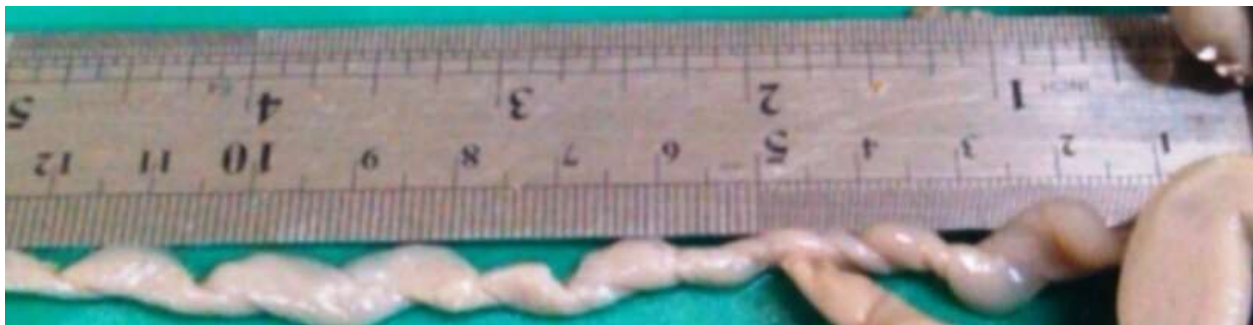**Figure 1.** Hyper coiled cord with intrauterine fetal demise (IUFD).

Figure 2. Hyper coiled cord, with 14 coil/10 cm length of the cord.

Doppler studies to impede venous return. Cord torsion is a rare form of cord constriction that can occur at any trimester but is more common during the second and third trimesters. Cord torsion is defined as excessive twisting of the cord at any site along the entire length of the umbilical cord. Umbilical cord torsion can lead to critically reduced fetal blood flow and fetal hypoxia, oligohydramnios, IUGR, and fetal death (Fleisch and Hoehn, 2008). Cord torsion is difficult to diagnose prenatally, and most cases are detected during postnatal examination of the placenta and umbilical cord (Fleisch and Hoehn, 2008). As in the index case.

The normal umbilical cord averages about 0.2 coils/cm (coiling index = number of coils per cord length) (Kraus et al., 2004). Umbilical cord with Coiling index of > 0.3 coils/cm is consider to be hyper coiled, while hypo coiled are those umbilical cord with coiling index of <0.1 coils/cm (Kraus et al., 2004) in the index case, the umbilical cord is hyper coiled with the coiling index >0.3 coils/cm (that is 1.4 coils/cm) (Figures 1 and 2). Umbilical cord coiling is thought to reflect fetal movement; it is decreased in association with uterine constriction or fetal abnormalities that affect movement. Twins and babies with chromosomal abnormalities have been reported to have high incidence of hyper coiled umbilical cord. Hyper coiling is more common in long cords, male fetuses, multigravidae (presumably due to more room for fetal movement), and in association with maternal illicit drug use commonly cocaine (Fleisch and Hoehn, 2008). Hyper coiling may be associated with stricture or may be

localize or affect the entire umbilical cord length as seen in this index case where the entire length of the umbilical cord is involved (Figure 2). Thrombosis of umbilical and chorionic plate vasculature, intimal fibrin cushions, and vascular calcification suggest a chronic process in some cases. No such evidences are noted in this index case. Hyper coiled umbilical cords have the potential for blood flow obstruction. Hyper coiling has been associated with adverse fetal outcome, including fetal IUGR, intolerance of labor, and IUFD (Fleisch and Hoehn, 2008). The index case is associated with adverse outcome of fetal demise.

Conclusion

Modern imaging techniques are useful in the evaluation of Umbilical Cord coiling Index especially during the second trimester. To predict the adverse prenatal and pregnancy outcomes with view of instituting appropriate measures to obviate them, therefore routine screening for those cases with high index of suspicions is suggested.

CONFLICT OF INTERESTS

The authors have not declared any conflict of interests

REFERENCES

Baergen RN (2007). Cord abnormalities, structural lesions, and cord "accidents". In Seminars in diagnostic pathology 24(1):23-32.

Baergen RN, Malicki D, Behling C, Benirschke K (2001). Morbidity, mortality, and placental pathology in excessively long umbilical cords: retrospective study. Pediatric and Developmental Pathology 4(2):144-153.

de Laat MW, Franx A, van Alderen ED, Nikkels PG, Visser GH (2005). The umbilical coiling index: a review of the literature. The Journal of Maternal-Fetal and Neonatal Medicine 17(2):93-100.

Fleisch MC, Hoehn T (2008). Intrauterine fetal death after multiple umbilical cord torsion-complication of a twin pregnancy following assisted reproduction. Journal of Assisted Reproduction and Genetics 25(6):277-279.

Frederick T, Kraus D, Gersell J (2002). The placenta in: Stocker J. Thomas, Dehner Louis P. editors. Chapter 10, Vol II, Pediatric Pathology, 2nd Edition, 2002 Lippincott Williams & Wilkins

Glanfield PA, Watson R (1986). Intrauterine death due to umbilical cord torsion. Archives of Pathology and Laboratory Medicine 110:357-358.

Hallak M, Pryde PG, Qureshi F, Johnson MP, Jacques SM, Evans MI (1994). Constriction of the umbilical cord leading to fetal death. A report of three cases. The Journal of Reproductive Medicine 39(7):561-565.

