Primary Motor Cortex in Stroke
A Functional MRI-Guided Proton MR Spectroscopic Study

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Background and Purpose—Our goal was to investigate whether certain metabolites, specific to neurons, glial cells, or the neuronal–glial neurotransmission system, in primary motor cortices (M1), are altered and correlated with clinical motor severity in chronic stroke.

Methods—Fourteen survivors of a single ischemic stroke located outside the M1 and 14 age-matched healthy control subjects were included. At >6 months after stroke, N-acetylaspartate, myo-inositol, and glutamate/glutamine were measured using proton magnetic resonance spectroscopic imaging (in-plane resolution = 5 × 5 mm²) in radiologically normal-appearing gray matter of the hand representation area, identified by functional MRI, in each M1. Metabolite concentrations and analyses of metabolite correlations within M1 were determined. Relationships between metabolite concentrations and arm motor impairment were also evaluated.

Results—The stroke survivors showed lower N-acetylaspartate and higher myo-inositol across ipsilesional and contralesional M1 compared with control subjects. Significant correlations between N-acetylaspartate and glutamate/glutamine were found in either M1. Ipsilesional N-acetylaspartate and glutamate/glutamine were positively correlated with arm motor impairment and contralesional N-acetylaspartate with time after stroke.

Conclusions—Our preliminary data demonstrated significant alterations of neuronal–glial interactions in spared M1 with the ipsilesional alterations related to stroke severity and contralesional alterations to stroke duration. Thus, MR spectroscopy might be a sensitive method to quantify relevant metabolite changes after stroke and consequently increase our knowledge of the factors leading from these changes in spared motor cortex to motor impairment after stroke. (Stroke. 2011;42:1004-1009.)

Key Words: 1H-MRS ■ motor impairment ■ plasticity ■ primary motor cortex ■ stroke ■ plasticity

After stroke, the spontaneous return of motor function is associated with the return of activity in the primary motor cortex (M1). Specifically, in subcortical stroke, arm function relies predominantly on the activity of M1 in the injured hemisphere (ipsilesional).1 The role of contralesional M1 in poststroke recovery is, however, less clear. Although the contralesional M1 can be recruited to compensate for damaged crossed pathways,2 some electrophysiological studies3,4 suggest that its inhibition improves motor function of the paretic arm, likely due to decreased abnormal interhemispheric inhibition from the contralesional M1 on the ipsilesional M1 during paretic arm movements.5 Although contralesional M1 recruitment might reflect recruitment of uncrossed pathways,6 there is no evidence that contralesional activation represents firing of uncrossed corticospinal tract fibers, which would be expected to involve proximal rather than distal movements.7 Contralesional M1 recruitment might also represent an epiphenomenon reflecting either diffuse recruitment of the motor networks driven by higher-order areas during paretic arm movement or dendritic overgrowth due to overuse of the healthy arm unmasked by the lack of transcallosal inhibition from ipsilesional M1.8

Therefore, understanding the neural events that parallel functional M1 changes should increase our knowledge of patient’s impairment. Proton MR spectroscopy (1H-MRS) provides insights into metabolic events involved in poststroke recovery.9 Specifically, low ipsilesional N-acetylaspartate (NAA), a marker of neuronal integrity, is related to cortical impairments in chronic stroke.10

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The online-only Data Supplement is available at http://stroke.ahajournals.org/cgi/content/full/STROKEAHA.110.601047/DC1.
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dysfunction,10 poor behavioral outcome,11 and possibly di- 
aschisis.12 Other 1H-MRS-visible metabolites might be inform- 
te. For example, myo-inositol (mi) provides insights into 
the role of glia in plastic brain changes13–15 or into nonsyn- 
aptic mechanisms underlying plasticity.16 Finally, glutamate/ 
glutamine (Glx), reflecting the neuronal–glial neurotransmis- 
sion system, might provide further insights into synaptic 
mechanisms underlying plasticity.16

We hypothesized that in patients with chronic (>6 months 
after onset) subcortical ischemic stroke, NAA, ml, and Glx in 
spared ipsilesional and contralesional gray matter of the hand 
representation area of M1, identified by functional MRI, 
would be altered compared with healthy control subjects. We 
also hypothesized that the metabolite concentrations would 
be related to arm/hand motor abilities.

