Early $[^{11}C]\text{Flumazenil}/H_2O$ Positron Emission Tomography Predicts Irreversible Ischemic Cortical Damage in Stroke Patients Receiving Acute Thrombolytic Therapy

Wolf-Dieter Heiss, MD; Lutz Kracht, MD; Martin Grond, MD; Jobst Rudolf, MD; Bernd Bauer, PhD; Klaus Wienhard, PhD; Gunter Pawlik, MD

**Background and Purpose**—Central benzodiazepine receptor ligands, such as $[^{11}C]\text{flumazenil}$ (FMZ), are markers of neuronal integrity and therefore might be useful in the differentiation of functionally and morphologically damaged tissue early in ischemic stroke. We sought to assess the value of a benzodiazepine receptor ligand for the early identification of irreversible ischemic damage to cortical areas that cannot benefit from reperfusion.

**Methods**—Eleven patients (7 male, 4 female, aged 52 to 75 years) with acute, hemispheric ischemic stroke were treated with alteplase (recombinant tissue plasminogen activator; 0.9 mg/kg according to National Institute of Neurological Disorders and Stroke protocol) within 3 hours of onset of symptoms. At the beginning of thrombolysis, cortical cerebral blood flow ($[^{15}O]H_2O$) and FMZ binding were assessed by positron emission tomography (PET). Those early PET findings were related to the change in neurological deficit (National Institutes of Health Stroke Scale) and to the extent of cortical damage on MRI or CT 3 weeks after the stroke.

**Results**—Hypoperfusion was observed in all cases, and in 8 patients the values were below critical thresholds estimated at 12 mL/100 g per minute, comprising 1 to 174 cm$^3$ of cortical tissue. Substantial reperfusion was seen in most of these regions 24 hours after thrombolysis. In 4 cases, distinct areas of decreased FMZ binding were detected. Those patients suffered permanent lesions in cortical areas corresponding to their FMZ defects (112 versus 146, 3 versus 3, 2 versus 1, and 128 versus 136 cm$^3$). In the other patients no morphological defects were detected on MRI or CT, although blood flow was critically decreased in areas ranging in size up to 78 cm$^3$ before thrombolysis.

**Conclusions**—These findings suggest that imaging of benzodiazepine receptors by FMZ PET distinguishes between irreversibly damaged and viable penumbra tissue early after acute stroke. *(Stroke. 2000;31:366-369.)*

**Key Words:** flumazenil $\bullet$ ligands $\bullet$ penumbra $\bullet$ stroke, acute $\bullet$ stroke, ischemic $\bullet$ thrombolytic therapy $\bullet$ tomography, emission computed

Therapeutic strategies in acute ischemic stroke are targeted at rescuing from infarction ischemic but potentially viable tissue, known as the “ischemic penumbra.”$^{1-3}$ This is vital because treatment can only be effective as long as tissue has not become necrotic. Of all the treatment efforts tested in controlled clinical trials, only thrombolytic therapy was shown to be effective, but only when initiated shortly after onset of clinical signs of cerebral ischemia.$^{4,5}$ Markers of irreversible tissue damage or indicators of neuronal integrity would be helpful for the selection of patients who might benefit from reperfusion induced by thrombolysis or from other therapeutic approaches, such as neuroprotection. γ-Aminobutyric acid receptors are abundant in the cortex and sensitive to ischemic damage$^{6}$; therefore, specific radioligands to their subunits, the central benzodiazepine receptors, could be used as markers of preserved morphological integrity before initiation of therapy.$^{7}$ Since previous studies have demonstrated that irreversibly damaged cortex can be reliably detected by reduced binding of the labeled benzodiazepine receptor ligand $[^{11}C]\text{flumazenil}$ (FMZ) in experimental focal ischemia$^8$ as well as in patients with acute ischemic stroke several hours after onset of symptoms,$^9$ the value of this marker of neuronal integrity was investigated for the very early identification of ischemic tissue that had suffered irreversible damage.

**Subjects and Methods**
Eleven patients (7 male, 4 female, aged 52 to 75) with acute, hemispheric ischemic stroke were treated with 0.9 mg/kg recombinant tissue plasminogen activator (alteplase, Actilyse) according to the National Institute of Neurological Disorders and Stroke protocol$^4$ within 3 hours of onset of symptoms, after their informed consent had been obtained. Five to 10 minutes before the beginning of recombinant tissue plasminogen activator infusion (95 to 180 minutes after onset of symptoms), cerebral blood flow (CBF) was measured by positron emission tomography (PET) (ECAT EXACT HR, CTI/Siemens) after intravenous bolus injection of $[^{15}O]$-labeled...
Areas of CBF and FMZ Binding Decreased Below Respective Thresholds, Final Infarct Size, and Change in National Institutes of Health Stroke Scale Score in Individual Patients

<table>
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<tr>
<th>Patient No.</th>
<th>Age, y</th>
<th>NIHSS</th>
<th>CBF 3 h</th>
<th>CBF 50–70%†</th>
<th>FMZ 3 h</th>
<th>CT/MRI Infarct</th>
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<tr>
<td></td>
<td></td>
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<td>Volume, cm³</td>
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<td>16</td>
<td>173.8</td>
<td>44</td>
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<td>64</td>
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</table>

NIHSS indicates National Institutes of Health Stroke Scale.
†Cortical regions with FMZ binding decreased below 4 times the mean value of white matter.
*Relative to noninfarcted hemisphere.

