Hemodynamic Effects of Middle Cerebral Artery Stenosis and Occlusion

Colin P. Derdeyn, William J. Powers, and Robert L. Grubb Jr

BACKGROUND AND PURPOSE: Middle cerebral artery (MCA) stenosis and occlusion may cause ischemic symptoms through both hemodynamic and embolic mechanisms. The purpose of this investigation was to determine the hemodynamic effects of these lesions.

METHODS: Ten patients with angiographically confirmed symptomatic occlusion (n = 5) or stenosis (n = 5) of the M1 segment of the MCA were studied by clinical examination, arteriography, and positron emission tomography (PET). Arterial supply to the distal MCA territory was classified from a review of the angiogram as being through the stenosis or from pial collaterals from anterior or posterior cerebral arteries. Regional measurements of cerebral blood flow, cerebral blood volume, cerebral rate of oxygen metabolism, oxygen extraction fraction, and ratio of cerebral blood volume/cerebral blood flow (mean vascular transit time, MTT) were obtained using PET. Hemodynamic status was categorized from PET scans as stage 0, normal hemodynamics; stage 1, autoregulatory vasodilatation (increased MTT); or stage 2, increased oxygen extraction fraction.

RESULTS: Of five patients with MCA occlusion, three had autoregulatory vasodilatation (stage 1) and two had increased oxygen extraction fraction distal to the lesion (stage 2). The MCA territory was supplied solely by pial collaterals in all five patients. Four of the five patients with focal MCA stenosis had normal hemodynamics (stage 0). One patient had stage 1 hemodynamic status. Blood flow to the MCA territory was through the stenosis in all patients; no pial collaterals were identified.

CONCLUSION: The frequency of hemodynamic compromise in patients with MCA occlusion is high. Pial collateralization is not a specific sign of increased oxygen extraction fraction in patients with MCA occlusion.
velocity at rest and after a vasodilatory stimulus. An absent or diminished response indicates autoregula-
tory vasodilatation. The second method relies on quan-
titative measurements of resting CBF and cere-
bral blood volume (CBV). CBV increases with auto-
regulatory vasodilatation and the CBV/CFB ratio (the mean vascular transit time [MTT] of red cells) also increases.

When autoregulatory vasodilatation is not ade-
quate to maintain normal CBF, CBF begins to fall. In
this situation, the brain can increase the amount of
oxygen it extracts from the blood (oxygen extraction
fraction [OEF]) to maintain normal cerebral oxygen
metabolism (CMRO₂) (9). This stage (stage 2) of
hemodynamic compromise has been termed “misery
perfusion” (10). At present, the measurement of OEF
is possible only with positron emission tomography
(PET).

A better understanding of the hemodynamic con-
sequences of intracranial stenosis and occlusion may
help provide a more rational basis for treatment de-
cisions or future clinical trials. We undertook this
review of PET examinations of patients with middle
cerebral artery (MCA) stenosis and occlusion in or-
der to evaluate the hemodynamic consequences of
these lesions.

Methods

Subjects

We selected from our laboratory records all PET studies of
regional cerebral blood flow (rCBF), regional cerebral blood
volume (rCBV), regional cerebral rate of oxygen metabolism
(rCMRO₂), and regional oxygen extraction fraction (rOEF)
 obtained in patients with either MCA stenosis or occlusion. All
patients had acute or chronic ischemic symptoms and were
being examined for possible extracranial-intracranial (EC/IC)
bypass. All patients had arteriographic evidence of MCA ste-
nosis or occlusion. PET studies performed after EC/IC bypass
were excluded. PET studies in two patients could not be quan-
titatively processed for technical reasons. A study in one pa-
tient with multiple sites of intracranial stenosis subsequent to
external-beam radiation therapy of the pituitary region was
excluded. This left 11 PET studies obtained in 10 patients
between 1981 and 1986. All patients had at least one cerebral
angiogram prior to the PET examination. Presenting symptoms
and neurologic findings at the time of the PET scan were
recorded.