Materials and Methods

Participants

Fourteen stroke survivors and 14 age- and sex-matched healthy 
control subjects signed informed consent in accordance with 
the University of Kansas Medical Center Human Subjects 
Committee (Institutional Review Board). Stroke survivors were included if 
they: (1) had a single ischemic stroke at least 6 months before 
participation; (2) had radiologically normal appearing M1 on 
T2-weighted MRI; and (3) were able to perform a handgrip task 
(Fugl-Meyer Upper Extremity Scale17 [FMUE] ≥10). Exclu- 
sion criteria are described in the Supplement (available at 
http://stroke.ahajournals.org). All patients were on antihypertensive 
therapy, and some were on cholesterol-lowering (n=7) and/or 
antiplatelet (n=7) therapy. No patients were receiving inpatient or 
outpatient rehabilitation therapy. Healthy control subjects, without 
neurological and psychiatric disorders, MRI contraindications and 
with normal T2-weighted images, were recruited.

Experimental Protocol

Arm motor impairment was assessed with the FMUE Scale. Because 
we used a handgrip task to elicit brain activation, we distinguished 
voluntary from involuntary (spastic finger flexion) contribution18 by 
subtracting the baseline from the maximal voluntary handgrip 
pressure using a Jamar dynamometer (Asimow Engineering Co, Los 
Angeles, CA).

Neuroimaging assessments were performed at 3 T (Siemens 
Medical Solutions, Erlangen, Germany). Whole-brain 3-dimensional 
T1-weighted MRI was acquired to estimate brain tissue volume in 
spectroscopic voxels (Magnetization Prepared Rapid Acquisition 
Gradient Echo; TR=2300 ms; TE=3 ms; field of view=240 mm; 
matrix size=256×256; resolution=1×1×1 mm3). An axial proton 
density/T2-weighted MRI parallel to the anterior commissure– 
posterior commissure (AC-PC) line was acquired (field of view=240 mm; 
matrix size=256×256; slice thickness=5 mm, no gap) to confirm the presence of a 
single ischemic lesion that did not involve M1 and to exclude other 
pathological conditions in stroke and undiagnosed pathology in 
control subjects.

Gradient echo blood oxygen level-dependent scans were acquired 
in 25 axial slices coincident with the PD/T2 series (TR=2000 ms; 
TE=50 ms; field of view=240 mm; matrix size=64×64; slice thick- 
ness=5 mm; 0 skip; in-plane resolution=5×5 mm2; 100 time 
points). One scan was performed for each hand and consisted of 2 
conditions: movement (20 seconds) and rest (20 seconds) repeated 5 
times (3 minutes 28 seconds). In the movement condition, partici- 
ants performed a single brief handgrip task repeated every 4 
seconds (further methodological details in the Supplement). We 
selected this task to broaden patient recruitment, because handgrip 
returns earlier than finger movements.19

Immediately after the acquisition was completed, the blood 
oxgen level-dependent data were analyzed using the scanner 
analysis software (online). Then, by visual inspection of all slices, 
we determined the slice corresponding to maximal M1 activation. 
This slice was used to select the corresponding coincident PD/T2 
image on which the 1H-MRS image slab was centered. Scalp lipid 
artifact was minimized with outer voxel suppression bands (thick- 
ness=30 mm) prescribed around and above the 1H-MRS image slab.

