Invasive Cortical Stimulation to Promote Recovery of
Function After Stroke
A Critical Appraisal

Ela B. Plow, PhD, PT; James R. Carey, PhD, PT; Randolph J. Nudo, PhD; 
Alvaro Pascual-Leone, MD, PhD

Background and Purpose—Residual motor deficits frequently linger after stroke. Search for newer effective strategies to
promote functional recovery is ongoing. Brain stimulation, as a means of directing adaptive plasticity, is appealing. 
Animal studies and Phase I and II trials in humans have indicated safety, feasibility, and efficacy of combining 
rehabilitation and concurrent invasive cortical stimulation. However, a recent Phase III trial showed no advantage of the 
combination. We critically review results of various trials and discuss the factors that contributed to the distinctive result. 

Summary of Review—Regarding cortical stimulation, it is important to determine the (1) location of peri-infarct representations 
by integrating multiple neuroanatomical and physiological techniques; (2) role of other mechanisms of stroke recovery; (3) 
viability of peri-infarct tissue and descending pathways; (4) lesion geometry to ensure no alteration/displacement of current 
density; and (5) applicability of lessons generated from noninvasive brain stimulation studies in humans. In terms of 
combining stimulation with rehabilitation, we should understand (1) the principle of homeostatic plasticity; (2) the effect of 
ongoing cortical activity and phases of learning; and (3) that subject-specific intervention may be necessary. 

Conclusions—Future cortical stimulation trials should consider the factors that may have contributed to the peculiar results 
of the Phase III trial and address those in future study designs. (Stroke. 2009;40:1926-1931.)

Key Words: electrical stimulation of the brain ▪ neuronal plasticity ▪ recovery of function ▪ stroke rehabilitation

Upper limb function is one of the best predictors of long-
term disability after stroke. Rehabilitation improves upper 
limb function and reduces disability. Nevertheless, despite 
extensive therapy, recovery is frequently incomplete. Improved 
rehabilitation methods are needed to achieve higher levels of 
recovery. One appealing approach is neuromodulation through 
invasive cortical stimulation to supplement the effects of reha-
bilitation. Studies in animals and humans, which combined 
rehabilitation with concurrent invasive cortical stimulation, have provided encouraging results. However, these results 
have been contradicted by a recent industry-sponsored Phase III 
trial that showed no advantage of the combination. We critique 
the relevant literature, discuss factors that contributed to this 
distinctive result, and provide guidance for future studies. It is, 
however, important to first understand mechanisms of recovery, 
rehabilitation, and brain stimulation.

Spontaneous, Rehabilitation-Based, and 
Stimulation-Based Stroke Recovery

Spontaneous recovery of upper limb function involves different 
mechanisms, including (1) peri-infarct reorganization; (2) re-
cruitment of ipsilesional or contralesional areas; and (3) 
shifts in interhemispheric interactions and bihemispheric 
connectivity. Rehabilitation modulates one or more of these 
mechanisms, enhancing some and suppressing others, to im-
prove function. For example, rehabilitative distal forelimb train-
ing in primates and hand retraining and language therapy in 
aphasia in humans are associated with peri-infarct reorganiza-
tion. Virtual reality training promotes ipsilesional sensorimotor 
activation. Lastly, active–passive bilateral training and 
constraint-induced movement therapy help return hemi-
spheric balance. Nonetheless, despite extensive therapy, effect 
sizes for upper limb neurorehabilitation are small and residual 
deficits linger.

Brain stimulation, as an adjunct to other therapies, may 
magnify therapeutic outcomes. Its overarching aim is to 
increase ipsilesional excitability or decrease contralesional 
excitability. Noninvasive brain stimulation techniques, 
like high-frequency repetitive transcranial magnetic stimulation 
(rTMS), anodal transcranial direct current stimulation, or 
intermittent θ-burst stimulation delivered ipsilesion-
ally, low-frequency rTMS, cathodal transcranial 
direct current stimulation, or continuous θ-burst stimula-
tion delivered contralesionally, improve hand func-
Table 1. Different Types of Cortical Stimulation Used in Stroke Motor Rehabilitation

