Autoregulatory Response and CO₂ Reactivity of the Basilar Artery

Cheol Wan Park, MD, PhD; Mathias Sturzenegger, MD; Colleen M. Douville, BA, RVT; Rune Aaslid, PhD; David W. Newell, MD

Background and Purpose—Transcranial Doppler has been extensively used to measure cerebrovascular control mechanisms, including autoregulation in humans and in patients with cerebrovascular diseases. There have been sufficient reports on the measurement of normal autoregulatory response (AR) and CO₂ reactivity (CR) of the middle cerebral artery (MCA) but few reports of these indices for the basilar artery (BA). We measured AR and CR in the BA in healthy volunteers to determine normal values and compared them with simultaneous measurements made in the MCA.

Methods—Sixteen normal subjects were enrolled. Time-averaged mean velocities of maximum blood flow in the BA and MCA were continuously and simultaneously monitored by using transcranial Doppler along with continuous measurement of mean arterial blood pressure (MABP). Values were obtained during rest, alterations of end-tidal PaCO₂ (ETCO₂), and acute decrease and recovery of MABP. AR was evaluated by using the thigh cuff method and graded by the standard dynamic autoregulatory index (ARI), with values between 0 and 9. CR was measured as percentage change in time-averaged mean velocity per mm Hg ETCO₂.

Results—The mean age of 16 subjects was 27.38±8.50 years. Average baseline values for MABP and ETCO₂ were 82.29±7.10 and 42.75±3.77 mm Hg, respectively. Mean ARI was 4.62±1.26 for the BA and was 4.77±1.23 for the MCA (n=15) (P=0.598). Average CR was 2.54±0.39%/mm Hg ETCO₂ for the BA and 2.51±0.29%/mm Hg ETCO₂ for the MCA (n=16) (P=0.686).

Conclusions—Our study demonstrates that ARI and CR values for the BA are similar to those for the MCA. (Stroke. 2003; 34:34-39.)

Key Words: autoregulation ▪ basilar artery ▪ blood flow velocity ▪ carbon dioxide ▪ ultrasonography, Doppler, transcranial

Cerebral autoregulation is a mechanism that allows cerebral blood vessels to maintain a constant cerebral blood flow (CBF) over a wide range of cerebral perfusion pressure.¹⁻³ The cerebral circulation is also profoundly affected by changes in PaCO₂ and CO₂ reactivity (CR) defines the changes in CBF in response to changes in PaCO₂.³⁻⁴ Transcranial Doppler (TCD) has been widely used to measure CBF velocity (BFV) and can be used to measure instantaneous changes in CBF in response to a variety of stimuli. TCD has recently been used to measure autoregulatory response (AR) and CR in various disease states that affect the brain.⁵⁻⁶ These measurements have led to an increased understanding of the effect of different pathological conditions on cerebrovascular function.

Numerous efforts have been made to establish normal criteria for AR and vasoreactivity of the cerebral circulation by the use of TCD. Although there has been ample research involving normal values for the anterior half of the circle of Willis, mainly for the middle cerebral artery (MCA),⁷⁻⁻¹⁵ we have found few studies involving these values for the basilar artery (BA). To the best of our knowledge, no previous study has investigated AR in the human BA and both AR and CR for the BA in the same individuals. The objectives of the present study were to assess normal values of both the AR and CR for the BA and to compare them with simultaneously investigated values for the MCA in the same subjects. We also compared our results with previously reported normal values of CR for the BA with the use of TCD.

Subjects and Methods

Subjects

The present study involved 16 normal volunteers aged 19 to 46 years. TCD and carotid/vertebral duplex ultrasound findings were normal and symmetric in all volunteers. All subjects were healthy, were taking no medication, had no history of cardiovascular,
cerebrovascular, or other preexisting diseases, such as pulmonary or endocrine disease, and had no orthostatic symptoms. The subjects were not permitted to smoke or have caffeine or alcohol for at least 12 hours before the examination.

This present study was approved by the Institutional Review Board at the University of Washington, and informed consent was obtained for all subjects before examination.

**TCD Examinations and Measurements**

TCD examinations were carried out with the subject in a supine position with the head elevated and rotated to the right slightly (15° to 30°) and with the eyes closed. BFVs were continuously recorded from the BA and left MCA simultaneously by using a multichannel TCD instrument (Multi-Dop X, DWL). A 2-MHz pulsed-wave Doppler transducer was fixed in position over the left MCA through the left temporal window with customized headgear. A second 2-MHz probe was held on the back of the neck, aiming upward through the foramen magnum throughout the test. A schematic drawing of simultaneous insonation on the BA and left MCA is given in Figure 1. The BA and left MCA were identified, and most suitable signals were obtained in a standard fashion.32 A continuous noninvasive blood pressure cuffs large enough for thighs were applied bilaterally and the eyes closed. BFVs were continuously recorded to 30 seconds and with the eyes closed. BFVs were continuously recorded for averaging ARI data was a minimum of 3 technically acceptable tests on each subject. As a result, 62 tests, ranging from 3 to 6 tests for each individual (4.13 ± 0.05) were available and considered as valid for all 16 subjects. The data for CR were available and considered as valid for all 16 subjects. Data for demographic and basic variables for 16 normal volunteers are presented in Table 1.

