



# Tensile and flexural moduli for human orbital wall bones – comparative study

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The main aims of the current research were: (1) to analyze in detail the tensile modulus and ultimate tensile strength (UTS) of orbital wall bones separately for the left and right orbit of the same cadaver and (2) to compare the obtained results with a flexural modulus of the left and right orbit reported earlier by A. C. van Leeuwen et al. [14].

A set of 54 specimens of orbital superior and/or medial walls harvested from 16 human skulls (4 female, 12 male) were tensioned at 0.01 mm/s till fracture. The samples were taken always from both orbits of the same cadaver. For each sample, cross-section area, apparent density, tensile modulus, and UTS were identified.

For pooled female and male group apparent density for right and left orbit was identified to be 1.59 ( $\pm 0.52$  SD) g/cm<sup>3</sup> and 1.51 ( $\pm 0.48$  SD) g/cm<sup>3</sup>, tensile modulus of 2028 ( $\pm 1729$  SD) MPa and of 2706 ( $\pm 2812$  SD) MPa, and UTS of 14.17 ( $\pm 15.00$  SD) MPa and of 15.03 ( $\pm 11.44$  SD) MPa, respectively. For tensile tests, there were no statistical differences between the left and right orbit for pooled male and female groups for (a) apparent density (Student's *t*-test  $p = 0.567$ ), (b) UTS (Mann–Whitney *U*-test  $p = 0.350$ ) and (c) tensile modulus (Mann–Whitney *U*-test  $p = 0.716$ ). For bending tests, there were no statistical differences between the left and right orbit for the pooled male and female group for (a) orbital wall thickness (Student's *t*-test  $p = 0.811$ ) and (b) flexural modulus (Mann–Whitney *U*-test  $p = 0.206$ ). The comparative analysis between tensile and flexural moduli for pooled left and right groups (with no distinction for male and female) revealed no statistically significant difference (Mann–Whitney *U*-test  $p = 0.074$ ). The maximum tensile modulus was 7279 MPa and 9913 MPa for the right and left orbit, respectively, and was similar to the maximum flexural modulus of 6870 MPa and 9170 MPa reported in an earlier study, for the right and left orbit, respectively.

*Key words: orbital wall bone, laboratory experiments, tensile modulus, flexural modulus, identification*

## 1. Introduction

For an anatomical reconstruction of the injured orbital wall, a wide range of different materials is used: biological materials (including autogenous materials, allografts or animal-derived materials), metals (especially titanium and cobalt alloys), polymers (polyethylene, silicon, nylon, polylactic acid – PLA, polyglycolic acid – PGA, Polydioxanone – PDS) and composites (like, eg., Titanium/PE, PLA-based polymer sheet, Bone marrow-

-coated PCL scaffolds, etc.). Application of the appropriate implant materials improves patient treatment considerably [6]. The principal role of the implant is to support the orbital content and to restore the orbit contour, especially in larger fractures, thus preserving from the occurrence of enophthalmos and hypoglobus [8], [25]. Therefore, during the reconstruction of the orbital floor, it is of the highest importance to identify a stable zone of bone where the bone graft or the implant can be securely anchored [19]. For patient safety and to avoid additional complicated surgeries, medical

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treatment in orbital zone injuries is more often preceded by numerical calculations based on the patient individual skull model [9], [13]. For instance, due to the blowout trauma, the type of fracture of the orbit bone depends on the mechanism of the orbit loading, which means the tensile loading character for the hydraulic mechanism and bending/compression loading for the buckling mechanism [18]. This issue was comprehensively studied through numerical modeling and clinical observations, and was reported before [27], [28]. For a comprehensive understanding of the mechanics and strength of the orbital wall bones and thus easier manufacturing of the implant or better selection of reconstruction technic, research on mechanical properties of the orbital wall bones is still required. However, the study toward Young's modulus identification is difficult, as the experiments are conducted on non-standardized samples due to large anatomic variations in bone thickness, geometry, and the presence of paranasal sinuses in the craniofacial zone [7]. To omit this problem, it is valuable to conduct and report more research including bending and tensile properties of the orbital wall bones. Only the independent, properly planned and direct experimental strength tests is able to throw light on the real mechanical properties of the interior bones of the human head. The mechanical properties (elastic tensile and bending) of the orbital walls are evidently different from the well-known mechanical properties of long bones or skull outside bones (such as mandibular or maxilla bone, parietal and occipital bones, etc.). Due to its small thickness and in-plane size, the orbital wall bones are difficult to extract for mechanical tests.

