Treatment-Induced Cortical Reorganization After Stroke in Humans

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Background and Purpose—Injury-induced cortical reorganization is a widely recognized phenomenon. In contrast, there is almost no information on treatment-induced plastic changes in the human brain. The aim of the present study was to evaluate reorganization in the motor cortex of stroke patients that was induced with an efficacious rehabilitation treatment.

Methods—We used focal transcranial magnetic stimulation to map the cortical motor output area of a hand muscle on both sides in 13 stroke patients in the chronic stage of their illness before and after a 12-day-period of constraint-induced movement therapy.

Results—Before treatment, the cortical representation area of the affected hand muscle was significantly smaller than the contralateral side. After treatment, the muscle output area size in the affected hemisphere was significantly enlarged, corresponding to a greatly improved motor performance of the paretic limb. Shifts of the center of the output map in the affected hemisphere suggested the recruitment of adjacent brain areas. In follow-up examinations up to 6 months after treatment, motor performance remained at a high level, whereas the cortical area sizes in the 2 hemispheres became almost identical, representing a return of the balance of excitability between the 2 hemispheres toward a normal condition.

Conclusions—This is the first demonstration in humans of a long-term alteration in brain function associated with a therapy-induced improvement in the rehabilitation of movement after neurological injury. (Stroke. 2000;31:1210-1216.)

Key Words: plasticity, neuronal transcranial magnetic stimulation reorganization physical therapy stroke

Research with animals has led to the discovery that cortical reorganization occurs after injury to the nervous system.1–3 Spontaneously occurring cortical reorganization phenomena that result from nervous system damage or conditions that involve abnormal sensory input have been shown to be associated with pathological states in humans; these include phantom limb pain,4 tinnitus,5 and focal hand dystonia.6 After motor stroke, a complex pattern of reorganization has been described.7–20 In the subacute stage after a stroke, a reduction in motor cortex excitability and a decrease in the cortical representation area of paretic muscles have been found to occur.17,19 This may represent a disadvantageous reorganization associated with an impaired motor function and could be due to the damage of neuronal structures or could reflect the disuse of the affected limb.21 In addition to injury-related cortical reorganization, there is a second kind of process, use-dependent cortical reorganization, that results from the increased use of body parts in behaviorally relevant tasks and leads to an enhancement of the representation of those body parts in the cerebral cortex.21,23–26 It is possible that this process could be used to remediate pathological symptoms through the reversal or elimination of disadvantageous cortical reorganization produced with nervous system damage.

Constraint-induced movement therapy (CI therapy) has been shown in controlled studies to be efficacious in chronic stroke patients.27 At this stage of their illness, these patients are presumed to have a stable motor deficit.28–30 Moreover, the short duration of CI therapy (12 days) further minimizes the possibility that spontaneous recovery of function could give the appearance of a treatment effect. CI therapy stems jointly from basic research in neuroscience with monkeys with somatosensory deafferentation of a single forelimb and from behavioral psychology.31,32 The effective therapeutic factor in this treatment33,34 appears to be the massing or concentration of practice in use of the extremity affected by a stroke for many hours a day during a period of consecutive weeks. This therapy has been found to produce a substantial long-term improvement in the amount of use of an affected upper extremity that transfers into the real world environ-
It is possible that CI therapy might produce its therapeutic effect through the induction of a use-dependent cortical reorganization that counteracts adverse brain function changes and enhances recovery-associated plastic changes that occur in the human brain after stroke.7–9,17–19 The main goal of the present study was not to evaluate the clinical effects of CI therapy or to compare this treatment with other physiotherapeutic approaches but rather to use CI therapy as a model to assess therapy-induced plasticity in stroke patients. Therefore, we did not introduce a control group. However, we did use a control procedure (ie, 2 complete pretreatment test batteries separated by the same length of time required by the intervention), and placebo controls have been used in other CI therapy research.34–38

We used focal transcranial magnetic stimulation (TMS) to assess plastic alterations that may have been induced by CI therapy. TMS involves the noninvasive mapping of motor regions of the brain to determine the cortical representation areas of muscles with the use of a focused magnetic field to stimulate loci in motor areas from points on the scalp. It has been used to assess the amount of reorganization of motor representations consequent to injury of the peripheral and central nervous systems and after various conditions of use.17–19,39–55 The amplitude-weighted center of the TMS map of a hand muscle corresponds closely to the hand area within the primary motor cortex as determined with anatomic and functional MRI (fMRI) studies.56–59 In contrast to typical fMRI or positron emission tomography (PET) experiments in stroke patients, TMS mapping is performance independent and therefore ideally suited for longitudinal studies as in rehabilitation of stroke, where motor ability may change markedly. Preliminary results from a limited sample of patients had indicated that motor cortex reorganization occurs immediately after CI therapy.60 In contrast to this earlier study, we performed TMS mappings and evaluations of motor functions in parallel at several time points before and after CI therapy to investigate the stability of the baseline and to determine short- and long-term effects of the therapy on the functional organization of the primary motor area of the brain in relation to clinical recovery.

