Stratification of Heterogeneous Diffusion MRI Ischemic Lesion With Kurtosis Imaging

Evaluation of Mean Diffusion and Kurtosis MRI Mismatch in an Animal Model of Transient Focal Ischemia

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Background and Purpose—Ischemic tissue damage is heterogeneous, resulting in complex patterns in the widely used diffusion-weighted MRI. Our study examined the spatiotemporal characteristics of diffusion kurtosis imaging in an animal model of transient middle cerebral artery occlusion.

Methods—Adult male Wistar rats (N=18) were subjected to 90 minutes middle cerebral artery occlusion. Multiparametric MR images were obtained during middle cerebral artery occlusion and 20 minutes after reperfusion with diffusion-weighted MRI obtained using 8 b-values from 250 to 3000 s/mm² in 6 diffusion gradient directions. Diffusion and kurtosis lesions were outlined in shuffled images by 2 investigators independently. T₂ MRI was obtained 24 hours after middle cerebral artery occlusion to evaluate stroke outcome.

Results—Mean diffusion lesion (23.5%±8.1%, percentage of the brain slice) was significantly larger than mean kurtosis lesion (13.2%±2.0%) during middle cerebral artery occlusion. Mean diffusion lesion decreased significantly after reperfusion (13.8%±4.3%), whereas mean kurtosis lesion showed little change (13.0%±2.5%) with their lesion size difference being insignificant.

Conclusions—We demonstrated that mean diffusion/mean kurtosis mismatch recovered reasonably well on reperfusion, whereas regions with concurrent mean diffusion and mean kurtosis deficits showed poor recovery. Diffusion kurtosis imaging may help stratify heterogeneous diffusion-weighted MRI lesions for enhanced characterization of ischemic tissue injury. (Stroke. 2012;43:2252-2254.)

Key Words: acute ischemia ■ diffusion ■ kurtosis

Diffusion-weighted imaging (DWI) detects severely damaged ischemic tissue that is likely to infarct and has been widely used in stroke imaging. However, tissue damage within DWI deficit is heterogeneous, which may partially recover with prompt treatment. There have been no well-established techniques capable of stratifying heterogeneously damaged DWI lesion. Diffusion kurtosis imaging is an emerging MRI technique that measures the degree of the non-Gaussian water diffusion and is sensitive to microscopic structural changes. Indeed, diffusion kurtosis imaging has been shown capable of detecting microstructural cerebral tissue changes in aging brains, acute stroke, and tumor. We postulated that diffusion kurtosis imaging could stratify heterogeneous DWI lesions, improving characterization of tissue injury. Our study examined the spatiotemporal characteristics of mean diffusion (MD) and kurtosis (MK) MRI using a transient filament middle cerebral artery occlusion (MCAO) rodent model.

Materials and Methods

Animal Model

Transient MCAO was induced in 18 adult male Wistar rats (Charles River Laboratory, Wilmington, MA), anesthetized under 1.5% to 2.0% isoflurane with heart rate and saturation of peripheral oxygen monitored online, following institution-approved guidelines. Animals were reperfused by withdrawing filament 95 minutes post-MCAO. One rat died during MRI and was excluded from analysis.

Magnetic Resonance Imaging

MR imaging was obtained using a Bruker 4.7-T small-bore scanner (5 slices, 2 mm/slice, field of view=25×25 mm², matrix size=64×64). Multiparametric MR imaging was obtained during MCAO (20–90 minutes post-MCAO), after reperfusion (120–190 minutes post-MCAO). DWI was acquired with b-values of 250, 500,
calculated as the percentage of the brain. During MCAO, MD

time [TE] 2500/40.5 ms, number of average
images were obtained with 2 TEs (repetition time/TE[1]/
3250/30/100 ms, number of average
images were obtained with 2 TEs (repetition time/TE[1]/
6500/14.8 ms, number of average
3.5 minutes); T2-weigthed
MRI with 7 delays from 250 to 3000 ms (repetition time/TE
)

750, 1000, 1500, 2000, 2500, and 3000 s/mm2 (repetition time/echo
time [TE]=2500/40.5 ms, number of average=4, duration=8 min-
utes) along 6 diffusion directions. Cerebral blood flow was acquired
with amplitude modulated arterial spin labeling MRI (repetition
time/time/TE[1]=6500/14.8 ms, number of average=32, duration=7 min-
utes). T1-weighted images were acquired using inversion-recovery
MRI with 7 delays from 250 to 3000 ms (repetition time/time/TE[1]=6500/14.8
ms, number of average=4, duration=3.5 minutes); T2-weighted
images were obtained with 2 TEs (repetition time/time/TE[1]/
TE[2]=3250/30/100 ms, number of average=16, duration=1.8 min-
utes). We also obtained follow-up T2 MRI 24 hours post-MCAO.

Data Analysis
Images were analyzed in Matlab (MathWorks, Natick, MA). DWI
signal (S[b]) was fitted per pixel using S(b)=S(0)*exp(−b*Dapp
+1/
6b2*D2 app*Kapp). MD and MK were obtained by averaging diffusion
(Dapp) and kurtosis coefficients (Kapp) along 6 directions, respec-
tively.5 Apparent diffusion coefficient (ADC) was derived from
S(b)=S(0)*exp(−b*ADC) using b=250 and 1000 s/mm2, and cere-
bral blood flow was obtained from amplitude modulated arterial spin
labeling MRI as described previously.9 MD and MK lesions were
independently outlined from shuffled images by 2 investigators in
the central slice (2 mm behind the bregma) and averaged. Lesions
were mirrored to the contralateral brain as reference region of
interest. Results were reported as mean±SD, and we used repeated
measures analysis of variance with Tukey multiple comparison test.