1H-MRS image was acquired using a point-resolved spectro- 
copy sequence (TE=30 ms; TR=1500 ms; matrix size=16×16; 
field of view=160 mm2; slice thickness=15 mm; in-plane resolu- 
tion=5×5 mm2; spectral width=1200 Hz). Automated, followed by 
manual, shimming was performed to achieve full-width at half 
maximum of <20 Hz of the water signal from the entire excitation 
volume.

To identify spectroscopic voxels corresponding to hand rep- 
resentation in M1, blood oxygen level-dependent data were analyzed 
using Brain Voyager (Brain Innovation BV, Maastricht, The 
Netherlands) and the general linear model was used to extract foci of 
activation in M1 (cluster threshold=100 contiguous voxels; 
P [Bonferroni]=0.01) and create a hand representation mask (further 
analysis details are presented in the Supplement). T1-weighted 
images were segmented using SPM2 (Welcome Department of 
Cognitive Neurology, London, UK) into white matter, gray matter 
(GM), and cerebrospinal fluid. 1H-MRS image data were analyzed 
using LCModel (linear combination of model spectra using a basis 
set included in the package)20 using a radiofrequency coil loading 
factor. Using custom-designed software (Matlab Version 7.1, 2005), 
the hand representation mask images were superimposed on seg-
metabolite T1-weighted images, 1H-MRS image, and LCModel output. Thus, 3 voxels that corresponded to M1 hand representation (Figure 1A, black squares) were selected to compute the mean concentrations for NAA, mI, and Glx with the following criteria: GM >75%, a signal-to-noise ratio >10, and Cramer-Rao lower bounds <20%. Metabolite concentrations were corrected for voxel parenchyma proportion as follows: c = cLCModel* [1/Fbrain], where c is corrected concentration, cLCModel the institutional unit from LCModel, and Fbrain the fraction brain tissue. Finally, metabolite concentrations were expressed in millimoles per kilogram wet weight by converting the institutional unit into molar concentrations (mM) with a calibration factor obtained by matching the mean NAA concentration in our control subjects to the mean concentration of GM NAA reported in healthy brain.21-23

Statistical Analysis
The analysis focused on 3 variables (NAA, mI, and Glx) in each M1 (ipsilesional and contralesional) and 2 outcomes (FMUE, handgrip strength). Means and SDs were computed for each variable. In addition, for each variable, between-group differences in mean concentrations were expressed as percentage change (SEs) of the healthy group by using bootstrapping. Stroke and healthy were compared for each variable individually and after adjusting for hemisphere and group-by-hemisphere interaction effects using 1- and 2-way analysis of variance, respectively. These models were controlled for GM fraction within region of interest in both groups and stroke duration in the stroke group. Spearman rank order correlation was used to quantify the relationships between metabolites within M1. Multiple regression was used to analyze the relationships between outcomes and metabolite variables. Bootstrapping was completed using R (Version 2.9.2). Other analysis was performed on SPSS 16.0 (Chicago, IL).

Results
Participants
Stroke and healthy participants did not significantly differ with respect to age (mean [SD] = 58.5 [9.4] years versus 52.1 [14.5] years, P = 0.18), years of education (13.4 [2.3] versus 14.6 [3.9], P = 0.30), or male/female distribution (10/4 in each group).

Stroke survivors had sustained a single cerebral infarction (41.7 [29.2] months previously leading to arm motor impair-

