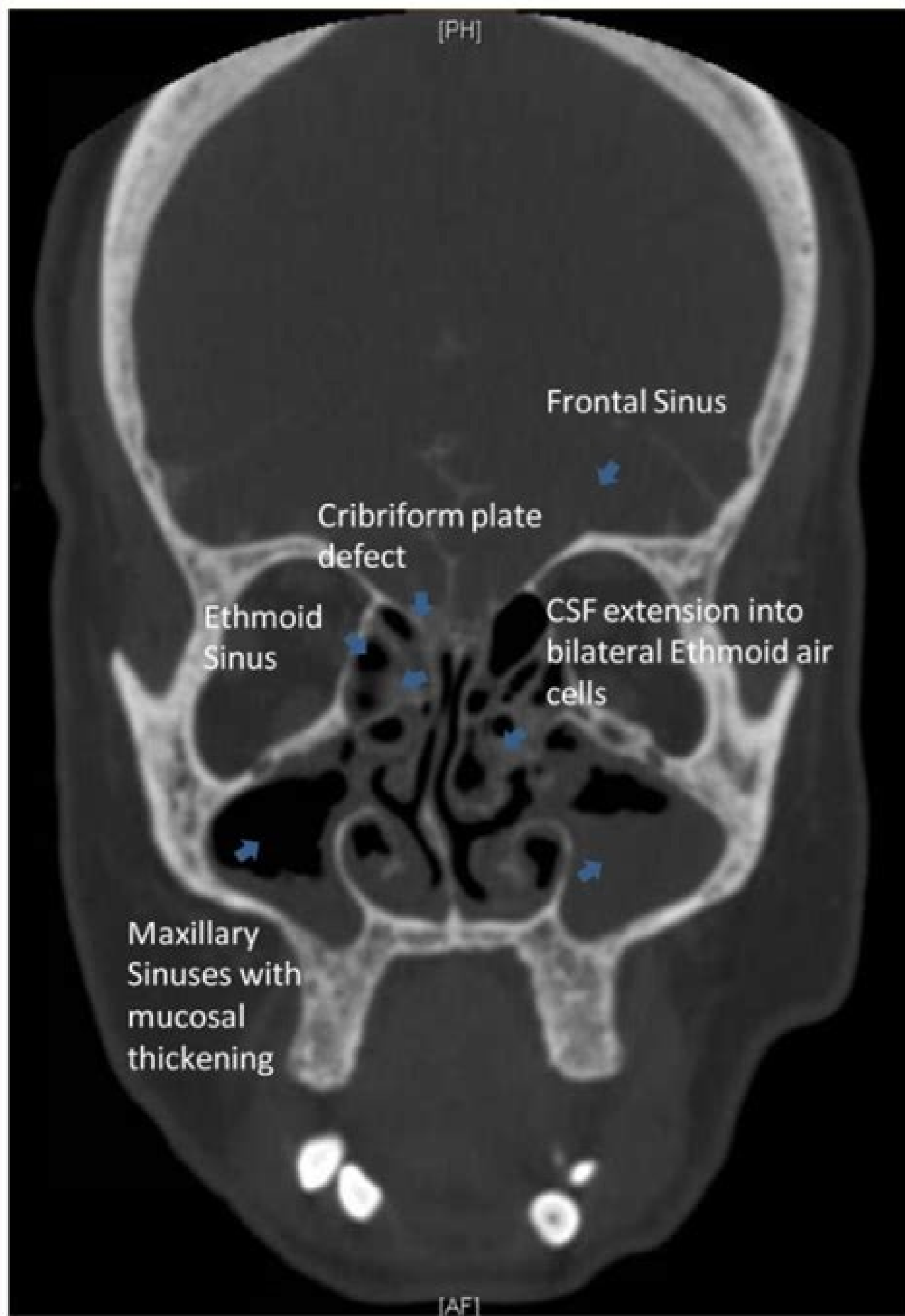
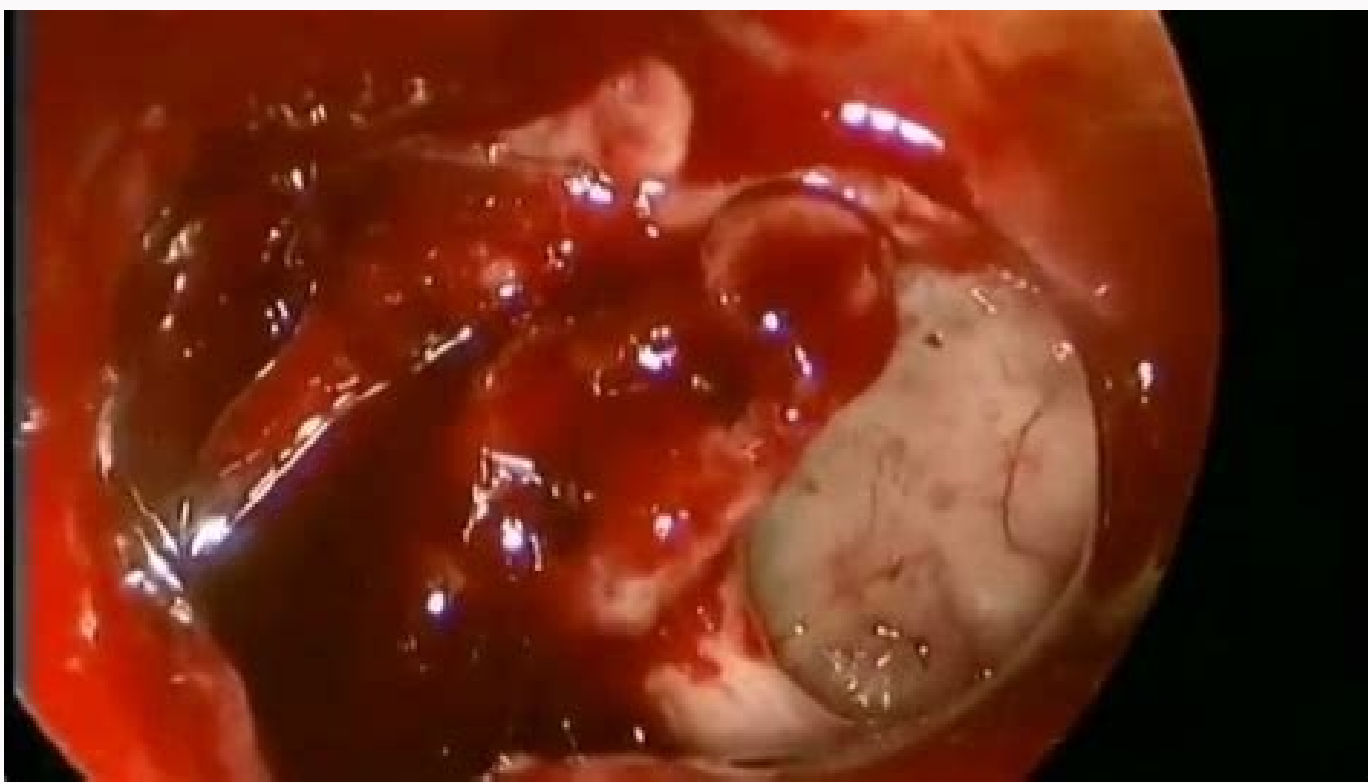
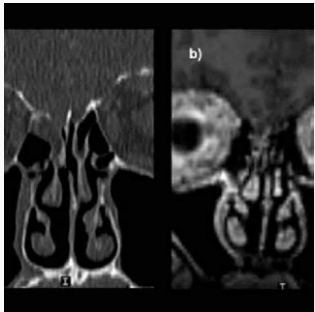
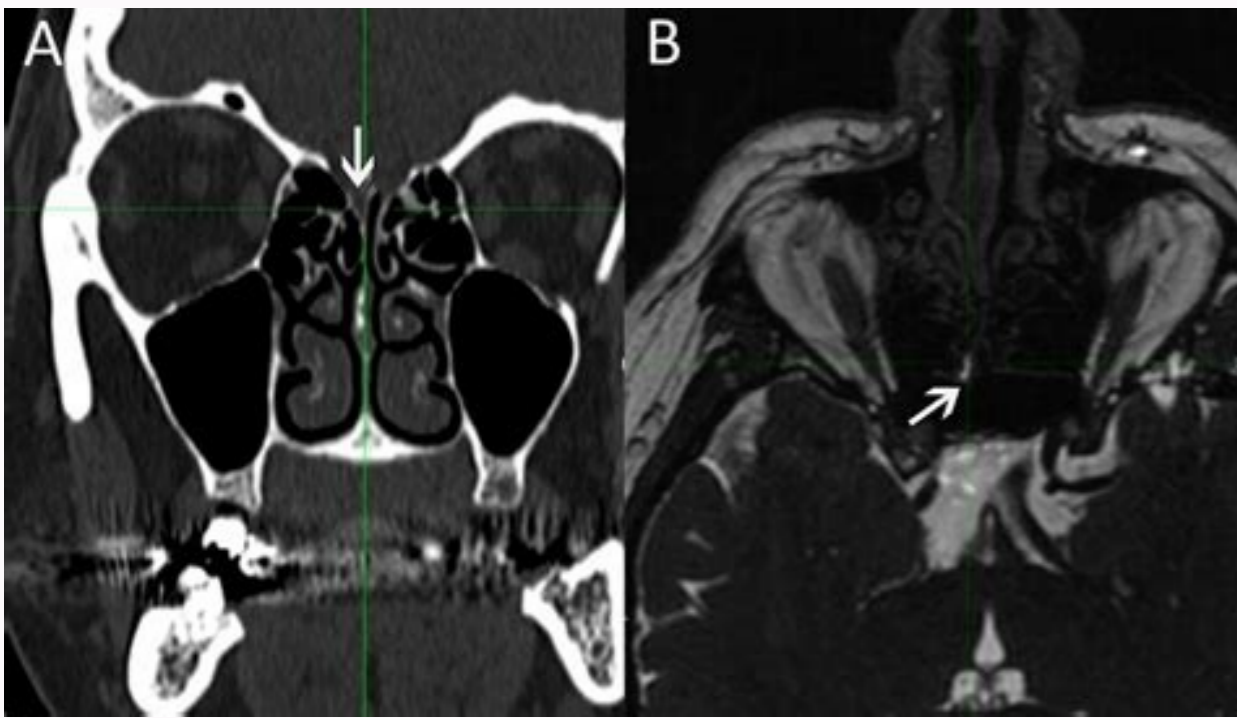