Results
Figure 1 shows that MD lesions were significantly larger than
MK deficits during MCAO. After reperfusion, MD lesions
decreased to approximately the size of MK lesions, which
showed negligible change. Notably, MD and ADC maps
showed very similar lesion, as expected. Stroke outcome was
confirmed using follow-up T2 MRI and histology.

Figure 2 shows reperfusion-induced change in lesion size,
calculated as the percentage of the brain. During MCAO, MD
lesion (23.5%±8.1%) was larger than MK (13.2%±2.0%,
P<0.01). MD lesion decreased significantly after reper-
fusion, and the difference between MD (13.8%±4.3%) and MK
(13.0%±2.5%) lesion became insignificant. However, the
follow-up T2 MRI showed infarction (28.1%±9.6%) signifi-
cantly larger than acute MD and MK lesions (P<0.01),
likely due to severe ischemia and reperfusion injury.

Figure 3 compares reperfusion-induced change in multipa-
rametric MRI values. During MCAO, MD in ischemic lesion
decreased significantly from the contralateral normal region
(0.55±0.03 versus 0.78±0.02 µm2/ms, P<0.01), whereas
MK was elevated (0.98±0.04 versus 0.69±0.03, P<0.01).
Using the contralateral region of interest as reference, the
percentage difference between nonischemic and ischemic
tissues was ~29.0%±3.6% and 42.6%±4.8% for MD and
MK, respectively. After reperfusion, the ischemic lesion MD
improved (0.60±0.04 µm2/ms, P<0.01) but was still signif-
ically less than the reference (P<0.01). Moreover, ischemic
tissue MK decreased significantly, yet it was still elevated
from the contralateral normal tissue (0.93±0.06 versus
0.70±0.03, P<0.01). The percentage differences between
nonischemic and ischemic tissues were −22.7%±5.3% and
33.9%±10.9% for MD and MK, respectively.

Discussion
Our study found that the MD/MK mismatch recovered reason-
ably well on reperfusion, whereas areas with concurrent MD and

![Figure 1. Multiparametric ADC, MD, and MK maps of a repre-
sentative MCAO rat during acute ischemia and immediately after
reperfusion. Tissue outcome was confirmed with follow-up T2
MRI and histology. ADC indicates apparent diffusion coefficient;
MD, mean diffusion; MK, mean kurtosis; MCAO, middle cerebral
artery occlusion.](https://stroke.ahajournals.org/)

![Figure 2. MD and MK lesion volumes, expressed as the per-
centage of the brain in the same section, during MCAO and
after reperfusion. Error bars represent SEM. **P<0.01; *P<0.05;
NS indicates nonsignificant. MD indicates mean diffusion; MK,
mean kurtosis; MCAO, middle cerebral artery occlusion.](https://stroke.ahajournals.org/)

![Figure 3. Comparison of MD (A) and MK (B) of the contralat-
eral normal (con.) and ipsilateral ischemic (ipsi.) regions before and
after reperfusion. MD indicates mean diffusion; MK, mean
kurtosis.](https://stroke.ahajournals.org/)
MK deficits showed little recovery. In comparison, T₁ and T₂ MRI are not sensitive to ischemic tissue injury during acute stroke. Our results suggest that MD/MK mismatch may represent mildly damaged and potentially salvageable ischemic lesion, whereas areas with simultaneous MD and MK deficits likely indicate aggravated cellular damage. However, the mechanisms of diffusion and kurtosis deficits in acute stroke are complex. MD decreases in the MD/MK mismatch is likely due to cytotoxic edema. In contrast, MK is sensitive to intracellular tortuosity and viscosity changes subsequent to breakdown of cytoskeletal structures and swelling of mitochondria, likely indicating more severe tissue damage. Nevertheless, the filament stroke model used in our study is subject to severe ischemia and reperfusion injury, and the DWI renormalization was transient. Indeed, we found that cerebral blood flow decreased significantly in the ipsilateral hemisphere from the contralateral region of interest both during MCAO (0.88 ± 0.27 versus 1.43 ± 0.33 mL/g/min) and after reperfusion (1.15 ± 0.23 versus 1.72 ± 0.25 mL/g/min). Importantly, reperfusion induced significant cerebral blood flow increase in both hemispheres (P<0.01). Therefore, rodent embolic stroke models that more closely resemble human stroke may be more suitable to elucidate the mechanisms of stroke diffusion kurtosis imaging. Moreover, the study may be improved with remote reperfusion techniques to enable pixel-based analysis of MD and MK evolution. Furthermore, histology immediately after reperfusion may help characterize early tissue damage of MD and MK deficits, augmenting evaluation of stroke outcome currently assessed by follow-up MRI.

**Conclusion**

We showed that MD/MK lesion mismatch recovered reasonably well on reperfusion, whereas regions with concurrent MK and MD deficits responded poorly. Diffusion kurtosis imaging may augment DWI for improved characterization of ischemic tissue injury.

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**Disclosures**

None.

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SUPPLEMENTAL MATERIAL

MCAO

- 20-90 min post MCAO
- 95 min post MCAO
- 120-190 min post MCAO
- 24 hr post MCAO

Reperfusion

MRI

- ~20 min: Loading animal into magnet + planning slices
- ~5 min: Withdrawing filament + ~20 min loading animal into magnet + planning slices

T2 MRI