**Subjects and Methods**

Thirteen patients (10 men; mean age 56.7±10.3 years, age range 33 to 73 years; duration of hemiparesis 4.9±4.7 years [mean±SD, range 0.5 to 17 years]) with chronic stroke (>6 months) were studied. Eleven of the subjects had a right-sided paresis; 3 had cortical lesions (2 ischemic and 1 hemorrhagic in origin), and 10 had lacunar subcortical lesions that involved the internal capsule. Informed consent for participation in the study was obtained from all patients. The study was approved by the local ethics committee.

Functional inclusion criteria were (1) the ability to extend ≥20° at the wrist and 10° at the fingers and (2) sufficient stability to walk when the less-affected arm is immobilized. Exclusion criteria were (1) serious uncontrolled medical conditions, (2) global aphasia or cognitive impairments that might interfere with understanding instructions for motor testing, (3) anything in the head that contained metal, (4) pregnancy, (5) epilepsy, and (6) cardiac pacemaker.

Each subject received 12 days of CI therapy preceded and followed by periods in which electrophysiological, neurological, and behavioral testing was conducted. For CI therapy, subjects agreed to wear a resting hand splint secured in a sling that prevented use of the nonparetic upper extremity for a target of 90% of waking hours. This arrangement induced greatly increased use of the paretic arm. In addition, on the 8 weekdays during the treatment period, the subjects came into the laboratory and received 6 hours per day of training in use of the affected arm in a variety of tasks according to a behavioral technique termed “shaping.”61 The shaping was designed to produce intensive use of the more-affected extremity while at the same time improving the quality of movement. Treatment efficacy was evaluated with the motor activity log (MAL),34 which tracked arm use in 20 common and important activities of daily living (ADL) performed outside the laboratory (1) for the week before the subject’s visit to the laboratory 2 weeks before the beginning of treatment, (2) for the week before the beginning of treatment, (3) 1 day after treatment, and (4) 4 weeks and (5) 6 months after the end of treatment (follow-up). The MAL has exhibited excellent intertest reliability for chronic stroke patients across a 2-week interval equal in length to the treatment period when no treatment was provided62 and when a placebo treatment was administered.63 Further details of the intervention and testing are available elsewhere.34,37 We mapped the cortical output area of the abductor pollicis brevis (APB) muscle of the more-affected and less-affected hands with TMS on the same day as the MAL was administered 1 day before treatment and 1 day and 4 weeks after treatment. (Two subjects died before the 4-week posttreatment testing could be carried out, and 1 subject had to be excluded at this time because of the intervening occurrence of an epileptic seizure.) As a control procedure, to confirm the stability of the electrophysiological and behavioral measures, 10 subjects were tested 2 weeks before the beginning of treatment. This is the same temporal interval that separates the second pretreatment and posttreatment tests and therefore controls for such nonspecific effects as expectancy of improved extremity function, initial contact with experimenters, and increased attention to use of the affected upper extremity. During the period between the testing 2 weeks and 1 day before treatment, there was no contact between patients and the project. Eight subjects have been tested 6 months after treatment to date.

For magnetic stimulation, we used a figure-8 coil (The Magstim Company) kept in an anteroposterior position with the grip pointing backward. The coil was moved systematically over the skull in steps of 1 cm to identify all scalp positions whose stimulation produced an EMG response in APB muscle. “Motor threshold” was defined as the minimal intensity of stimulation capable of inducing motor evoked potentials (MEPs) of >0.05 mV in at least 5 of 10 trials. Five transcranial magnetic pulses with an intensity 10% above the individual motor threshold were applied over each position to be tested. Both hemispheres were studied consecutively in a pseudorandom order. MEPs were recorded with surface electrodes from the contralateral and the ipsilateral APB muscle, respectively (Vicon IV; Nicolet).

