INTRODUCTION

In the course of our neuropathologic investigations on victims of sudden intrauterine unexplained death syndrome (SIUDS) and sudden infant death syndrome (SIDS), we have highlighted specific abnormalities of nuclei and/or structures mediating vital functions, mainly located in the brainstem (Matturri et al., 2002; Lavezzi et al., 2004, 2010, 2012a, b; Matturri and Lavezzi, 2007; Lavezzi and Matturri, 2008a). These neurodevelopmental defects could play a key role in the pathogenetic mechanism of sudden and unexplained perinatal death.

Recently, our attention has been focused on the cytoarchitecture of important neuronal formations assembled in a limited area of the caudal pons that are involved in the respiratory rhythm-generating circuit. In particular we have shown in these pathologies alterations of the facial/parafacial complex (F/PFfc) and of the adjacent retrotangential nucleus (RTN) (Lavezzi and Matturri, 2008b; Lavezzi et al., 2012a, b).

The aim of the present study was to expand our understanding of the organization of this brainstem compartment by evaluating whether a further bordering structure, the superior olivary complex (SOC), may somehow be involved in the same developmental pattern and undergo disarranging in SIUDS and SIDS.

The SOC is known as a prominent component of the auditory system being committed to integrate inputs arising from the cochlear nuclei (Moore, 1987; Heffner and Masterton, 1990; Schofield, 2002). Experimental studies (Ollo and Schwartz, 1979; Schofield and Cant, 1991) and researches in adult humans (Kulesza, 2007, 2008) have identified with the same terminology some nuclei into this complex: the “lateral superior olivary nucleus,” the “medial superior olivary nucleus” and a large number of smaller cell groups defined as “periolivary nuclei.”

Here, we provide a morphologic characterization of the human SOC, in particular of its predominant component, the medial superior olivary nucleus (MSO), in perinatal life (75 subjects aged from 25 gestational weeks to 8 postnatal months, died of both known and unknown causes) and discuss pathological details of this nucleus found in victims of SIDS (30 cases) and SIUDS (24 cases).

MATERIALS AND METHODS

STUDY SUBJECTS

The cases included in this work are distributed into three groups: 24 cases of SIUDS (mean age 38 gestational weeks/gws, range 25–41 gws), 30 cases of SIDS (mean age 3.7 months, from 1 to 8 months), and 21 control cases (9 fetuses: mean age 36 gws, from 1 to 8 months), and 12 infants: mean age 3.4 months, from 1 to 8 months) who died suddenly but in whom a complete autopsy was performed by us (Matturri et al., 2005, 2008).

Briefly, after fixation in 10% phosphate-buffered formalin, the brainstem and cerebellum were processed and embedded in paraffin. Transverse serial sections were removed from the midbrain, pons, medulla oblongata and cerebellum at intervals.
of 0.5–1.5 cm (in relation to the victim age). From each sample, 15 levels were obtained and from each level, twelve 5 µm sections, three of which were stained for histological examination using hematoxylin-eosin, Klüver-Barrera stains and Bielchowsky’s silver impregnation technique, respectively. The remaining sections were stained/immunostained as deemed necessary or saved for further investigations.

**HISTOLOGICAL EXAMINATION**

Routine microscopic evaluation of the brainstems was focused on the hypoglossus, the dorsal motor vagal, the tractus solitarius, the ambiguus, the inferior olivary complex, the caudal raphé, the arcuate nuclei and the pre-Bötzinger complex in the medulla oblongata; on the locus coeruleus, parabrachial/Kölliker-Fuse complex, rostral raphé nuclei in the cranial pons/mesencephalon; on the F/PFc and RTN in the caudal pons. In addition, particular care was paid to examine the SOC and its components, the focus of this study, following the published studies on SOC (Ollo and Schwartz, 1979; Schofield and Cant, 1991; Kulesza, 2007, 2008).

Histological examination of the cerebellum included evaluation of cortex layers (external granular layer; molecular layer, Purkinje cell layer and internal granular layer) and of the medullary deep nuclei (dentate nucleus, fastigial nucleus, globose nucleus, and emboliform nucleus).