The current study aims at providing quantitative data on tensile properties identified for orbital wall bones, thus improving numerical models for adult patients with orbital zone fractures and helping with the selection of the best implant to be used during the anatomical reconstruction of the fractured orbital zone.

## 2. Materials and methods

### 2.1. Sample preparation

Results presented hereby are a part of a larger research carried out before by Żerdzicki et al. [26], where focus was put on the mechanical differences between properties identified for the specimens cut in coronal and sagittal planes. Here, we compare in detail the tensile properties between the left and right

orbit only to enable direct comparison with the similar procedure done by A.C. van Leeuwen et al. [14] for bending tests.

The research was carried out after acceptance from the Independent Bioethics Committee and was performed according to Declaration of Helsinki [1] and the European Union's Directive 2004/23/WE art. 13,15 [23]. Informed consent to use the clinical data was obtained from the family, when possible. The biological material was harvested from 16 cadavers (aged between 35 to 75 years old, 12 male and 4 female). The samples were collected exclusively from patients without any chronic diseases or head injuries and a history indicating pathological fractures, which may have been caused by osteoporosis. The whole orbital wall blocks were collected from cadavers no later than 2–5 days after their death. Specimen blocks were kept hydrated in the 0.9 NaCl solution and frosted at  $-20\text{ }^{\circ}\text{C}$  for a maximum of 36 hours before testing. Then, the samples were defrosted for about 12 hours at room temperature before measurements and mechanical testing. They were gently placed in a specially prepared container, without direct contact with other items and heat sources such as sunlight or heaters to prevent their damage and avoid changing their properties. The sample preparation method was comparable to the procedure proposed by Morgan et al. [16] for mechanical experiments on human vertebra, tibia, and femur.

After defrosting, the specimens were cut out from the superior and medial walls of the orbit. As many as possible bone samples were prepared from one orbit (minimum 1, maximum 3), thus, the final count of the specimens tested was 54. The final specimens had approximately the following dimensions: 7–15 mm wide, 0.7–2.3 mm thick and, 30–40 mm long. There was also a principal rule, that from the left orbit, only samples in the coronal direction were cut and from the right orbit, only samples cut along the sagittal plane were prepared. Then, the apparent density of every specimen was obtained based on the Archimedes principle. The samples were weighed in the dry state with an accuracy of 0.01 G, and their volume was determined by immersing the samples into water and basing them on the change in water level in the measuring glass with an accuracy of 1 ml. The time of immersion was as short as possible, and then the samples were surface-dried with a paper towel and were tested almost immediately.

For the study regarding bending tests upon orbital wall bones [14], two samples were collected from every of 14 fresh-frozen cadaveric heads (12 male and 3 female, aged  $70 \pm 8.3$  years), therefore, the total



number of samples was 28. The samples were cut from the medial part of the orbital floor, the medial of the infraorbital nerve, and the lateral of the medial wall [14]. The reported value of flexural modulus was taken for each patient and with distinction for left and right orbit (Table 3 in [14]).

## 2.2. Mechanical testing

The tests were conducted using the Zwick/Roell Z020 testing machine (Fig. 1). Dedicated machine grips for asymmetric, non-linear-shaped samples were used for the steady fixation of bone fragments at a testing machine. The preload of 10 N was applied, and then the samples were uniaxial tensioned till fracture with 0.01 mm/s crosshead speed. During the test, the elongation of the sample was precisely measured by the