<table>
<thead>
<tr>
<th>Mode and Depth</th>
<th>Duration</th>
<th>Frequency</th>
<th>Intensity</th>
<th>Location</th>
<th>No. of Sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td>rTMS Transcranial</td>
<td>10 minutes</td>
<td>1 Hz</td>
<td>80%</td>
<td>Contralesional M1</td>
<td>1 day</td>
</tr>
<tr>
<td></td>
<td>8 minutes</td>
<td>3 Hz</td>
<td>90%</td>
<td>ipsilesional M1, contralesional PMC</td>
<td>5 days</td>
</tr>
<tr>
<td></td>
<td>20 minutes</td>
<td>10 Hz</td>
<td>80%</td>
<td>ipsilesional M1</td>
<td>8 days</td>
</tr>
<tr>
<td></td>
<td>25 minutes</td>
<td>10 Hz</td>
<td>120% MT</td>
<td>contralesional PMC</td>
<td>10 days</td>
</tr>
<tr>
<td>tDCS Transcranial</td>
<td>7 minutes</td>
<td>NA</td>
<td>1 mA</td>
<td>Anodal over ipsilesional M1, cathodal over contralesional M1</td>
<td>1 day 40,66 5 daily or 4 weekly, 30 sessions/6 weeks</td>
</tr>
<tr>
<td></td>
<td>20 minutes</td>
<td>(3 pulses at 50 Hz), applied at 5 Hz</td>
<td>80%</td>
<td>Intermittent over ipsilesional M1 and continuous over contralesional M1</td>
<td>1 day 42</td>
</tr>
<tr>
<td>TBS Transcranial</td>
<td>600 pulses</td>
<td>(3 pulses at 50 Hz)</td>
<td>100%</td>
<td>Ipsi-M1</td>
<td>1 day</td>
</tr>
<tr>
<td></td>
<td>300 pulses</td>
<td>(continuous)</td>
<td>120%</td>
<td>contralesional PMC</td>
<td>1 day</td>
</tr>
<tr>
<td>DCS Epidural</td>
<td>150 minutes</td>
<td>50–100 Hz</td>
<td>50% MT or 6.5 mA</td>
<td>Ipsilesional M1</td>
<td>3–6 weeks</td>
</tr>
</tbody>
</table>

tDCS indicates transcranial direct current stimulation; TBS, theta-burst stimulation; DCS, direct cortical stimulation; MT, motor threshold; PMC, premotor cortex; NA, not applicable.

...and greater neuronal density in peri-infarct M1. In summary, studies in nonhuman primates and rodents provided evidence that cortical stimulation is safe, effective for rehabilitation, and induces peri-infarct reorganization.

**Pilot Study of Combined Rehabilitation and Invasive Brain Stimulation in Humans**

An initial case study was conducted on a patient with subcortical stroke. Using functional MRI (fMRI), the wrist area of activation in M1 was defined. A 3×3 array of electrodes was implanted epidurally over the fMRI location. Viability of descending pathways was confirmed by evoking movements. The paretic arm and hand were trained concurrent with subthreshold invasive cortical stimulation (Table 2). After 3 weeks of combined treatment, the patient was able to perform a pincer movement; additionally, the scores on the Upper Extremity Fugl-Meyer (UEFM) and Stroke Impact Scale improved significantly.

**Phases I, II, and III of Combined Rehabilitation and Invasive Brain Stimulation in Humans**

After the successful case study, a Phase I trial was conducted to evaluate the safety of the combined approach. Eight patients were divided into 2 groups; one received invasive cortical stimulation concurrent with rehabilitation of the paretic upper limb and the other received rehabilitation alone. Methods were the same as described earlier. During confirmation of the stimulation site, high current levels were needed to evoke movements because patients were under general anesthesia. After 3 weeks of combined treatment, one patient sustained a postoperative infection due to protocol deviation and another had electrode lead breakage. Overall, however, the intervention proved safe.

In the Phase II trial, 24 patients were divided equally into 2 groups like in Phase I. Rehabilitation lasted 6 weeks.
Frequency was 50 Hz or 101 Hz versus 50 Hz in Phase I (Table 2). During confirmation of the stimulation site, movements or sensations were elicited in the contralateral arm in 42% of the patients in the combined treatment group. Significantly more patients in the combined treatment group showed clinically significant improvement on the UEFM (combined treatment: 67%; rehabilitation alone: 25%). Half the patients in the combined treatment group reached the composite end point, ie, clinically significant improvement on UEFM as well as Arm Motor Ability Test at posttest19 and at follow-up.18 Thus, the results of Northstar Neuroscience’s Phase III study were released in January 2008, which showed no advantage for concurrent invasive cortical stimulation than rehabilitation alone.