Table 1. Demographic and Clinical Characteristics of Stroke Survivors

<table>
<thead>
<tr>
<th>Age, Yrs/Sex</th>
<th>Stroke Duration, Months</th>
<th>Site of Stroke</th>
<th>FMUE (60)</th>
<th>Handgrip Strength (&gt;89%)</th>
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</thead>
<tbody>
<tr>
<td>68/M</td>
<td>63</td>
<td>L/basal ganglia, internal capsule</td>
<td>65</td>
<td>84.7</td>
</tr>
<tr>
<td>46/M</td>
<td>52</td>
<td>L/basal ganglia, internal capsule</td>
<td>63</td>
<td>96.4</td>
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<tr>
<td>48/F</td>
<td>11</td>
<td>L/MCA territory, striatocapsular distribution</td>
<td>61</td>
<td>93.6</td>
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<tr>
<td>71/M</td>
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<td>L/corona radiata, basal ganglia</td>
<td>54</td>
<td>96.0</td>
</tr>
<tr>
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<td>24</td>
<td>R/basal ganglia, internal capsule</td>
<td>50</td>
<td>87.2</td>
</tr>
<tr>
<td>61/F</td>
<td>27</td>
<td>L/MCA territory, striatocapsular distribution</td>
<td>50</td>
<td>86.4</td>
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<tr>
<td>65/M</td>
<td>36</td>
<td>R/MCA territory, striatocapsular distribution</td>
<td>42</td>
<td>88.1</td>
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<tr>
<td>71/M</td>
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<td>L/MCA territory, striatocapsular distribution</td>
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<td>84.4</td>
</tr>
<tr>
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<td>R/basal ganglia, internal capsule</td>
<td>36</td>
<td>41.9</td>
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<tr>
<td>63/F</td>
<td>48</td>
<td>L/pons</td>
<td>34</td>
<td>34.8</td>
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<tr>
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<td>15</td>
<td>L/pons</td>
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<td>61/M</td>
<td>24</td>
<td>L/MCA territory, striatocapsular distribution</td>
<td>10</td>
<td>7.2</td>
</tr>
</tbody>
</table>

M indicates male; F, female; L, left; MCA, middle cerebral artery; R, right.

Imaging Findings
The percentages of brain tissue and GM within M1 were similar between stroke and control subjects (ipsilesional 90.5% [5.7%] versus left 93.6% [2.3%], P = 0.07; GM: 75.1% [6.1%] versus 75.6% [9.3%], P = 0.95; contralesional 82.9% [11.8%] versus right 87.2% [6.7%], P = 0.3; 75.1% [3.6%] versus 75.4% [3.9%], P = 0.8). Although larger M1 activations were found in stroke compared with control subjects (ipsilesional 27.6% [9.9%] versus left 8.2% [4.9%], P < 0.001; contralesional 14.8% [10.1%] versus right 0.8% [1.2%], P = 0.002), the anatomic locations of spectroscopic voxels were similar in both groups.

1H-MRS Findings
In our control subjects, similar concentrations of NAA, mI, and Glx were found in both left and right M1 (Table 2). Consistent with previous studies,21,22,24 left NAA and mI concentrations were correlated with region of interest GM fraction (r = 0.58, P = 0.03; 0.58, P = 0.03, respectively).

Significant metabolite differences between stroke and control subjects were found for NAA and mI (Table 2). Follow-up analysis found generally lower NAA (ipsilesional: −14.2% [5.2%], P = 0.02; contralesional: −10.9% [4.9%], P = 0.05) and higher mI (ipsilesional: +13.2% [7.6%], P = 0.08; contralesional: +12.6% [6.6%], P = 0.06) in stroke (Figure 2A). In stroke survivors, NAA was lower in ipsilesional than contralesional M1 (9.7 mM [1.6 mM] versus 10.7 mM [1.6 mM], P = 0.03). No significant correlations were found between ipsi- or contralesional metabolites and region
of interest GM fraction. Contralesional NAA was positively correlated with time after stroke ($r=0.61$, $P=0.02$).

Stronger and significant correlations between NAA and Glx were detected in each M1 in stroke (ipsilesional, $r=0.67$, $P=0.009$; contralesional, $r=0.80$, $P=0.002$) than in control subjects ($r=0.46$, $P=0.10$; $r=0.16$, $P=0.69$; Figure 2B).

FMUE scores were correlated ($R^2=0.60$) to ipsilesional NAA ($\beta=12.4$, $P=0.01$) and Glx ($\beta=-6.9$, $P=0.04$). No significant correlations were found between ipsi- or contralesional metabolites and handgrip strength.