The observations were carried out by two independent and blinded pathologists. Comparison among the results was performed employing Kappa statistics (Kappa Index—KI) to evaluate inter-observer reproducibility (see Table 1). The Landis and Koch (1977) system of K I interpretation was used, where 0–0.2 indicates slight agreement, 0.21–0.40 indicates fair agreement, 0.41–0.60 is moderate agreement, 0.61–0.80 is strong or substantial agreement, 0.81–1.00 indicates very strong or almost perfect agreement (a value of 1.0 being perfect agreement).

This analysis revealed a very satisfactory agreement index (0.85). In addition, in case of discordance among the investigators, the slides were reviewed and discussed until the same result was obtained.

**ETHICS CONSIDERATIONS FOR THE INVESTIGATION**

Ethical approval for this study was granted by the Italian Health Ministry in accordance with Italian Law n. 31/2006 “Regulations for Diagnostic Post Mortem Investigation in Victims of Sudden Infant Death Syndrome and Sudden Intrauterine Unexpected Death.” Parents of all subjects (Controls, SIUDS and SIDS) provided written informed consent to both autopsy and anatomopathologic study, under protocols approved by the Milan University, L. Rossi Research Center institutional Review Board.

**INFORMATION COLLECTION**

For every case, a complete clinical history was collected. Additionally, mothers were asked to complete a questionnaire on their smoking habit, detailing the number of cigarettes smoked before, during and after pregnancy. Twenty-two of the 54 SIUDS/SIDS mothers (40%) were active smokers before and during the pregnancy, smoking more than 3 cigarettes/day. The remaining 32 mothers (60%) admitted no history of cigarette smoking. Six of the 21 mothers of the control group (28%) reported a smoking habit. The remaining 15 mothers (72%) were non-smokers.

**STATISTICAL ANALYSIS**

The statistical significance of direct comparison between the groups of victims was determined using analysis of variance (ANOVA). Statistical calculations were carried out on a personal computer with SPSS statistical software (version 11.0; SPSS Inc., Chicago, IL, USA). The selected threshold level for statistical significance was p < 0.05.

**RESULTS**

**MORPHOLOGICAL EXAMINATION OF THE SUPERIOR OLIVARY COMPLEX (SOC)**

The SOC is well recognizable in the most caudal transverse histological sections of the pons as a dense roundish area anterior and slightly medial to the F/PFc and the adjacent RTN. Overall, the SOC can be rostrally observed in our cases, depending on age, for nearly 1–2 mm toward the mid-pons.

Even if in perinatal life the process of myelinization is still incomplete, the relative density of myelinated fibers in the SOC region made difficult to us the identification and the examination of its components as defined in literature, although in some cases we have dared to define their boundaries (Figure 1). The only clearly delineated nucleus, given the distinctive rarefraction and peculiar thinness of the fibers in its neuropil, is the MSO nucleus.

**Table 1** | Results of the brain microscopic examinations carried out by two pathologists (1 and 2) in 54 victims of sudden unexplained death and interobserver agreement percentage (mean value: 85%).

<table>
<thead>
<tr>
<th>Brain alterations</th>
<th>Pathologist 1</th>
<th>Pathologist 2</th>
<th>Path.1/Path.2 agreement</th>
<th>Interobserver agreement (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>(%)</td>
<td>Yes</td>
</tr>
<tr>
<td>Hypopl./Agenesis MSO</td>
<td>23</td>
<td>31</td>
<td>87</td>
<td>20</td>
</tr>
<tr>
<td>Hypopl./Agenesis arcuate nucleus</td>
<td>11</td>
<td>43</td>
<td>100</td>
<td>11</td>
</tr>
<tr>
<td>Hypopl./Agenesis pre-Bötzinger nucleus</td>
<td>7</td>
<td>47</td>
<td>90</td>
<td>3</td>
</tr>
<tr>
<td>Hypopl./Agenesis raphé nuclei</td>
<td>8</td>
<td>46</td>
<td>74</td>
<td>3</td>
</tr>
<tr>
<td>Hypopl./Agenesis inferior olivary nucleus</td>
<td>10</td>
<td>44</td>
<td>85</td>
<td>3</td>
</tr>
<tr>
<td>Hypopl./Agenesis parafacial nucleus</td>
<td>9</td>
<td>45</td>
<td>79</td>
<td>3</td>
</tr>
<tr>
<td>Decreased number Purkinje cells</td>
<td>15</td>
<td>39</td>
<td>80</td>
<td>10</td>
</tr>
</tbody>
</table>
Lavezzi and Matturri Superior olivary complex in SIUDS and SIDS

**FIGURE 1** | Histological section of human caudal pons (3 month-old control) showing the localization of the superior olivary complex (SOC), anterior and slightly medial to the facial/parafacial complex (F/PFc), and the adjacent retrotrapezoid nucleus (RTN), and its cytoarchitectural organization. Klüver–Barrera stain. Magnification: 4×.

