Pneumatization of the sphenoid sinus, dorsum sellae and posterior clinoid processes in computed tomography

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Abstract

Purpose: Assessment of sphenoid sinus (SS), posterior clinoid process (PCP), and dorsum sellae (DS) pneumatisation is significant when planning surgical approaches both to intra- and extrasellar pathologies. The authors analysed pneumatisation of the SS, with particular attention paid to pneumatisation of the PCP and DS.

Material and methods: The study was based on 100 computed tomography angiography examinations. SS, PCP, and DS pneumatisation grades were assessed using the classification system proposed by Hardy. The analyses were conducted in sagittal planes: midline plane (MP), sagittal posterior clinoid plane right (SPCP-R), and sagittal posterior clinoid plane left (SPCP-L). The occurrence of the highest pneumatisation grade (IVB according to Hardy), which encompasses DS and PCP, prompted the authors to conduct a further analysis in the coronal plane. In this way, seven DS and PCP pneumatisation symmetry types were identified.

Results: In the MP and SPCP-R, the most frequent pneumatisation grade was grade III (41% and 38%, respectively). In the SPCP-L, grade IV A prevailed (41%). Grade IVB was found in 12% of the SPCP-R images, 10% of the SPCP-L images, and in 12% of the MP images. Consistent pneumatisation grades in all analysed planes were found for 64% of cases. This was usually grade III noted in 28% of cases.

Conclusions: SS pneumatisation is characterised by considerable individual variability. There are a number of SS pneumatisation classification systems, but the system proposed by Hardy is the most useful for assessment of DS and PCP pneumatisation. Grade III of SS pneumatisation is the most common. Pneumatisation encompassing DS and PCP was found in 10-12% of cases.

Key words: posterior clinoid process, dorsum sellae, sphenoid sinus, pneumatisation, computed tomography.

Introduction

The sphenoid sinus (SS) is located within the body of the sphenoid bone, and its shape and size are characterised by considerable individual variability. The average SS volume is approximately 7.5 ml in an adult. In cases of considerable pneumatisation, the SS can extend even to the foramen magnum. Owing to its natural connection with the nasal cavity, the SS is significant when planning surgical approaches to both intra- and extrasellar pathologies [1]. The posterior clinoid process (PCP) and dorsum sellae (DS) are located in the middle cranial fossa on the superior surface of the sphenoid bone and form slight bony eminences of variable shapes and pneumatisation grades.
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In 1920, Congdon was the first to present a division of SS pneumatisation with reference to the sella turcica. He distinguished three types: I (conchal), II (presellar), and III (sellar) [5]. Later Hardy added types IVA and IVB to include more developed cases of pneumatisation.

The subject of SS pneumatisation is usually undertaken in the context of surgical approaches to intrasellar pathologies [6]. PCP and DS pneumatisation, on the other hand, is mentioned together with surgical accesses to pathologies located within the clivus or interpeduncular cistern [7,8].

Moreover, DS and PCP can form an obstacle by concealing deeper anatomic structures, for instance the basilar artery apex. In such cases, surgical conditions can be improved by reducing these structures (usually the posterior clinoidectomy [PCP]) using a microdrill [9].

In the case of pneumatised DS or PCP removal (grade IVB according to Hardy), the risk of a dangerous complication in the form of cerebrospinal rhinorrhoea must be taken into account [10,11].

In the case of extensive pneumatisation encompassing the DS and PCP, lesions in the clivus or interpeduncular cistern can also be accessed through the trans-sphenoidal approach [9,12].

There are a number of SS pneumatisation classification systems, but the system proposed by Hardy is the most useful for assessment of DS and PCP pneumatisation [5,10].

The aim of this research was to develop reproducible and useful study methods to evaluate SS pneumatisation, with particular emphasis on DS and PCP pneumatisation grades.

Material and methods

The retrospective analysis involved anonymised computed tomography angiography (CT angiography) images of 100 patients (54 women and 46 men) aged 18-88 years (mean age 52.49 years, standard deviation 18.64) diagnosed for headache. CT parameters were as follows: 16-row helical CT scanner GE BrightSpeed, collimation of 1 mm, slice thickness of 0.625 mm, pitch 1.0., voltage 120 kV. Non-ionic contrast material (Omnipaque 350) was injected into the one of the veins of the cubital region, i.e. the median cubital vein, at a rate of 3.5-4.5 ml/s to the total volume of 80-100 ml using a power injector.

The study involved imaging scans encompassing all anatomic structures relevant for this investigation, without motion artefacts or foreign bodies, e.g. vascular clamps.

The study excluded patients:
- after craniocerebral trauma,
- after a neurosurgical procedure within the head,
- with a diagnosed intracranial tumour,
- with a pathology (tumour, inflammation etc.) within the SS.

SS pneumatisation in relation to the sella turcica, DS, and PCP was analysed in the sagittal plane using the classification system proposed by Hardy (Figure 1). The analyses were carried out in the planes shown in Figure 2.

The occurrence of the highest pneumatisation grade, encompassing the DS and PCP (IVB according to Hardy), prompted the authors to conduct a further analysis in the coronal plane. In this way, seven pneumatisation symmetry types were identified within the DS and PCP (Figures 3 and 4).

This study complies with the current laws of Poland and it was approved by the Ethics Committee of the Medical University of Silesia in Katowice, Clinical Research Ref.: KNW/0022/KB/74/1/17.

Statistical analysis

Statistical calculations were performed in the PQStat version 1.6.2.901.

