Cerebral Microembolism During Cardiac Catheterization and Risk of Acute Brain Injury
A Prospective Diffusion-Weighted Magnetic Resonance Imaging Study

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Background and Purpose—Cerebral microembolism detected by transcranial Doppler occurs systematically during cardiac catheterization, but its clinical relevance remains unknown. Studies suggest that asymptomatic embolic cerebral infarction detectable by diffusion-weighted (DW) MRI might exist after percutaneous cardiac interventions, especially after retrograde catheterization of the aortic valve in patients with valvular aortic stenosis, with a frequency as high as 22% of cases. We investigated the incidence of new ischemic lesions on serial cerebral DW MRI after cardiac catheterization.

Methods—This prospective study involved 46 patients with severe aortic valve stenosis. To assess the occurrence of cerebral infarction, all patients underwent cerebral DW MRI and neurological assessment within 24 hours before and 48 hours after cardiac catheterization and retrograde catheterization of the aortic valve. A subgroup was monitored by transcranial power M-mode Doppler during cardiac catheterization to observe cerebral blood flow and track emboli.

Results—One patient had a focal diffusion abnormality on DW MRI before cardiac catheterization. After catheterization, we detected only 1 additional acute cerebral diffusion abnormality in a single case (2.2%), although cerebral microemboli were detected in all transcranial Doppler–monitored patients during cardiac catheterization, as expected. All patients remained asymptomatic. Based on these results a mid-point incidence of 5.9% (95% CI, 0.01 to 12.5) for abnormalities on DW MRI in asymptomatic cardiac catheterization patients in our center can be assigned.

Conclusions—Unsuspected cerebral infarctions can be detected by DW MRI after cardiac catheterization, but this phenomenon remains unfrequent in our series. Further studies are needed to identify factors explaining the discrepancy between these results and those of previous studies. (Stroke. 2006;37:2035-2038.)

Key Words: cardiac catheterization ■ cerebral embolism ■ diffusion magnetic resonance imaging ■ magnetic resonance imaging ■ ultrasonography, Doppler, transcranial
in the present study after informed consent was obtained. This population represents 76.6% of all the 60 eligible patients screened during the same period in our center. All patients were scheduled for cardiac catheterization because of aortic valve stenosis to assess coronary artery tree and aortic valve disease before surgery. Exclusion criteria were a contraindication to MRI or inability to give written informed consent. Among the 14 patients excluded 4 had unclear echocardiographic findings, 2 had contraindication to MRI and 8 were excluded because of MRI unavailability.

Cardiac Catheterization

All patients were examined clinically and assessed for any history of previous cerebral embolism. Transthoracic echocardiography, 12-lead surface ECG, and coronary angiography were performed for all patients. Cardiac catheterizations were undertaken by expert interventional cardiologists using a standard Seldinger technique using 5 French (F) catheters. Sheaths were removed immediately after the procedure in all patients. We gave 5000 IU of unfractionated heparin intravenously to all patients at the beginning of the procedure. Retrograde catheterization of aortic valve was attempted in a right oblique projection using a long exchange guide wire (0.035 inch, 260 cm length to ensure exchange of the pigtail catheter) using a left amplatz 1 catheter or a right Judkins catheter. During attempts to cross the aortic valve, the wire was regularly withdrawn and cleaned and the catheter flushed every 2 minutes according to Grossman’s recommendations. When the pigtail catheter was placed in the left ventricle, the wire was withdrawn and the catheter vigorously aspirated and pressure measurements performed. After left ventriculography, the catheter was rapidly withdrawn from the left ventricle into the ascending aorta with simultaneous pressure measurements. Maximum and mean pressure gradients were established. We recorded the duration of the whole procedure and fluoroscopic time in all patients.

MRI

MRI was done within 24 hours before and 48 hours after cardiac catheterization. We performed MRI examinations with 1.5 Tesla system (GE Health Care). The imaging protocol included a DW single-shot spin echo echoplanar sequence acquired in the AC-PC (anterior commissure-posterior commissure) plane with 24 contiguous sections (diffusion gradient b values of 0 and 1000 s/mm2, repetition time [TR] 6000 ms, echo time [TE] 120 ms, slice thickness 6 mm with no gap, matrix of 128 x 128 pixels, and field of view of 240 mm); fluid-attenuated inversion recovery (FLAIR; TR/TE 10 000/160 ms, inversion time 2200 ms); and T2-weighted turbo spin echo sequences (TR/TE 3500/94 ms). For DW MRI, the diffusion gradients were successively and separately applied in 3 orthogonal directions for a total acquisition time of 24 seconds. Trace images were then generated and apparent diffusion coefficient maps calculated with a dedicated software tool (FuncTool; General Electric). The image analysis was performed independently by 2 experienced neuroradiologists (Michèle Hamon, C.O.) who were blinded to the clinical data and were unaware of the technical aspects of the angiographic cardiac procedure. For analysis of DW MRI, the neuroradiologists were asked to determine the presence, size, number, and vascular distribution of any focal diffusion abnormalities (bright lesions) which defines them as representing emboli and facilitating exclusion of potential artifacts. In particular, artifacts tend to show significant power signature as representing emboli and facilitating exclusion of potential artifacts. In particular, artifacts tend to show significant power signature as representing emboli and facilitating exclusion of potential artifacts. In particular, artifacts tend to show significant power signature as representing emboli and facilitating exclusion of potential artifacts. In particular, artifacts tend to show significant power signature as representing emboli and facilitating exclusion of potential artifacts.

