Pediatric Sensorineural Hearing Loss, Part 1: Practical Aspects for Neuroradiologists

B.Y. Huang, C. Zdanski and M. Castillo

*AJNR Am J Neuroradiol* 2012, 33 (2) 211-217
doi: https://doi.org/10.3174/ajnr.A2498
http://www.ajnr.org/content/33/2/211

This information is current as of November 1, 2023.
Pediatric Sensorineural Hearing Loss, Part 1: Practical Aspects for Neuroradiologists

SUMMARY: SNHL is a major cause of childhood disability worldwide, affecting 6 in 1000 children. For children with prelingual hearing loss, early diagnosis and treatment is critical to optimizing speech and language development, academic achievement, and social and emotional development. Cross-sectional imaging has come to play an important role in the evaluation of children with SNHL because otolaryngologists routinely order either CT or MR imaging to assess the anatomy of the inner ears, to identify causes of hearing loss, and to provide prognostic information related to potential treatments. In this article, which is the first in a 2-part series, we describe the basic clinical approach to imaging of children with SNHL, including the utility of CT and MR imaging of the temporal bones; we review the most recent proposed classification of inner ear malformations; and we discuss nonsyndromic congenital causes of childhood SNHL.

SNHL is a major cause of childhood disability worldwide, with an estimated prevalence of 1 in 2000 neonates and 6 in 1000 children by 18 years of age. Early diagnosis and treatment of SNHL in children is critical because it is well recognized that a delay in identification of hearing impairment can adversely affect speech and language development, academic achievement, and social and emotional development. The institution of universal neonate hearing screening in the United States has altered the management of childhood SNHL by substantially lowering the average age at diagnosis from 24–30 months before the introduction of screening programs to 2–3 months.

Cross-sectional imaging has become an integral tool in the clinical evaluation of SNHL. Otolaryngologists now routinely order CT or MR imaging examinations of the inner ear in infants and young children to identify a potential etiology for hearing loss, to define the anatomy of the temporal bone and the central auditory pathway, to identify abnormalities that may predict hearing loss progression or prognosis, and to identify additional intracranial abnormalities that may require further work-up and/or intervention.

The aim of this 2-part series is to review the clinical and imaging evaluation of children presenting with SNHL, with an emphasis on aspects that neuroradiologists should know. Here we describe our typical clinical approach to imaging of children with SNHL, including the utility of CT and MR imaging of the temporal bones; we review the most recent proposed classification of inner ear malformations; and we discuss nonsyndromic congenital causes of childhood SNHL.
added cost of routinely performing both studies or even alters outcomes remains an area of debate.

Both modalities have their relative strengths and weaknesses. MR imaging avoids ionizing radiation and provides superior soft-tissue contrast. Advances in MR imaging technology, including high-field-strength units, improved coil technology, and parallel imaging, also allow increasingly high-resolution images of the inner ear and brain. High-resolution temporal bone CT is better for assessing bone detail and can be performed at lower cost and in less time, resulting in less frequent need for sedation or anesthesia compared with MR imaging.

At our institution, MR imaging is the preferred initial imaging test performed in children with newly diagnosed SNHL. Our pediatric temporal bone MR imaging protocol, which is performed in approximately 20 minutes, includes either high-resolution FSE T2-weighted images (TR/TE/NEX, 1000/136 ms/1; echo-train length, 21; flip angle, 180°; FOV, 140 mm; matrix size, 192) or CISS images (TR/TE/NEX, 5.42–12.25/2.42–5.9 ms/1–2; flip angle, 50°–80°; FOV, 120–180 mm; matrix size, 256) through the temporal bones, as well as standard spin-echo T1-weighted images, fluid-attenuated inversion recovery, and diffusion-weighted images through the entire brain. The CISS sequence generates near-isotropic voxels measuring 0.5–0.7 mm in length, which is adequate to visualize the anatomy of the fluid-filled inner ear and the nerves within the IACs. Intravenous contrast is not routinely administered in children unless there is a clinical suspicion of neoplasm or an infectious or inflammatory cause of hearing loss.

