Cerebral Blood Flow and Metabolism in Normotensive and Hypertensive Patients With Transient Neurologic Deficits

Kenichiro Fujii, MD, Seizo Sadoshima, MD, Yasushi Okada, MD, Hiroshi Yao, MD, Yasuo Kuwabara, MD, Yuichi Ichiya, MD, and Masatoshi Fujishima, MD

We used positron emission tomography to examine retrospectively the effects of blood pressure on regional cerebral blood flow and oxygen metabolism in seven normotensive and eight hypertensive patients with a history of transient neurologic deficits. In the hypertensive patients, a decrease in regional cerebral blood flow was closely related to blood pressure; these changes were most pronounced in the supratentorial structures, especially the striatum and thalamus. In contrast, the regional cerebral metabolic rate for oxygen was less related to blood pressure. Consequently, the regional oxygen extraction fraction was increased in the hypertensive patients, while regional cerebral blood volume and the regional cerebral blood flow:volume ratio were unchanged. Multivariate regression analysis confirmed that hypertension was an independent factor affecting regional cerebral blood flow. The analysis also disclosed that age, sex, hematocrit, smoking, and PaCO₂ affected regional cerebral blood flow. These findings suggest that the hemodynamic reserve in hypertensive individuals is reduced, which may predispose them to cerebral ischemia and perhaps stroke, even during small decreases in cerebral perfusion pressure. (Stroke 1990;21:283–290)

Cerebral blood flow (CBF) in hypertensive persons is maintained at the same level as in normotensive individuals until significant arteriosclerosis and hypertensive vascular disease develop.¹ ² Using the xenon-133 inhalation method, Rodriguez et al³ recently demonstrated a significant inverse correlation between mean arterial blood pressure (MABP) and mean hemispheric CBF. Structural adaptation of the vascular wall to long-standing hypertension, such as hypertrophy of smooth muscle and proliferation of connective tissue,⁴ ⁵ may play an important role in reducing CBF by encroaching on the arterial lumen. However, the effects of blood pressure on regional cerebral blood flow (rCBF), especially in deep structures such as the striatum and thalamus, or on regional cerebral oxygen metabolism are not yet known.

Persons with histories of transient neurologic deficits are considered to have more advanced vascular changes than asymptomatic individuals and are thought to be susceptible to subsequent cerebral ischemia. In such persons, thorough evaluations of cerebral hemodynamic reserve are needed.

We designed our study to explore retrospectively how blood pressure affects rCBF and cerebral oxygen metabolism measured by positron emission tomography (PET) in patients with transient neurologic deficits. Although the study design has some limitations, several interesting relations between blood pressure and rCBF and cerebral oxygen metabolism were disclosed.