Kraus FT, Redline RW, Gersell DJ, Nelson DM, Dicke JM (2004). Placental Pathology: Atlas of Nontumor Pathology (First Series, Fascicle 3). Washington DC: Armed Forces Institute of Pathology, American Registry of Pathology P 57.

Moshiri M, Zaidi SF, Robinson TJ, Bhargava P, Siebert JR, Dubinsky TJ, Katz DS (2014). Comprehensive Imaging Review of Abnormalities of the Umbilical Cord. Radiographics 34(1):179-196

Parast MM, Crum CP, Boyd TK (2008). Placental histologic criteria for umbilical blood flow restriction in unexplained stillbirth. Human pathology 39(6):948-953.

Sun Y, Arbuckle S, Hocking G, Billson V (1995). Umbilical cord stricture and intrauterine fetal death. Pediatric Pathology and Laboratory Medicine 15(5):723-732.

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Full Length Research Paper

Temporal bone histopathology study on cochlear otosclerosis: A memoir for the cochlear implant surgeon

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The aim of this study was to describe the pathologic changes in temporal bones with cochlear otosclerosis that may have implications for cochlear implantation. Fifteen human temporal bones with otosclerosis were used for this study. In each temporal bone was studied: (1) medial wall of the middle ear and in particular the horizontal segment of the facial nerve canal; (2) the round window niche and the corresponding part of the scala tympani; (3) the area of the labyrinthine segment and first genu of the facial nerve. Six temporal bones revealed otosclerotic pathology spanning the otic capsule between the cochlear endosteum and the facial nerve canal. The labyrinthine facial nerve was enveloped by otosclerosis in two cases, while the horizontal segment was involved in four temporal bones. Complete obstruction of the round window niche was observed in three cases, while round window niche obstruction was observed in four temporal bones. Otosclerosis presents difficulties for implant candidates. These otosclerotic changes with obstruction are usually present at the round window or at the scala tympani. The histology described underpins the need to counsel patients regarding the possibility of facial nerve stimulation and difficult implantation.

Key words: Cochlear otosclerosis, histopathology, round window, obstruction.

INTRODUCTION

Otosclerosis is a localized hereditary disorder characterised by disordered resorption and deposition of bone with foci which is sharply demarcated from surrounding normal bone and shows a marked affinity for certain parts of the otic capsule (Stankovic and McKenna, 2006).

Otosclerosis usually involves the stapes footplate or stapediovestibular joint presenting with conductive hearing loss. "Cochlear Otosclerosis" on the hand is a term used to describe occurrence of pure sensorineural hearing loss due to otosclerosis in an ear without a conductive loss to the hearing impairment. In other words, there is otosclerotic foci in the cochlear endosteum but it does not result in/or cause stapes fixation (de Souza and Goycoolea, 2014; Sebahattin et al., 2010).

The incidence of Otosclerosis as reported in the

Minnesota Temporal collection is 12.5% in Caucasian and 1.5% in temporal bones of Japanese origin (Hueb et al., 1991; Ohtani et al., 2003). While the overall prevalence of histologic Otosclerosis is 10%, only 10% of these are clinically apparent making the overall prevalence of clinical otosclerosis approximately 1% in the population. A Belgian study (Declau et al., 2001) reported Otosclerotic foci in 2.5% of temporal bones and 3.4% of autopsy cases. Similarly, about 20% of Caucasians are said to have histologic otosclerosis while only 1% African Americans are seen with this disorder. Unfortunately, no data is available for sub-Saharan Africa.

Otosclerosis is a process of bone remodelling unique only to the Otic capsule (Michaels and Soucek, 2011; Sebahattin et al., 2010) and Ossicles (malleus and incus) (Escada et al., 2007). This bone remodelling is not readily obvious, but it is said to occur when molecular factors trigger the process in individuals who are genetically predisposed or due to environmental factors. It is inherited in an autosomal dominant manner with incomplete penetrance. Several gene loci have been implicated such as $OTSC_{1-5}$, $OTSC_7$, COL1A1, TGFβ, BMP2, BMP4, ACE, AGT and RELN gene (Chen et al., 2002; Richard et al., 2015; Sebahattin et al., 2010; Thys et al., 2007; Velegrakis, 2011) Osteoprotegerin (OPG) is a protein secreted by the spiral ligament and is a potent inhibitor of bone re-modelling; it is secreted in perilymph and acts by inhibiting recruitment, formation, and activity of osteoclasts.

According to Sebahattin et al. (2010), Cochlear otosclerosis can be classified as a "mixed type" or a "sensorineural type" based on the clinical appearance. Cochlear otosclerosis located in the otic capsule, involving the cochlear endosteum causing sensorineural hearing loss without any stapes fixation or any conductive component has two histologic phases, an early spongiotic (Otospongiosis) phase and a late sclerotic phase (Sebahattin et al., 2010). The early phase is rich in multiple cell types such as osteocytes, osteoblasts and histiocytes. This spongy appearance is due to vascular dilation secondary to osteocyte resorption of bone surrounding blood vessels. This can lead to the appearance of a red hue behind the drumhead popularly termed "Schwartz sign" (describe by Schwartz in 1873). Active otosclerosis foci appear as finger-like projections of disorganized bone, and its foremost part is particularly rich in osteocytes while the centre is composed of multinucleated osteocytes. The sclerotic phase shows dense sclerotic bone formation in the areas of previous resorption. Both the sclerotic and spongiotic as well as intermediate phases may be present at the same time. Otosclerotic foci always begin at the endochondral bone but may progress to involve endosteal and periosteal layers and even enter into the membranous labyrinth.