PET studies were also performed in 17 healthy volunteers
aged 18 to 30 years. The volunteers were recruited by public
advertisement, and none had a history or evidence of neuro-
logic disease. Informed written consent was obtained from
each subject before the PET measurements. All protocols were ap-
proved by the Human Studies Committee and the Radioactive
Drug Research Committee of Washington University School of
Medicine.

Arteriograms

All arteriograms were reviewed by an investigator before the
PET study. All studies were carotid only or carotid and verte-
bral selective cut-film arteriograms, obtained in two or more
planes of view. Stenoses were measured as a percentage of
narrowing relative to the normal distal lumen. The location of
occlusion or stenosis was assigned by using conventional arte-
riographic terminology: M1, sphenoidal segment (from the
origin to the sylvian fissure); M2, insular segment; M3, oper-
cular segment; and M4, cortical segment. Supply to the distal
MCA territory was categorized as being through the stenosis or
from pial collaterals from anterior and posterior cerebral ar-
teries.

PET Studies

Regional measurements of CBF, CBV, and OEF were per-
formed on a PET VI tomograph in the low-resolution mode
with a reconstructed transverse resolution of 15 mm full width
at half-maximum intensity (17). This tomograph collects seven
parallel sections 1.4 cm apart (14-mm section thickness). After
the patient was positioned on the scanner gantry, an individu-
ally molded thermoplastic face mask was applied to ensure that
the head remained in a constant position during the scanning
period. The exact position of the patient’s head relative to the
scanning plane was recorded on a lateral skull film obtained
after head immobilization. Venous and arterial catheters were
placed for intravenous radiotracer administration and for ar-
terial blood gas analyses and arterial time-activity curve deter-
mination, respectively (18).

A transmission scan was obtained before radiotracer admin-
istration using a germanium-68/gallium-68 ring source. The
skull film and attenuation data from this scan were used to
define the limits of the calvaria for quantitative processing of
PET data. Each PET study consisted of three separate physi-
ological studies. During each, arterial blood samples were
drawn by hand in order to convert quantitative regional radio-
activity data to quantitative physiological measurements. CBF
was measured using a bolus intravenous injection of oxygen-
15–labeled water (18, 19). CBV was measured by inhalation of
air containing trace amounts of carbon monoxide labeled with
oxygen-15 (20). After the patient took one or two breaths of the
oxygen-15–labeled air, OEF was measured in combination with
data from the CBV and CBF measurements (21). The PET
scans were converted to quantitative measurements of these
parameters on a voxel-by-voxel basis. CMRO₂ was calculated
as the product of OEF, CBF, and arterial oxygen content (21).
The entire PET examination could be performed within 1 hour
because of the short half-life (123 seconds) of oxygen-15. All
radioisotopes were produced in the cyclotron facility of our
institution (22).

Data Analysis

For each physiological PET study, seven 1.43 × 1.43-cm
regions of interest were placed in the cortical territory of the
MCA in each hemisphere using stereotactic coordinates (23,
24). Areas of prior infarction were identified by review of
CMRO₂ images as well as CT scans. CT studies were obtained
in all patients. Neither the regions within these infarcted areas
nor the corresponding contralateral regions were used for anal-
ysis. The mean vascular transit time (MTT) was calculated as
the CBV/CMRO₂ ratio for each of the seven regions of interest.
The mean hemispheric values of CBF, CBV, CMRO₂, OEF,
and CBV/CBF ratio were then calculated.

The hemodynamic status of the cerebral circulation in the
hemisphere ipsilateral to the symptomatic MCA lesion was
determined on the basis of the CBV/CMRO₂ ratio and the rOEF,
as described previously (8). Ratios outside the normal range
obtained from the 17 healthy subjects were considered to be
abnormal (8). Hemodynamic status was classified into three
stages according to the PET data. Stage 0 (normal): normal
CBF/CBF and OEF ratios; stage 1 (autoregulatory vasodilata-
tion, normal flow): increased CBV/CBF ratio, normal OEF
ratio; and stage 2 (reduced flow): increased CBV/CBF and
OEF ratios (8).