The results of Northstar Neuroscience’s Phase III study were released in January 2008, which showed no advantage for concurrent invasive cortical stimulation than rehabilitation alone. The trial enrolled 146 patients (combined=91, rehabilitation alone=55). Methods were the same as in Phase II. The proportion of patients in the combined treatment group, who (1) improved on the UEFM alone; (2) improved on the Arm Motor Ability Test alone; or (3) achieved the composite end point, was not significantly different from that of the rehabilitation group alone. The findings of this Phase III trial seem surprising in light of positive findings in the previous studies. We discuss various aspects of the combination treatment that warrant future investigation.

### Table 2. Studies of Concurrent Direct Cortical Stimulation and Physical Rehabilitation for Functional Recovery in Stroke

<table>
<thead>
<tr>
<th>Study</th>
<th>Phase</th>
<th>Purpose</th>
<th>Electrode Type</th>
<th>Frequency Current Duration</th>
<th>Behavioral Results</th>
<th>Reorganization Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pflautz et al (2003)</td>
<td>Primate</td>
<td>Feasibility and safety</td>
<td>Subdural (circular 1.5 mm²)</td>
<td>50 Hz 50% MT 1 s</td>
<td>Improved distal forelimb function</td>
<td>Expansion of distal forelimb representation in peri-infarct M1</td>
</tr>
<tr>
<td>Klein et al (2003)</td>
<td>Rodent</td>
<td>Compare different electrodes</td>
<td>Subdural (0.4 mm²)</td>
<td>50 Hz 50% MT 1 s</td>
<td>Higher reach accuracy in monopolar monopodal group</td>
<td>Increased functional peri-infarct cortex</td>
</tr>
<tr>
<td>Teskey et al (2003)</td>
<td>Rodent</td>
<td>Compare different frequencies</td>
<td>Subdural (0.4×3 mm²)</td>
<td>0, 25, 50, 100, 250 Hz 50% MT 3 s</td>
<td>Frequency ≥50 Hz showed increased accuracy</td>
<td>Frequency ≥50 Hz showed increased polysynaptic potentiation</td>
</tr>
<tr>
<td>Adkins-Muir and Jones (2003)</td>
<td>Rodent</td>
<td>Compare different frequencies</td>
<td>Subdural (1×3 mm²)</td>
<td>0, 50, 250 Hz 50–70% MT 3 s</td>
<td>50 Hz group improved most in accuracy</td>
<td>50 Hz group—increased MAP-2 reactivity in the perilesional cortex</td>
</tr>
<tr>
<td>Adkins et al (2006)</td>
<td>Rodent</td>
<td>Compare polarities and try epidural method of electrode implantation</td>
<td>Epidural (0.4×2 mm²)</td>
<td>0, 100 Hz 50% MT 3 s</td>
<td>Reaching performance better in stimulated groups</td>
<td>Neuronal density increased in perilesional cortex in cathodal 100-Hz group</td>
</tr>
<tr>
<td>Adkins et al (2008)</td>
<td>Animal</td>
<td>Variation of Cortical stimulation effects based on impairment level</td>
<td>Epidural monopolar</td>
<td>100 Hz 40–50% MT</td>
<td>Reaching improved in moderately impaired rats, not in severely impaired rats</td>
<td>Moderately impaired rats showed increase in the efficacious synapses</td>
</tr>
<tr>
<td>Brown et al (2003)</td>
<td>Human-single case</td>
<td>Explore combined treatment in humans</td>
<td>Epidural</td>
<td>50 Hz 4.5 mA 100 s</td>
<td>Improvement on pincer movement, UEFM, and SIS</td>
<td>Not explored</td>
</tr>
<tr>
<td>Brown et al (2006)</td>
<td>Human-Phase I (8 patients)</td>
<td>Safety</td>
<td>Epidural (3×3 array of 2-mm electrodes)</td>
<td>50 Hz 50% MT or 6.5 mA 3 s</td>
<td>Improvement on UEFM and SIS—2 patients withdrawn</td>
<td>Not explored</td>
</tr>
<tr>
<td>Phase II (Huang et al, 2008; Levy et al, 2008)</td>
<td>Human (24 patients)</td>
<td>Efficacy and safety</td>
<td>Epidural (2×3 array of 3-mm electrodes)</td>
<td>50 and 101 Hz 50% MT or 6.5 mA 3-s pulse trains</td>
<td>Combined group showed greater improvement on UEFM and AMAT</td>
<td>Not explored</td>
</tr>
<tr>
<td>Phase III clinical trial</td>
<td>Humans (146 patients)</td>
<td>Effectiveness and safety</td>
<td>Epidural (2×3 array of 3-mm electrodes)</td>
<td>50 Hz 50% MT or 6.5 mA 250-μs pulse duration</td>
<td>Combined group not better than control group on UEFM and AMAT</td>
<td>Not explored</td>
</tr>
</tbody>
</table>