Cochlear Otosclerotic lesions are commonly found around or anterior to the oval window, round window niche, cochlear wall, and wall of anterior internal auditory canal and in some instances there is new bone formation in the scala tympani of the basal cochlear segment (Gildener-Leapman and Linthicum-Fred, 2011). Cavitations can also occur in severe cases of otosclerosis. The otosclerotic focus shows extensive bone resorption and replacement by vascular fibrous tissue which can subsequently form large cavities as the soft tissue undergoes dissolution. In patients with bilateral severe to profound hearing impairment due to otosclerosis, the use of cochlear implantation is a viable option. A review of the available literature shows that patients derive significant benefit from cochlear implant (Yaralı et al., 2015), but there is also evidence of misplaced electrode arrays, difficulty in inserting or partially inserted arrays, increased cochlear ossification, implant failures, and tinnitus (Balkany et al., 1996; Berrettini et al., 2002; Frijns et al., 2009; Munoz-Fernandez et al., 2012).

Cochlear otosclerotic patients have been found to derive immense benefit from cochlear implants, and in fact is now the preferred mode of managing clinical variants such as Far-advanced otosclerosis, a condition in which Otosclerotic involvement of the otic capsule has progressed to result in undetectable air- and bone-conduction hearing thresholds (Ruckenstein et al., 2001). However, a minimum speech discrimination score of 30% or lower in severe to profound sensorineural hearing losses suffices for cochlear implantation in Otosclerotic patients. This procedure presents challenges to the surgeon as a result of the pathogenic relics of Otospongiosis. These are difficulty with passing electrode arrays, partial insertion or misplaced arrays (Rotteveel et al., 2004) due to either osteoneogenesis or obliteration in the cochlear, round window niche, narrowing in the basal turn of cochlear or in the oval window.

An area of bone resorption (cavitation) may sometimes extend anteriorly from the internal auditory canal containing cerebrospinal fluid in continuity with the subarachnoid space (Michaels and Soucek, 2011). Electrode misplacement and cerebrospinal fluid gushing during cochlear implantation have been linked to third window lesions due to cavitating cochlear otosclerosis around the middle and apical turns of the cochlea (Makarem and Linthicum, 2008).

This study aims to describe histopathologic changes in human temporal bones (TB) with cochlear otosclerosis that may have implications for cochlear implantation.

MATERIALS AND METHODS

Fifteen human temporal bone sections from 12 patients with histopathologic diagnosis of otosclerosis from the archival library of the UCL Ear Institute were used for this study. Six (6) males and three (3) females and six (6) of unknown gender with age ranges from 41 to 85 years were studied. The specimens have been decalcified, embedded, and cut in horizontal sections from the upper surface of the temporal bone down to the lower section. The embedding material was low-viscosity nitro-cellulose [LVN - a

substance related to celloidin] and in some sections paraffin wax. Slides embedded with LVN were cut at a thickness of 20 µm while for paraffin wax sections 7 µm thickness. Thereafter, each tenth of a section was mounted on a glass slide and stained with Haematoxylin and Eosin [H & E].

The 15 temporal bone sections were selected based on confirmation of otosclerosis from the archival library of the University College London, Ear Institute Temporal Bone Collection. The inclusion criteria included: clarity of the otic capsule and medial half of the middle ear cavity in the horizontal section and presence of otosclerosis. This will help visualize the course of the facial nerve and the surgical access into the otic capsule. A total of eleven (11) temporal bone slides were either poor slides or had localised otosclerotic involvement of only the oval window area and as such were excluded. Controls: Eight (8) non-otosclerotic temporal bone slides at approximately the same section levels were used as control.

A Lietz Dialux 22 EBB microscope with lens magnification of 2.5, 10, 20, 40 and 100× was used for observation. A camera (Sony CCD-IRIS) was mounted on the microscope and the micrograph image captured, converted and transferred through an Analogue-Digital Converter (DATAVIDEO DAC-2) projected on a laptop screen with pinnacle movie box studio 9. Photomicrographs of representative temporal bone slides were taken with the AxioVision Software.

In each of the temporal bone sections the following structures were studied thoroughly: Medial wall of the middle ear especially the tympanic segment of the facial nerve, the round window niche and round window membrane; the membranous labyrinth especially the cochlea turns and labyrinthine/first genu of the facial nerve. The level of the sections utilized was approximately from the level of the first genu of the facial nerve to the level of the round window niche. This will particularly help to view the round window niche or membrane for obstructing or bridging lesions.

For ease of description, we arbitrarily divided the RW area into those with greater than 80% and those with less than 80% obstruction. This we hope may provide an idea of possible ease of access in the passage of electrode arrays. By this classification little or no difficulty is expected in obstructions in which less than 80% (that is, 20% obstruction or less) of the niche is obstructed with or without a thickened membrane.

Permission to use the archival temporal bone database was given by the UCL Ear Institute, ethical approval was not required in this instance.

RESULTS

A total of 15 temporal bone (TB) sections were examined. Some of the TB photomicrographs were not of good quality and artefacts were noted. The round window niche and round window membrane was obstructed and/or narrowed by Otosclerotic plaque in 6 (40%) of the temporal bone slides. The round window was affected in varying severity in 6/15 TB sections while total bridging/obstruction of the round window niche was observed in 3 out of this 6 TB sections. Otosclerosis affecting the Scala tympani with subsequent total obstruction of round window niche and round window membrane was observed in 1 of 6 TB sections (Figure 1).

