

vestibule or at the scala vestibuli. This result is consistent with clinical data of patients suffering from PLF (Goto et al., 2001). At low frequencies, the pressure generated in the cochlea with a fistula becomes lower than the pressure in the intact cochlea because the lymphatic fluid easily flows in and out through the fistula. By contrast, at high frequencies, the movement of the lymphatic fluid depends on the inertia of the lymphatic fluid itself rather than on the boundary condition surrounding the lymphatic fluid. This is a reason why the changes in the vibration of the BM at high frequencies are smaller than those at low frequencies.

Meanwhile, when a fistula existed adjacent to the RW, the maximum amplitude was not changed significantly even though the size of the fistula adjacent to the RW is larger than that of the fistula at other places (Table 3). Foster and Luebke (2002) reported that the RW fistula itself does not cause hearing loss, and air bubbles entered into the cochlea from the fistula. Our findings are in agreement with this result. The RW membrane is far more mobile than the bony wall of the cochlea, and the lymphatic fluid at the vicinity of the RW can naturally flow easily. In other words, the RW can be regarded as a large fistula. This is the reason why a fistula near the RW does not affect the vibration of the BM. On the other hand, Kelly and Khanna (1984) reported that opening the round window caused histological damage in the apical region of the BM presumably due to a large momentary pressure differential created across the organ of Corti. This damage was similar to that induced by low-frequency sound and may cause the loss of sensitivity of the BM (Leonard and Khanna, 1984). In our present analysis, the damages of the organ of Corti and the BM have not been considered, and hearing loss was estimated based on only the attenuation of the BM vibration. To clarify the actual mechanism of hearing loss caused by a perilymphatic fistula, the effects of the histological damages should most likely be considered in the future.

5. Conclusions

In this study, a three-dimensional finite-element model of the human cochlea was created. Passive dynamic behavior of the BM, which is closely related to auditory activity at moderate to high SPLs, and the cochlear fluid caused by the vibration of the stapes footplate were analyzed. When a fistula exists at the vestibule or at the scala vestibuli, the maximum amplitude of the BM becomes smaller than that in the intact cochlea. The losses in the amplitude increased with decreasing frequency. In particular, when the fistula exists at the basal part of the scala vestibuli, the effect extends to high frequencies. By contrast, when a fistula exists at the vicinity of the RW, the vibration of the BM scarcely changes. This model assists in elucidating mechanisms of hearing loss due to a PLF, and is useful in the establishment of new treatments for the PLF.

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