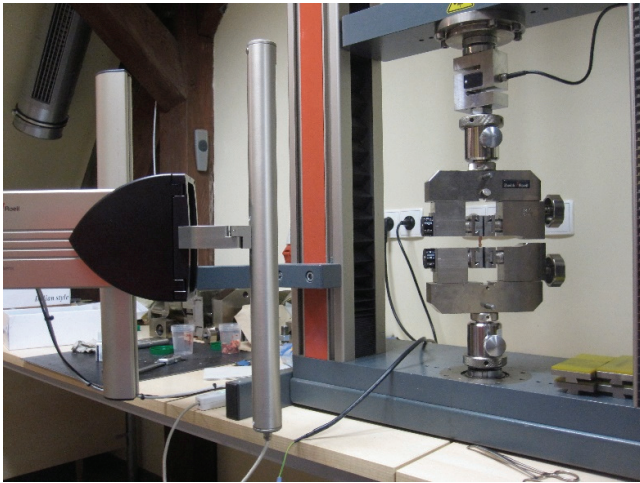


Fig. 1. Experimental stand with the video-extensometer

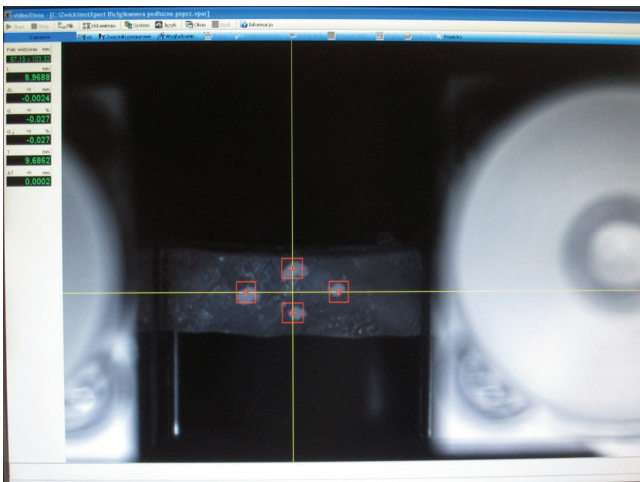


Fig. 2. Video extensometer view on human orbital wall bone sample placed in Zwick Roell Z020 testing machine. Displacement of white markers used for elongation calculation

video extensometer that tracked white markers put on each sample in the central zone of the bone fragment (Fig. 2). The changes of force and elongation were recorded with 10 Hz frequency by TestXpert software of the Zwick/Roell testing stand. No slippage of the samples was observed during the loading. The specimen behavior was almost purely elastic till the fracture, only small plastic effects were noticed. The samples are usually fractured in the middle part of the specimen. The sample did not split into two regular parts, rather the failure had a local character. Right after the sample failure, the specimen was cut in half near the fracture line and the cross-section of both obtained parts was imprinted with ink on the plain not-absorbable fabric material (Fig. 3). Next, the photographs of the imprints close to a ruler were taken and imported to the AutoCAD software to calculate the cross-section area according to the scale given. In Table 1, the mean cross-section area of the left and right imprints of the same specimen is reported for every specimen included in the study.

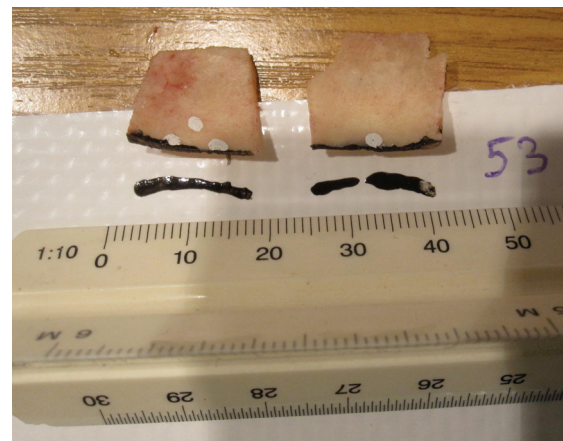


Fig. 3. Orbital wall sample cut in the middle and cross-section of both parts outlined by ink for cross-section area evaluation by AutoCAD software (scale specified by millimetre ruler)

## 2.3. Elastic tensile modulus identification

Firstly, having the force, cross-section area, and elongation change between extensometer markers, the stress and strain values were calculated using the standard formulas. Then, the stress-strain curves were prepared and its beginning linear part up to 0.5% of total strain was approximated by a linear function using the least squares method (Fig. 4). The elastic tensile modulus (usually called Young's modulus) was defined as the slope of the approximation line. The ultimate tensile stress (UTS) was specified as the

greatest stress value registered before the fracture of the sample. The mean value of the particular parameter was calculated for each patient separately with distinction for left and right orbit, as it was reported in the same manner in the previous research [14].

