Perfusion-Weighted Imaging/Diffusion-Weighted Imaging Mismatch on MRI Can Now Be Used to Select Patients for Recombinant Tissue Plasminogen Activator Beyond 3 Hours

Pro

Peter D. Schellinger, MD; Jochen B. Fiebach, MD

“...It’s now or never. I was caught in a dead end street. A look (into your eyes) can heal me. And after this moment, you gave me something (back). What I really need.”

Primal Fear, “Nuclear Fire,” 2001

Of course, the “dead end street” refers to computed tomography (CT), “the healing look” to reading a stroke MRI, and being “given something that one really needs” to thrombolytic therapy.

What do we need to establish that a new methodology is ready to be put to use instead of an older one? We need to show that it is at least as good, if not better, than the old modality with regard to safety, feasibility, cost efficiency, and diagnostic and prognostic power. Over the last years, a growing number of reports on the use of multiparametric MRI protocols including diffusion-weighted imaging (DWI) and perfusion-weighted imaging (PWI) for guiding treatment in acute stroke patients have been published.1

MRI is safe in acute stroke patients; side effects such as allergic reactions to contrast agent and x-ray load virtually do not exist. Feasibility of stroke MRI is estimated between 75% and 95%,2–4 granted, somewhat lower than that of CT. The feasibility of stroke MRI depends in part on how patient instability, and therefore safety concerns, is defined in different centers. When compared with noncontrast CT alone, the cost of stroke MRI is higher; as soon as CT angiography and perfusion CT are added to the CT protocol, the difference in cost is marginal. Again, we admit that cost effectiveness of stroke MRI has not been proven yet.

However, it has been shown beyond doubt that the diagnostic accuracy of stroke MRI for ischemic stroke is significantly higher than that of CT, and for intracerebral hemorrhage, it is equally as good as CT.5,6 On the other hand, time to treatment is a very strong prognostic variable within the first 90 to 180 minutes after stroke onset.7 All recombinant tissue plasminogen activator trials with a time window exceeding 3 hours were negative, suggesting that thereafter, patient selection may be more important than time in combination with an insensitive diagnostic tool.

Several open controlled studies used the PWI/DWI mismatch concept to extend the therapeutic time window for thrombolytic therapy and showed that selected patients profit from treatment.8,9 Another series showed that patients who are treated on the basis of stroke MRI criteria within 3 to 6 hours fare at least as well as those being treated on the basis of CT within 3 hours.10 Finally, the recently presented Desmoteplase In Acute Ischemic Stroke phase II trial illustrated 3 important things.11 First, it demonstrated that thrombolysis beyond 3 hours works if an appropriate tool (ie, stroke MRI) for patient selection is applied. Second, reperfusion on stroke MRI paralleled clinical outcome, showing that stroke MRI may be used as a surrogate parameter for outcome. Third, the therapeutic effect on clinical and MRI outcomes did not depend on time to treatment, illustrating that patient selection may be more important than time. To prevent time loss where it really counts, CT should be the primary diagnostic tool within 3 hours if a center is not able to provide stroke MRI as fast as CT. In keeping with the times, stroke MRI can and should be applied to guide stroke therapy within institutional protocols outside the 3-hour time window if inclusion in a randomized controlled trial is not possible.

Conclusion

“Yes all need it—who. Who all need it—you. Who all need it, who all need it (yes you do). You all breathe it, we all need it. Are you ready for a good time? Are you ready?”

Taken from AC/DC, “The Razors Edge”, 1990

Yes, we are ready for stroke MRI!
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Con

Justin A. Zivin, MD, PhD

My German colleagues claim that MRI can now be used to select patients for tissue plasminogen activator (tPA) therapy beyond the 3-hour time window. I wish that were so. As a clinical investigator, it would make my life much easier. However, I still have important reservations.