Subjects and Methods

From July 1984 to September 1987, we used PET to examine 96 patients admitted to the Second Department of Internal Medicine at Kyushu University Hospital in Fukuoka City, Japan. Among these 96 patients, we retrospectively studied 17 who were neurologically normal on admission but had histories of transient neurologic symptoms. None of these 96 patients had evidence of head trauma, brain tumor, epilepsy, or valvular heart disease. Two patients with atrial fibrillation were excluded from the study because thromboembolism was considered to be responsible for their neurologic events. Table 1 shows the transient neurologic abnormalities in the remaining 15 patients. Transient central nervous system disorders were considered to be responsible for all neurologic...
<table>
<thead>
<tr>
<th>Pt/age/sex</th>
<th>Transient neurologic deficits</th>
<th>Duration (yr)</th>
<th>Known highest (mm Hg)</th>
<th>Blood pressure (mm Hg)</th>
<th>On admission</th>
<th>On PET study</th>
<th>Electrocardiography</th>
<th>Antihypertensive treatment on admission</th>
<th>Mean scoring points</th>
<th>Brain CT (low-density area)</th>
<th>Angiography</th>
</tr>
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<tbody>
<tr>
<td><strong>Normotensive</strong></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1/66/M</td>
<td>R numbness</td>
<td></td>
<td></td>
<td></td>
<td>158/70</td>
<td>99</td>
<td>S/D MABP</td>
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<td>0.75</td>
<td>L striatum</td>
<td>B ICA and R VA stenosis</td>
</tr>
<tr>
<td>2/61/F</td>
<td>Amnesia</td>
<td></td>
<td></td>
<td></td>
<td>112/74</td>
<td>87</td>
<td>S/D MABP</td>
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<td>0.25</td>
<td>–</td>
<td>–</td>
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<td>132/84</td>
<td>100</td>
<td>S/D MABP</td>
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<td>–</td>
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<td>4/58/M</td>
<td>L numbness</td>
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<td></td>
<td></td>
<td>138/86</td>
<td>103</td>
<td>S/D MABP</td>
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<td>0</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>5/62/F</td>
<td>Amnesia</td>
<td></td>
<td></td>
<td></td>
<td>112/76</td>
<td>88</td>
<td>S/D MABP</td>
<td>None</td>
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<td>–</td>
<td>Arteriosclerosis</td>
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<td></td>
<td></td>
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<td>81</td>
<td>S/D MABP</td>
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<td>0</td>
<td>–</td>
<td>–</td>
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<tr>
<td>7/52/M</td>
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<td></td>
<td></td>
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<td>130/84</td>
<td>99</td>
<td>S/D MABP</td>
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<td>0.25</td>
<td>–</td>
<td>R ICA and L VA stenosis</td>
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<tr>
<td>Mean±SD</td>
<td>59±5</td>
<td></td>
<td></td>
<td></td>
<td>94±8</td>
<td>92±11</td>
<td></td>
<td></td>
<td>0.32±0.31</td>
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<td></td>
</tr>
<tr>
<td><strong>Hypertensive</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8/64/M</td>
<td>Paraparesis</td>
<td>0.5</td>
<td>200/110</td>
<td>150/84</td>
<td>106</td>
<td>136/86</td>
<td>S/D MABP</td>
<td>IIb</td>
<td>None</td>
<td>1.5</td>
<td>L cerebellum</td>
</tr>
<tr>
<td>9/66/F</td>
<td>Amnesia Dyscalculia</td>
<td>0.8</td>
<td>200/110</td>
<td>190/84</td>
<td>119</td>
<td>174/88</td>
<td>S/D MABP</td>
<td>IIb</td>
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<td>1.5</td>
<td>–</td>
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<td>10/71/M</td>
<td>L hemiparesis</td>
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<td>130</td>
<td>140/88</td>
<td>S/D MABP</td>
<td>I–+</td>
<td>Ca 8</td>
<td>1.5</td>
<td>L caudate</td>
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<tr>
<td>11/70/F</td>
<td>Dizziness, dysarthria</td>
<td>5</td>
<td>190/100</td>
<td>156/86</td>
<td>109</td>
<td>142/84</td>
<td>S/D MABP</td>
<td>IIa</td>
<td>None</td>
<td>1.25</td>
<td>–</td>
</tr>
<tr>
<td>12/60/F</td>
<td>Paraparesis</td>
<td>11</td>
<td>Unknown</td>
<td>142/70</td>
<td>94</td>
<td>138/76</td>
<td>S/D MABP</td>
<td>I–+</td>
<td>β-B 10</td>
<td>1.25</td>
<td>–</td>
</tr>
<tr>
<td>13/53/M</td>
<td>Amnesia</td>
<td>6</td>
<td>160/110</td>
<td>128/88</td>
<td>101</td>
<td>134/84</td>
<td>S/D MABP</td>
<td>IIa</td>
<td>None</td>
<td>1.25</td>
<td>B ICA stenosis</td>
</tr>
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<td>14/61/M</td>
<td>Amaurosis fugax</td>
<td>16</td>
<td>180/110</td>
<td>134/88</td>
<td>103</td>
<td>126/74</td>
<td>S/D MABP</td>
<td>IIb</td>
<td>D 16</td>
<td>1.75</td>
<td>B ICA stenosis</td>
</tr>
<tr>
<td>15/65/M</td>
<td>Dizziness, gait disturbance</td>
<td>6</td>
<td>180/90</td>
<td>170/90</td>
<td>117</td>
<td>130/80</td>
<td>S/D MABP</td>
<td>IIa</td>
<td>None</td>
<td>1.5</td>
<td>L striatum</td>
</tr>
<tr>
<td>Mean±SD</td>
<td>64±6</td>
<td></td>
<td></td>
<td></td>
<td>110±12*</td>
<td>102±8</td>
<td></td>
<td></td>
<td>1.44±0.18†</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Pt, patient; S, systolic blood pressure; D, diastolic blood pressure; MABP, mean arterial blood pressure; PET, positron emission tomography; LVH, left ventricular hypertrophy; CT, computed tomography; M, male; F, female; R, right; L, left; +, presence; -, absence of abnormal findings; Ca, calcium antagonist; β-B, beta blocker; D, diuretics; AC, angiotensin-converting enzyme inhibitor; B, bilateral; ICA, internal carotid artery; VA, vertebral artery.

