Longitudinal Optical Imaging Study for Locomotor Recovery After Stroke

Ichiro Miyai, MD, PhD; Hajime Yagura, MD; Megumi Hatakenaka, MD; Ichiro Oda, PhD; Ichiro Konishi, PhD; Kisou Kubota, MD, PhD

Background and Purpose—We sought to investigate cerebral mechanisms underlying locomotor recovery after stroke.

Methods—We measured cortical activities during hemiparetic gait on the treadmill before and after 2 months of inpatient rehabilitation in 8 patients with initial stroke (5 men, 3 women; 4 with right and 4 with left hemiparesis; aged 57 years; 3 months after stroke on average), using an optical imaging system.

Results—On the initial evaluation, hemiparetic gait was associated with increased oxygenated hemoglobin levels in the medial primary sensorimotor cortex (SMC) that were greater in the unaffected hemisphere than in the affected hemisphere as well as in the premotor cortex (PMC) and supplementary motor area. On the second examination, the asymmetry in SMC activation significantly improved, and there was enhanced PMC activation in the affected hemisphere. Improvement of the asymmetrical SMC activation significantly correlated with improvement of gait parameters.

Conclusions—Locomotor recovery after stroke may be associated with improvement of asymmetry in SMC activation and enhanced PMC activation in the affected hemisphere. (Stroke. 2003;34:2866-2870.)

Key Words: cerebral cortex ■ gait ■ optics ■ rehabilitation ■ spectroscopy, near-infrared ■ stroke

As a result of recent advances in functional neuroimaging such as positron emission tomography and functional MRI, there is growing evidence that functional recovery of paretic hand after stroke depends on cortical reorganization, including the peri-infarct area in the primary sensorimotor cortex (SMC), other motor-related areas such as the premotor cortex (PMC) and supplementary motor area (SMA) in the affected hemisphere, and some combination of these areas in the unaffected hemisphere.1–10 Little is known about the mechanisms underlying locomotor recovery, one of the essential determinants of rehabilitation outcome in stroke, mainly because of technical limitations in assessing cerebral activation during dynamic movements. An optical imaging technique using near-infrared spectroscopy (NIRS)1–14 has enabled visualization of cortical activation during human gait that centered in the medial SMC and SMA.15 In patients with stroke, hemiparetic gait was associated with asymmetrical SMC activation and recruitment of PMC and pre-supplementary motor area (pre-SMA).16,17 In this longitudinal study we sought to clarify how cortical activation changed in the course of locomotor recovery after stroke.

Subjects and Methods
We evaluated cortical activation during hemiparetic gait on the treadmill in 8 patients with initial stroke (Table). All were right-handed. All were transferred to our hospital for inpatient multidisciplinary rehabilitation based on neurodevelopmental technique.18,19 The patients did not reach an independent level in ambulation and activities of daily living after medical treatment and less intensive physical therapy for 2 to 3 months in acute hospitals. Each patient underwent NIRS recording before and after 2 months of inpatient rehabilitation. This study was approved by the local ethical committee. Written informed consent was obtained from each patient.

For NIRS recording, patients walked on the treadmill at a speed of 0.2 km/h. Each 30 seconds of task period for walking was alternated by 30 seconds of rest period for 4 times. Experienced therapists, standing by the patients on the paretic side, assisted them mechanically to ensure safe gait performance by holding them on the foot or thigh of the paretic leg if necessary. Four patients (cases 1, 5, 6, and 7) with severe hemiplegia needed 20% of partial body weight support using the overhead harness with a pelvic belt and thigh strips20,21 to perform the walking task. Task conditions were identical in the 2 measurements before and after inpatient rehabilitation in each individual.

Details of the optical imaging system (Shimadzu) were previously described.15,17 In brief, it consisted of 12 light source fibers and 12 detector fibers, resulting in a 36-channel recording of cortical changes in oxygenated hemoglobin (oxyHb), deoxygenated hemoglobin (deoxyHb), and total hemoglobin. The spatial resolution was a few centimeters beyond the interoptode distance set at 3.0 cm, and the temporal resolution was 380 ms. The optodes were placed tightly on the skull with the use of a holder cap fabricated from custom-made thermoplastic resin. Cz was the marker for ensuring replicable placement of the optodes. An anatomic MRI scan22 revealed that the optodes were located over an area of 13×13 cm in the bilateral...
frontoparietal regions (Figure 1). The medial SMC was covered by the medial parts of the posterior channels (channels 16 and 17 in the left hemisphere and channels 22 and 23 in the right), SMA by the medial parts of the middle channels (channels 14 and 15 in the left hemisphere and channels 20 and 21 in the right), and PMC by the lateral parts of the middle channels (channels 2, 3, 8, 9 in the left hemisphere and channels 26, 27, 32, 33 in the right). Pre-SMA was located in regions rostral to the SMA and above the anterior commissure line (channel 13 in the left hemisphere and channel 19 in the right). The prefrontal cortex was partially covered by channels 1 and 7 in the left hemisphere and channels 25 and 31 in the right.