The computed tomography (CT) criteria for excluding stroke victims within 3 hours were defined in the National Institutes of Health tPA trial3 as being the presence of an increased density on the image. This is associated with hemorrhage. However, as my colleagues note, “Although never formally assessed, CT is commonly considered the ‘gold standard’ to demonstrate intracranial hemorrhage.”4 Nevertheless, the tPA trials showed that excluding patients with this abnormality leads to demonstrable efficacy of treatment for acute stroke patients. The reason we want to exclude patients with hemorrhage is that a thrombolytic will not be efficacious and may increase the hemorrhage rate.1,3

Now the imagers want to substitute MRI for CT. We would like MRI to provide us with 2 types of information: (1) identification of salvageable tissue, and (2) exclusion of hemorrhage. Unfortunately, at present, we are not sure that MRI can do either. At least 3 clinical trials are currently in progress to find out whether perfusion/diffusion mismatch can be used to select patients with salvageable tissue. However, none of these trials have been published, so I cannot review the data. The claim is that the area in between the adequately perfused tissue and the DWI abnormality is the potential salvageable tissue. This is a common-sense idea, but similar armchair speculations in the past have been shown to be inaccurate. The standards for measurement of these differences are not yet well worked out, and there is much work left to be done. A problem with MRI is that we are not sure what the images mean. At a basic level, DWI, semiquantitatively, measures proton movement, and PWI

References

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Using Mismatch on MRI to Select Thrombolytic Responders
An Attractive Hypothesis Awaiting Confirmation

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O ur ability to image the ischemic penumbra in vivo raises the attractive possibility of individualized selection of acute therapy, particularly with thrombolytic agents. In other words, clinicians could potentially use magnetic resonance (MR) mismatch as a physiological tissue clock in acute stroke and allow selection of therapy beyond the accepted time windows. Indeed, this was foreshadowed nearly 25 years ago by the originators of the penumbral concept.1 As indicated by Schellinger and Fiebach, there is a body of evidence from small phase II studies to support this approach.2–4 However, prospective trials are still in progress to more rigorously test this hypothesis, and there remain significant uncertainties about the precise MRI definition of the penumbra. These include the optimal measure of perfusion (eg, mean transit time, Tmax, or time to peak), the issues of thresholding of perfusion because of benign oligemia, and the relationship between recanalization on MR angiography and reperfusion on perfusion-weighted imaging.

A further critical question that remains unanswered is the potential for diffusion-weighted imaging reversibility with thrombolysis.5 Hence, it is plausible that some mismatch patients might be recombinant tissue plasminogen activator (rtPA) responders. Therefore, when we designed the Echoplanar Imaging Thrombolysis Evaluation Trial (EPITHET) (testing the hypothesis that using mismatch, treatment responders to rtPA can be selected in the 3- to 6-hour window), we elected not to use this as an entry criterion.6 Only by including patients without mismatch in a prospective study can this hypothesis be adequately tested. Interestingly, in the Desmoteplase in Acute Ischemic Stroke trial7 of desmoteplase 3 to 9 hours, MR mismatch was used as an entry criterion. Conversely, in the nonrandomized Diffusion-weighted imaging Evaluation for Understanding Stroke Evo-
ution study,7 entry criteria are similar to EPITHET to enable the identification of MR patterns that predict response.

In selecting patients for thrombolysis beyond 3 hours, prediction of risk is as important as prediction of benefit. Hence, additional information required from these prospective trials will include the risk of hemorrhagic transformation in relation to the size of baseline perfusion and diffusion deficits. This emphasizes the uncertainties that exist and that it is premature to use MR treatment algorithms as a selection tool at present.

Hence, although not as skeptical as Zivin, we share his view that a higher level of evidence is required before MR mismatch can be used as a routine clinical tool. However, the concept is so attractive that it seems likely to be useful in some form or other.

"You may say I'm a dreamer, but I'm not the only one."

John Lennon, “Imagine,” 1977

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Key Words: mismatch ■ penumbra ■ stroke, ischemic ■ thrombolytic therapy
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