Round window niche obstruction together with thickened RW membrane was observed in 4 out of 6 of the TB sections. Two of these had greater than 80% of the RW obstructed, while the other two had less than

80% obstruction (Figures 2 and 3). The remaining 2/6 TBs had only thickening of the RW membrane. Amongst the six TB sections with otosclerosis in contact with lateral cochlea wall and facial nerve, there were features of associated atrophy and hyalinisation of spiral ligament in 3 out of 6 TB sections. Cochlear hydrops was also noted in 1/6 TB section with detachment of the spiral ligament in the middle cochlea turn (Figure 4). Evidence of microfissures and microfractures were also noted at the junction of otosclerotic and normal endochondral bone (Figures 2 to 5).

DISCUSSION

Histopathologic studies hold prospects for predicting potential difficulties during surgical procedures especially cochlear implantation. This study estimates that 1 out of every 5 persons with otosclerosis (20%) may potentially have insertion difficulties during cochlear implantation due mainly to structural obstruction from Otosclerotic foci.

However studies about otosclerosis using temporal bones (TB) are difficult due to paucity of donors, and the Ear Institute Temporal Bone archive is an invaluable source of temporal bones. Therefore, this study is unique as it is able to assess potential clinical problems from a histopathologic standpoint.

There were several limitations to this study such as missing temporal bone sections, loss of quality over time of the TB sections, lack of complete clinical and audiological data, and small sample size (15) to infer clinically-based significant conclusions. There was also some bias in the selection process due to the aforementioned reasons in order to get presentable sections. We admit that temporal bone studies can be complicated by multiple uncontrollable variables.

Insertion difficulties due to neo-ossification is particularly common in patients with otosclerosis within or around the round window and scala tympani; this was the finding of Silveira and Linthicum (2011). In this study, 6 (40%) of the temporal bone slides revealed areas of neo-ossification/obstruction of the round window, scala tympani and round window niche by active otosclerosis.

Occasionally during cochlear implantation for otosclerosis, the round window niche may be obstructed by neo-ossification thus making insertion of electrode arrays difficult. The round window and round window niche was obstructed in varying severity in 6 out of 15 TB sections. In three of fifteen TB section (20%), there was complete obstruction of the round window niche (RWN). Intra-operatively this may potentially cause difficulties with insertion of the electrode arrays necessitating drill-out procedures (Fayad et al., 1990). However, with a high index of suspicion, proper pre-operative planning with imaging studies, decisions can be made to proceed or to reschedule the procedure. Added with ossification of the round window membrane and/or scala tympani (Quaranta et al., 2005) is a dilemma which may require implantation
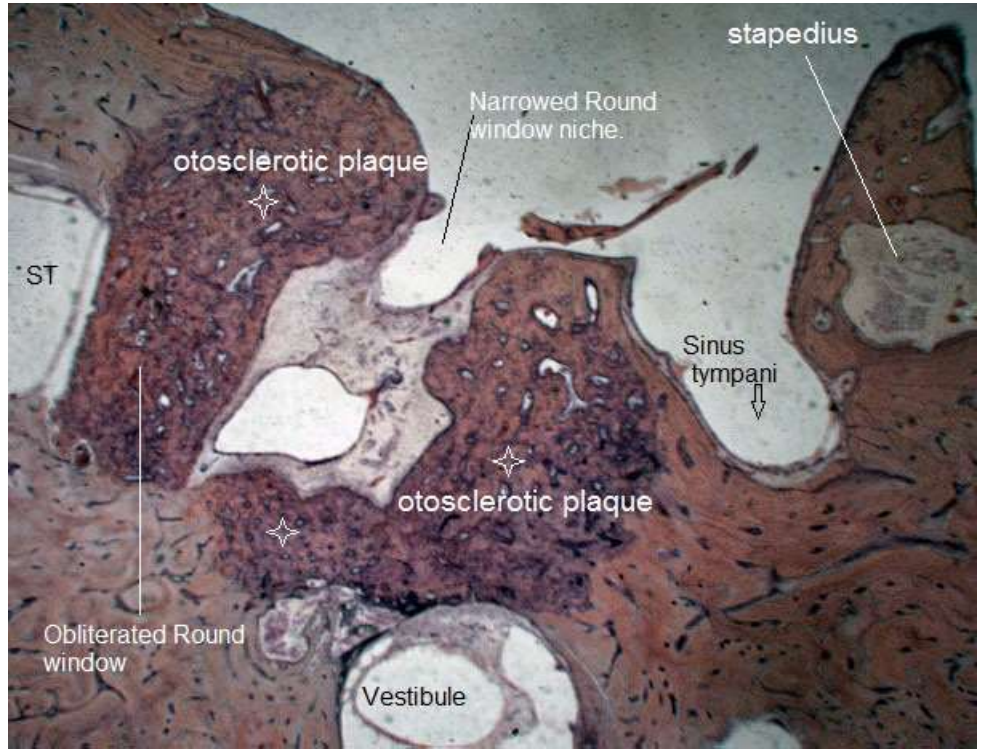
Figure 1. Growth of otosclerosis in the scala tympani and obliteration of the Round window with narrowing of the round window niche (Right side-Magnification ×2.5).
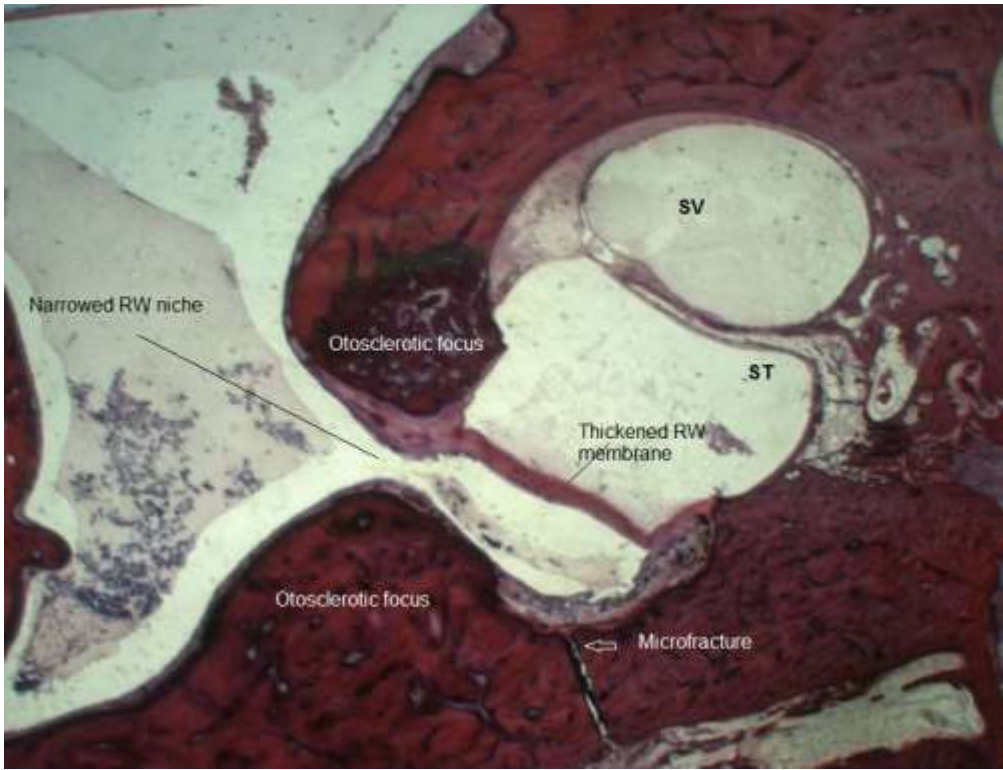