SIS indicates Stroke Impact Scale; AMAT, Arm Motor Ability Test; MT, motor threshold; MAP, microtubule-associated protein.

### Review of Factors That Need Further Investigation in Cortical Stimulation Trials

#### Localization of the Site of Stimulation

Invasive cortical stimulation trials have used fMRI to localize site of stimulation. However, there are important limitations of fMRI data collection and analysis in relation to rehabilitation. First, the fMRI task should correspond with the parts of the body targeted by rehabilitation. In all trials, fMRI was used to find the locus of hand/wrist/finger movement,46–49 but rehabilitation was aimed at improving coordination of shoulder, elbow, and distal joints during reach/grasp and self-care. Second, patients with stroke show greater head motion than healthy control subjects.48

Head motion should be included as a covariate in analysis.49 Third, besides fMRI, techniques like (1) morphological localization of M1 using craniometer landmarks; (2) phase reversal to localize the central sulcus; and (3) motor mapping50 would provide a more accurate location for stimulation in future studies.

#### Targeted Pattern of Reorganization: Differences Between Animal Studies and Human Trials

Human trials have attempted to translate the results from animal studies in the hope of achieving similar success without accounting for the fundamental differences between patterns of reorga-
nization in animals and humans. First, animal trials use focal artificially induced lesions that usually lead to sparing in the adjacent cortex.10–13 However, in humans, the lesion typically is more diffuse, leading to lower survival of “peri-infarct” representations. Second, although human stroke recovery can be associated with peri-infarct reorganization,29–32 there is extensive evidence from studies of spontaneous improvement, noninvasive brain stimulation, and rehabilitation that indicate involvement of other mechanisms. These alternative mechanisms include recruitment of contralesional areas33–36 and surviving networks ipsilesionally37–40 or unaffected M1,41,42,63,67 they are nonfocal, including recruitment of contralesional areas38–40 and surviving networks ipsilesionally37–61 and interhemispheric interactions.31,38,42,43,45,46,63 Varied mechanisms might be operative depending on the type and location of lesion and the stage of recovery. Thus, targeting patient-specific and stage-specific mechanisms of recovery in humans, instead of attempting literal translation from animal studies, promises to improve efficacy of cortical stimulation interventions.

Predicting the Effect of Cortical Stimulation: Importance of Assessing Descending Pathways’ Viability
Viability of descending projections is an important factor in stroke motor prognosis.64 Viability of pathways could be assessed presurgically by evoking movements using TMS or intraoperatively using epidural electrodes. Only 16% of patients in the combined treatment group in the Phase III trial showed evoked movements intraoperatively as compared with 100% and 42% of patients in the Phase I and II trials, respectively. Indeed, the subset of patients in Phase III, who showed evoked movements, demonstrated significantly greater improvement than patients in the rehabilitation alone group (Northstar, unpublished data, 2008).

Influence of Tissue Characteristics on Current Distribution: Need for Mapping the Induced Currents
Using MRI-derived finite head modeling for examining effects of TMS, it is shown that in patients with cortical stroke, (1) location of maximal current density is displaced; (2) magnitude of maximal current density is altered due to cerebrospinal fluid shunting; and (3) the site of stimulation is disjointed and multifocal around the infarct.65 This will affect epidural more than subdural stimulation, thus making it more critical for human trials. In either case, modeling current distributions would optimize cortical stimulation paradigms and ensure that the desired brain region is targeted.