**Discussion**

We introduced a novel approach to studying poststroke reorganization by measuring metabolites specific to neurons, glia, or the neuronal–glial neurotransmission system. Overall, we found altered metabolite concentrations and high metabolite correlations within M1 in chronic stroke. Metabolite concentrations were correlated with stroke severity and duration.

Because metabolite changes occurred in spared M1, diaschisis is possibly involved.$^{12,25}$ Diaschisis, that is, neural dysfunction due to structural or functional disconnectivity of intact brain regions remote from, but connected, to the insult location, might impair motor recovery by preventing post-injury neural reorganization.$^{26}$ Alternatively, diaschisis is considered a part of neural reorganization, for example, development of new cortical connections.$^{27}$ Although diaschisis has been reported several weeks to months after stroke,$^{12}$ our data suggest that metabolite alterations might persist considerably longer, that is, up to 9 years after injury.

Mechanisms such as neuronal death and/or altered neuronal metabolic activity$^{16}$ might induce low ipsilesional NAA. Retrograde degeneration could be a potential candidate for neuronal death. Although limited retrograde degeneration has been detected after subcortical infarction,$^{28}$ data on incidence, development period, or distance of this process are lacking in humans. Findings in animal models support the presence of this phenomenon but suggest that it is limited to just a few millimeters above the lesion.$^{29}$ Thus, neuronal death due to retrograde degeneration seems an unlikely cause. Alternatively, low NAA might indicate altered neuronal metabolism. In addition, the positive relationships between ipsilesional NAA and clinical severity and between contralesional NAA and stroke duration provide support for NAA as a marker of poststroke reorganization in both injured and uninjured hemispheres.

Myo-inositol was significantly increased across ipsilesional and contralesional M1 compared with control subjects, possibly indicating glial involvement. Owing to their plasticity and sensitivity to neuronal activity, we have hypothesized that glia could play a significant role in poststroke plasticity. Indeed, astrocytes release trophic factors promoting neuronal survival and synaptogenesis, neurogenesis, and angiogenesis after stroke$^{13,14}$ and participate in long-term synaptic plasticity.$^{13,14}$

![Table 2. Between-Group Comparisons of Metabolite Concentrations](http://stroke.ahajournals.org/)

<table>
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<th>NAA</th>
<th>ml</th>
<th>Glx</th>
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<tr>
<td>Healthy vs Stroke</td>
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<tr>
<td>Left+right vs ipsilesional</td>
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<tr>
<td>Healthy</td>
<td>11.7 (1.8)</td>
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<tr>
<td>Stroke</td>
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<td>6.1 (0.9)</td>
<td>11.6 (3.4)</td>
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<tr>
<td>$F_{1,56}$</td>
<td>9.97</td>
<td>7.2</td>
<td>0.7</td>
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<td>$P$</td>
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<td>0.01</td>
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<td>0.059</td>
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Metabolite concentrations are shown as Mean (SD), concentration expressed as mmol/L.

Figure 2. A, Metabolite changes (%) and SE (bootstrapping) in stroke vs controls in ipsilesional (gray bars) and contralesional (black) M1. B, Correlation coefficients ($r$) and 95% CI between NAA, ml, and Glx within M1 in control subjects (white dots) and patients with stroke (black). Lines indicate the statistically significant $r$ ($P<0.05$).

Table 2. Between-Group Comparisons of Metabolite Concentrations

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Metabolite concentrations are shown as Mean (SD), concentration expressed as mmol/L.
Alternatively, high mI might indicate gliosis. However, as noted previously, neuronal death that might trigger gliosis seems unlikely in spared M1. Moreover, there were no significant changes in the correlations between NAA and mI in either M1 (Figure 2B). Thus, high mI is not due solely to a gliotic process. Another explanation for increased mI would lie in its osmolyte proprieties. Because glutamate and glutamine, other major brain osmoles, tend to be lower in these areas, it is therefore unlikely that increased mI was driven by hyperosmolarity, which would also increase glutamate and glutamine. Finally, mI is also involved in various cellular functions, that is, cellular membrane-based secondary messenger system, as stated earlier. Although the exact mechanisms underlying mI increase remain unsettled, our data suggest that glial cells could be actively involved in poststroke reorganization.