Results

The range of left-to-right hemispheric ratios for the
17 healthy subjects were as follows: CBF, 0.902 to
### TABLE 1: Middle cerebral artery stenosis

<table>
<thead>
<tr>
<th>Patient No.</th>
<th>Age, y/</th>
<th>Sex</th>
<th>Symptoms</th>
<th>Time of Most Recent Symptom Relative to PET, days</th>
<th>Degree of M1 Stenosis at Angiography, %</th>
<th>Time Relative to PET, days</th>
<th>Associated Lesions</th>
<th>MCA Supply</th>
<th>Time to Repeat Angiography</th>
<th>CT Findings</th>
<th>Time Relative to PET, days</th>
<th>Hemodynamic Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>60/F</td>
<td>TIA</td>
<td>TIA</td>
<td>−3</td>
<td>50L</td>
<td>−2</td>
<td>40% L ICA stenosis</td>
<td>M1</td>
<td>−2 wk/NC</td>
<td>Normal</td>
<td>−14,0</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>82/M</td>
<td>TIA</td>
<td>TIA</td>
<td>−92</td>
<td>50R</td>
<td>−91</td>
<td>Diffuse mild intracranial stenoses</td>
<td>M1</td>
<td>None</td>
<td>Normal</td>
<td>−91</td>
<td>0</td>
</tr>
<tr>
<td>5</td>
<td>52/M</td>
<td>TIA</td>
<td>TIA</td>
<td>−4</td>
<td>83L</td>
<td>−2</td>
<td>None</td>
<td>M1</td>
<td>+2 wk/NC</td>
<td>Normal</td>
<td>−2</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>64/F</td>
<td>CI</td>
<td>TIA</td>
<td>−29</td>
<td>80R</td>
<td>−27</td>
<td>40% R ICA stenosis</td>
<td>M1</td>
<td>None</td>
<td>Lacunar infarction</td>
<td>−37, +11</td>
<td>0</td>
</tr>
<tr>
<td>7</td>
<td>37/M</td>
<td>CI</td>
<td>CI</td>
<td>−15</td>
<td>70L</td>
<td>−1</td>
<td>None</td>
<td>M1</td>
<td>−1 mo, 20% L M1</td>
<td>Normal</td>
<td>−12</td>
<td>0</td>
</tr>
</tbody>
</table>

Note.—ICA, internal carotid artery; NC, no change; TIA, transient ischemic attack; CI, cerebral infarction.

### TABLE 2: Middle cerebral artery occlusion

<table>
<thead>
<tr>
<th>Patient No.</th>
<th>Age, y/</th>
<th>Symptoms</th>
<th>Time of Most Recent Symptom Relative to PET, days</th>
<th>Time of Arteriography Relative to PET, days</th>
<th>Associated Lesions</th>
<th>MCA Supply</th>
<th>Repeat Angiography</th>
<th>CT Findings</th>
<th>Time Relative to PET, days</th>
<th>Hemodynamic Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>49/F</td>
<td>TIA</td>
<td>−2</td>
<td>0</td>
<td>None</td>
<td>ACA (pial)</td>
<td>+2 mo/NC</td>
<td>Normal</td>
<td>−19, −6</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>35/M</td>
<td>CI</td>
<td>−16</td>
<td>−9</td>
<td>Mild proximal MCA stenosis</td>
<td>ACA/PCA (pial)</td>
<td>+2 wk/NC</td>
<td>Parietal/occipital</td>
<td>−14</td>
<td>2</td>
</tr>
<tr>
<td>8</td>
<td>59/M</td>
<td>CI</td>
<td>−57</td>
<td>−1</td>
<td>None</td>
<td>ACA/PCA (pial)</td>
<td>+1 mo/NC</td>
<td>Putamen/internal capsule</td>
<td>−2, +27</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Repeat</td>
<td></td>
<td>−92</td>
<td>−35</td>
<td>None</td>
<td>ACA/PCA (pial)</td>
<td></td>
<td></td>
<td>−35</td>
<td>2</td>
</tr>
<tr>
<td>9</td>
<td>51/F</td>
<td>CI</td>
<td>−270</td>
<td>−270</td>
<td>25% opposite CCA</td>
<td>ACA/PCA (pial)</td>
<td>None</td>
<td>Putamen and posterior temporal</td>
<td>−15</td>
<td>1</td>
</tr>
<tr>
<td>10</td>
<td>44/M</td>
<td>CI</td>
<td>−3</td>
<td>0</td>
<td>None</td>
<td>ACA (pial)</td>
<td>None</td>
<td>Central sulcus</td>
<td>−3, −2</td>
<td>1</td>
</tr>
</tbody>
</table>

