Thrombotic Occlusion of the Middle Cerebral Artery

Shinsuke Ueda, MD; Kazuhiko Fujitsu, MD; Shigeo Inomori, MD; and Takeo Kuwabara, MD

Background and Purpose: Epidemiological study of middle cerebral artery occlusion is important because the indication for extracranial–intracranial arterial bypass remains in dispute. To help clarify this issue, we investigated the prognosis of thrombotic middle cerebral artery occlusion in Japanese patients.

Methods: We studied 40 patients with thrombotic middle cerebral artery occlusion who were selected on the basis of clinical features, computed tomographic findings, and angiographic findings. Patients with causes of embolism (i.e., cardiomyopathy, valvular heart disease, cardiac arrhythmia, and carotid ulceration) were excluded. The 40 patients were classified into three groups according to the site of middle cerebral artery occlusion: there were 13 patients with occlusion of the proximal portion of the M1 segment, 13 with distal M1 segment occlusion, and 14 with occlusion of the M2 segment.

Results: Good collateral circulation was associated with improved outcomes both clinically and by computed tomography in patients with occlusion of the proximal and distal portions of the M1 segment but not in those with M2 occlusion.

Conclusions: It is reasonable to assume that not only collateral circulation but also the site of occlusion plays an important role in the outcome of middle cerebral artery occlusion. Our finding that good collateral circulation improves the outcome for thrombotic occlusion of the proximal and distal M1 segments supports the possible benefits of such surgery. (Stroke 1992;23:1761-1766)

KEY WORDS • arterial occlusive diseases • cerebral infarction • collateral circulation • thrombosis
Angiographic findings of middle cerebral artery occlusion were classified into three groups. Left panel: Occlusion of the proximal portion of the M1 segment (group A). Center panel: Occlusion of the distal portion of the M1 segment (group B). Right panel: Occlusion of the M2 segment (group C).

Results

Occlusion of the MCA occurred on the left side in 24 patients and on the right in 16. Eleven of the 40 patients had hypertension and had been treated by antihypertensive medications. The prevalence of diabetes mellitus was 8% in this study. Mortality was 10%.

At the onset of stroke, 22 patients (55%) had a mild disturbance of consciousness, but no patients were comatose. Mild hemiparesis was found in 14 patients, moderate hemiparesis in nine, and severe hemiparesis in 17. Two patients (5%) had a transient ischemic attack (TIA), and the remaining 38 patients had a complete stroke. Four patients (10%) had had previous ischemic events in the symptomatic side. Two of these four patients had TIA, and the remaining two had complete stroke.

In 13 patients the MCA was occluded at the proximal portion of the M1 segment. Another 13 patients showed the MCA occluded at the distal portion of the M1 segment, and the remaining 14 had occlusion of the M2 segment. Two patients had mild ipsilateral ICA stenosis of less than 50%.

The degree of hemiparesis of each patient on admission was graded as mild, moderate, or severe using DeJong's definition,\textsuperscript{18} in which mild was defined as normal or movement against gravity and resistance, moderate was movement against gravity with resistance eliminated, and severe was partial movement with gravity eliminated, with a trace of muscle contraction. Outcomes were also graded: good outcome, full work and minimal disability; fair outcome, partial disability; and poor outcome, bed rest, vegetative state, or death. The follow-up period was from 43 days to 4 months (with the exception of four patients who died of complications). Correlations were made between the angiographic site of occlusion, retrograde filling, CT findings, degree of hemiparesis on admission, and outcome.
with hemispheric type findings on CT only two (33%) showed retrograde filling. In the patients with occlusion of the distal M1 (group B), findings on CT were basal ganglia–centrum semiovale in four, localized cortex–subcortical in four, lobular cortex–subcortical in three, hemispheric in one, and normal in one patient. The group B patients with basal ganglia–centrum semiovale type findings on CT showed an LDA in the centrum semiovale but not in the basal ganglia. In the patients with occlusion of the M2 (group C), findings on CT

FIGURE 2. Computed tomographic findings were classified into five categories (see text): basal ganglia–centrum semiovale type; localized cortex–subcortical type; lobular cortex–subcortical type; hemispheric type; and normal type (not shown).

FIGURE 3. Chart showing degree of hemiparesis on admission in relation to site of occlusion, computed tomographic (CT) findings, and retrograde filling. ○, Mild hemiparesis; Δ, moderate hemiparesis; X, severe hemiparesis.
were localized cortex–subcortical type in 10 and normal type in four patients (Figures 3 and 4).

Most patients with severe hemiparesis showed lobular cortex–subcortical and hemispheric type findings on CT. All patients with normal type findings on CT showed mild hemiparesis, and most patients with basal ganglia–centrum semiovale or localized cortex–subcortical type findings on CT had moderate hemiparesis (Figure 3). The degree of hemiparesis on admission was well correlated to the CT findings.

The outcome was rated good in 12 (30%), fair in eight (20%), and poor, including death, in 20 (50%) patients. Four patients (10%) died of complications at the acute stage of the disease. Outcomes of patients in group A and group B were poor. However, the outcome was better in patients in group A and group B with retrograde filling than in those without retrograde filling. Outcomes of patients in group C were generally good irrespective of the presence or absence of retrograde filling (Figure 4). Patients with occlusion of the distal MCA branches to the motor cortex, however, showed poor outcome.