TCD

TCD studies for this work were performed with the TCD power M-mode Doppler 100 (PMD100, Spencer Technologies) which calculates a power M-mode Doppler image concurrently with a 2-MHz single-gate spectrogram as previously described. Microembolic signals present a unique signature or “track” in the power M-mode Doppler image (slope consistent with the speed of blood flow across the vessel segments in view) which defines them as representing emboli and facilitating exclusion of potential artifacts. In particular, artifacts tend to show significant power signature at all gates simultaneously, whereas true embolic signals have a progression across depth as time changes.

TABLE 1. Baseline Characteristics of the Study Population

<table>
<thead>
<tr>
<th>No. of patients</th>
<th>46</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>27 (59%)</td>
</tr>
<tr>
<td>Age, years</td>
<td>76 ± 8</td>
</tr>
<tr>
<td>BMI, kg/m²</td>
<td>25.8 ± 3.8</td>
</tr>
<tr>
<td>Hypertension</td>
<td>28 (61%)</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>4 (9%)</td>
</tr>
<tr>
<td>Hypercholesterolemia</td>
<td>21 (45%)</td>
</tr>
<tr>
<td>Smokers</td>
<td>18 (39%)</td>
</tr>
<tr>
<td>Family history of CAD</td>
<td>4 (9%)</td>
</tr>
<tr>
<td>Prior stroke</td>
<td>2 (4.5%)</td>
</tr>
<tr>
<td>Associated CAD</td>
<td>28 (61%)</td>
</tr>
<tr>
<td>Atrial fibrillation</td>
<td>12 (27%)</td>
</tr>
<tr>
<td>Mean Doppler gradient, mm Hg</td>
<td>51 ± 14</td>
</tr>
<tr>
<td>AVA, cm²</td>
<td>0.83 ± 0.31</td>
</tr>
<tr>
<td>Invasive LVEF, %</td>
<td>69 ± 13</td>
</tr>
<tr>
<td>No. of catheters used per procedure</td>
<td>3.8 ± 0.7</td>
</tr>
<tr>
<td>Fluoroscopy time, min</td>
<td>5.4 ± 3.0</td>
</tr>
<tr>
<td>Procedure duration, min</td>
<td>16.0 ± 5.0</td>
</tr>
</tbody>
</table>

CAD indicates coronary artery disease; BMI, body mass index; LVEF, left ventricular ejection fraction; AVA, average valve area.
Table 2. Comparison of Recent Studies Exploring Brain Injury Using Serial DW at MRI After Cardiac Catheterization.

<table>
<thead>
<tr>
<th>Study</th>
<th>n</th>
<th>Heparin</th>
<th>Fluoroscopy Time (min)</th>
<th>Catheter Size (French)</th>
<th>Serial DW MRI</th>
<th>New Cerebral Infarction Observed %</th>
<th>New Cerebral Infarction Mid-Point (95% CI)</th>
<th>Indication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Omran 2003</td>
<td>101</td>
<td>5000 IU</td>
<td>6.1/2.9</td>
<td>6 F-7 F</td>
<td>100%</td>
<td>22%</td>
<td>23% [15–31]</td>
<td>Aortic stenosis</td>
</tr>
<tr>
<td>Lund 2005</td>
<td>47</td>
<td>5000 IU</td>
<td>11.3/5.2</td>
<td>6 F</td>
<td>89%</td>
<td>13.5%</td>
<td>15.7% [6–26]</td>
<td>CAD</td>
</tr>
<tr>
<td>Busing 2005</td>
<td>48</td>
<td>2500 IU</td>
<td>10.1/7.4</td>
<td>5 F-6 F-7 F</td>
<td>94%</td>
<td>15%</td>
<td>17% [7–28]</td>
<td>CAD</td>
</tr>
<tr>
<td>Hamon 2006</td>
<td>46</td>
<td>5000 IU</td>
<td>7.0/5.4</td>
<td>5 F</td>
<td>100%</td>
<td>2.2%</td>
<td>5.9%* [0.01–12.5]</td>
<td>Aortic stenosis</td>
</tr>
</tbody>
</table>

CAD indicates coronary artery disease.

*Only 1 new cerebral infarction in our consecutive series of 46 patients was documented (2.2%, observed proportion). The mid-point of the adjusted Wald interval and 95% CI is calculated for all studies. It is noteworthy that by comparison to previous studies a lower rate of new cerebral infarction was documented by DW MRI in our series (P<0.02) and especially by comparison with the results of Omran et al (P<0.002).