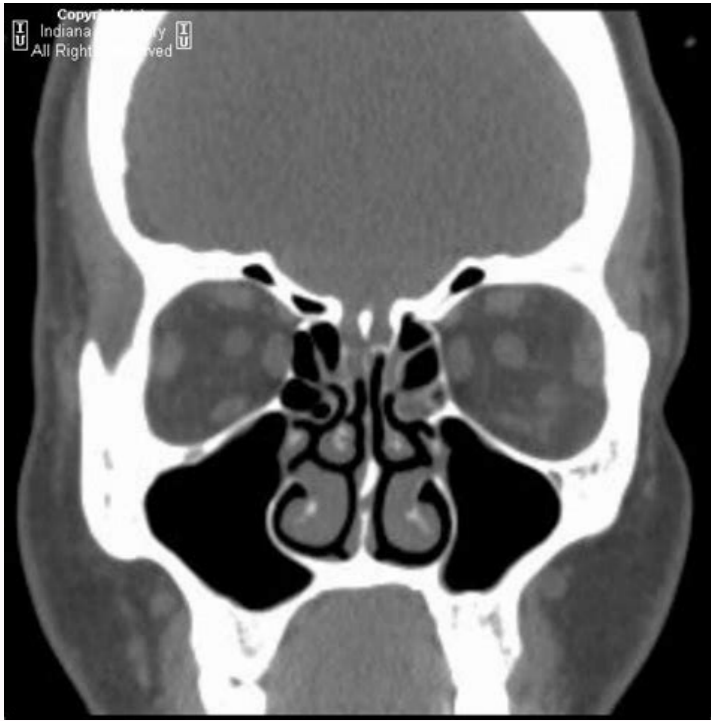


Cribriform plate csf leak

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What test shows a csf leak. Cribriform plate fracture csf leak. Cribriform plate csf leak radiology. How to determine if csf is leaking. Csf leak through cribriform plate. Cribriform plate csf leak symptoms. Are csf leaks common. How are csf leaks diagnosed.

