Successful Microbubble Sonothrombolysis Without Tissue-Type Plasminogen Activator in a Rabbit Model of Acute Ischemic Stroke

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Background and Purpose—Microbubbles (MB) combined with ultrasound (US) have been shown to lyse clots without tissue-type plasminogen activator (tPA) both in vitro and in vivo. We evaluated sonothrombolysis with 3 types of MB using a rabbit embolic stroke model.

Methods—New Zealand White rabbits (n = 74) received internal carotid angiographic embolization of single 3-day-old cylindrical clots (0.6×4.0 mm). Groups included: (1) control (n = 11) embolized without treatment; (2) tPA (n = 20); (3) tPA + US (n = 10); (4) perfluorid lipid MB + US (n = 16); (5) albumin 3 μm MB + US (n = 8); and (6) tagged albumin 3 μm MB + US (n = 9). Treatment began 1 hour postembolization. Ultrasound was pulsed-wave (1 MHz; 0.8 W/cm²) for 1 hour; rabbits with tPA received intravenous tPA (0.9 mg/kg) over 1 hour. Lipid MB dose was intravenous (0.16 mg/kg) over 30 minutes. Dosage of 3 μm MB was 5×10⁶ MB intravenously alone or tagged with epifibatide and fibrin antibody over 30 minutes. Rabbits were euthanized at 24 hours. Infarct volume was determined using vital stains on brain sections. Hemorrhage was evaluated on hematoxylin and eosin sections.

Results—Infarct volume percent was lower for rabbits treated with lipid MB + US (1.0%±0.6%; P = 0.013), 3 μm MB + US (0.7%±0.9%; P = 0.018), and tagged 3 μm MB + US (0.8%±0.8%; P = 0.019) compared with controls (3.5%±0.8%). The 3 MB types collectively had lower infarct volumes (P = 0.0043) than controls. Infarct volume averaged 2.2%±0.6% and 1.7%±0.8% for rabbits treated with tPA alone and tPA + US, respectively (P = nonsignificant).

Conclusions—Sonothrombolysis without tPA using these MB is effective in decreasing infarct volumes. Study of human applicability and further MB technique development are justified. (Stroke. 2011;42:2280-2285.)

Key Words: animal models ■ ischemia ■ microbubble ■ thrombolysis ■ ultrasound
without exogenous tPA using transcutaneous US. The work in dogs and pigs was mechanistically similar to our current stroke model in the rabbit. However, these studies lacked evaluation of the possible therapy side effects on ischemic brain and especially lacked evaluation of hemorrhage associated with reperfusion of ischemic brain. This rabbit model uses infarct volumes as an end point, a much more important end point than simple large vessel recanalization, which neglects distal embolization and potential “no reflow” problems. Apparently, endogenous tPA in animal endothelium is adequate to lyse small clots when coupled with MB + US. Therefore, exogenous tPA is not necessary and associated hemorrhagic complications may also be avoided. Still, sonothrombolysis trials without tPA in humans are lacking.

To evaluate this concept in actual ischemic strokes, we tested MB of various types in an embolic clot stroke model in rabbits. A similar model previously led to successful human trials without exogenous tPA using transcutaneous US. The preparation of embolus and use of various therapies on infarcts of fairly uniform location and size.

Materials and Methods

Animal Protections

Animal procedures were approved by the Institutional Animal Care and Use Committee. New Zealand white rabbits (Myrtle’s Rabbitry, Thompson’s Station, TN; n = 74; mean body weight, 5.2 ± 0.07 kg) were randomly chosen and randomly placed into the various treatment groups.

Surgical and angiographic procedures were described previously. Briefly, rabbits were sedated with an intramuscular injection of 35 mg/kg ketamine and 5 mg/kg xylazine and anesthetized with isoflurane. A femoral artery was exposed, and a 3-Fr vascular sheath was used to place a modified 65-cm angled-tip 3-Fr catheter into the artery. Using standard angiographic techniques, the 3-Fr catheter was advanced to the internal carotid artery.

Subselective internal carotid artery magnification angiography (Figure 1A) preceded embolization, accomplished by injecting a 4.0 × 0.6-mm cylindrical clot with 0.7 to 2.0 mL of saline. Repeat angiography 1 minute later documented occlusion (Figure 1B).