Results

The Table shows the areas of CBF and FMZ binding decreased below the respective thresholds, final infarct size, and the change of National Institutes of Health Stroke Scale score in the individual patients. Eight of the patients exhibited cortical tissue of different size perfused below the critical threshold. All had additional areas perfused in the moderately hypoperfused range. Only 4 patients, however, exhibited significant defects in FMZ binding within their severely hypoperfused regions, and corresponding infarcts were detected on final CT/MRI. In the other cases, the hypoperfusion could be reversed by thrombolysis to values above the 70% threshold 24 hours after the stroke, and no cortical defects on morphological images were found. Therefore, severe decreases in early FMZ binding significantly (P<0.005 by Fisher’s exact test) predicted irreversible cortical damage. As reflected in their National Institutes of Health Stroke Scale changes, all but 1 infarct patient improved clinically. The defects in FMZ binding were not related to the size of the critically hypoperfused area: in small ischemic areas of 2 patients, irreversible damage was indicated by early loss of FMZ binding (Figure 1). In patient 10, even a small penumbral area was associated with decreased FMZ binding, predicting a small cortical infarct. The discrepancies in these small volumes are likely due to differences in the partial...
volume effects of the applied imaging procedures. In contrast, fairly large hypoperfused regions could also benefit from reperfusion and did not become infarcted, as long as reperfusion began before decreased FMZ binding indicated irreversible damage (Figure 2). The largest and most severely hypoperfused cortical area (patient 6; 174 cm$^3$), however, included a rather large region of decreased FMZ binding (112 cm$^3$). This suggested widespread irreversible neuronal damage at this early stage (Figure 2), with subsequent infarct growth as indicated by late CT.

**Discussion**

Penumbral tissue can be demonstrated by functional imaging procedures visualizing conditions such as the mismatch between blood flow and energy metabolism ("misery perfusion," expressed as increased oxygen extraction fraction in multitracer PET studies\textsuperscript{14}) or between changes in perfusion and water diffusion (perfusion disturbance without irreversible damage, assessed by subtraction of diffusion-weighted from perfusion-weighted MR images\textsuperscript{17}). Special tracers, such

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**Figure 1.** Two patients demonstrate small areas with critically disturbed cortical perfusion (white arrows): patient 5 (pat05) with area of decreased FMZ binding (blue arrow) and corresponding area with gyral contrast enhancement on late MRI (red arrow), and patient 4 (pat04) with no defect in FMZ binding and no infarcted cortex in late MRI.

**Figure 2.** Two patients demonstrate large ischemic areas (white arrows): patient 6 (pat06) with area of decreased FMZ binding (blue arrow) and corresponding large infarction on late cranial CT (red arrow), and patient 2 (pat02) with no defect in FMZ binding and no infarcted cortex on late cranial CT.
as the imidazole derivative [18F]fluoromisonidazole, selectively identify hypoxic peri-infarct tissue that may represent the penumbra surrounding an infarct.18 Several studies have shown that this critically hypoperfused tissue can be salvaged by reperfusion therapy.19–21 The early detection of irreversibly damaged tissue within a critically perfused territory is more difficult, since CT does not disclose the full extent of irreversible damage during the first hours after a stroke.22–24 Likewise, the results of diffusion-weighted MRI might be misleading for various reasons.25,26 Tracers, however, that bind only to intact neurons, such as the central benzodiazepine receptor ligand FMZ, can be used for this purpose, namely, to distinguish potentially viable cortex from tissue that cannot be salvaged by any treatment. While the areas of severe early ischemia and decreased FMZ binding showed considerable overlap in this study, it was only the FMZ result that predicted morphological outcome. The CBF changes, by contrast, were too nonspecific. In all cases with normal FMZ binding, critical hypoperfusion, even in large areas, could be reversed by thrombolysis, as indicated by the repeated CBF measurement 24 hours after the attack. The similarity in clinical improvement between patients who developed cortical infarcts and those who did not may be explained by differences in topographical involvement and in the degree of subcortical damage.

As a tracer of neuronal integrity, FMZ clearly has some limitations, the most important being that benzodiazepine receptors are abundant only in cerebral cortex and that receptor binding can only be assessed in a steady state after tracer injection. However, the early phase of tracer distribution needs not involve the complex logistics required by11 C and 14 O water and PET without arterial blood sampling. In: Carson RE, Daube-Witherspoon ME, Herscovitch P, eds. Quantitative Functional Brain Imaging With Positron Emission Tomography. San Diego, Calif: Academic Press; 1995:151–154.


References
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