Note.—CCA, common carotid artery; ACA, anterior cerebral artery; PCA, posterior cerebral artery; NC, no change; TIA, transient ischemic attack; CI, cerebral infarction.
The clinical, angiographic, and CT characteristics and the hemodynamic stage for each patient are given in Tables 1 and 2. All patients had either stenosis (n = 5, Table 1) or occlusion (n = 5, Table 2) of the M1 segment of the symptomatic MCA. No significant proximal ICA stenosis was observed in either group. The pattern of flow to the MCA territory beyond the lesion was through the stenosis in all patients with stenoses. Pial collaterals from the anterior cerebral artery or both the anterior and posterior cerebral arteries supplied the cortical territory of the MCA in all patients with occlusion. Repeat arteriography was obtained in three of the five patients with stenosis. The stenotic lesion remained stable in two patients and regressed from 70% to 20% in the third. Three patients with MCA occlusion underwent repeat arteriography. No evidence of interval recanalization was observed. The intervals between each patient’s most recent symptom, cerebral arteriogram, CT scan, and PET scan are given in Tables 1 and 2.

The hemispheric mean values and left-to-right ratios of CBF, CBV, MTT, CMRO2, and OEF for each patient are shown in Table 3. Only one of the five patients with symptomatic M1 stenosis had PET evidence of hemodynamic compromise (Fig 1). None of the patients with MCA occlusion had normal cerebral hemodynamics. The CBV/CBF ratio was elevated in three patients with normal CBF and OEF (hemodynamic stage 1). Ipsilateral OEF and CBV/CBF ratios were elevated beyond the normal range in the remaining two patients (hemodynamic stage 2).

### Discussion

These data raise several important points. First, they show that the presence of occlusion in the MCA is frequently associated with hemodynamic impairment of the distal cerebral circulation. Stage 1 or 2 hemodynamic compromise was observed in the distal MCA territory in all six PET studies of the five patients with MCA occlusion. This is not the case for extracranial atherosclerotic carotid stenosis and occlusion. The availability of circle of Willis and external carotid to internal carotid collaterals often provides normal perfusion pressure distal to an occluded or stenotic ICA. Only pial or meningeal to pial collaterals are available in patients with MCA occlusion, however; and the present data indicate that pial collaterals are not adequate to maintain normal cerebral hemodynamics.

Second, the presence of pial collateralization may not be associated solely with stage 2 hemodynamic compromise. In a study by Powers et al (8) of 19 patients with extracranial carotid stenosis or occlusion, pial collaterals were observed only with increased OEF in the MCA territory (hemodynamic stage 2). In the present study, stage 2 hemodynamic compromise was seen on two of six PET examinations in five patients with MCA occlusion. The remaining four studies revealed only increased MTT ratios and
normal OEF ratios (stage 1). All five patients had arteriographic evidence of pial collateralization. One explanation for this apparent discordance is the small sample size in the data presented by Powers et al (four patients with increased OEF and eight patients with autoregulatory vasodilatation) (8).