*p<0.01, 0.001, respectively, different from normotensive.
events including amnesias, which were defined as transient global amnesia.

Blood pressure was measured by indirect auscultation with the patient in the supine position after at least 10 minutes of rest (Table 1). Laboratory examination included complete blood cell count and serum chemistries, electrocardiography, chest roentgenography, electroencephalography, and brain computed tomography (CT) (TCT 60A, Toshiba Inc., Tokyo, Japan) in all 15 patients. Digital subtraction angiography (Angiotron, Siemens Inc., Erlangen, FRG) of the neck and brain was taken in 14 patients. We included patients with small low-density areas on CT in our study even though these findings were not responsible for the patients’ transient neurologic symptoms.

The patients were divided into normotensive and hypertensive groups (Table 1) according to the criteria of mean scoring points.6 History of hypertension, blood pressure on admission and during hospitalization, retinopathy graded by Keith-Wagener-Keidai classification, and electrocardiographic findings were scored from 0 to 3 according to severity, and the total score in each patient was divided by the number of items scored. Patients with a mean score of >1 point were defined as hypertensive, and those with a mean score of ≤1 point were defined as normotensive. Hypertension in all patients was considered to be essential hypertension.

Informed consent was obtained from all patients before the PET study. The interval between the transient neurologic symptoms and the PET study was 1–3 months in all patients. rCBF and regional oxygen extraction fraction (rOEF) were measured by the H215O continuous infusion method and the 15O2 continuous inhalation method, respectively, according to the oxygen-15 steady-state technique described by Frackowiak et al.7 Regional cerebral metabolic rate for oxygen (rCMRO2) was calculated as rCMRO2 = rCBF x rOEF x arterial oxygen content. Both rOEF and rCMRO2 were corrected using regional cerebral blood volume (rCBV) measured using a single inhalation of C15O gas.8 We used a HEADTOME-III device (Shimadzu Inc., Kyoto and Akita Noken, Akita, Japan) with planar and axial resolutions of 8.2 mm full-width at half-maximum and corrected for attenuation by means of a transmission scan using an external germanium-68–gallium-68 ring source in each patient. During the PET study, each patient was placed in the supine position with the eyes open and the ears unplugged in a dimly lit room. One femoral artery was cannulated to sample blood for radioactive concentration and blood gases. Arterial blood gases were analyzed at the start and end of each scan.

Five slices (20, 35, 50, 65, and 80 mm above the orbitomeatal line) were obtained and imaged in each scan. Regions of interest 18x14 mm were set on the bilateral cerebral cortical areas (frontal, temporal, parietal, and occipital cortices), the bilateral white matter (centrum semiovale) and deep gray matter (striatum and thalamus), the bilateral cerebellar hemispheres, and the brainstem (Figure 1) using the brain CT image corresponding to each PET slice as a reference. Regions of interest were placed to minimize the partial volume effect and the inclusion of other structures and thus represent each anatomic structure appropriately. Brain CT images were also used to avoid placing regions of interest on either infarcted areas or on the ventricles. The values of all pixels within a region of interest were averaged to demonstrate rCBF, rOEF, rCMRO2, and rCBV. In addition, the average value for all four regions of interest on the cerebral cortices was considered to be the mean value for the cortical measures.

Data are given as mean±SD. We compared average rCBF, rOEF, rCMRO2, rCBV, and the rCBF:rCBV ratio in each region of interest between the normotensive and hypertensive groups using Student’s small-sample t test and Welch’s t test for unequal variances. The relations between MABP on admission or at the PET study and rCBF, rOEF, rCMRO2, and rCBV in each region of interest were evaluated by linear regression analysis. To elucidate the clinical parameters that could influence rCBF, we performed multivariate regression analysis. Parameters were chosen for the multiple regression model by the stepwise forward selection method. We used Paco2 in our analysis.
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rCBF, rCBV, regions of interest, except for brainstem, which are mean±SD for number of patients.