Discussion

According to previous studies, the rate of stroke after cardiac catheterization ranges from 0.11% to 0.4%.1–2,15 However, these studies on the risks of cardiac catheterization have included only obvious new neurological deficits as complications. Clinically unapparent damage, related to microscopic air embolism or to thromboembolism, were not taken into account. With the advent of cerebral DW MRI, which is very sensitive in detecting acute ischemic lesions early after onset, it has been shown that asymptomatic embolic events might be far more frequent than the apparent neurological complication rate would indicate.3,4,5,9

Based on a previous study of Omran et al1 in patients with aortic stenosis who had undergone retrograde catheterization of the aortic valve, a 22% rate of silent cerebral infarction was expected in our series of patients. However, in our prospective evaluation including 46 patients and using serial cerebral DW MRI, we identified only 1 asymptomatic patient (2.2%) with such an event in association with retrograde catheterization of the aortic valve.

Other groups have recently documented that silent acute brain injury can also be associated with percutaneous cardiac interventions (PCI), with possible cognitive impairment for patients in whom new lesions are identified on DW MRI.4,5 It seems that only the length of the procedure or the procedural fluoroscopy time can be independently associated with the risk of cerebral infarction in these studies. These 2 parameters are related to the overall influence of the catheter manipulation, including additional periods of time required while the catheter acts as an embolic source; this factor may lead to thrombus formation or affect the vessel wall during manipulation or placement in patient’s vascular system. In addition, as previously assumed, plaque debris broken off from the aorta or the aortic arch, blood clots from the tip of the catheter, or air embolism risk must also be considered in assessing microembolism during heart catheterization. It appears likely that all these well-recognized risks of cerebral embolism for patients who undergo heart catheterization can be related to the duration of the procedure. It is notable that in our study the mean fluoroscopy time needed to cross the aortic valve was shorter than in the study of Omran et al.

All our catheterization procedures were performed at a high-volume center (>3000 diagnostic and 1300 interventional procedures per year) with standard techniques that appear similar to those recently reported and that are associated with a high rate of acute brain injury, as documented by DW MRI.3,4,5 All reported studies (see Table 2) used heparin during the procedure with standard commercially available materials for catheters and contrast media. The only characteristic that could have influenced the results in addition to the length of the procedure is the size of catheters used; in previous studies, catheters were 6 F and sometimes 7 F for PCI. Smaller catheters, such as the 5 F used in all our cases, could have minimized the risk of arterial injury and the source of embolism during retrograde passage of the aortic valve.

Because all cardiac catheterizations are associated with microembolism as detected by TCD (confirmed in our substudy analysis), it has been suggested that most of these microembolisms are likely benign microbubbles.6,7 However, some recent studies have raised the possibility that some microparticles embolized during heart catheterization could be responsible for acute brain injuries.3,4,5 In fact, the most likely sources of embolic material are catheters and guidewires that dislodge atheromatous material from the aortic arch. Visible aortic debris...
may be seen on withdrawal of catheters during PCI cases. Patients with a large atherosclerotic burden in the aorta (such as those with advanced coronary artery disease), as documented by transesophageal echocardiography, have an increased risk of cardiac catheterization-induced stroke.16,17,18 The more extensive coronary artery disease and longer fluoroscopy times identified in previous studies as risk factors for stroke can be considered as surrogate markers of prolonged, complex catheter manipulations in a severely atherosclerotic aorta. It has been shown that patients with cardiac catheterization-induced stroke often have multiple acute lesions (often tiny, cortical, and in different vascular territories) on DW MRI distinct from the occasional symptomatic lesion and consistent with a shower of embolic material. Given the rate of these unsuspected lesions and the potential consequences related to cognitive impairment, other studies are warranted to determine the risk factors associated with these deleterious effects of heart catheterization.

Among potential limitations of the present study one could argue that differences might exist in the interpretation of cerebral DW MRI. Such differences in MR image interpretation between centers seem unlikely because DW MRI has been routinely used for diagnosis of infarcted brain tissue for several years now and all images were evaluated by experienced neuroradiologists. Another issue is related to the delay between the cardiac catheterization and the postprocedural DW MRI. Indeed the optimal time to detect potential ischemic lesions using DW MRI is unknown. However, it has been documented that 24- to 48-hour DW MRI did not increase diagnostic accuracy in any case in which the 2- to 4-hour study was negative suggesting that early assessment could be performed in asymptomatic patients.19 Finally, given the number of high-intensity transient signals observed during each catheterization procedure we cannot exclude diffuse and subtle brain injury undetectable by DW MRI in some cases. The ability of neuropsychological tests to address this specific issue warrants further study.

In conclusion, in this prospective study we confirm that cerebral microembolism as detected by TCD occurs for all patients during cardiac catheterization without correlation with the risk of brain injury. Even after retrograde catheterization of valvular aortic stenosis, new cerebral lesions on DW MRI are infrequent in our center. Further studies are warranted to identify factors—including catheterization methods, pharmacological environment, and selection of materials20,21—that could explain this discrepancy with previous studies. Finally, performing pre- and postprocedure DW MRI could be used to monitor the procedure-related frequency of ischemic lesions and to assess the benefit of changes in practice to improve the safety of cardiac angiography and catheterization.

References

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