Principal variables and statistical significances for comparing AR of the BA with that of the MCA are contained in Table 2. The differences in MABP and HR between baseline and during cuff up were <2 mm Hg increase in MABP and <1 bpm in HR, as noted in Table 1. The magnitudes of drop on cuff release were 18.37 ± 3.74 mm Hg in MABP, 12.64 ± 2.56 cm/s in BA TAMV, and 15.16 ± 4.25 cm/s in
MCA TAMVs. These values were relevant to drops of corresponding values before cuff release of 21.90±3.75% in MABP, 27.52±4.48% in BA TAMV, and 23.25±3.65% in MCA TAMV. The time intervals for drops were 3.08±0.17 seconds in BA TAMV, and 2.33±0.18 seconds in MABP, and 2.35±0.17 seconds in MCA TAMV. Recovery time intervals restoring cuff-up values were 17.05±2.70 seconds in MABP, 6.88±2.47 seconds in BA TAMV, and 6.88±2.96 seconds in MCA TAMV. A typical response of TAMVs to change in ETCO2 showed no significant difference from the MCAs in the same individuals.

Many methods have been proposed for the evaluation of static or dynamic AR. Although the thigh cuff method has been the most common approach for dynamic AR, other studies have used techniques involving vasoactive drugs, the Valsalva maneuver, cold pressor, isometric hand grip, lower body negative pressure, carotid artery compression, and spontaneous fluctuations in arterial blood pressure.7,13,14 Each technique has its own merits and limitations. Advantages and limitations of the thigh cuff test that we used have been described,7,9,10,14 and we tried to reduce the drawbacks of determining ARI using this method during examination and analysis. For instance, we performed the thigh cuff testing at least 3 times to obtain a mean ARI for each subject, and we permitted sufficient breaks between each thigh cuff test for the return of MABP and TAMV to baseline values. We conducted recordings in a single session for each individual to remove possible day-to-day variance, adjusted critical closing pressure manually to diminish the error, and monitored MABP continuously throughout the examination. We thought that the effect of MABP on ARI was negligible because baseline MABP was normotensive in all subjects, and the mean difference between baseline and during cuff up MABP was only <2 mm Hg, as stated above.

In the present study, there was no significant difference in ARI or in other variables between the BA and MCA, as shown in Table 2. Interestingly, the mean recovery time interval of the BA to recover TAMVcuff was identical to that of the MCA. To our knowledge, there is no reported reference to compare ARI for the BA with our results. Our value of ARI

**TABLE 1. Basic Data of 16 Normal Subjects**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age, y</td>
<td>27.38±8.50</td>
</tr>
<tr>
<td>Male-to-female ratio</td>
<td>1.29</td>
</tr>
<tr>
<td>MABPbase, mm Hg</td>
<td>82.29±7.10 (n=15)</td>
</tr>
<tr>
<td>HRbase, beat/min</td>
<td>64.89±10.81 (n=15)</td>
</tr>
<tr>
<td>MABPcuff, mm Hg</td>
<td>84.05±8.21 (n=15)</td>
</tr>
<tr>
<td>HRcuff, beat/min</td>
<td>65.29±10.99 (n=15)</td>
</tr>
<tr>
<td>BA TAMVcuff, cm/s</td>
<td>46.39±8.56 (n=15)</td>
</tr>
<tr>
<td>MCA TAMVcuff, cm/s</td>
<td>65.24±16.39 (n=15)</td>
</tr>
<tr>
<td>MABPnormo, mm Hg</td>
<td>82.82±15.51</td>
</tr>
<tr>
<td>ETCO2normo, mm Hg</td>
<td>42.75±3.77</td>
</tr>
<tr>
<td>BA TAMVnormo, cm/s</td>
<td>48.38±8.74</td>
</tr>
<tr>
<td>MCA TAMVnormo, cm/s</td>
<td>70.00±14.39</td>
</tr>
</tbody>
</table>

Values are mean±SD. MABP indicates mean arterial blood pressure; HR, heart rate; BA, basilar artery; MCA, middle cerebral artery; ETCO2, end-tidal carbon dioxide; TAMV, time-averaged mean velocity.