TABLE 3. rCBF, rOEF, rCMRO₂, rCBV, and rCBF/rCBV Ratio in Six Normotensive and Seven Hypertensive Patients With Transient Neurologic Symptoms

<table>
<thead>
<tr>
<th>Supratentorial structures</th>
<th>Cerebral cortices</th>
<th>Deep gray matter</th>
<th>White matter</th>
<th>Infratentorial structures</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frontal</td>
<td>Temporal</td>
<td>Parietal</td>
<td>Occipital</td>
</tr>
<tr>
<td>rCBF (ml/100 g/min)*</td>
<td>N 14</td>
<td>34.4±4.3</td>
<td>32.6±4.4</td>
<td>33.8±6.4</td>
</tr>
<tr>
<td></td>
<td>H 16</td>
<td>30.4±4.7†</td>
<td>30.8±4.8</td>
<td>31.5±4.7</td>
</tr>
<tr>
<td>rOEF</td>
<td>N 12</td>
<td>0.39±0.02</td>
<td>0.39±0.02</td>
<td>0.40±0.03</td>
</tr>
<tr>
<td></td>
<td>H 14</td>
<td>0.43±0.04</td>
<td>0.44±0.05</td>
<td>0.44±0.05</td>
</tr>
<tr>
<td>rCMRO₂ (ml/100 g/min)</td>
<td>N 12</td>
<td>2.47±0.20</td>
<td>2.34±0.24</td>
<td>2.52±0.41</td>
</tr>
<tr>
<td></td>
<td>H 14</td>
<td>2.22±0.31</td>
<td>2.28±0.22</td>
<td>2.32±0.15</td>
</tr>
<tr>
<td>rCBV (ml/100 g)</td>
<td>N 12</td>
<td>3.11±0.78</td>
<td>2.97±0.72</td>
<td>2.80±0.79</td>
</tr>
<tr>
<td></td>
<td>H 14</td>
<td>3.08±0.53</td>
<td>3.23±0.37</td>
<td>3.08±0.71</td>
</tr>
<tr>
<td>rCBF:rCBV</td>
<td>N 12</td>
<td>10.16±5.28</td>
<td>10.10±5.44</td>
<td>11.05±6.12</td>
</tr>
</tbody>
</table>

rCBF, regional cerebral blood flow; rOEF, regional oxygen extraction fraction; rCMRO₂, regional cerebral metabolic rate for oxygen; rCBV, regional cerebral blood volume; n, number of regions of interest; N, normotensive; H, hypertensive. Values are mean±SD for n regions of interest, except for brainstem, which are mean±SD for number of patients.

*Data for seven normotensive and eight hypertensive patients.

† Significant differences at p<0.05, 0.01, respectively, from normotensive.
latter four measures for two patients (one normoten-
sive and one hypertensive) were excluded because of
inappropriate head position during the PET study.
rcBF and rCMRO₂ in the hypertensive group were
lower than in the normotensive group, and the dif-
fERENCE was significant in the frontal cortex for rCBF
and in the striatum and thalamus for both rCBF and
rCMRO₂. In contrast, rOEF in the hypertensive
group was significantly higher than in the normoten-
sive group in all regions except the brainstem. rCBV
in the cerebral cortices and cerebellum were virtually
the same in the two groups. The rCBF:rCBV ratio
was slightly lower in the hypertensive than in the
normotensive group, but the values in both groups
were higher than the 5.5–6.0 thought to be the lower
limit of autoregulation.⁹

Table 4 shows the correlation coefficients (rs) for
rcBF, rOEF, rCMRO₂, rCBV, and the rCBF:rCBV
ratio versus MABP on admission for the two groups
combined. Regions of interest for both hemispheres
were considered. Among the supratentorial struc-
tures, highly significant inverse correlations were
present between rCBF and MABP for all except the
frontal cortex. Similarly, rOEF was significantly
correlated with MABP in all supratentorial structures.
On the other hand, significant but weaker inverse
correlations were observed between rCMRO₂ and
MABP in the temporal and parietal cortices, the
thalamus, and the white matter. rCBV was signifi-
cantly (inversely) correlated with MABP only in the
white matter. The rCBF:rCBV ratio tended to
decrease with rising MABP, but the correlations
were not significant in any region. Among the infra-
tentorial structures, there were no significant corre-
lATIONS between MABP and any of these five mea-
sures. The relations between MABP and rCBF,
rOEF, and rCMRO₂ are shown in Figure 2.