CT is reserved for the following cases: 1) The SCC defects or cochleovestibular anomalies are identified, so that the course of the facial nerve and cochlear anatomy can be delineated before cochlear implantation; 2) inner ear obstruction is evident, to determine whether the process is fibrous or osseous; 3) the IAC is narrow, precluding adequate visualization of the cochlear nerve, and it is necessary to determine patency of the bony cochlear nerve canal; or 4) if there is a conductive component to the hearing loss, to determine the integrity of the ossicular chain. Our routine pediatric temporal bone CT protocol includes both direct axial and coronal contiguous sequential acquisitions by using a collimation of 0.6–0.75 mm, 120 kV(peak), and variable mAs with current modulation (CARE Dose; Siemens Medical Systems, Erlangen, Germany) at a reference milliampere-second of 200. Scans extend from the top of the petrous apex to the mastoid tip in the axial direction and from the anterior tip of the petrous apex to the posterior margin of the mastoid in the coronal direction. In patients unable to tolerate direct coronal scanning, an axial
spiral acquisition is performed, with axial and coronal image sets reconstructed at a section thickness of 0.6–0.75 mm.

Classification of Inner Ear Malformations
Inner ear malformations causing hearing loss are often discovered in infancy; however, some malformations, such as vestibular aqueduct enlargement, may not come to light until later in life. Malformations can range in severity from relatively mild dysplasias to complete inner ear aplasia. It is theorized that the spectrum of anomalies reflects interruptions to inner ear development occurring at different junctures during embryogenesis. Failure of otic placode formation during the third gestational week results in complete labyrinthine aplasia (Michel anomaly, Fig 1), whereas insults occurring later (during the seventh week) would only cause mild abnormalities (IP-II or Mondini dysplasia, Fig 2). In 2002, Sennaroglu and Saatci proposed a classification for cochleovestibular malformations that included, in order of decreasing severity: labyrinthine aplasia (Fig 1), cochlear aplasia (Fig 3), common cavity deformities (Fig 4), cystic cochleovestibular malformations (IP-I) (Fig 5), cochleovestibular hypoplasia (Fig 6), and IP-II (Fig 2), each of which is thought to result from an insult occurring at a progressively later stage of development. Features of each of these malformations are described in the Table.

Vestibular aqueduct enlargement (also referred to as enlarged vestibular aqueduct syndrome) is the single most common inner ear anomaly seen in individuals with SNHL and is frequently seen in association with other inner ear anomalies, such as IP-II, vestibular enlargement, and SCC dysplasias. On CT, vestibular aqueduct enlargement is diagnosed when the aqueduct is >1.5 mm in width (roughly the diameter of the simultaneously visualized posterior SCC) at the midpoint between the common crus and its external aperture. MR imaging additionally demonstrates enlargement of the endolymphatic duct and sac (Fig 7), which may occasionally be seen without enlargement of the aqueduct.

SCC malformations also frequently occur in association with other inner ear anomalies and follow a similarly predictable spectrum based on the timing of the causal growth disturbance. The SCCs begin as disk-shaped evaginations arising from the vestibular appendage in the sixth gestational week. The central portion of each disk is resorbed and replaced by mesenchyme, which results in formation of a characteristic semicircular duct. Failure of 1 of these disks to form results in the absence of the involved SCC, while incomplete absorption of the central portion of the disk results in a dysplastic or pocket-shaped SCC. The superior SCC is the first to form, followed by the posterior and then the lateral SCC. Therefore, superior and posterior SCC anomalies are almost invariably associated with anomalies of the lateral SCC, whereas abnormalities of the lateral SCC can occur in isolation (Fig 8). The 2 main exceptions to this rule are Waardenburg syndrome and Alagille syndrome, both of which may show absence of the posterior SCC without involvement of other SCCs. On axial CT images, subtle SCC abnormalities may be indicated by a small or enlarged lateral SCC bony island (Fig 9). Normally, the transverse diameter of this bony island measures between 2.6 and 4.8 mm.

Children with milder inner ear malformations (eg, vestibular aqueduct enlargement, IP-II, and partial SCC dysplasias) tend to perform better on tests of speech perception following cochlear implantation than children with other malformations (eg, common cavity or cochlear hypoplasia) or syndromes such as CHARGE syndrome, but even the presence of a severe malformation (provided a cochlea is present) does not preclude implantation. Identification of these anom-

Fig 3. Cochlear aplasia. Axial CT image through the right temporal bone demonstrates a dysplastic vestibule fused to an abnormal lateral SCC, with absence of the cochlea. Notice the small canal for the vestibular nerve (arrow).