We used oxyHb value as the marker for cortical activity because there was a task-related increase of oxyHb levels without apparent changes in deoxyHb levels in the medial SMC, and the cortical maps based on changes in oxyHb levels were similar to those from functional MRI during foot movements and gait imagery.15 Experience-based on changes in oxyHb levels were similar to those from changes in deoxyHb levels in the medial SMC, and the cortical maps in each region. CS indicates central sulcus.

Figure 1. Location of optodes. The NIRS system consists of 12 light source (white) and 12 detector (gray) fibers, resulting in 36 channels of source-detector pairs. The light source fiber next to the posterior one in the center column was located in the Cz portion. See text for the corresponding channel for each cortical region. CS indicates central sulcus.

Demographic Data of Patients

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Mean (SD) = 57 (12) 27.4 (2.6) 81 (30) 159 (29) 7.1 (2.2) 16.1 (7.2) 8.5 (5.0) 21.9 (7.6)

M indicates male; F, female; H, hemorrhage; I, infarction; Days, days poststroke; 1, first evaluation; 2, second evaluation; Sub, subcortex; Ctx, cortex; R, right; L, left; MMSE, Mini-Mental State Examination; FM, Fugl-Meyer Motor Scale; UE, upper extremity; LE, lower extremity; FM/UE, full=66; FM/LE, full=34.

Cortical Mapping of Gait in Patients With Stroke

Cortical activation maps during hemiparetic gait in individual cases are shown in Figure 2. In the first evaluation, activities were observed in the medial SMC that were fewer in the affected hemisphere than in the unaffected hemisphere, SMA, and PMC. Activation in the pre-SMA and prefrontal cortex varied but tended to be seen in patients with large cortical lesions and severe hemiplegia (Figure 2C and 2D), but there was no activation in the damaged cortical areas, as expected in these patients. In the second study, the asymmetry in SMC improved, and there was enhanced PMC activation, particularly in the affected hemisphere. Prominent pre-SMA or prefrontal activation was observed in patients with large areas of cortical damage (Figure 2C and 2D).

Regional Activation During Hemiparetic Gait

To confirm the findings from individual cortical maps, we performed group analyses. For regional activation, ANOVA
Figure 2. Cortical mapping of hemiparetic gait in patients with stroke. Cortical activation maps are based on changes in oxyHb levels during gait before (pre) and after (post) inpatient rehabilitation. Images in bottom row show site of lesions on T2-weighted MRI. L indicates left. A, Cortical mapping of gait in case 2, with infarction in the left corona radiata (arrow). On day 53 after stroke, the patient needed moderate assistance to take a step. SMC activation was much less in affected hemisphere than in unaffected hemisphere. After inpatient rehabilitation (118 days after stroke), the patient needed minimal assistance to perform the task. SMC activation was symmetrical and new activation was seen in SMA and PMc, especially in affected hemisphere. B, Cortical mapping of gait in case 3, with infarction in left corona radiata (arrow). On day 107 after stroke, the patient needed mild assistance with gait. There was less SMC activation in affected hemisphere than in unaffected hemisphere, but PMc and SMA were bilaterally activated. On the second imaging (176 days after stroke), the patient needed little assistance with gait. SMC were symmetrically activated, and there was persistent activation in PMc and SMA. C, Cortical mapping of gait in case 6, with diffuse infarction in right frontoparietal lobe. On day 102 after stroke, the patient needed maximum assistance with gait; this was the patient’s first opportunity to walk after the ictus. Mild activation was observed in PMc and prefrontal regions in affected hemisphere, parietal regions in unaffected hemisphere, and bilateral pre-SMA. There was little activation in the medial SMC. On the second evaluation (173 days after stroke), the patient needed mild assistance. NIRS imaging revealed enhanced activation in bilateral PMc, pre-SMA, and prefrontal areas and mild SMC activation in unaffected hemisphere. D, Cortical mapping of gait in case 8, with a large hemorrhagic lesion centered in right parietal lobe (arrow). On day 32 after stroke, the patient needed moderate assistance with gait. NIRS imaging showed prominent activation in unaffected hemisphere. After inpatient rehabilitation (98 days after stroke), the patient needed minimal assistance with gait, and enhanced activation was observed in the bilateral SMC, PMc, SMA, and prefrontal cortices.