The relation between rCBF and MABP on the day
of the PET study also revealed a highly significant
inverse correlation in the thalamus (r = -0.498,
p<0.01) but not in the other regions.

Table 5 depicts the standardized multiple regression
coefficients for various clinical parameters ver-
sus rCBF. Age, male sex, and hematocrit were neg-
atively correlated with rCBF in the cerebral cortices
and white matter. Smoking was negatively correlated
with rCBF in the cerebral cortices and the thalamus.
MABP was also negatively and strongly correlated
with rCBF in the parietal and occipital cortices, the
striatum, and the thalamus. The correlation between
total cholesterol, triglyceride, or fasting blood sugar
concentrations and rCBF was relatively weak and
differed from region to region. On the other hand,
alcohol drinking was positively correlated with mean
cortical rCBF and with rCBF in the occipital cortex.
There was also a positive correlation between Paco₂
and rCBF in the cortices, the striatum, the white
matter, and the brainstem.

Discussion

There are several limitations to interpreting our
results. The design of our study has its major disad-
vantange in the retrospective selection of patients and
their matching between groups. Multivariate regres-
sion analysis was necessary because we could not
exclude hypertensive patients with other risk factors
for stroke from the study due to the overall limited
number of patients. In addition, lack of magnetic
resonance imaging restricted our information about
underlying tissue changes such as white matter dis-
ease. Finally, our patients had a history of transient
neurologic deficits so our results cannot necessarily
be generalized to asymptomatic hypertensive per-
sons. Even considering these limitations, our study
has disclosed several interesting relations between
blood pressure and regional cerebral circulation and
metabolism.

rcBF was decreased in the hypertensive patients,
and the decrease was closely related to MABP. In
contrast, rCMRO₂ was less closely related to MABP.
Consequently, the brain in hypertensive individuals
eextracts more oxygen from the blood (increased
rOEF) to maintain rCMRO₂, while rCBV and the
rCBF:rCBV ratio were unchanged. In addition,
interesting differences among brain regions were
disclosed. The relations of MABP with brain regions
and rCMRO₂ was pronounced in the supratentorial struc-

Table 4. Correlation Coefficients for rCBF, rOEF, rCMRO₂, rCBV, and rCBF:rCBV Ratio vs. Mean Arterial Blood Pressure on Admission in 13 Patients With Transient Neurologic Symptoms by Brain Region

<table>
<thead>
<tr>
<th></th>
<th>Supratentorial structures</th>
<th>Deep gray matter</th>
<th>White matter</th>
<th>Infratentorial structures</th>
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<tbody>
<tr>
<td></td>
<td>Frontal Temporal Parietal Occipital Mean Striatum Thalamus White matter Cerebellum Brainstem</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>n</td>
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</tr>
<tr>
<td>rCBF* 30</td>
<td>-0.327</td>
<td>-0.580†</td>
<td>-0.521†</td>
<td>-0.570†</td>
</tr>
<tr>
<td>rOEF 26</td>
<td>0.480†</td>
<td>0.626†</td>
<td>0.559†</td>
<td>0.521†</td>
</tr>
<tr>
<td>rCMRO₂ 26</td>
<td>-0.206</td>
<td>-0.424‡</td>
<td>-0.422‡</td>
<td>-0.375</td>
</tr>
<tr>
<td>rCBV 26</td>
<td>-0.006</td>
<td>0.165</td>
<td>0.025</td>
<td>0.106</td>
</tr>
<tr>
<td>rCBF:rCBV 26</td>
<td>-0.234</td>
<td>-0.370</td>
<td>-0.342</td>
<td>-0.328</td>
</tr>
</tbody>
</table>

rcBF, regional cerebral blood flow; rOEF, regional oxygen extraction fraction; rCMRO₂, regional cerebral metabolic rate for oxygen; rCBV, regional cerebral blood volume; n, number of regions of interest. Data are values of r for n regions of interest, except for brainstem, which are values of r for number of patients.