Fig 4. Common cavity deformity. Axial CT (A) and CISS (B) images through the left inner ear demonstrate an enlarged cystic cavity representing the cochlea and vestibule without differentiation.
Cochlear malformations are important in surgical planning, however, because the presence of cochlear malformations may make implant placement more challenging and also increases the risk for perilymph/CSF leak, postimplantation meningitis, and potential electrode misplacement, including placement into the IAC. In addition, the facial nerve course is aberrant in approximately 15%–32% of patients with cochleovestibular anomalies, a finding that influences surgical planning and occasionally precludes placement of the cochleostomy in the optimal position in relation to the round window.

Cochlear nerve dysplasia is usually congenital, but it can occasionally develop subsequent to birth due to atrophy of the nerve in patients who previously demonstrated normal hearing in the affected ear. Because cochlear implants are generally contraindicated in CND, it is important to identify this condition in children being considered for implantation.

MR imaging is the most sensitive technique for diagnosing CND. On CISS images, the normal cochlear nerve is easily identifiable within the IAC. Oblique sagittal reconstructions oriented perpendicular to the long axis of the IAC are useful for visualizing the cochlear nerve, which is situated in the anterior inferior quadrant of the canal, as well as the intracanalicular segment of the facial nerve and the superior and inferior divisions of the vestibular nerve (Fig 10). CND can be seen in isolation (with the vestibular nerve) or as part of other inner ear anomalies.

**Spectrum of congenital inner ear malformations as proposed by Sennaroglu and Saatci**

<table>
<thead>
<tr>
<th>Time of Insult (week)</th>
<th>Malformation</th>
<th>Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Third</td>
<td>Labyrinthine aplasia (Michel deformity)</td>
<td>Complete absence of cochlea and vestibule</td>
</tr>
<tr>
<td>Third-to-fourth</td>
<td>Cochlear aplasia</td>
<td>Complete absence of cochlea; vestibule present</td>
</tr>
<tr>
<td>Fourth</td>
<td>Common cavity</td>
<td>Single cystic cavity representing cochlea and vestibule, without any differentiation</td>
</tr>
<tr>
<td>Fifth</td>
<td>Cystic cochleovestibular anomaly (IP-I)</td>
<td>Cystic-appearing cochlea lacking entire modiolus and cribriform area, large cystic vestibule</td>
</tr>
<tr>
<td>Sixth</td>
<td>Cochlear hypoplasia</td>
<td>Cochlea and vestibule are separate but are smaller than normal; hypoplastic cochlea resembles small bud off the IAC</td>
</tr>
<tr>
<td>Seventh</td>
<td>Incomplete partition type II (IP-II)</td>
<td>Cochlea consists of 1.5 turns, in which middle and apical turns coalesce to form a cystic apex; vestibule and VA may be enlarged</td>
</tr>
</tbody>
</table>

**Fig 5.** Cystic cochleovestibular anomaly (IP-I). Axial CT (A) and CISS (B) images through the right temporal bone demonstrate a cystic-appearing and featureless cochlea and vestibule. The cochlea and vestibule form a “figure 8” or “snowman” contour, with slightly increased separation compared with the common cavity deformity demonstrated in Fig 4.

**Fig 6.** Cochlear hypoplasia. Axial CT (A) and FSE T2-weighted (B) images through the left temporal bone demonstrate a small cochlea, resembling a bud off of the IAC. The vestibule is also enlarged and dysplastic and is fused with a pocketlike lateral SCC.
tibular nerve divisions present) or in conjunction with aplasia of the vestibular nerve (complete absence of the eighth cranial nerve). Commonly, there will be associated narrowing of the IAC (defined as an IAC diameter of <4 mm), and it has been theorized that this occurs because the IAC depends on the presence of vestibulocochlear nerve cells to form normally.21,24

CT is less sensitive than MR imaging for the detection of CND but may demonstrate secondary signs, such as an absent or stenotic BCNC (normal between 1.4 and 3.0 mm)25 or a stenotic IAC (Fig 11). Children with narrow IACs on CT perform worse following implantation than those with normal caliber IACs, presumably because the cochlear nerve is likely to be absent or small when the IAC is narrow.19 Cochlear nerve–deficient ears may demonstrate normal caliber BCNCs in 23% of cases9 and normal sized IACs in 73% of cases.26

### Congenital Hearing Loss

Congenital hearing loss is defined as hearing loss present at birth and is generally divided into genetic and nongenetic forms. It is estimated that in >50% of patients, SNHL can be linked to a genetic cause, of which approximately 75%–80% demonstrate autosomal recessive inheritance; 15%–20%, autosomal dominant inheritance; and 1%–2%, X-linked inheritance. Approximately 30% of inherited forms of hearing loss are syndromic, and the remaining 70% are considered nonsyndromic.27 To date, >300 syndromic forms of hearing loss have been described.28 Of the nongenetic forms of SNHL, an environmental cause can be identified in half and the remainder are considered idiopathic.29
Most children with congenital SNHL show normal inner ear morphology on CT and MR imaging, with congenital inner ear anomalies reported in only 20%–30%. This is because hearing loss is frequently due to isolated abnormalities on a cellular or microscopic level, which are not resolvable by current imaging techniques and which do not overtly affect the appearance of the bony otic capsule or membranous inner ear.