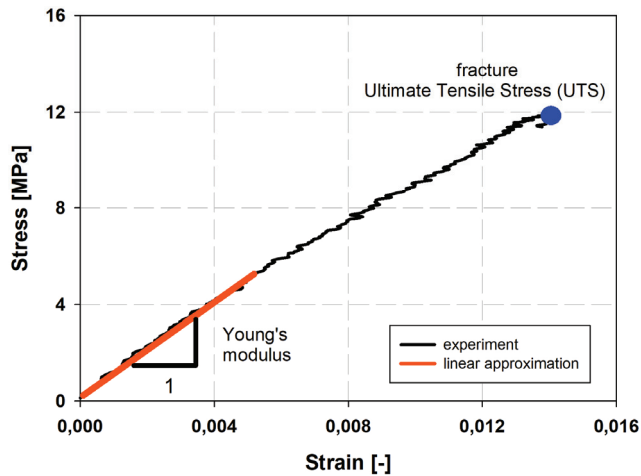


Fig. 4. Exemplary stress–strain graph with parameters analyzed

## 2.4. Statistical evaluation

The statistics of the results acquired in the current research and reported in [14] were realized in SigmaPlot 12.5 software. For both studies separately, the results for female and male specimens were pooled together and divided into left and right orbit groups. As the number of female samples was smaller than the male ones it was pointless to divide the results additionally into female and male groups. The Shapiro–Wilk test was used to assess the normal distribution of the relevant parameters. The Student’s *t*-test was used to

individually compare groups with normal distribution, while the Mann–Whitney *U*-test was used for the individual comparisons between groups with non-normal distribution.

## 3. Results

The bone tissue material was collected from 16 different cadavers (aged between 35 to 75 years old, mean age  $56.7 \pm 9.9$  years old, 14 males and 2 females) in the current study and from 14 different cadavers (aged between 55 to 79 years old, mean age  $70.4 \pm 8.4$  years old, 12 males and 2 females) in the previously reported research [14]. The results from the current study including sample mean cross-section area, tensile modulus, and UTS values exhibited non-parametric distribution, therefore minimum, maximum, median, and interquartile range (IQR) values of the parameters are presented in Table 1. The outcomes of the flexural modulus and thickness of the samples tested are presented in Table 3 in [14]. The flexural modulus values also exhibited non-parametric distribution with a median of 2555 MPa and IQR of 1260–4550 MPa [14].

The comparative analysis of the elastic modulus obtained from uniaxial tensile tests and three-point bending tests is enclosed in Table 2. For tensile tests, there were no statistical differences between the left and right orbit for pooled male and female groups for (a) apparent density (Student’s *t*-test  $p = 0.567$ ), (b) UTS (Mann–Whitney *U*-test  $p = 0.350$ ) and (c) tensile modulus (Mann–Whitney *U*-test  $p = 0.716$ ). For bending tests, there were no statistical differences between the left and right orbit for the pooled male and female

Table 1. Identification results of all specimens included in the current study [26]

Specimen	Sex	Age [years]	Side	Average cross-section area [mm <sup>2</sup> ]	Density [g/cm <sup>3</sup> ]	Density mean for side [g/cm <sup>3</sup> ]	UTS [MPa]	UTS mean for side [MPa]	Tensile modulus [MPa]	Tensile modulus mean for side [MPa]			
1	2	3	4	5	6	7	8	9	10	11			
1	M	62	right	10.8	1.66	1.34	2.99	4.26	1617	1574			
			right	25.5	1.42		5.36		1899				
			right	19.8	0.95		4.42		1206				
			left	28.2	1.60		1.45		5.95		6.40	1109	3708
			left	12.9	1.30		6.85		6307				
2	M	60	right	14.9	2.00	1.53	26.74	19.03	2982	3309			
			right	22.0	1.07		11.32		335				
			left	23.3	1.42		1.29		17.80		10.65	5072	3362
			left	31.3	1.15		3.51		1651				