Cerebrospinal fluid (CSF) leaks from the nose, and sinusitis are infrequent problems that require skilled techniques to manage. Whether iatrogenic or spontaneous, CSF leaks occurring in the cribriform area of the ethmoid sinuses are aptly suited for minimally invasive and endoscopic repair. While CSF leaks were in the past solely within the purview of the neurosurgeon, these defects can be approached via a transnasal endoscopic route and typically repaired using a variety of reconstructive techniques—many of them including grafts harvested from within the nasal cavity or sinuses—by an otolaryngologist. Today, endoscopic repair of cribriform CSF leaks is the mainstay of surgical repair, and this technique enjoys a very high success rate with few complications, recurrence rates, and morbidity. cribriform plate, CSF leak repair, CSF rhinorrhea, endoscopic sinus surgery, skull base surgery ■ Cerebrospinal fluid (CSF) rhinorrhea originating near the cribriform plate results from the breakdown of barriers separating the subarachnoid space and the paranasal sinuses. This may result from traumatic, iatrogenic, neoplastic, congenital, and inflammatory processes. ■ A CSF leak in the cribriform region may also be spontaneous in nature and may present with a meningoencephalocele, which is the herniation of the anterior cranial fossa soft tissue through the skull base. ■ Although conservative management may be used to treat cribriform CSF leaks after blunt force trauma, surgical intervention is generally required for closure of other forms to prevent serious complications, including meningitis and abscess formation. ■ Open intracranial approaches for CSF leak repair involving frontal craniotomy, first described by Dandy in the 1920s, were limited by significant morbidity, including anosmia, intracerebral hemorrhage, frontal lobe deficits, extended hospital stay, and higher recurrence rates. ■ The endoscopic approach for repair of cribriform CSF leaks occurring during endoscopic ethmoidectomy was first described by Wigand and Stankiewicz in the 1980s and further detailed by many others. ■ Today, transnasal endoscopic approaches for repair of cribriform CSF leaks and encephaloceles are the mainstay of surgical therapy, with success rates as high as 98%, low complication and recurrence rates, and decreased morbidity. ■ The ethmoid labyrinth forms the bulk of the anterior skull base, with the cribriform plate being the lowest portion of the anterior skull base in the midline. The cribriform plate is suspended bilaterally by the lateral cribriform lamellae, which thicken as they extend laterally into the fovea ethmoidalis. Therefore, when performing an ethmoid skull base dissection, the surgeon is, in fact, operating above the lowest level of the anterior cranial fossa. ■ The depth of the cribriform plate is dictated by the length of the lateral cribriform lamellae, as classified by Keros ( Fig. 26.1 ): – Keros type 1: The cribriform plate is located 1 to 3 mm below the roof of the ethmoid, resulting in a short lateral cribriform lamella. – Keros type 2: The cribriform plate is located 4 to 7 mm below the roof of the ethmoid. – Keros type 3: The cribriform plate is located 8 to 16 mm below the roof of the ethmoid, resulting in a long vertical lamella. Fig. 26.1 Illustration depiction of computed tomography scans showing the Keros classification. (A) Keros Class I; (B) Keros Class II; (C) Keros Class III; (D) asymmetric skull base. ■ The cribriform plate is perforated by numerous olfactory fibers ( Fig. 26.2 ). Despite these perforations, the cribriform plate itself is fairly thick. Fig. 26.2 Illustration of the intracranial view of the floor of the anterior cranial fossa, with the olfactory tracts traversing the floor (A) . Note the thin cribriform plate and lateral lamella medially and thicker fovea ethmoidalis (ethmoid roof) laterally (B) . Adapted from Logan BM, Reynolds, PA, Hutchings RT, eds. McMinn's Color Atlas of Head and Neck Anatomy . 