The subjects were seated comfortably in a chair with hands resting in their laps and wore a tight-fitting cap with a coordinate system (distances of 1 cm) indicated on it. They were provided with information about their muscular tension through auditory signals presented over a speaker that were proportional to the amount of prestimulation EMG activity recorded from APB muscle. The instruction was to relax the target muscle completely during the TMS mapping. Three parameters were used for analysis of the neurophysiological data: (1) size of the cortical motor output map, defined as the number of positions whose stimulation evoked MEPS of >0.05 mV, (2) motor thresholds, expressed as a percentage of the maximal stimulator output intensity, and (3) location of the amplitude-weighted center of gravity (CoG) of the motor output map. A detailed description of the calculation of the CoG is given elsewhere.62 Changes in all parameters were calculated for the more-affected and less-affected hemispheres. The investigator who performed the TMS mapping (J.L.) was blinded for the motor treatment outcome data. The experimenter who evaluated the motor function (H.B.) was blinded for the TMS mapping data. The behavioral and electrophysiological data were analyzed with repeated measures ANOVAs, followed by Tukey’s tests. Bonferroni-corrected paired t tests were used to compare the motor output area size of the affected
and the unaffected hemisphere at each measurement day. \( P<0.05 \) was used as the criterion for statistical significance.

**Results**

The MAL data are presented in Figure 1. CI therapy produced a significant and large improvement in motor functions from 1 day before treatment to 1 day after treatment (\( t_{12} = -12.781, \ P<0.0001 \)). The MAL scores at 2 weeks and 1 day before treatment were not significantly different from each other. The treatment gain persisted undiminished in follow-up. Four weeks after treatment, the MAL scores were not significantly different from the scores at 1 day after treatment (\( t_{9} = 1.026, \ NS \)). A separate analysis for just the 8 subjects for whom there were 6-month follow-up data indicated that, again, the change from day 1 before treatment to the first day after treatment was significant (\( F_{4,20} = 31.4, \ P<0.001, \ \epsilon = 0.336 \)) and that the change remained undiminished 4 weeks and 6 months after treatment. The subjects scored a mean of 2.2 on the MAL 1 day before treatment and a mean of 3.7 at 1 day after treatment. To provide an idea of the nature of the treatment change, a score of 2 indicates slight use; 3, half as much use as before stroke, and 4, three fourths as much use as before stroke. The effect size was 1.5; in the meta-analysis literature, effect sizes of \( \geq 0.8 \) are considered large.\(^{63} \)

Clinical and electrophysiological results were very similar in patients with cortical and subcortical strokes (\( P>0.1 \)), so the data from both groups were combined.

The TMS mapping data 1 day after treatment paralleled the behavioral results. Figure 2 indicates that the area of the cortex that yielded a response of the paretic hand muscle to stimulation of the contralateral hemisphere showed a massive increase from 1 day before treatment to 1 day after treatment. One day before treatment, there were 40% fewer active positions in the infarcted hemisphere than in the noninfarcted hemisphere (\( P<0.001 \)). By the first day after treatment, this relationship had reversed, with 37.5% more active positions in the infarcted hemisphere than in the noninfarcted hemisphere. The number of active positions in the infarcted
The motor threshold was elevated over the affected hemisphere and remained very similar at the different times throughout the experiment (infarcted hemisphere: before treatment $53.7 \pm 13.5$, after treatment $53.7 \pm 12.8$; noninfarcted hemisphere: before treatment $53.7 \pm 10.3$, after treatment $44.9 \pm 10.1$, 4 weeks after treatment $44.8 \pm 10.3$ [values indicate a percent- 

age of the maximal stimulator output intensity]). We did not observe any MEPs when stimulating the ipsilateral cortex on either the more- or the less-affected side.

### Discussion

The most salient result of the present study is the almost doubling of the excitability of neurons already involved in the innervation of more-affected hand movements or an increase in excitatory neuronal tissue in the infarcted hemisphere, or both. The short time course of 12 days makes the formation of new anatomic connections by means of sprouting as a major mechanism unlikely because clear evidence of axonal growth has not been found until months after a lesion occurred. A more likely mechanism is a reduction in...
activity of local inhibitory interneurons, thus unmasking preexisting excitatory connections. An alternate and possibly complementary mechanism would be the enhancement of the synaptic strength of existing synaptic connections. Regardless of the mechanism, rehabilitation appears to lead to a recruitment of a large number of neurons in the innervation of movements of the stroke-affected extremity adjacent to those involved before therapy. This hypothesis is further supported by larger shifts of the CoGs in the infarcted hemisphere. These CoG dislocations suggest that in addition to the enlargement of excitable cortical areas, a new maximum had developed adjacent to the former one. A similar finding was reported in adult monkeys that had received a unilateral lesion of the motor cortex during infancy: a relatively complete hand representation was found to occupy a new territory, medial to the old lesion. In another intracortical microstimulation study, Nudo et al demonstrated in adult squirrel monkeys that received a surgically induced ischemic infarct in a cortical area that controlled the movements of a hand that training of the more-affected limb and partial restraint of the less-affected extremity resulted in both improved motor functioning and cortical reorganization. The intervention was similar to the CI therapy approach that had been used previously. The present study demonstrates that CI therapy has a parallel effect in humans after stroke. Similarly, in recovered stroke patients, a large lateral extension of the brain area that is active during finger movements was found. Our results suggest that a reorganization occurred on a cortical level. However, the results do not permit exclusion of the possibility that additional plastic changes occurred on a subcortical or spinal level.