Lessons From Noninvasive Brain Stimulation Trials
Some investigators using noninvasive brain stimulation methods38,40 have speculated that although these techniques target affected38–40,66 or unaffected M1,44,45,63,67 they are nonfocal, possibly modulating other motor areas that critically contribute to the beneficial effects. If so, focal stimulation of M1 may be undesirable or even inefficient. Additionally, careful analysis of noninvasive brain stimulation studies in stroke indicates that dosage, frequency, and other parameters of stimulation are important factors to consider when predicting functional benefit.68 Hence, a detailed exploration of the focus and parameters of invasive cortical stimulation could possibly reveal results similar to those of noninvasive trials.

The impact of the type of behavioral coupling with stimulation should also be carefully considered. Pomeroy et al69 discussed that rTMS of the affected M1 in conjunction with voluntary biceps and triceps contraction increased cortical excitability but failed to induce functionally significant changes. Possibly brain stimulation exerts a task-specific effect that fails to generalize. Consistent with this notion, Mansur et al found transfer of motor training to dexterity and reaction time tests but not to finger tapping44 and Liepert et al saw differences in dexterity but not grip strength70 after inhibitory rTMS of the unaffected hemisphere. Coupling a more general training paradigm with stimulation might produce generalized improvements.

Customizing stimulation to the neural activation, genomic polymorphisms, and an individual’s response to stimulation is likely also critical. Malcolm et al,71 in a study of rTMS of the affected hemisphere, found a subgroup of patients showing desirable effects from stimulation (“stimulation responders”). “Stimulation responsiveness” could be a consequence of genetic predispositions. For example, Kleim et al72 found that “absence of val66met polymorphism” in the brain-derived neurotrophic factor gene allows for training-induced cortical reorganization. Furthermore, “stimulation responsiveness” could also be artificially promoted by customizing cortical stimulation to the cortical activation and function of patients. Nowak et al73 treated patients who showed contralesional recruitment of the dorsal premotor cortex in association with poor baseline function by using inhibitory 1 Hz rTMS over the contralesional M1. Thus, to predict the stimulation responsiveness, use of neurophysiological mapping or functional neuroimaging is critical.

Timing the Stimulation: Consider Ongoing Cortical Activity and the Different Phases of Motor Learning
Fluctuations in brain activity before or after stimulation can impact the effect of cortical stimulation. Homeostatic plasticity, as conceptualized by the Bienenstock-Cooper-Monroe theory,74 proposes that learning, through long-term potentiation-inducing mechanisms, strengthens synaptic connections to a level such that the effect of a subsequent long-term potentiation-inducing protocol is occluded.75 Thus, the specific timing between rehabilitation and cortical stimulation is critical. Additionally, state-dependency, ie, a targeted region’s varying response to stimulation based on its previous state of activity, should be studied in the context of combination of rehabilitation with stimulation.76 Closed-loop systems that record brain activity and gate the timing of stimulation might maximize the consistency of brain stimulation effect.77 Discontinuous patterns of invasive cortical stimulation could also be used to ensure that critical skill consolidation is not disrupted as witnessed with the use of TMS.78,79 Last, it is especially important to avoid intervening 2 training sessions with wakeful periods of declarative learning; instead, influence of sleep needs to be considered.80

Conclusions
Clearly, combining cortical stimulation with rehabilitation to promote functional recovery after stroke is complex and various
obscur but important issues have to be considered. Localization, descending pathways’ integrity, and pattern of reorganization to the target may need to be carefully individualized and guided by ongoing physiological monitoring in future invasive cortical stimulation trials. Lessons from noninvasive brain stimulation trials about task specificity and subject selection should also be understood to plan more valid designs in the future. The divergent findings of the Phase III trial compared with the Phase I, Phase II, and animal trials should also guide future noninvasive stimulation trials; lesion geometry–current modeling, integration of multiple site-localizing techniques, and monitoring of ongoing cortical activity could be helpful.

Disclosures

A.P.L. has served on Northstar Neuroscience’s Medical Advisory Board and has received an honorarium for that work in the past.

References

Plow et al.  Brain Stimulation for Motor Recovery in Stroke


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