Discussion

Most of the published studies on MCA occlusion have not excluded embolic occlusion. The differential diagnosis between thrombotic and embolic MCA occlusion may be difficult. To improve the reliability of the selection of thrombotic MCA occlusion, patients who had atrial fibrillation or carotid artery ulceration were excluded based on clinical features, CT findings, and angiographic findings.6 It has been reported frequently that embolic MCA occlusion is more common than thrombotic MCA occlusion; Lhermitte et al8 found that only 12.5% of 40 MCA occlusions were due to local thrombosis. However, in the Japanese population thrombotic MCA occlusion is reported to be more common.13

In this study, the mean age of 66.4 was higher than that in other reports.15,21,22,27 The mortality rate of this series was essentially the same as that in the study of Bogousslavsky et al.27 Therefore, age did not have a significant influence on death.27 Male predominance was noted in this series, as in other reports.27,28 Allcock19 reported no laterality of the side of the lesion, although others have reported left side predominance.21 In this series we reported no laterality of the lesion. In our patients, 18 of 40 (45%) had hypertension, and three (8%) had diabetes mellitus resulting in hypertension. Hypertension is an important risk factor in thrombotic MCA occlusion. This finding agrees with other reports.27,29

TIA has been defined as a temporary, focal neurological deficit presumably related to ischemia, lasting less than 24 hours. Only two patients presented with TIA; the remaining 38 patients presented with complete stroke. Caplan et al30 and Sindermann et al34 reported that TIA, as an initial symptom, was more frequently observed in ICA occlusion than in MCA occlusion. Thrombotic MCA occlusion has a more benign effect than embolic MCA occlusion,4,20,21,22 perhaps because the development of collateral circulation is better in gradual thrombotic occlusion than in sudden embolic occlusion. Therefore, although disturbance of consciousness was found in 21 patients (53%), severe disturbance of consciousness as occurs in the case of embolic occlusion was not observed.

In group A, most patients with good retrograde filling showed basal ganglia–centrum semiovale type findings on CT, whereas four of five patients without retrograde filling showed hemispheric type findings on CT (Figures 3 and 4). We offer two possible explanations for the fact that basal ganglia–centrum semiovale type findings oc-
Perforators of M1 segment are most distal to collateral circulation. Center panel: Atherosclerotic changes may involve origin of perforators. Right panel: Paraventricular zone may be supplied by medullary branches (arrows) rising from distal middle cerebral artery (MCA). See text for further discussion.

Outcomes were worse in patients with hemispheric type findings than in patients with basal ganglia–centrum semiovale type findings. In addition to CT findings, presence or absence of retrograde filling appears to affect the outcome and degree of hemiparesis in group A patients. Krayenbuhl and Yasargil,24 Fisher et al,14 and Saito et al29 found that the amount of collateral circulation was intimately related to final outcome. In contrast, Sindermann et al24 noted no correlation between collateral circulation and outcome. In our series, collateral circulation was found to affect outcome in group A and group B patients but not in group C patients. It is reasonable to assume that not only collateral circulation but also the site of occlusion plays an important role in the outcome of MCA occlusion.

Taking MCA distribution into consideration, it is understandable that most of the patients in group B showed localized cortex–subcortical or lobular cortex–subcortical type findings on CT. However, basal ganglia–centrum semiovale type findings on CT were also shown in four patients in group B. LDAs in these four patients were found in the centrum semiovale but not in the basal ganglia. These findings suggest that the centrum semiovale in these patients was supplied by the medullary branches rising from the distal MCA (Figure 5, right panel). Patients in group C showed either localized cortex–subcortical or normal type findings on CT.

No ischemic events occurred in this series, probably because of the short duration of the follow-up period (from 43 days to 4 months). According to Bogousslavsky et al,27 ischemic events during the follow-up period (35–72 months) recurred in only 10% of the patients with isolated MCA occlusion. Therefore, surgical indication for revascularization after thrombotic MCA occlusion should be determined carefully in the chronic stage. If surgical revascularization is regarded as the construction of an artificial collateral circulation, our finding that good collateral circulation improves the outcome for thrombotic occlusion of the proximal and distal M1 segments supports the possible benefits of such surgery.

**Acknowledgments**

We thank Drs. Ilu Kim, Masaharu Oda, and Akihito Saito for referring patients into this study.

**References**

34. Krayenbuhl H, Yasargil G: Der cerebrate kollaterale blutkrceilauf im angiographischen BuitLActa Neuroctur (Wien) 1958;6,10-80
Thrombotic occlusion of the middle cerebral artery.
S Ueda, K Fujitsu, S Inomori and T Kuwabara

*Stroke*. 1992;23:1761-1766
doi: 10.1161/01.STR.23.12.1761

*Stroke* is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 1992 American Heart Association, Inc. All rights reserved.
Print ISSN: 0039-2499. Online ISSN: 1524-4628

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://stroke.ahajournals.org/content/23/12/1761

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published in *Stroke* can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the Permissions and Rights Question and Answer document.

Reprints: Information about reprints can be found online at:
http://www.lww.com/reprints

Subscriptions: Information about subscribing to *Stroke* is online at:
http://stroke.ahajournals.org/subscriptions/