Figure 2. Round window niche narrowed and nearly obstructed >80% due to active otosclerosis. A thickened round window membrane is also seen, all causes of structural obstruction (Left side-Magnification ×2.5).
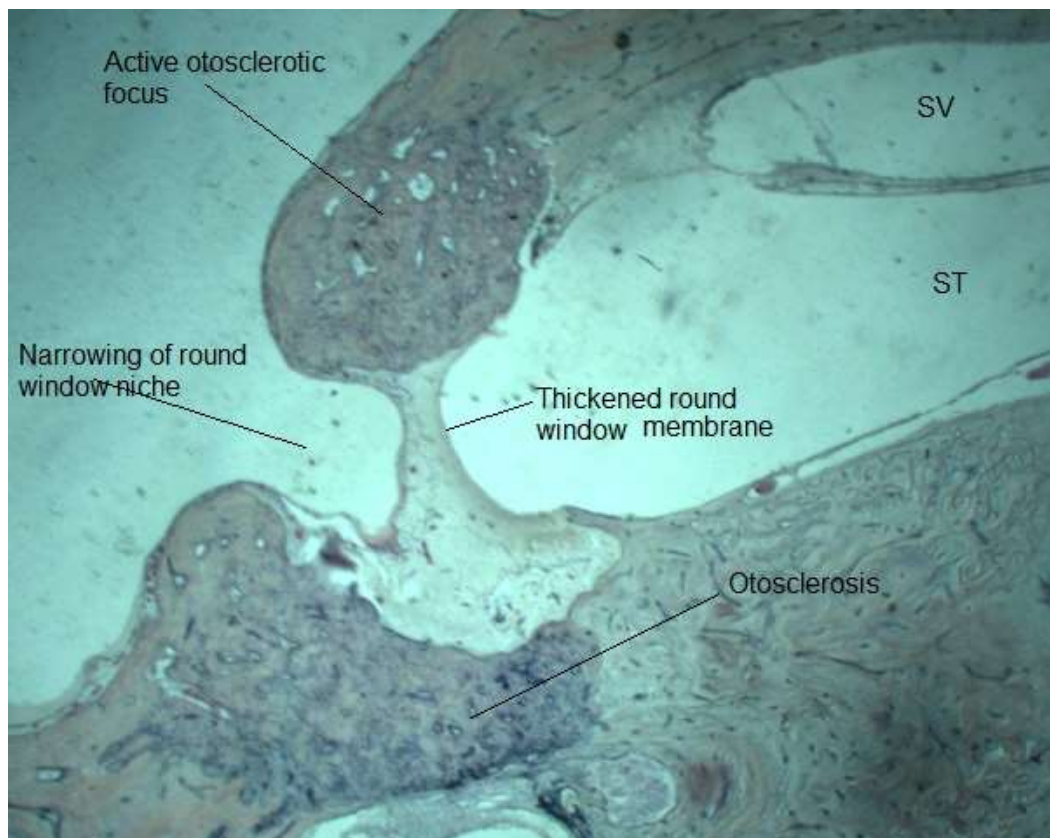
Figure 3. Narrowing of the round window niche by otosclerotic foci and thickening of the RW membrane. Less than 80% narrowing (left side- Magnification ×2.5).
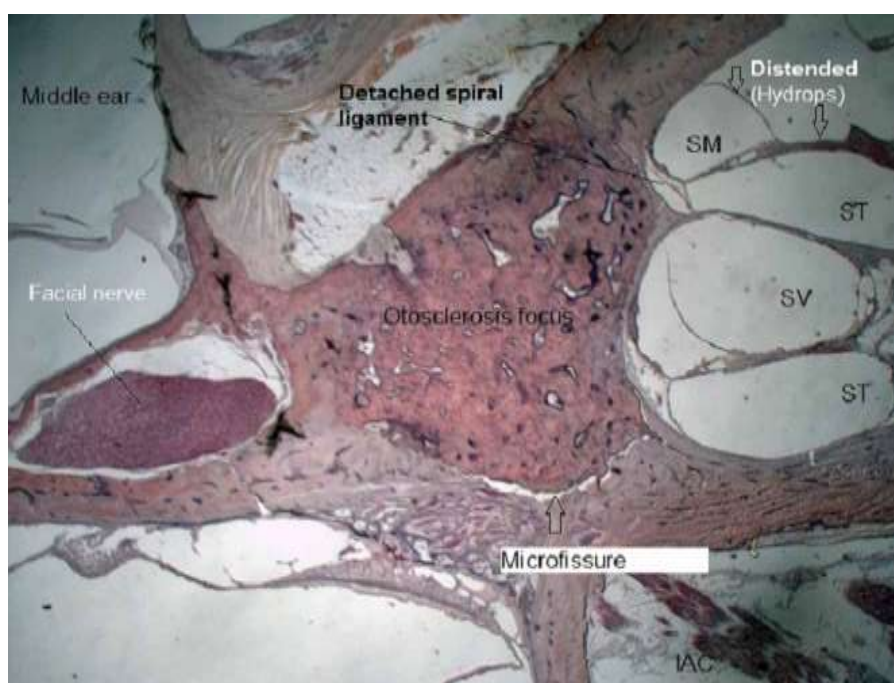

