OTOPLAN, Cochlear Implant, and Far-Advanced Otosclerosis: Could the Use of Software Improve the Surgical Final Indication?

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Cochlear implant surgery in far-advanced otosclerosis can be challenging due to the degenerative process that affects the cochlea. We used OTOPLAN® to plan and define the details of surgery in a patient with such severe alteration of the cochlea that cochlear implant could be contraindicated. A 73-year-old man affected by bilateral far-advanced otosclerosis, previously treated by bilateral stapedotomy, presented 0% of speech discrimination using bilateral hearing aids. A unilateral cochlear implant was planned. The patient underwent radiologic investigation pre-surgery with temporal bone computer tomography, magnetic resonance imaging, and OTOPLAN. Radiology confirmed bilaterally advanced signs of fenestral and cochlear otosclerosis with large osteolytic cavities along the whole cochlea leading to the mixture of endolymph and perilymph. The OTOPLAN identified the alteration of the cochlea in detail. Based on the results of the software, we used a perimodiolar implant on the left ear. No intraoperative or post-operative surgical complications were observed. The patient was checked 6 months after surgery, he did not refer any problems and obtained 75% of speech discrimination at 65 dB. Our case suggests that OTOPLAN is a useful tool in far-advanced otosclerosis because careful planning of the surgery can positively affect the results. Despite the complexity of the anatomy, the software exactly described the real intrasurgical finding. We think that the use of OTOPLAN might improve the surgical indication.

KEYWORDS: Cochlear implant, far-advanced otosclerosis, OTOPLAN, software, surgical indication

INTRODUCTION

Far-advanced otosclerosis (FAO) indicates a severe form of otosclerosis which has progressed ossification of the cochlea and sensorineural hearing loss (SNHL).1 Cochlear implant (CI) is the best option for treating severe SNHL,2 but in FAO could be challenging because of the alteration of cochlea anatomy and the presence of spongy bone.3,4 These factors limit the use of CI in FAO.

Other controversies about the use of the best surgical approach,5,6 electrodes to choose,7 and the side to implant8 are still open.

Recently, we showed that despite cochlea alterations due to bone remodeling (third ring), the good surgical plan based on computer tomography (CT) analysis allowed us to define the correct surgical approach guaranteeing to the patient, excellent auditory results.9 When the cochlea's turns are destroyed or completely ossified,10 it is not easy to define the best approach.

Today a software (OTOPLAN®, MED-EL (Innsbruk, Austria)) is available that is able to analyze deeply the anatomy of the ear and to measure the length of the cochlea duct via the 3D reconstruction based on CT scan. Thanks to these analyses, it is possible to plan the best method for the electrode insertion and to identify the correct length of it.11

We present a case of FAO with the destruction of cochlear turns, in which we used the OTOPLAN to plan the surgery, identify the best electrode (perimodiolar vs. later wall), and check the correct position of the CI into the cochlea duct.
CASE PRESENTATION

A 73-year-old man affected by bilateral FAO, previously treated by bilateral stapedotomy came to our clinic due to the worsening of his hearing (Figure 1); he presented 0% speech discrimination in the free field with bilateral hearing aids. For this reason, we proposed a single-side cochlear implant. Written informed consent was obtained from patients’ parents.

The CT on the temporal bone and the magnetic resonance imaging confirmed bilaterally advanced signs of fenestral and cochlear otosclerosis with large osteolytic cavities along the whole cochlea leading to the mixture of endolymph and perilymph. Due to the radiologic results, we decided to use OTOPLAN software to obtain precise details of the anatomy and for choosing the best ear for implantation and the type of CI.

OTOPLAN Results

The right cochlea presented the following characteristics: diameter: 10.3 mm; height: 3.6 mm; width: 6.8 mm; estimated cochlear duct length (CDL): 37.6 mm. The reconstructed 3D images pointed out large areas of demineralization at the level of the distal part of the basal turn and an ossified round window, which made it impossible to access it (Figure 2A and B).

The left cochlea showed the following findings: diameter: 10.8 mm; height: 3.4 mm; width: 6.7 mm; estimated CDL: 37.9 mm. The reconstructed images showed large areas of demineralization greater than the ones observed on the right side, which were located in the basal, middle, and apical turn of the snail, and presented a wide connection with the vestibule. The normal anatomy of the cochlea was completely destroyed; in fact, there was a big hole located in the initial tract of the basal turn which put in communication this structure with the round window, creating a unique cavity. This finding could be a limitation to the correct insertion of the electrode (Figure 3C and D).

Surgery Plan and Execution

In consideration of these morphological findings, the decision had to be a right implant with a 31.5-mm lateral wall-designed electrode (FLEXSOFT®). However, due to the patient’s refusal of having surgery on the right (he affirmed “having benefit thanks to the hearing aids”), in the end, we performed a left-side implant.

We choose a CI with a perimodiolar-designed electrode to bypass the problem of the widening communication between the round window, the basal turn, and the basal osteolytic cavitation.

Through posterior tympanotomy, we accessed the cochlea promontory and performed a cochleostomy far from the lateral wall (initial tract of the basal turn) to avoid a possible dislocation of the electrode in the accessorial cavity (Figure 3A). First, we did the insertion with Contour Advance® electrode template with the Advance Off-Stylet® technique; but, the intraoperative radioscopy showed the dislocation of the electrode outside the cochlea, at the same level of known basal cavitation (Figure 3B and C). The electrode was removed and we inserted a Slim Modiolar® array. This electrode was chosen because it presented the following advantages: (i) it could be reloaded into the inserter sheath to improve insertion if necessary, and (ii) thanks to its external sheath of 0.5 mm in length, combined with promontorial cochleostomy, it could allow overstepping the osteolytic enlargement of the proximal part of the basal turn.

After the radioscopical verification of successful insertion of the electrode template, Cochlear™ Nucleus® CI632 was implanted. Its correct allocation was confirmed first by intraoperative radioscopy and then...
by post-operative CT scan (Figure 3D-F). Also, the intraoperative telemetry confirmed the correct insertion of the array; in fact, we obtained good impedances for all electrodes and neural responses for all electrodes except for the basal 1-5 ones, probably due to the advanced osteolytic area.

No intraoperative or post-operative surgical complications were observed.

The patient was checked 6 months after surgery; he did not refer any problems and obtained 75% of speech discrimination at 65 dB.

**DISCUSSION**

Thanks to the use of the OTOPLAN, we successfully implanted a severe case of FAO; our patient did not suffer from traditional otosclerosis problems (cochlea ossification\(^1\)\(^4\) and third ring\(^9\)) he presented a cochlea with several perforations that were not clearly
The patient’s post-operative auditory recovery overlapped the cochlea because of the patient’s refusal of CI on the right side.

Despite the improvement of CT, the technique still presents limitations, and the new methods, that is, cone-beam CT, which showed promising results for CI surgery, still lacks evidence in otosclerosis.

The new software, as OTOPLAN, uses conventional CT imaging, reconstructing the cochlear lumen and can calculate the cochlear measurements (diameter, height, width, and length of the cochlear duct) and can facilitate cochlear implant surgery, and its validity has been confirmed by several studies.

The use of OTOPLAN could change the surgical indication for identifying the side of cochlear implant insertion. In fact, the choice of the ear could be done choosing the one with the worse auditory thresholds even in presence of the worse cochlea anatomy (compared with the contralateral side).

CONCLUSION

Our case suggests that OTOPLAN is an extremely useful tool in FAO. We think that large studies including patients with different severity of otosclerosis and auditory thresholds should be performed to confirm the usefulness of the software in changing the indication of the cochlear implant in these patients.

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