Ultrasound

Ultrasound with MB was performed by sonication of a decafluorobutane gas-saturated solution of 5% w/v human serum albumin (Plasbin; Talecris Biotherapeutics, Inc, Research Triangle Park, NC) and 10% w/v dextrose (Sigma-Aldrich Co, St Louis, MO) using a Fisher 500 Sonic Dismembrator (Fisher Scientific, Waltham, MA). Sonication was in 2 steps: 30 seconds at 250 W and 20 seconds at 450 W.

Preparation of Embolus

Donor rabbit arterial blood was immediately transferred into 1.5-mm inner diameter glass tubes (Natelson Blood Collecting Tube; Fisher Scientific, Waltham, MA), clotted at 37°C for 6 hours, and incubated at 4°C for 66 hours. The clot was expelled from the tubing and cut to size (4.0 × 0.6-mm cylinder). A single clot was drawn into a 3.0-mL syringe containing physiological saline for injection into the internal carotid artery.

Treatments

Rabbits were randomly assigned to groups: (1) control (n = 11); (2) tPA only (n = 20; (3) tPA + US (n = 10); (4) lipid MB + US (n = 16); (5) 3 μm MB + US (n = 8); and (6) tagged 3 μm MB + US (n = 9). Control rabbits were embolized but received no therapy. Rabbits administered tPA received intravenous tPA in a standard dose (0.9 mg/kg) with an initial 10% bolus and the remainder administered over 1 hour. This corresponds to the standard human dosage and a classic previous rabbit study that has been efficacious in our preliminary studies. Rabbits administered lipid MB (LMB) received intravenous perflutren lipid microspheres (Definity; Lantheus Medical Imaging; North Billerica, MA) at a dose rate of 0.16 mg/kg, a 10-fold increase over standard image contrast dose, over 30 minutes.

LMB were activated by vigorous mechanical shaking per the manufacturer’s instructions. The required dose was diluted to 6.0 mL with physiological saline and administered in 1-mL boluses every 5 minutes.

Custom 3 μm MB were prepared by sonication of a decafluorobutane gas-saturated solution of 5% w/v human serum albumin (Plasbin; Talecris Biotherapeutics, Inc, Research Triangle Park, NC) and 10% w/v dextrose (Sigma-Aldrich Co, St Louis, MO) using a Fisher 500 Sonic Dismembrator (Fisher Scientific, Waltham, MA). Sonication was in 2 steps: 30 seconds at 250 W and 20 seconds at 450 W.
The 3 μm MB were isolated on the basis of differential buoyancy. Some 3 μm MB were then dual tagged using a 3b2a inhibitor, eptifibatide, at a very low dose20 and a monoclonal antibody to the human D-dimer fibrin degradation product (American Diagnostics, Inc, Stamford, CT). Antibody was chemically crosslinked to the MB with a chemical crosslinker using 100 μg of antibody per 10^10 MB. Our testing confirmed the reaction and binding to clotted rabbit blood, in agreement with another study.23 The 3 μm MB were diluted to provide 5×10^9 MB for injection as stated previously.

**Functional Testing**

Before euthanasia, each rabbit received a neurological assessment score using the wryneck test procedure described previously. The neurological assessment score tests motor, sensory, balance, and reflex measures and ranges from 0 to 10 with higher scores indicating greater neurological injury.

**Measurement of Infarct Volume**

At 24 hours, rabbits were euthanized by intravenous administration of 1.5 mL pentobarbital. The brain was harvested, chilled in saline for 1 hour, and sliced at 0.4-cm intervals using a chilled brain mold (RBM-7000C; ASI Instruments Inc, Warren, MI). Coronal brain sections (n=8 in each rabbit) were placed in 1% 2,3,5-triphenyltetrazolium chloride for 45 minutes at 37°C, fixed in 10% formalin, and digitally photographed (Figure 2). Areas of infarction were measured using digital analysis (ImageJ; National Institutes of Health, Bethesda, MD). Each brain section volume and stroke volume was calculated by multiplying the section area by the slice thickness (0.4 cm). Images were measured by technicians blinded to treatment group. Percent infarct volume was calculated.

**Hemorrhage Determination**

Fixed brain sections were embedded in paraffin, sectioned at 4 μm, stained with hematoxylin and eosin, and evaluated by a veterinary pathologist. Intracranial hemorrhage was defined as extravasation of erythrocytes and fluid into the extravascular space. The presence of intracerebral hemorrhage and its location were recorded (Figure 2). All hemorrhage analyses were performed by a veterinary pathologist blinded to treatment group.

**Blood Tests**

Blood samples were collected from an auricular artery before embolization (baseline) and at 3 and 24 hours postembolization. The serum was stored at −80°C until analysis. S-100B serum concentrations were measured by enzyme-linked immunosorbent assay.