FN, facial nucleus; F/PFc, facial/parafacial complex; LNTB, lateral nucleus of the trapezoid body; LSO, lateral superior olivary nucleus; MNTB, medial nucleus of the trapezoid body; MSO, medial superior olivary nucleus; PFN, parafacial nucleus; RTN, retrotrapezoid nucleus; SOC, superior olivary complex; SPO, superior paraolivary nucleus; VNTB, ventral nucleus of the trapezoid body.

So, for a comparative and homogeneous analysis, we focused our study on the MSO.

**THE MEDIAL SUPERIOR OLIVARY NUCLEUS (MSO) IN CONTROL CASES**

The MSO is clearly visible from the 25th gestational week as a compact layer of neurons included in a narrow column with ventral/dorsal orientation.

We find similar cytoarchitecture of the MSO in nearly all subjects of the control group with only some differences in neuronal morphology, orientation and density between fetal and infant deaths. In fetuses around 25–30 gestational weeks we observed a layer of assembled round neurons with rare sketched processes (**Figure 2**); at the end of pregnancy (from the 35th gestational week) and in postnatal life the neurons were reduced in number with the same orientation, prevalent bipolar fusiform/multipolar stellate in shape, clearly showing dendritic maturation (**Figure 3**). A broad dendritic arbor of these cell types were well evident in Bielchowsky’s stained sections (**Figure 4**).

Only in 4 control cases (2 fetuses and 2 infants) we highlighted decreased number of neurons with rarefaction of fibers into the MSO.

**THE MEDIAL SUPERIOR OLIVARY NUCLEUS (MSO) IN SIUDS AND SIDS CASES**

Marked disarrangement of the MSO was frequently observed in subjects died of sudden death. In particular, the MSO column was largely devoid of fibers with few scattered immature neurons provided of rare dendrites, frequently distributed on the lateral side of the nucleus, in 7 SIUDS and 9 SIDS cases (MSO hypoplasia) (**Figure 5**). In addition, in 4 SIUDS it was not possible to recognize the MSO column as expected in the suitable histological sections (MSO agenesis). On the contrary in further 3 suddenly dead infants a very dense population of prevalently immature neurons with limited dendritic...
arbor and disrupted orientation were found, similar to the ones we typically have seen during fetal stages in control group (Figure 6).

Overall, SIDS and SIUDS cases show a significantly higher incidence of histological alterations of the MSO, as compared with age-matched controls. In fact, 23 of the 54 victims of sudden death (43%), precisely 11 SIUDS and 12 SIDS, but only 4 out of the 21 subjects belonging to control group (19%) showed MSO modifications ($p < 0.01$).

In addition, we observed a significant relation between maternal smoking and developmental disarranging of the MSO. Precisely, 13 of the 22 victims of sudden death with a smoker mother (59%) showed developmental alterations of this nucleus. In the control group, 3 out of the 4 cases with MSO changes had a smoking mother, confirming the detrimental role of prenatal smoke absorption in the pathogenetic mechanism of neuronal defects.

Table 2 summarizes the case profiles of this study, with their relative death diagnosis, the mother’s smoking status and the distribution of the MSO alterations.

### ROUTINE HISTOLOGICAL EVALUATION OF THE BRAINSTEM AND CEREBELLUM

In both sudden fetal and infant death victims, in addition to the MSO abnormalities, morphological alterations of different brainstem and cerebellar structures (namely hypoplasia/agenesis of the arcuate nucleus, pre-Bötzinger nucleus, inferior olivary nucleus, serotonergic raphé nuclei, parafacial nucleus in the medulla oblongata/pons; decreased number of Purkinje cells in the cerebellum) were disclosed. In particular, Purkinje cell loss was a frequent finding (observed in 9 SIUDS and 6 SIDS). The most frequent association was between MSO agenesis/hypoplasia, hypodevelopment of the adjacent structures (F/PFc and RTN) (Figure 7) and decreased number of Purkinje cells, pointed out in 8 SIUDS victims.