1	2	3	4	5	6	7	8	9	10	11
3	M	49	right right left left	18.1 28.0 26.7 48.6	1.28 1.55 1.49 1.33	1.41	4.72 5.71 17.00 13.14	5.22 15.07	1452 2057 1555 1459	1754 1507
4	M	49	right left left	31.0 27.5 59.1	1.69 1.52 1.68	1.69 1.60	2.83 8.81 1.14	2.83 4.98	363 455 541	364 498
5	M	42	right left left	11.2 41.5 33.7	2.32 1.75 1.56	2.32 1.65	6.75 20.83 29.68	6.75 25.25	298 2193 6408	298 4301
6	M	35	right right left left	13.2 13.8 12.4 4.4	1.48 1.50 1.50 1.71	1.49 1.60	24.90 49.80 32.16 24.52	37.35 28.34	4978 3216 9913 1049	4097 5481
7	M	54	right right left left	23.6 9.1 31.2 27.5	1.91 1.60 1.47 1.40	1.75 1.43	14.47 11.37 16.12 16.62	12.92 16.37	983 3020 5634 25021	2002 4068
8	M	59	right left	30.8 16.5	2.00 2.04	2.00 2.04	11.88 40.77	11.88 40.77	829 8962	829 8962
9	M	75	right left left	12.4 29.4 13.7	2.18 1.30 1.68	2.18 1.49	4.65 5.16 8.37	4.65 6.77	875 1042 1087	875 1065
10	M	50	right right left	22.2 19.0 19.4	1.44 2.20 0.59	1.82 0.59	32.72 29.16 26.90	30.94 26.90	7279 3030 2700	5154 2700
11	M	64	right left	52.2 53.5	2.09 2.98	2.09 2.98	5.00 7.50	5.00 7.50	888 2061	888 2061
12	F	62	right right left left	17.0 16.6 20.5 22.7	0.66 1.06 1.42 1.19	0.86 1.30	2.79 2.02 1.70 1.96	2.41 1.84	343 893 812 252	618 532
13	F	54	right left	16.3 33.9	2.20 2.00	2.20 2.00	1.12 0.43	1.12 0.43	996 114	996 114
14	F	66	right left left	13.3 23.0 21.3	0.62 1.71 2.20	0.62 1.95	60.02 34.60 30.11	60.02 32.36	5444 3131 6386	5444 4759
15	F	64	right right left left	25.7 45.0 22.1 20.5	1.87 1.39 1.42 1.08	1.63 1.25	5.04 5.44 7.63 14.67	5.24 11.15	2378 1891 216 325	2135 270
16	F	63	right right right left	9.8 27.5 13.4 12.7	2.00 2.26 0.62 0.40	1.63 0.40	27.02 8.98 15.34 11.78	17.11 11.78	1032 976 204 126	737 126
		60 ± 10			1.55 ± 0.50 median 1.51 IQR 1.30 -1.93		median 10.15 IQR 4.93 -24.62		median 1507 IQR 863 -3055	

group for (a) orbital wall thickness (Student's *t*-test  $p = 0.811$ ) and (b) flexural modulus (Mann–Whitney *U*-test  $p = 0.206$ ). The comparative analysis between tensile and flexural moduli for pooled left and right groups (with no distinction for male and female) revealed no statistically significant difference (Mann–Whitney *U*-test  $p = 0.074$ ). There were only two samples with flexural moduli identified for females, thus it

was not possible to perform comparisons between genders.

The minimum values for left and right orbit are much lower for tensile modulus (115 MPa and 204 MPa, respectively) than for flexural moduli (790 MPa and 670 MPa, respectively), but the maximum values for tensile modulus (9913 MPa and 7279 MPa, respectively) and flexural modulus: (6870 MPa and 9170 MPa,

Table 2. Comparison between flexural [14] and tensile modulus (current study) for the left and right human orbit

Parameter	Flexural modulus [1] [MPa]			Tensile modulus [MPa]		
	Left	Right	Pooled (left + right)	Left	Right	Pooled (left + right)
Minimum	670	790	670	115	204	115
Maximum	9170	6870	9170	9913	7279	9913
Median	2180	3185	2555	1555	1452	1507
IQR	775–3850	1980–4660	1260–4550	540–5072	888–3019	863–3055

respectively) are very similar. The median for the left and right sides is almost identical for the tensile modulus (1555 MPa and 1452 MPa, respectively), while for the flexural modulus, the dispersion is much higher (3185 MPa and 2555 MPa, respectively).