Figure 4. Photomicrograph of otosclerosis focus affecting basal and middle turn of lateral cochlea wall & medial side of facial nerve canal (Left side- Magnification ×2.5).
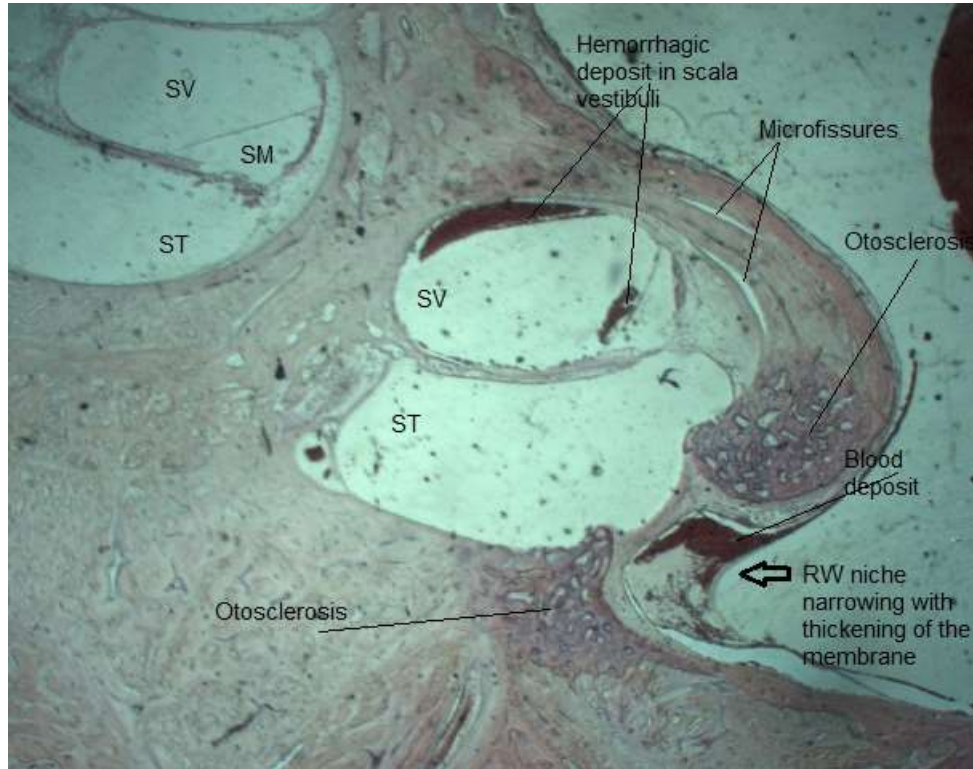
Figure 5. Haemorrhagic deposits seen in scala vestibuli and microfissures on the lateral wall with associated narrowing of the round window niche. The blood spots may probably be due to a fenestration procedure for the patient with spillage of blood into the membranous labyrinth (Right side- Magnification ×2.5).

on the contralateral ear (Figure 1). However, Fayad et al. (1990) compared results to surgical data on the extent of drilling and depth and ease of placement of the electrode in 20 patients' deaf from otosclerosis (Fayad et al., 1990). They concluded that obstruction of the basal turn, which occurs in some otosclerotic patients, does not preclude implant surgery. This was however not the case with Rotteveel et al. (2004) who recorded problematic insertion in 10 (19%) of their cohort resulting in partial/misplaced insertion requiring revision surgery (Rotteveel et al., 2004).