In the control group, hypoplasia of the arcuate nucleus was found in 10 cases.

### DISCUSSION

Our results constitute the first report on the morphological characterization of the human MSO nucleus, component of the SOC known as an important site of convergence of auditorium information from both ears (Moore, 1987; Heffner and Masterton, 1987).
In our study, MSO dysgenesis was frequently associated with SIUDS and SIDS cases. They interpret the morphological alterations in SIUDS/SIDS victims. We can suppose in these cases that a complete failure of formation of these rhombomeres cause lack of the facial nucleus and superior olive in transgenic knockout mice.

Evident demonstrations don’t exist in literature that the RTN arises from the same rhombomeres. Different investigators refer, however, that neurons located around the facial motor nucleus, called “parafacial respiratory group” (pFRG), together with neurons of the confined RTN, serve as a single pre-inspiratory and/or expiratory-modulating complex in newborns (Onimaru and Homma, 2003; Janiczewski and Feldman, 2006). Then it is plausible the involvement of the RTN in the ontogenetic process of the parafacial complex. Moreover, experimental studies on Phox2b expression in rats provide genetic evidence for a similar embryological origin of the two nuclei (Dubreuil et al., 2008).

So, also the alterations of the MSO observed by us in this study and those reported in autism may indicate a disruption of the excitatory/inhibitory eupneic inputs reaching this nucleus, with different degree of severity and pathological consequences, even leading to death in a vulnerable period of perinatal development.

The presence of the triad of abnormalities (MSO, F/PFc, and RTN hypoplasia) confined to victims of sudden fetal death leads to wonder whether breathing alterations can cause death during intrauterine life. It is known that the respiratory-related neuronal network is active before birth checking ventilatory-like rhythmic movements in the mammalian fetus (Barcroft and Barron, 1937; Boddy and Dawes, 1975). Therefore, it becomes vital only after birth. Thus, defects of this occasional respiratory activity in prenatal life would be not sufficient to justify the fetal death. One possibility is that these neuronal structures participate not only in breathing but, more extensively, are essential to the control of all the vital functions.

In autism the MSO disorders are frequently associated with additional anomalies of the brainstem and cerebellum. Increased cell packing density, cell body size decrease with limited dendritic arbor, reduced binding of GABA and nicotinic receptors in different brainstem nuclei and regions and decreased

FIGURE 7 | Triple hypoplasia of MSO, retrotrapezoid nucleus, and facial/parafacial complex in a SIDS victim 2 month-old. Klüver-Barrera stain. Magnification: 4× F/PFc, facial/parafacial complex; MSO, medial superior olivary nucleus; RTN, retrotrapezoid nucleus.
The high incidence of Purkinje cell loss in cerebellar cortex and in particular the high correlation with the MSO dysmorphology represents an additional point of convergence between sudden perinatal death and autistic disorders. In addition it enhances our assumption of a MSO involvement in breathing, given the fundamental role of the Purkinje cells in eupneic ventilation (Xu et al., 2004).

As we did in our previous studies (Lavezzi et al., 2005, 2007, 2010, 2012a,b), we ascribe once again the neuropathological findings of this study to smoke absorption in fetal life. Prenatal chronic nicotine exposure primarily alters the development of fetal cholinergic and other neurotransmitter systems, so potentially affecting brainstem centers critical to cardiorespiratory and, more generally, all the autonomic functions control (Duncan et al., 2009). The noxious role of multiple neurotoxins in cigarette smoking during and after pregnancy should be taken into account also in the etiology of autism for which currently underlying biological causes remain to be established.

The conclusion of this work is that considerable remodeling takes place in the MSO of sudden death victims, in addition to neurological alteration of brainstem and cerebellum previously highlighted by us (Matturri et al., 2002; Lavezzi et al., 2004, 2010, 2012a,b; Matturri and Lavezzi, 2007; Lavezzi and Matturri, 2008a). This leads to attribute to the MSO more important functions than those well-known related to hearing. However, this hypothesis should be tested in a larger sample of SIUDS/SIDS for a more detailed understanding of the pathogenesis and neurobiology of these syndromes, and ultimately to more effective preventive interventions, given the relationship with prenatal smoke absorption here reported.

**REFERENCES**


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Conflict of Interest Statement: The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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