The relationship of sex and age with a pneumatisation grade was analysed using the $c^2$ test and Fisher's exact test.

The tested probability was deemed significant at $p < 0.05$, and highly significant at $p < 0.01$. 

Figure 1. Sphenoid sinus pneumatisation grades in relation to the sella turcica, dorsum sellae (DS), and posterior clinoid process (PCP). I – conchal, II – presellar, III – sellar, IVA – postsellar (no pneumatisation of the DS and PCP), IVB – post-sellar (pneumatisation of the DS and PCP)
Results

In the analysed material \((n = 100)\), scans in the MP plane showed grade III pneumatisation in 41% of cases, which together with grade IVA, identified in 38% of cases, accounted for 79%. In the SPCP-R plane, grade III was the most frequent (38%) while in the SPCP-L, grade IVA prevailed (41%). Grade I was the rarest in MP, SPCP-R, and SPCP-L planes.

The highest pneumatisation grade, i.e. grade IVB, was found in 12% of the SPCP-R scans, 10% of the SPCP-L scans, and 12% of the MP scans (Table 1).

In women \((n = 54)\), the most common pneumatisation grade in all planes was grade III.
The frequency of grade IVB pneumatisation in women in the SPCP-R plane was 6%, in the SPCP-L plane 4%, and in the MP plane 6% (Table 2).

In men (n = 46), the SPCP-R and SPCP-L images most frequently presented pneumatisation grade IVA: 37% and 43%, respectively. In the MP plane, grade III prevailed: 39%.

The frequency of grade IVB pneumatisation in men in the SPCP-R plane was 17%, in the SPCP-L plane 19%, and in the MP plane 19%.

There were no cases of grade I pneumatisation in men (Table 3).

There were no significant (p > 0.05) correlations between pneumatisation grades and sex or age of the patients.

In this material (n = 100), consistent pneumatisation grades for all planes (MP, SPCP-R, SPCP-L) were found for 64% of cases. Grade III was the most common: in 28% of cases (19 women and nine men), while grade I was the rarest: in 1% (only one female patient) (Table 4).

There were no cases of type A pneumatisation in the DS and PCP in men only (3% of cases), whereas type B was present only in women (3% of cases).
Type G was the most common (5% of cases) and occurred only in men. There were no cases of type D (Table 5).

**Discussion**

The SS is a pneumatic space located within the body of the sphenoid bone. Its size and shape are variable, and it is lined with mucous membrane and divided with one or several vertical septa [1].

It is formed in the fourth month of the foetal development from the nasal capsule of the embryonic nose [1]. At birth, the SS is not fully developed, shows no signs of pneumatisation, and its diameter reaches approximately 2 mm [13].

SS pneumatisation progresses with age. It reaches the sella turcica at approximately seven years of age and ends during puberty [1,13,14].

SS agenesis is seen in rare cases (1-1.5%), and no progress of the SS pneumatisation process up to the age of 10 years may indicate a pathology within the SS [1,15].

SS pneumatisation is an interesting subject for numerous fields of medicine (neurosurgery, laryngology, maxillofacial surgery). Owing to the anatomic connection between the SS and the nasal cavity, the SS constitutes a route for an endoscope to reach different intra- and extrassellar pathologies [16].

According to Teatini et al., the SS is the most variable space in the human body [17]. That is why thorough analysis of the anatomy in this region prior to a surgery is very important. Due to its location in close proximity to various vital structures, such as the pituitary gland, the cavernous sinus, the optic nerve, or the internal carotid artery, extensive SS pneumatisation that encompasses the DS or PCP might lead to the thinning of its walls and secondary inclusion of these structures into the sinus. This entails the risk of their damage during a surgical procedure [17].

The initial division of SS pneumatisation proposed by Congdon was created mainly for the purposes of transsphenoidal access to intrasellar pathologies [5,18].

Subsequently, as endoscopy developed and the transsphenoidal access was broadened to regions neighbouring the sella turcica, such as the clivus or suprasellar region, other classification systems that included the DS and PCP were developed, including the one proposed by Hardy.

Güldner et al. analysed CT scans of the paranasal sinuses in 580 patients (313 women and 267 men). They found conchal grade I pneumatisation in three patients (0.3%), presellar type II in six patients (6%), sellar type III in 41 patients (41%), and postellar type IV in 50 patients (50%): IVA in 38 and IVB in 12 patients.

For the most accurate assessment, the authors analysed SS pneumatisation in three sagittal planes (MP, SPCP-R, and SPCP-L). When classifying a case to the IVB group in the MP plane, the DS was considered completely pneumatised. When classifying a case to the IVB group in the SPCP-R or SPCP-L planes, the authors assumed that the right and left PCPs, respectively, were pneumatised completely. In this way, the frequency of right PCP pneumatisation was 12%, left PCP pneumatisation 10%, and DS pneumatisation 12%.

Güldner et al. found no significant differences between the frequency of given SS pneumatisation types depending on gender [19]. Tomovic et al., on the other hand, showed no correlations between SS pneumatisation and age [20].

In the material analysed in the present study (n = 100) there were no statistically significant (p > 0.05) correlations between pneumatisation grades and sex or age of the patients.

**Conclusions**

SS pneumatisation is characterised by considerable individual variability. Pneumatisation encompassing the DS and PCP, i.e. Hardy IVB, was found in 10-12% of cases. Type IVB by Hardy includes seven types of pneumatisation.

**Conflict of interest**

The authors report no conflict of interest.