**TABLE 2. Dynamic Autoregulatory Response in the BA Versus MCA (n=15)**

<table>
<thead>
<tr>
<th>Variable</th>
<th>BA</th>
<th>MCA</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARI</td>
<td>4.62±1.26</td>
<td>4.77±1.23</td>
<td>0.598</td>
</tr>
<tr>
<td>Time for drop, s*</td>
<td>2.33±0.18</td>
<td>2.35±0.17</td>
<td>0.121</td>
</tr>
<tr>
<td>Time for recovery, s†</td>
<td>6.88±2.47</td>
<td>6.88±2.96</td>
<td>0.997</td>
</tr>
</tbody>
</table>

Values are mean±SD. ARI indicates autoregulation index.

*Represents time interval to reach the lowest velocity after cuff release.
†Represents time interval to recover the cuff up velocity from the lowest velocity.

**Discussion**

During the last 2 decades, TCD has been one of the most valuable tools to estimate functional changes in the control of the cerebral circulation and to detect morphological alterations, such as stenosis in intracranial vessels. Measurements of AR and CR using TCD have provided reliable information about the physiologic state of cerebrovascular reactivity and in various pathological situations. There is an increasing trend for AR and CR to be regarded as useful indices to measure the hemodynamic alterations that occur in cerebrovascular occlusive diseases.5,6,32 Alterations in AR and CR have also been described after brain injury.6,12,32

The BA is the only posterior axis supporting and supplying blood to the circle of Willis, providing a highly constant collateral blood flow system in physiological and many pathological conditions, although the efficiency of the circle of Willis in each individual is hard to predict.32 Nevertheless, AR and CR for the BA have received little attention, and most of the published data on AR and CR are for the anterior circle of Willis.7–25 We found a few reports on vasoreactivity for the BA,26–31 but we failed to find a report on AR for the human BA with the use of TCD. Using the thigh cuff method of AR testing and 5.6% CO2 inhalation and voluntary hyperventilation methods, we demonstrated that ARI and CR of the BA were 4.62±1.26%/mm Hg ETCO2 and 2.54±0.39%/mm Hg ETCO2, showing no significant difference from the MCAs in the same individuals.

Many methods have been proposed for the evaluation of static or dynamic AR. Although the thigh cuff method has been the most common approach for dynamic AR, other studies have used techniques involving vasoactive drugs, the Valsalva maneuver, cold pressor, isometric hand grip, lower body negative pressure, carotid artery compression, and spontaneous fluctuations in arterial blood pressure.7,13,14 Each technique has its own merits and limitations. Advantages and limitations of the thigh cuff test that we used have been described,7,9,10,14 and we tried to reduce the drawbacks of determining ARI using this method during examination and analysis. For instance, we performed the thigh cuff testing at least 3 times to obtain a mean ARI for each subject, and we permitted sufficient breaks between each thigh cuff test for the return of MABP and TAMV to baseline values. We conducted recordings in a single session for each individual to remove possible day-to-day variance, adjusted critical closing pressure manually to diminish the error, and monitored MABP continuously throughout the examination. We thought that the effect of MABP on ARI was negligible because baseline MABP was normotensive in all subjects, and the mean difference between baseline and during cuff up MABP was only <2 mm Hg, as stated above.

In the present study, there was no significant difference in ARI or in other variables between the BA and MCA, as shown in Table 2. Interestingly, the mean recovery time interval of the BA to recover TAMVcuff was identical to that of the MCA. To our knowledge, there is no reported reference to compare ARI for the BA with our results. Our value of ARI
for the MCA (4.77±1.23) was similar to that in a previously published study using the thigh cuff technique by Tiecks et al14 (4.8±1.0), by Jünger et al12 (4.7±1.0), and by Mahony et al9 (4.98±1.06). These reports also included mean ages of normal subjects and mean MABP drops on cuff release that were similar to those of our study (for Tiecks et al, 35±10 years and 20±4 mm Hg drop; for Jünger et al, 38±16 years and 22±5 mm Hg drop; for Mahony et al, 31.8±8.5 years and 26.4±7.1 mm Hg drop; and our result, 27.38±8.50 years and 18.37±3.74 mm Hg drop). Some studies using the same thigh cuff technique reported an ARI for the MCA that was higher than that in our study (Dawson et al,8 6.18±2.34; White and Markus,11 6.3±1.1). These discrepancies could be explained by use of a correlation coefficient instead of adjustment of critical closing pressure for the best model fitting and by use of an MABP drop on cuff release that was relatively smaller than ours.