Furthermore, Balkany et al. (1996) found that neo-ossification was usually partial. Fluid-filled scala tympani were identified in most cases, by imaging and/or intra-operatively, and all the electrodes were inserted successfully (Balkany et al., 1996). Moreover, in the present study, 3 out of 15 (20%) TB sections showed evidence of obstruction of the RW niche but in only one section was ossification of the basal turn/scala tympani observed. This ossification was also partial, it did not affect the entire basal turn/scala tympani (Figure 1). In comparison, Quaranta et al. (2005) in their series observed 'ossification of the basal turn' in 3 of 9 (33%) patients versus one out of 15 TB (>6%) sections in the present study (Quaranta et al., 2005). The higher

percentage may be due to a smaller cohort compared to our TB samples, although this may not be clinically and/or statistically significant.

Round window 'obstruction' coupled with 'thickened' RW membrane was observed in four of fifteen TB sections (26.7%). Quaranta et al. (2005) in their series reported eight of nine otosclerosis patients (>88%) with ossification of the round window (RW) membrane. We observed ossification/obstruction of the RW membrane in only one of 15 TB (6.7%) sections as well. This frequency of RW obstruction by Quaranta et al. (2005) is quite high when compared with the present series despite our larger sample population (Quaranta et al., 2005). Although, our value may not be as high but it is equally significant, since more than 26.7% of our sections were similarly affected. By implication during cochlear implantation, this neo-ossification may result in damage to spiral ligament and stria vascularis due to insertional resistance. By implication, this may mean that obstructive neo-ossification in the RW is perhaps not an uncommon finding amongst patients with cochlear otosclerosis.

In addition, the low frequency of obstruction (6%) of the RW membrane of the present study due purely to ossification may not be correct since the selection was somewhat biased. Early detection therefore may be the

easiest prophylaxis even though our values may not be statistically significant. This study being a post-mortem study, but in life this is readily achieved with imaging studies. The sensitivity of high resolution computer tomography (HRCT) in detecting cochlear ossification is said to be between 71 and 78%, with complimentary magnetic resonance imaging (MRI) this value is much higher (Arriaga and Carrier, 1996; Quesnel et al., 2013). Some of the features to look out for on CT are the double ring effect or enchondral banding which are radiolucent areas surrounding the cochlea. Pericochlear lucencies have been reported to be highly specific for cochlear otosclerosis (Marsh et al., 1992; Purohit and Hermans, 2014).

Furthermore, in RW areas with greater than 80% obstruction (Figure 2), some difficulty is to be anticipated requiring possible drill-out or cochleostomy via an alternative route. These obstructions/narrowing are in the form of growth by active otosclerosis obscuring the round window niche. We found 2 of 15 TB (13%) sections with less than and greater than 80% obstruction by neo-ossification, respectively. In addition, thickened RW membrane is easily perforated during or after the cochleostomy, thus, presents no real threat to insertion of the electrode arrays. In our series, only two of six TB sections revealed thickening of the RW membrane without associated narrowing of the RW niche.

Implications for cochlear implant surgeons

Balkany et al. (1996) described three ossification patterns in the cochlea of their patients: obliteration of the round window niche, obstruction confined to the lower segment of the basal turn, and complete basal turn obstruction (Balkany et al., 1996). We were able to identify two of such patterns but not complete basal turn obstruction. Meaning these observations are not uncommon and devising alternative means to electrode insertion techniques as well as substitute electrode material, is paramount if these complications are to be avoided or minimised.

Unanswered questions and future research

There were a few grey areas; this study was unable to answer such as: Why does cochlear otosclerosis have a predilection for certain parts of the otic capsule or the otic capsule in general, what other approach may avert insertion resistance?

The latter question has had several suggestions from different authors, Balkany et al. (1996) suggested a middle fossa approach. Inserting the electrode, this way obviates the need for cumbersome surgery such as radical mastoidectomy, carotid artery skeletonization, and drilling of the bone surface of the basal turn around, the modiolus. Why does facial nerve stimulation occur in otosclerotic patients before or after cochlear implantation? These unanswered questions are beyond the scope of this study and further research is required.

Conclusion

The outcome of this TB study revealed a 40% prevalence of narrowed or obstructed RW niches. Complications during cochlear implantation such as RW niche obstruction may be an impediment to a favourable surgical outcome among patients with otosclerosis. Neo-ossification around the RW may actually have a high frequency of occurrence and as such implant surgeons must be wary. Anterior superior cochleostomy in the RW area is the current method of choice and is adjudged to have less morbidity compared to the middle fossa approach as reported in a related study (Balkany et al., 1996). Therefore, early high-resolution imaging is advised in advanced otosclerosis to identify possible round window and/or scala tympani obstruction by otosclerotic changes. These histological features underpin the need to counsel patients regarding the possibility of facial nerve stimulation, difficult implantation and why this may occur. It is hoped that this will serve as a memoir for the cochlear implant surgeon in Nigeria.

CONFLICT OF INTERESTS

The author has not declared any conflict of interests.

REFERENCES

Arriaga MA, Carrier D (1996). Mri and clinical decisions in cochlear implantation. American Journal of Otology 17(4):547-553.

Balkany T, Gantz BJ, Steenerson RL, Cohen NL (1996). Systematic approach to electrode insertion in the ossified cochlea. [Case Reports]. Otolaryngology - Head and Neck Surgery 114(1):4-11.