**Statistical Analysis**

Percent infarct volume was compared among experimental groups using 1-way analysis of variance. Percent infarct volume for each group is reported as least square mean±SE as generated by PROC GLM in the SAS software (SAS Institute Inc, Cary, NC). Median neurological assessment score scores are reported for each group and the distribution of scores among the treatment groups compared with the Kruskal-Wallis test. The incidence of hemorrhage within or outside the stroke was compared using the χ^2 test. Three-hour and 24-hour S-100B values for each rabbit were divided by that rabbit’s baseline measurement to create 3- and 24-hour fold change values. The effects of treatment and time on these S-100B fold changes were tested using an unstructured covariance matrix in PROC MIXED in SAS, a repeated-measures analysis of variance procedure followed by individual group comparisons using least squares means. Fold changes are reported as least squares means±SEs. Pearson correlation was used to evaluate the association between percent infarct volume and 24-hour S-100B values.

**Results**

Seventy-four rabbits completed the protocol and were evaluated (Figure 3). Mean infarct volume percent was lower for
rabbits treated with LMB+US (1.0%±0.6%; P=0.013), 3 μm MB+US (0.7%±0.9%; P=0.018), and tagged 3 μm MB+US (0.8%±0.8%; P=0.019) compared with control rabbits (3.5%±0.8%). Infarct volume averaged 2.2%±0.6% and 1.7%±0.8% for rabbits treated with tPA alone and tPA+US, respectively, and did not differ from controls, P=0.18 and P=0.10, respectively. The 3 MB types collectively differed (P=0.0043) from control, showed a trend versus tPA (P=0.058), and were not different from tPA+US (P=0.36).

Mean fold increases over pre-embolization levels at 3 and 24 hours postembolization in S-100B values (n=58) reveal significant increases at 3 hours for the tPA (1.6-fold) and tPA+US (1.7-fold) groups (P=0.01 each) and at 24 hours for control (3.1-fold), tPA (3.0-fold) and tPA+US (3.7-fold) groups (P=0.001 each; Figure 4). LMB+US, 3 μm MB+US, and tagged 3 μm MB+US did not increase S-100B levels significantly at 24 hours (1.7-fold, 1.6-fold, and 2.2-fold, respectively, P=0.21, 0.46, and 0.19, respectively). Twenty-four-hour S-100B increases of the 3 MB types collectively were lower than those of control, tPA, and tPA+US (P<0.05 for each). S-100B values at 24 hours were positively correlated with infarct volume (r=0.45, P<0.001).

Microscopic hemorrhage rates were similar in all groups both in areas of stroke (P=0.47) and areas outside stroke (P=0.85). Hemorrhage within stroke was seen in controls (73%), tPA (50%), tPA+US (50%), LMB+US (31%), 3 μm MB+US (50%), and tagged 3 μm MB (56%). Hemorrhage outside of stroke was 36%, 45%, 50%, 50%, 25%, and 33%, respectively.

Median neurological assessment score values were also similar in all groups: control 3.0, tPA 1.0, tPA+US 1.0, LMB+US 2.5, 3 μm MB+US 0.0, and tagged 3 μm MB+US 2.0 (P=0.27).

Angiography (n=74) showed occlusions of the middle cerebral artery in 88%, anterior cerebral artery in 47%, and posterior cerebral artery in 4%. No visible embolus was seen in 5%, but 3 of these 4 had measurable areas of appropriate stroke on 2,3,5-triphenyltetrazolium chloride stains. The fourth had no visible stroke but was in the control group, lowering that mean value. Eleven other animals did not complete the protocol: 5 with posterior cerebral artery occlusions and symptoms requiring early euthanasia (1 control, 2 tPA+US, 1 MB+US, 1 tagged 3 μm MB+US), 4 with superior cerebellar artery occlusion and early death (1 control, 1 tPA, 1 MB+US, 1 3 μm MB+US), 1 with occlusion of 4 vessels and outlier severe stroke volume (1 control), and 1 died overnight and volumes could not be measured (1 tPA).

These were distributed randomly in the groups and not included in statistical evaluations.

Discussion

Improved stroke therapy with better efficacy and without the severe hemorrhagic complications associated with tPA is needed urgently. Although MB augmentation of sonothrombolysis has been previously established, demonstration in an ischemic stroke model is required before human trials without intravenous tPA, the standard of care, can be seriously considered.