3rd ed. St. Louis: Mosby; 2003. ■ The anterior ethmoidal artery originates from the ophthalmic artery and passes through the anterior ethmoidal foramen near the frontoethmoidal suture. Its bony canal may be partially or completely deficient in 40% of cases. The artery crosses the skull base until it gives rise to meningeal branches at the cribriform plate. ■ Preoperative intrathecal injection of fluorescein is frequently used to localize the source of CSF leakage. Although neurologic complications—including seizures, headaches, and cranial nerve deficits—have been reported, a concentration of 0.1 mL of 10% fluorescein mixed with 10 mL of CSF injected slowly has been shown to be of low risk. ■ The utility of lumbar drainage in the early management of cribriform CSF leak repair is controversial. When used, they can be conduits for fluorescein administration and are deployed to divert CSF for 2 to 5 days. ■ The routine use of perioperative prophylactic antibiotics in patients undergoing cribriform CSF leak repairs is also controversial, albeit reasonable. ■ Patients with cribriform CSF leaks should be evaluated with high-resolution computed tomography (CT) scanning with coronal, axial, and sagittal views to clarify the location of the skull base defect and the anatomy of the skull base itself (asymmetry, low-lying, and so on; Fig. 26.3 ). Coronal views are best to evaluate defects of the cribriform plate and fovea ethmoidalis. Fig. 26.3 Preoperative computed tomography scan of the anterior skull base with attention to the cribriform region. The skull base is notably asymmetric and there is a dehiscence along the right cribriform (red arrow) with soft tissue opacification of the olfactory cleft suggesting a meningoencephalocele. ■ Patients presenting with spontaneous CSF rhinorrhea should be evaluated with magnetic resonance imaging (MRI) with axial, coronal, and sagittal views to evaluate for the presence of a meningoencephalocele if a soft tissue mass is identified near a skull base defect on CT imaging ( Fig. 26.4 ). Fig. 26.4 Preoperative magnetic resonance image (MRI) of a child who presented with soft tissue fullness in the prenasal space. The MRI revealed a meningoencephalocele based on the right anterior skull base involving the cribriform region. ■ Stereotactic image-guidance CT imaging is helpful for intraoperative localization of the skull base defect but is neither required nor is the standard of care ( Fig. 26.5 ). Fig. 26.5 While not essential, stereotactic navigation can be useful intraoperatively for localizing the cribriform defect and assessing intraoperatively the size of the defect. ■ Hand-held conventional and powered endoscopic sinus instruments ■ Instrumentation for obtaining extranasal graft tissue ■ Stereotactic image-guidance surgical system ■ Electrocautery, including needle-tip monopolar, bipolar, and/or radiofrequency or cold ablation device ■ Subarachnoid drain and/or 10% injectable (nonopthalmitic) fluorescein ■ Fibrin glue/sealant ■ Absorbable packing materials (e.g., CellFoam or GelFilm) ■ Nonabsorbable packing materials (e.g., nasal sponge) ■ Hemostatic agents (e.g., Floseal) ■ 10% fluorescein is not approved by the US Food and Drug Administration for intrathecal administration, and full informed consent is recommended. Administration, however, can greatly aid in identification of leaks intraoperatively ( Fig. 26.6 ). Only gold members can continue reading. 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