Some PET and fMRI studies in recovered stroke patients have suggested that plastic changes take place in the ipsilateral, noninfarcted hemisphere that might contribute to the restitution of motor function. In our study, MEPs could not be evoked with ipsilateral brain stimulation; therefore, no evidence for an involvement of the motor cortex ipsilateral to the paretic arm was found in this subgroup of patients. This does not exclude the possibility of an additional ipsilateral cortical reorganization because different factors (e.g., submaximal intensity of the magnetic stimulator output, recordings from relaxed muscles, selection of patients, passive response to stimulation rather than active movement) could be responsible for our result.

It is interesting that at 4 weeks and 6 months after treatment, the number of active positions in the 2 hemispheres were almost identical. This represents a return of the balance of area of excitability in the innervation of muscular activity between the 2 hemispheres toward what is, in effect, a normal condition after a temporary, therapy-induced hyperexcitability. Because the MAL data remained unchanged, the TMS data could indicate that with continued increased use of the more-affected upper extremity for 6 months after treatment, there was an improvement in effective connectivity of the neuronal networks involved in the motor performance. Such a plastic change, presumably involving an increase in synaptic efficiency, would permit the reduction in the excitability of the neuronal connections without a deterioration of function. A similar reduction in excitability along with an increased effective connectivity associated with repeated exposure to identical stimuli in associative learning was reported by Büchel et al. Pascual-Leone et al demonstrated that gaining explicit knowledge of a task also reduced motor cortex excitability. An analogous process might have occurred here as the patients became adjusted with time to the newly acquired increased use of the more-affected extremity. Another explanation of our results could be that brain areas that are not accessible by focal TMS took over the execution of motor functions, thus allowing a reduction in the excitability of the primary motor cortex. This possibility could be addressed experimentally with fMRI techniques. Before treatment, the representation area of the nonparetic muscle in the unaffected hemisphere was significantly larger than the motor representation of the paretic muscle in the infarcted hemisphere. This area in the unaffected hemisphere decreased nonsignificantly after therapy. Several factors might have contributed to these changes. Before treatment, an increase in unaffected hand use, which was required to compensate for the greatly decreased use of the paretic hand in everyday life, could have resulted in relative large cortical representations. During and after therapy, the nonparetic hand was used less frequently than before therapy. Similar to results obtained in an immobilization study, this reduced use might have produced a shrinkage of the representation area. An alternate explanation could be a transhemispheric cross-talk between the 2 primary motor cortices (M1), mediated through transcallosal fibers. In normal subjects, TMS over 1 M1 was found to reduce the excitability of the contralateral M1. This interhemispheric inhibition may still be operative in stroke patients with intact transcallosal connections. Thus, a therapy-associated enhanced activation of M1 in the affected hemisphere could induce an increased inhibition of the contralateral M1.

CI therapy is predicated on the demonstration in deafferented monkeys after neurological injury that the nonuse of an affected extremity can be due to a learning phenomenon that involves a conditioned suppression of movement. CI therapy is considered to be effective because it increases the motivation to use the extremity and thereby overcomes the "learned nonuse." (This formulation has been described in detail elsewhere.) The current results indicate that the intervention, which involves massed and sustained practice of functional arm movements, also produces a massive use-dependent cortical reorganization that may provide the basis for the long-term persistence of the treatment effect for the 6 months studied in this experiment and for the 2 years reported in other research. Other examples of use-dependent cortical plasticity, resulting from the increased use of body parts in behaviorally relevant tasks, have been described in animals and humans.

One of the aims of neuroscience has been to generate effective new rehabilitation strategies that would give pragmatic importance to this area of basic research. Moreover, if a central nervous system correlate of such a therapy could be found, a new vista would be opened in which further improvements in rehabilitation might be produced through manipulation of that correlate. The present study addresses both of these objectives.
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