revealed that there was no significant main effect of time or site. There was a significant interaction between time and site (F2,56 = 2.329, P = 0.0370). These findings indicated that time had distinct effects on regional activation. The effect of time on regional activation was significant only in the PMc in the affected hemisphere (F1,7 = 5.686, P = 0.0486), suggesting that enhanced activation in this area may be associated with locomotor recovery (Figure 3). For LI, there was no main effect of time or site. There was a significant interaction between time and site (F1,30 = 3.156, P = 0.0403), indicating that time had distinct effects on regional LI. The effect of time on regional LI was significant only in the SMC (F1,3 = 10.016, P = 0.0158), suggesting that asymmetrical SMC activation significantly improved after inpatient rehabilitation (Figure 4).

Gait Performance
After inpatient rehabilitation, motor impairment as measured by the Fugl-Meyer scale and gait performance significantly improved (P < 0.05; Table). Cadence was significantly greater (P < 0.005) on the second evaluation (55.3 ± 18.6 steps per minute; mean ± SD) than on the first evaluation (49.5 ± 17.6). Swing-phase LI was significantly greater (P < 0.05) after rehabilitation (−0.113 ± 0.095) than before rehabilitation (−0.199 ± 0.108). Importantly, changes of swing-phase LI significantly correlated with changes of LI in SMC (r = 0.723, P < 0.047) but not with changes of LI in PMc, SMA, or pre-SMA (Figure 5). Physiological parameters were comparable between the first and second NIRS measurements. There were no significant differences in baseline blood pressure (measurement 1 versus 2: 120 ± 8/85 ± 12 versus 123 ± 9/86 ± 10 mm Hg), heart rate (84 ± 12 versus 80 ± 10 beats per minute), and arterial oxygen saturation (96 ± 1% versus 96 ± 1%). After the tasks were performed, blood pressure (measurement 1 versus 2: 127 ± 10/92 ± 8 versus 128 ± 8/91 ± 8 mm Hg) and heart rate (93 ± 8 versus 89 ± 7 beats per minute) significantly increased from baseline levels (P < 0.01), but the changes were comparable. There were no significant changes in arterial oxygen saturation after the task was performed in either the first or second evaluation (97 ± 1% versus 97 ± 1%).

Discussion
There are 2 major differences in cortical activation patterns during gait between healthy subjects15 and patients with...
activation in these areas may possibly be related to improved gait performance. Second, enhanced PMC activation may reflect the need for stabilizing proximal limbs and trunk during gait since it participates in control of the contralateral proximal and bilateral axial musculature. Finally, altered activation patterns may result from reorganization of cortical motor networks. Similarly, hand recovery after stroke has been associated with bilateral activation in SMC, PMC, SMA, and cerebellum. The emerging importance of the ipsilesional PMC in motor recovery finds additional support in the experimental literature and the clinical finding that PMC damage decreased locomotor recovery.

Notable activities were seen in pre-SMA and prefrontal cortex. Pre-SMA activation is associated with performance of complex sequential motor tasks, selection of response in a simple choice reaction time task, and the initial stages of skill acquisition. Prefrontal lesions diminished attention to novel events. Thus, these activations are possibly associated with learning of gait, especially in severely affected patients, since patients showed enhanced prefrontal activation in the second evaluation; further studies are needed, however.

It is possible that some of our findings may depend on changes in basic cerebral blood flow rather than changes in brain function since cerebral blood flow and diaschisis evolve over time after stroke. Further studies are also needed to investigate how gait speed, cadence, and body weight support affect cortical activation patterns. NIRS imaging is a highly noninvasive technique, and patients with stroke tolerated the repeated measurements well. If we can elucidate cerebral activation patterns associated with improved real-world outcome, we might develop a brain-based as well as evidence-based rehabilitation technique that would induce the preferred cerebral activation.

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References


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