Berrettini S, Forli F, Neri E, Segnini G, Franceschini SS (2002). Scala vestibuli cochlear implantation in patients with partially ossified

cochleas. [Case Reports]. Journal of Laryngology and Otology 116(11):946-950.

Chen W, Campbell C, Green G, Van Den Bogaert K, Komodikis C, Manolidis L, Aconomou E, Kyamides Y, Christodoulou K, Faghel C, Giguere C, Alford R, Manolidis S, Van Camp G, Smith R (2002). Linkage of otosclerosis to a third locus (otsc3) on human chromosome 6p21.3-22.3. Journal of Medical Genetics 39(7):473-477.

de Souza C, Goycoolea MV (2014). Pathology of otosclerosis. Otosclerosis: Diagnosis, Evaluation, Pathology, Surgical Techniques, and Outcomes P 3.

Declau F, Van Spaendonck M, Timmermans JP, Michaels L, Liang J, Qiu JP, Van de Heyning P (2001). Prevalence of otosclerosis in an unselected series of temporal bones. Otology and Neurotology 22:596-602.

Escada PA, Capucho E, Chorão M, da Silva JF (2007). Otosclerosis of the incus. [Case report]. Otology and Neurotology 28:301-303.

Fayad J, Moloy P, Linthicum FH-Jr (1990). Cochlear otosclerosis: Does bone formation affect cochlear implant surgery? [Comparative Study Review]. American Journal of Otolaryngology 11(3):196-200.

Frijns JHM, Kalkman RK, Briaire JJ (2009). Stimulation of the facial nerve by intracochlear electrodes in otosclerosis: A computer modeling study. [Research Support, Non-U.S. Gov't]. Otology and Neurotology 30(8):1168-1174.

Gildener-Leapman N, Linthicum-Fred H-Jr (2011). Histopathology of cochlear otosclerosis: Implications for cochlear implantation. Otology and Neurotology 32(7):e56-e57.

Hueb MM, Goycoolea MV, Paparella MM, Oliveira JA (1991). Otosclerosis: The university of minnesota temporal bone collection. Otolaryngology and Head and Neck Surgery 105:396-405.

Makarem A, Linthicum FH (2008). Cavitating otosclerosis. Otology and Neurotology 29:730-731.

Marsh MA, Coker NJ, Jenkins HA (1992). Temporal bone histopathology of a patient with a nucleus 22-channel cochlear implant. American Journal of Otology 13(3):241-248.

Michaels L, Soucek S (2011). Origin and growth of otosclerosis. Acta Oto-Laryngologica 131(5):460-468.

Munoz-Fernandez N, Morant-Ventura A, Achiques MT, Dualde-Beltran D, Garcia-Callejo FJ, Monrroy-Parada MV, Marco-Algarra J (2012). Evolution of otosclerosis to cochlear implantation. Acta otorrinolaringologica espanola 63(4):265-271.

Ohtani I, Baba Y, Suzuki T, Suzuki C, Kano M, Deka RC (2003). Why is otosclerosis of low prevalence in Japanese? Otology and Neurotology 24:377-381.

Purohit B, Hermans R (2014). Imaging in otosclerosis: A pictorial review. Insights into Imaging 5(2):245-252.

Quaranta N, Bartoli R, Lopriore A, Fernandez-Vega S, Giagnotti F, Quaranta A (2005). Cochlear implantation in otosclerosis. [Evaluation Studies]. Otology and Neurotology 26(5):983-987.

Quesnel AM, Moonis G, Appel J, O'Malley JT, McKenna MJ, Curtin HD, Merchant SN (2013). Correlation of computed tomography with histopathology in otosclerosis. Otology and Neurotology 34(1):22-28.

Richard C, Doherty JK, Fayad JN, Cordero A, Linthicum FHJ (2015). Identification of target proteins involved in cochlear otosclerosis. Otology and Neurotology 36(5):923-931.

Rotteveel LJC, Proops DW, Ramsden RT, Saeed SR, Van Olphen AF, Mylanus EAM (2004). Cochlear implantation in 53 patients with otosclerosis: Demographics, computed tomographic scanning, surgery, and complications. Otology and Neurotology 25:943-952.

Ruckenstein MJ, Rafter KO, Montes M, Bigelow DC (2001). Management of far advanced otosclerosis in the era of cochlear implantation. Otology and Neurotology 22(22):471-474.

Sebahattin C, Muzeyyen, Yildirim B, Michael MP (2010). Cochlear otosclerosis. Current Opinion in Otolaryngology and Head and Neck Surgery 18(5):357-362.

Silveira ARO, Linthicum FH-Jr (2011). New bone formation in patients with cochlear implants and otosclerosis. Otology and Neurotology, 32(9):e38.

Stankovic KMM, McKenna MJ (2006). Current research in otosclerosis. Current Opinion in Otolaryngology and Head and Neck Surgery 14:347-351.

Thys M, Van Den Bogaert K, Iliadou V, Vanderstraeten K, Dieltjens N, Schrauwen I, Van Camp G (2007). A seventh locus for otosclerosis, otsc7, maps to chromosome 6q13-16.1. European Journal of Human Genetics 15(3):362-368.

Velegrakis GA (2011). Otosclerosis: State of the art. [Review]. Otorhinolaryngologia - Head and Neck Surgery 43:6-16.

Yaralı M, Özkan HB, Bajin D, Batuk M, Çınar B, Sennaroğlu G, Sennaroğlu L (2015). Cochlear implantation after failed stapes surgery in far advanced otosclerosis. Journal of International Advanced Otology P 11.

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