*Data for 15 patients.
†p<0.01, 0.05, respectively, different from 0.
Hypertension has been shown to be an important risk factor for reduced CBF among neurologically normal volunteers\textsuperscript{10} and among patients with transient ischemic attacks.\textsuperscript{11} An autopsy study in Hisayama, Japan,\textsuperscript{12} has shown that cerebral atherosclerosis occurs 20–30 years earlier in hypertensive than in normotensive patients. In stroke-prone spontaneous

![Diagram of relations between mean arterial blood pressure on admission (MAP) and regional cerebral blood flow (rCBF), regional oxygen extraction fraction (rOEF), and regional cerebral metabolic rate for oxygen (rCMRO$_2$) in cerebral cortex, basal ganglia (striatum), thalamus, and cerebellum.](image_url)

**FIGURE 2.** Relations between mean arterial blood pressure on admission (MAP) and regional cerebral blood flow (rCBF), regional oxygen extraction fraction (rOEF), and regional cerebral metabolic rate for oxygen (rCMRO$_2$) in cerebral cortex, basal ganglia (striatum), thalamus, and cerebellum. One region of interest for each hemisphere was considered. n.s., not significant.

**TABLE 5.** Standardized Multiple Regression Coefficients for Clinical Parameters vs. Regional Cerebral Blood Flow in 15 Patients With Transient Neurologic Symptoms

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Cerebral cortices</th>
<th>Deep gray matter</th>
<th>White matter</th>
<th>Infratentorial structures</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frontal</td>
<td>Temporal</td>
<td>Parietal</td>
<td>Occipital</td>
</tr>
<tr>
<td>Age (yr)</td>
<td>-0.580*</td>
<td>-0.404†</td>
<td>-0.822*</td>
<td>-0.686*</td>
</tr>
<tr>
<td>Male sex (yes)</td>
<td>-0.454‡</td>
<td>-0.614*</td>
<td>-0.621*</td>
<td>-0.680‡</td>
</tr>
<tr>
<td>Mean arterial blood pressure (mm Hg)</td>
<td>-0.362†</td>
<td>-0.615*</td>
<td>-0.807*</td>
<td>-0.669*</td>
</tr>
<tr>
<td>Total cholesterol (mg/dl)</td>
<td>-0.234†</td>
<td>0.281‡</td>
<td>-0.406‡</td>
<td>0.321†</td>
</tr>
<tr>
<td>Triglyceride (mg/dl)</td>
<td>0.267†</td>
<td>0.286‡</td>
<td>-0.420‡</td>
<td>0.321†</td>
</tr>
<tr>
<td>Fasting blood sugar (mg/dl)</td>
<td>-0.398‡</td>
<td>-0.493*</td>
<td>-0.673*</td>
<td>-0.878*</td>
</tr>
<tr>
<td>Hematocrit (%)</td>
<td>-0.424‡</td>
<td>-0.455‡</td>
<td>-0.393*</td>
<td>-0.327†</td>
</tr>
<tr>
<td>Smoking (yes)</td>
<td>0.810*</td>
<td>0.650*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drinking (yes)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PacO$_2$ at PET study</td>
<td>0.237†</td>
<td>0.313†</td>
<td>1.183*</td>
<td>0.545†</td>
</tr>
</tbody>
</table>

PET, positron emission tomography. Values are $r$ for 30 regions, except for brainstem, which are $r$ for 15 patients. Only significant values are indicated.

*†‡$p<0.001$, 0.05, 0.01, respectively, different from 0.
ously hypertensive rats, it was suggested that thick-
ening of the arterial wall at the terminal stage of
severe hypertension caused an irreversible and
severe decrease in rCBF. These findings suggest
that rCBF is markedly influenced by structural vas-
cular changes promoted by hypertension. Our
patients had histories of transient signs of neurologic
deficits and were considered to have advanced vas-
cular changes. Thus, our hypertensive patients might
have lower rCBF than asymptomatic hypertensive
individuals.

Interestingly, the correlation between MABP on
the day of the PET study and rCBF was weak and
nonsignificant except in the thalamus. The blood
pressure of hypertensive patients usually falls after
hospital admission, although the mechanism is not
fully understood. Restriction of sodium intake to
137–171 meq/day compared with the Japanese aver-
age daily sodium intake of 222–256 meq/day and bed
rest during hospitalization may be part of the reason
for the decline in blood pressure. Thus, the lack of a
significant relation between rCBF and MABP on the
doctor the day of the PET study seems to be due to narrowing of the
MABP range by a spontaneous decline in blood pressure after hospital admission. The reason why a
significant correlation was observed only in the thal-
amus is unclear.