Below we discuss some nonsyndromic causes of congenital hearing loss, including both nonhereditary and hereditary etiologies. Syndromic hereditary forms of SNHL will be discussed in Part 2 of the series.

Nonhereditary Causes of Sensorineural Hearing Loss

Approximately half of the cases of congenital SNHL have a nonhereditary basis, and in roughly half of these, an underlying environmental cause can be identified. Etiologies include pre- and perinatal infections (CMV, rubella, measles, syphilis, and so forth), exposure to alcohol or ototoxic drugs (aminoglycosides, antineoplastic agents, and so forth), prematurity, hypoxic-ischemic injury, and hyperbilirubinemia. In general, these entities are not associated with gross inner ear abnormalities detectable by imaging.

CMV infection is the most prevalent environmental cause of prelingual hearing loss in the United States and has been implicated in approximately 10% of infants with congenital hearing loss and 34% of children with moderate-to-severe late-onset idiopathic hearing loss. Roughly 90% of neonates with congenital CMV have subclinical infections, but of these, approximately 10% develop significant permanent hearing loss. Furthermore, among children with clinically apparent congenital CMV infection, the prevalence of SNHL is roughly 30%. Hearing loss associated with congenital CMV can be unilateral, fluctuating, or progressive, and onset can be delayed for months or years. Inner ear abnormalities in deaf children with congenital CMV infection are not typical; however, associated brain abnormalities, which may include variable degrees of hemispheric white matter hyperintensity on T2-weighted images and cortical malformations, are present in ≤80%.

Nonsyndromic Hereditary Causes of Hearing Loss

As already mentioned, most cases of hereditary SNHL are nonsyndromic. To date, >110 chromosomal loci and at least 65 genes causing nonsyndromic hearing loss have been identified. Of note, ≤50% of all cases of prelingual SNHL are attributable to mutations of the GJB2 gene, which encodes for the gap junction protein connexin 26. Most reports suggest that inner ear malformedations are uncommon in children with GJB2 mutations, and several authors have suggested that routine imaging is not necessary in individuals with hearing GJB2-related deafness. This topic is controversial, however, because 1 report has suggested that 72% of subjects with biallelic GJB2 mutations have at least 1 temporal bone anomaly by CT imaging, with mild endolym-
astic fossa enlargement and modiolus hypoplasia being the most common findings. 39

By far, the most common inner ear malformation seen in children with nonsyndromic hearing loss is vestibular aqueduct enlargement. The prevalence of enlarged vestibular aqueducts in children with SNHL is estimated to be 10%–15%. 40 The malformation is bilateral in approximately 90% of cases, and patients may present with profound congenital SNHL, progressive SNHL, or fluctuating SNHL. Initially, hearing loss may be of the high-frequency variety, and some patients may experience acute hearing decline related to episodes of minor head injury, overexertion, or barometric pressure changes (eg, related to air travel, deep sea diving, or Valsalva maneuver). 14,41 In approximately 63% of nonsyndromic individuals with vestibular aqueduct enlargement, a mutation at the PDS locus on chromosome 7q31—which is the same gene responsible for Pendred syndrome—can be identified, suggesting a genetic basis for most cases of the malformation. 53

Conclusions

Causes of hearing loss in the pediatric population are numerous and varied, often making evaluation and management of the condition quite challenging for otolaryngologists. Imaging plays a central role in the work-up of childhood SNHL because it depicts anomalies in the structures of the inner ear, frequently provides clues as to the etiology of the hearing loss, and may detect associated comorbid conditions. Although CT and MR imaging are both viable imaging choices, we prefer MR imaging due to its ability to directly assess not only the inner ear but also the cranial nerves and brain. In cases of congenital hearing impairment, inner ear malformations and CND are fairly common, and identification of these anomalies is critical when surgical intervention is being considered because they may complicate or even preclude cochlear implantation in a child with SNHL.

References