In the present study, CR for the BA (2.54±0.39%/mm Hg ETCO2) also showed no significant disparity from the MCAs (2.51±0.29%/mm Hg ETCO2). Our results of CR for the BA and MCA are hard to compare with the results of earlier reports11,15,18 because of methodological differences in the evaluation of CR. The major dissimilarities are equations to calculate CR, techniques to induce change in ETCO2, concentrations of inhaled CO2, kinds of capnic stimuli used (hypercapnia, hypocapnia, or both), positions of subjects during examination, and mean ages of the subjects. When compared with reports that were conducted under a method relatively similar to ours, the CR values in our study are similar to the data reported by Hida et al31 (BA CR, 85.63±15.96%) and by Weiller et al15 (87±15%). This relatively lower value of our VMR for the MCA than found in the studies described above might be accounted for by lower maximum ETCO2 and/or lower concentrations of inhaled CO2 in the present study.

There have long been debates about the mechanisms that govern the CBF.1–3,17,31–33 Principal techniques to determine VMR of cerebral vessels by TCD have made use of the administration of acetazolamide or CO2 and the breath-holding method.16,18,25,34 Each of these methods has limitations and advantages. However, discussions about CBF mechanisms and VMR techniques are beyond the scope of the present study.

The present study bears some limitations and possible sources of error. Although we assumed that the variations in BFV can be used to precisely pursue concomitant changes in CBF and that the diameters of the BA and MCA remain unaffected during examinations, whether the changes in BFV measured with TCD can accurately reflect the relative changes in CBF and whether the diameter of the BA and MCA are relatively constant throughout acute blood pressure perturbations and capnic stimuli have long been argued.17,20,35–40

Panerai et al7,10 and Mahony et al9 pointed out several problems with autoregulation testing by use of the thigh cuff method. We made efforts to minimize these problems as stated above, but potential errors might not be entirely eliminated. During CR testing, capnic challenges could cause fluctuation of MABP and HR, which, in turn, might lead to

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### TABLE 3. CO2 Reactivity in the BA Versus MCA (n=16)

<table>
<thead>
<tr>
<th>Variable</th>
<th>BA</th>
<th>MCA</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>CR, %/mm Hg ETCO2</td>
<td>2.54±0.39</td>
<td>2.51±0.29</td>
<td>0.686</td>
</tr>
<tr>
<td>VMR, %</td>
<td>77.69±12.57</td>
<td>76.51±9.08</td>
<td>0.663</td>
</tr>
<tr>
<td>Increased TAMV, %†</td>
<td>32.02±12.65</td>
<td>32.84±9.95</td>
<td>0.748</td>
</tr>
<tr>
<td>Decreased TAMV, %†</td>
<td>45.66±7.56</td>
<td>43.67±5.59</td>
<td>0.403</td>
</tr>
</tbody>
</table>

| Values are mean±SD. CR indicates carbon dioxide reactivity; VMR, vasomotor reactivity. |
| Represents % increased velocity during hypercapnia from normocapnic value. |
| Represents % decreased velocity during hypercapnia from normocapnic value. |
deviations in the estimation of CR. Other reported factors may have an impact on the reliability of CR as representative of vasoreactivity for cerebral vessels, including reproducibility of CR, age and sex dependency, variability with posture and time, extent of collaterals with completeness of the circle of Willis, and food (such as containing caffeine) just before the examination. Factors such as those described above could also influence the ARI.

Previous reports have indicated equal responses in BFVs and autoregulatory functions for the right and left MCAs. We presumed that there was little error in using the left MCA BFV as a representative of BFV for both the MCAs. We insonated the BA with a handheld probe, whereas the MCA probe was fixed by the use of headgear. Therefore, BFV recording from the BA might have less constant placement of sample volume and/or angle of insonation than recording from the MCA. However, in the present study, because time-averaged spectral outline velocity (TAMV) was used as BFV, we thought that some movement of sample volume would have little, if any, effect on BFV for the BA. Other factors are also relevant to our finding. In the present study, the mean MABP alteration during hypercapnia was 8.99 ± 12.32% and 3.28 ± 18.70% during hypocapnia from the baseline value as described above. Blood pressure alterations may affect the calculation of CR if they are severe. The values of ARI and CR for the BA and MCA in the present study are insufficient as normal values of the whole normal population because the mean age in the present study was 8.50 years.

We are also aware that besides anatomic inequality, there are conflicting observations through human and animal studies on functional differences, including AR and CR between vertebrobasilar and carotid systems. We could not find any significant functional dissimilarity between the BA and MCA in the aspect of ARI and CR in normal subjects. However, this similarity may be disturbed in patients with cerebrovascular disorders.

Several indices (including ARI, CR, and VMR) using TCD are increasingly being used as indispensable parameters to manage patients with cerebrovascular diseases. It is important to continue to establish standards of testing methods and normal values for vascular reactivity in the anterior and posterior circulation to compare these values with the values in patients with disease states.

Acknowledgment

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References

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