The above-mentioned reduction in MABP might
reduce cerebral perfusion pressure and CBF in hypertensive individuals in whom the autoregulatory
curve is shifted to the right, especially patients recei-
ving antihypertensive treatment. In such patients with
hemodynamic failure, the cerebral vessels usually
dilate and increased rCBV and a decreased rCBF:rCBV ratio are expected in addition to an
increased rOEF. However, neither rCBV nor the
rCBF:rCBV ratio in our hypertensive group differed
from those in the normotensive group. The absence
of increased rCBV and a decreased rCBF:rCBV ratio despite increased rOEF and similar MABP
during the study in our patients with chronic hyper-
tension rather suggests a baseline narrowing of vessel
lumen, probably due to either advanced arterioscle-
rosis or excess vasoconstriction.

The differences in rCBF and rCMRO₂ between
our normotensive and hypertensive groups were
more pronounced in the deep gray matter, that is, in
the striatum and thalamus, than in the cerebral
cortices. In the deep gray matter, the reduced
rCMRO₂ in the hypertensive group seemed not to be
effectively compensated for in spite of increased
rOEF. The increased rOEF, including measurements
in two hypertensive patients with deep-seated small
lesions proven by CT, minimizes the possible effects
of infarction, where matched hyperperfusion is
expected. The absence of increased rCBV and a
decreased rCBF:rCBV ratio in the deep gray matter
as in the cerebral cortices suggests a minimal con-
tribution of the reduction in MABP after admission in
patients with hypertension to the greater reduction in
rCBF. Also, it is well known that systemic hypoten-
sion and/or arterial occlusive disease in the neck
mainly produce ischemic lesions in arterial border
zone territories and not in the deep gray matter. A
greater reduction of rCBF within the striatum and
thalamus suggests that hypertensive vascular alter-
ations occurred more markedly and selectively with
elevated vascular resistance in the deep structures of
the brain. The striatum and thalamus are the areas
most susceptible to lacunar thrombotic infarction.

Since their small branches are separated directly
from the main trunks of the middle cerebral artery or
the posterior cerebral artery, high intraluminal pres-
sure is conducted directly to the vessel wall, which
may lead to intimal thickening, angioneurosis, and
the formation of fibrous nodules. In contrast, the
relation of MABP with rCBF and rCMRO₂ was
obscure in the infratentorial structures, especially the
cerebellum. Less marked arteriosclerosis in the
cerebellum might account for this finding.

After multivariate regression analysis, strong neg-
ative correlations between MABP on admission and
rCBF were still present in the striatum, the thalamus,
and the parietal and occipital cortices. In several
supratentorial structures, age, male sex, hematocrit,
and smoking habits were negatively correlated with
rCBF. These factors are risk factors for stroke, and
our results suggest that they could also affect rCBF.
In other studies, similar effects of sex and smoking
on CBF are also shown. In our study, there were
more smokers among the hypertensive than among
the normotensive patients. Although this difference
was not significant, it might be responsible in part for
the greater reduction in rCBF in our hypertensive
group. Hematocrit is a major determinant of blood
viscosity and plays an important role in regulating
CBF. Our results also support this concept. Hyperglycemia and hypercholesterolemia are known
risk factors for stroke, but our study did not
reveal any consistent relation between these clinical
parameters and rCBF, possibly because of the few
patients with these abnormalities or the mildness of
these abnormalities. Also, in some brain regions we
could not exclude the effect of PaCO₂, which is a
well-known cerebrovascular regulator.

In conclusion, patients with chronic hypertension
had lower rCBF and higher rOEF than normotensive
patients despite similar perfusion pressures (the
rCBF:rCBV ratio). These findings suggest that hyper-
tensive individuals have reduced hemodynamic reserve and are more susceptible to cerebral ischemia
and perhaps to stroke during small reductions in cerebral perfusion pressure. One implication of these findings is that care should be taken in such individuals to avoid
reductions in cerebral perfusion pressure, especially
during antihypertensive treatment.

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References


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