## 4. Discussion

Floor and medial orbital wall zones remain the most common locations of all orbital fractures [2], [5]. For a reconstruction of the fracture, a computer-assisted approach including patient-specific anatomical modeling and custom-made implant fabrication is still being developed to produce the individually ideal implant in regards to geometry and material parameters [4]. Computer-aided design (CAD), computer-aided manufacturing (CAM), and computer-aided analysis (CAE) technologies already demonstrated significant advantages in implant reconstruction of facial and cranial bones [3], [4]. It allows not only for the design and manufacturing of the final implant by 3D printing [10] or mould performed [3] technology but also for precise evaluation of the injury pattern with its range and exact measurements of the orbital volume and its pathological or induced changes [4], [27]. One of the most often performed is the finite element (FE) modeling which is willingly used for biomechanical analysis of different head region traumas. Numerical modeling always requires geometry, which is usually taken from computer tomography, and material properties of the implant and human tissues where the implant is to be anchored. When it comes to the surgery technic, it is also stated that improvement of endoscopic sinus and skull base surgery (ESSBS) with virtual reality simulators (VRS) is to be based on the biomechanical research on skull base tissue [7], where the orbital wall bone need special attention. This technique involves hepatic feedback which is a powerful tool [11] but still needs more data, especially the Young's modulus of the human tissues to work properly during surgery.

There are several studies concerning the mechanical properties of the human head, where different testing approaches were implemented, including static bending tests [24], dynamic bending tests [2], [17], as well as indentation [15], nanoindentation and  $\mu$ CT measurements [17]. However, these studies were limited to the facial [21] and cranial [2], [17], [24] bones only. For numerical calculations of the inner bones of a human head usually, the approximated properties of the outer bones are taken [18] or the parameters obtained by Hounsfield unit recalculation based on CT scans of the human skull [20]. The authors of the current study are involved in the comprehensive analysis of the blowout trauma and accompanying fracture mechanisms, therefore they started extended numerical simulations and some preliminary laboratory testing toward mechanical properties of the human orbital wall bones [27], [28]. Appropriate modeling of the eyeball is an inseparable and very sophisticated aspect of the orbit region traumas [12], [22] as well.

To develop the state of the art and for a better understanding of the orbital zone biomechanics, the current paper provides new results on the tensile modulus of orbital wall bones and compares the results concerning elastic modulus identified in two different ways, based on uniaxial tensile tests and three-point bending tests [14]. The results of flexural and tension moduli are very close when comparing values of maximum moduli and very comparable in the IQR values, which confirms the correctness of the performed laboratory experiments and tensile modulus identification.

The presented results of apparent density, wall thickness, tensile modulus, flexural modulus, and UTS show no statistical dependency on the side of the human head and the sex of patients.

Among the limitations of the current study, the difficulty of getting a regular and repetitive shape of the finally tested samples should be mentioned. However, it is impossible to get better samples from the human orbital zone due to its irregular, curved shape according to the complicated anatomy of this region. Next, the diversification of results due to age was also omitted,

as most of the patients were above 50 years old and it was not possible to get samples from younger donors. Another drawback was the application of only four markers followed by a video-extensometer for specimen deformation analysis, instead of a more comprehensive DIC method. Unfortunately, the experimental laboratory was not equipped with a DIC system at the time of this research. The comparative analysis between tensile and bending properties of the orbital wall bones could be also more comprehensive, however, this kind of experiment is very rare, and studies regarding the bending mechanical tests are not widely reported.

Upon the assumption that the flexural and tensile modulus should be similar in the range of small deformations, the obtained from the current research study results of the tensile modulus can be used for the calculation of the implant based on the mathematical model presented in [14]. It is of the greatest importance to continue numerical modeling and computer simulations of the orbital wall region injuries, as the consensus of the best technique for repairing the medial wall fractures has not been achieved yet.

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## Conflict of interests

The authors declare that there is no conflict of interest regarding the presented research.

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