This series of rabbits clearly shows good efficacy of MB+US without any exogenous tPA when using any of 3 MB techniques (Figure 3). Significantly smaller stroke volumes and attenuated S-100B increases confirm improved end-organ (brain) status with these techniques. Treatment with standard tPA or tPA+US trended toward improvement in stroke volume but did not reach statistical significance with the power available in this study. Potential mechanisms for reduced infarct volume may include: arterial thrombolysis and prompt reperfusion, US dilation of vessels and improved blood flow, and collateral augmentation.26 Unknown factors dealing with endogenous immune mechanisms are suspect but not yet proven.27 This suggests that MB+US therapy is even more efficacious than tPA alone, but this study did not have sufficient power to differentiate between tPA and MB techniques.

These results are based primarily on direct measurement of stroke volumes, a 24-hour 2,3,5-triphenyltetrazolium chloride measurement reflective of basic brain infarction, and confirmed with histological evidence. The improved brain outcomes are apparent, whether they are due to large vessel clearing, small vessel dilatation, collateral recruitment, or a combination of factors.11 Overall survival of more brain, the object of therapy, was clearly demonstrated.

As a peripheral blood biochemical marker of brain injury, S-100B elevation has been correlated with infarct volume, hemorrhagic transformation, and functional outcomes. Serum levels of S-100B, an astrogial protein, have been used to support conclusions drawn about therapeutic agents in ischemic stroke.28–30 The S-100B scores support the stroke volume data with detection of less damage in the MB groups than in controls (Figure 4).

The stable levels of hemorrhage are particularly encouraging. Increased bleeding in the Transcranial Low-Frequency Ultrasound-Mediated Thrombolysis in Brain Ischemia (TRUMBI) Trial of ultrasound augmentation of thrombolysis...
with tPA was seen with much different equipment and a frequency of 300 kHz. Apparently this was not a problem at 2 MHz in Molina’s and Alexandrov’s initial studies. Increased bleeding was encountered in the prematurely terminated Transcranial Ultrasound in Clinical SONothrombolysis (TUCSON) trial that used 2 MHz US and high levels of MB with normal tPA doses, but this may be due to patient selection differences. It was not seen in the current study at 1 MHz using even higher MB levels. Although the microscopic hemorrhages seen here have yet to be followed for long-term symptomatic intracranial hemorrhage development, the data here with unchanged incidence of bleeding is promising. Our earlier work with smaller strokes in rabbits (unpublished data) showed decreased microscopic hemorrhage with MB+US, but this did not continue with these larger strokes. Perhaps larger areas of ischemia elevate hemorrhage risk and the favorable findings in small strokes disappear. It was hypothesized that tagged 3 μM MB would be delivered more effectively to the embolus than other MB and would further improve outcomes. This was not observed nor was there improvement with the 3 μM untagged MB compared with the LMB, although both types of 3 μM MB showed superiority to LMB using in vitro sonothrombolysis studies. This model did not provide much opportunity for further improvement from the 1.0%±0.6% stroke volume obtained with LMB. A more severe model will be required. Although lower than controls in all treatment groups, neurological assessment score values derived from physiological tests were not significantly improved or different between these groups, reflecting a lack of sensitivity of this scoring system to anterior strokes. Posterior strokes cause dramatic neurological deficits with high scores. However, the targeted anterior circulation in rabbits is more forgiving or silent, even with large infarcts.

Although this study focused on stroke therapy, the brain is a difficult US target compared with others. US delivery through the skull must contend with high attenuation of acoustic energy in bone. This difficulty has been overcome using narrow beams of focused 2-MHz transcranial Doppler, and with IV delivery using special catheters tipped with 2-MHz transducers, which travel through the vessel directly to clot. Other anatomic sites, including dialysis grafts and peripheral blood vessels, are easily accessed with either large transcutaneous or intravascular transducers. Although deeper structures may require sophisticated approaches, successful transcutaneous sonothrombolysis has been reported in coronary occlusions in pigs and, ultimately, almost all anatomic areas are likely to be served.

Study limitations include the inability to separate in vivo the effects of 3 different MB, which are clearly different in in vitro testing. A more severe stroke model is needed and is under development. Another limitation is that correlation of microscopic bleeding at 24 hours in rabbits with symptomatic human bleeding is not yet proven. We are addressing this with long-term survival studies.

In summary, using the rabbit model, MB sonothrombolysis with no exogenous tPA produces significant improvement in strokes without apparent side effect. A long series of animal studies has now shown that human trials without tPA or in patients in whom tPA is contraindicated are warranted.

References


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