The third point raised by this data is the relative infrequency of hemodynamic compromise observed in the patients with symptomatic MCA stenosis. Only one of the five patients had evidence of distal autoregulatory vasodilatation. However, MCA stenosis can be quite dynamic (25–28). Three patients with MCA stenosis underwent repeat arteriography to confirm the stability of their lesions. The only patient with MCA stenosis and hemodynamic abnormality (patient 5) was studied within days of symptom onset. Repeat angiography 2 weeks later confirmed the stability of the lesion. The degree of stenosis in one patient who had repeat imaging (patient 7) improved from 70% before the PET examination to 20% 1 month later. Therefore, the actual degree of stenosis at the time of PET examination in three of five patients with MCA stenosis is not certain.

These data add support to the hypothesis that many ischemic events caused by MCA stenosis are embolic in nature. Embolism from MCA stenosis has been documented (6, 7). EC/IC bypass, which improves cerebral hemodynamics, is detrimental to patients with MCA stenosis. In one study (29), 50 patients with MCA stenosis treated with EC/IC bypass experienced a statistically significant increase in subsequent stroke as compared with 59 patients treated with aspirin (22 versus 14; Mantzel-Haenszel χ²-test, 4.74). On the other hand, recent data from a study designed to monitor patients for emboli suggest that hemodynamic factors may be important, particularly in long-standing rather than acute disease (5). These investigators used transcranial Doppler sonography to monitor 58 patients with 78 chronic MCA stenoses (mean follow-up period, 53 months) for microembolic signals. They found no sonographic evidence of emboli during 30 minutes of monitoring in each patient and concluded that hemodynamic factors are most likely responsible for recurrent ischemia in these patients. However, only patients with both high-grade and symptomatic stenoses had recurrent symptoms (n = 11). The number and distribution of patients who were symptomatic were not reported. None of the patients with low-grade or moderate stenosis suffered a transient ischemic attack or stroke.
The results obtained in the present study are also consistent with findings by Sgouropoulos and coworkers (4), who used PET to measure rCBF, rCMRO₂, and rOEF in the distal MCA cortical territory in three patients with MCA occlusion and three with high-grade (>90%) stenosis. Significantly increased rOEF was found in one patient with occlusion and in one with stenosis. rCBF was significantly reduced in all MCA regions of interest in the three patients with occlusion and in one region of interest in two patients with stenosis. No rCBV measurements (or rMTT calculations, consequently) were made, and the arteriographic pattern of collateralization was not reported.

Several important issues regarding the validity of the observations in this report should be mentioned. First, the PET examinations were performed on an older-generation scanner with less resolution than available on more modern equipment. However, large regions of interest, including both gray and white matter, were used in the data analysis for this study. The resolution of the scanner does not affect the accuracy of these quantitative measurements. The issue of interval changes in the degree of stenosis has been discussed above.

Finally, there is evidence that hemodynamic compromise may change over time if no interval stroke occurs. Derdeyn and coworkers (30) studied 22 patients with unilateral carotid artery occlusion by serial PET examinations. Patients with normal cerebral hemodynamics at entry remained hemodynamically normal (n = 9). Selected patients with no interval stroke and increased OEF on entry showed interval improvement in OEF ratios relative to baseline (n = 10, P = .023). These data are consistent with observations from Widder and colleagues (31), who used transcranial Doppler measurements before and after CO₂ challenge. They found that CO₂ reactivity improved in over half their patients (28 of 55) with rCBF in patients with carotid artery stenoses of the MCA and one of the ICA. The chronicity of the lesions in these patients was not described.

Conclusion

The presence of symptomatic occlusion of the MCA was associated with hemodynamic compromise (stage 1 or 2) in all patients studied. This was not the case for patients with ICA occlusion, presumably because of the inability of pial collaterals to maintain normal cerebral hemodynamics. However, pial collateralization does not necessarily indicate exhausted vasodilatory capacity and increased OEF (stage 2 hemodynamic compromise). Finally, symptomatic MCA stenosis was frequently associated with normal cerebral hemodynamics, although the actual degree of underlying stenosis at the time of the PET examination was not known in all patients.

References

22. Welch MJ, Kilbourne MR. A remote system for the routine pro-