Glutamate, involved in neurotransmission (80% to 100% of glutamate is rapidly cycled to glutamine) and other metabolic processes, is a major component of Glx. Although our data did not show significant Glx changes, the correlation between ipsilesional Glx and motor impairment as well as the presence of stronger and significant correlations between NAA and Glx in both M1s suggests a potential role of Glx in poststroke plasticity. However, we cannot confirm whether the Glx involvement represents a consequence or the source of motor disability.

There were some potential pitfalls with the current approach. The use of antiplatelet therapy (ie, clopidogrel) could increase the resting cerebral blood flow, which would decrease the blood oxygen level-dependent response. We found, however, larger blood oxygen level-dependent responses in our stroke participants.

Although the effects of the cerebral blood flow alterations on the cerebral metabolites are inconclusive, we cannot rule out that low NAA could be the result of carotid stenosis. Our unpublished data have shown no significant NAA decrease in the dorsal premotor cortex. Thus, misery perfusion is an unlikely explanation because a global effect would be expected.

Because our stroke sample included mostly left hemispheric strokes, we did not address the potential differences between brain reorganization of left- versus right-sided, limiting the generalizability of results.

Although no power analysis was performed in this exploratory study, our data provide important information for formulating hypotheses in future confirmatory studies.

Conclusions
The current study adds new perspectives to address poststroke plasticity and provides further evidence that 1H-MRS might broaden our understanding of cellular processes underlying plasticity in vivo.

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Disclosures
None.

References


Primary Motor Cortex in Stroke: A Functional MRI-Guided Proton MR Spectroscopic Study


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SUPPLEMENTAL MATERIAL

Supplemental Methods

Participants
Candidates were selected from the University of Kansas Medical Center stroke database between 2006 and 2009. Out of a 134-candidate pool, 29 met inclusion criteria (i) single ischemic stroke six months previously, (ii) no chronic/degenerative disease predating the stroke and affecting the central nervous system, and (iii) no MRI contraindications. Of these, 9 patients were excluded for severe hemiparesis (FMUE<10, 17%) or claustrophobia (14%). Thus, 20 participants were enrolled. All but six completed the protocol. These six were excluded due to stroke location after the inspection of T2-weighted images (cortical stroke affecting M1 or cerebellum).

Exclusion criteria included: (i) other neurological disorders (medical chart review); (ii) receptive aphasia (Token test); (iii) visual attention deficits (Cancellation test); (iv) apraxia (clinical observation of the use of scissors to cut paper and making coffee); and (iii) contraindications to MRI.

Experimental protocol
The total scan duration for both fMRI and 1H-MRSI was about 45 min. Participants’ heads were immobilized with head cushions and instructed not to move during scanning.

BOLD acquisition: During BOLD scan, instructions were presented through MRI-compatible goggles. To ensure similar performance, participants performed the handgrip until the target pressure (25% of MVHG) was attained, at which point the grip was released. In the rest condition, a sign instructed the participants to lie motionless.

BOLD analysis: Functional MRI data were analyzed using Brain Voyager. Motion correction was performed by a rigid body transformation, estimating three translation and three rotation parameters. These parameters were inspected for head movement. None of the participants moved their head >2mm in any direction. Then, 3D spatial smoothing with a 4mm Gaussian filter was used to permit valid statistical inference according to the Gaussian random field theory. The time series in each voxel was high pass filtered at 0.01Hz to remove low frequency confounds. Movement and rest periods were modeled by a boxcar function with hemodynamic response modification (predictor movement).