Can DWI-ASPECTS Substitute for Lesion Volume in Acute Stroke?

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Background and Purpose—The extent of diffusion lesion on pretreatment imaging is a risk factor for poor outcome and hemorrhagic transformation after thrombolysis, and volumes of 70 to 100 mL have been advocated as cutoffs. However, estimating diffusion-weighted imaging (DWI) lesion volume (Vol_{DWI}) in the acute setting may be cumbersome. We aimed to determine whether the DWI-Alberta Stroke Program Early CT Score (DWI-ASPECTS) can substitute for Vol_{DWI}.

Methods—DWI-ASPECTS and Vol_{DWI} were measured retrospectively on pretreatment MRI (median onset-to-MRI delay=122 minutes) in 330 consecutively treated patients with middle cerebral artery stroke.

Results—DWI-ASPECTS and Vol_{DWI} were strongly correlated (p=-0.82), but each DWI-ASPECTS point corresponded to a wide range of Vol_{DWI}. All patients with DWI-ASPECTS ≥7 (n=207) had Vol_{DWI} <70 mL, whereas 32 of the 34 patients with DWI-ASPECTS <4 had Vol_{DWI} >100 mL. However, intermediate DWI-ASPECTS (4–6; n=89) corresponded to highly variable Vol_{DWI} (median, 66 mL; interquartile range, 40–98).

Conclusions—Although each DWI-ASPECTS point corresponds to a wide range of volumes, DWI-ASPECTS <4 or ≥7 may be used as reliable surrogates of Vol_{DWI} >100 or <70 mL, respectively. (Stroke. 2013;44:3565-3567.)

Key Words: ASPECTS ■ diffusion-weighted imaging ■ stroke ■ thrombolytic therapy

In acute anterior circulation stroke, the extent of the diffusion-weighted imaging (DWI) lesion is a predictor of poor outcome and symptomatic hemorrhage after reperfusion therapy.1,2 Specifically, volumes of 70 and 100 mL have been advocated as reliable cutoffs.3,4 Accordingly, the DWI lesion volume (Vol_{DWI}) is used as exclusion criterion in ongoing recanalization trials. However, manual outlining for Vol_{DWI} measurements is time consuming, whereas automated tools are not widely available and may imply manual correction.5 Conversely, the semiquantitative DWI-Alberta Stroke Program Early Computed Tomography Score (DWI-ASPECTS) is increasingly used because it is straightforward, reproducible,6 and assessable at bedside. One study showed that DWI-ASPECTS <4 predicted Vol_{DWI} ≥100 mL within 48 hours after stroke onset.7 Our aim was to determine whether DWI-ASPECTS can reliably substitute for Vol_{DWI}. In the first 6 hours, we assessed the relationships between DWI-ASPECTS and Vol_{DWI} in patients with middle cerebral artery stroke. We particularly focused on one hand, on DWI-ASPECTS cut points previously reported to be associated with Vol_{DWI} >100 mL (<47), hemorrhagic transformation (<61 and <82), or outcome (<5, <6, <7, and <8) and, on the other hand, on the 70 and 100 mL Vol_{DWI} cutoffs.3,4,11

Patients and Methods

Data were extracted from a monocentric prospective register of consecutive patients treated by intravenous and intra-arterial thrombolysis for ischemic stroke (2001–2013), where MRI was implemented as first-line pretherapeutic imaging. Patients were included if they had a middle cerebral artery stroke confirmed by pretreatment MRI (1.5 Tesla; DWI: 3 directions; b=0–1000 s/mm²; 6-mm contiguous slices). DWI-ASPECTS was scored by a stroke neurologist and Vol_{DWI} measured by a neuroradiologist using a semiautomated method.12 In 20% of the population, DWI-ASPECTS and Vol_{DWI} were reassessed independently by another neuroradiologist. Interobserver agreement for DWI-ASPECTS and Vol_{DWI} was assessed using weighted-kappa and intraclass correlation coefficients, respectively. Correlation between DWI-ASPECTS and Vol_{DWI} was determined using Spearman rank correlation coefficient. Based on the current literature, specific ASPECTS bins1,2,5-10 were assessed against Vol_{DWI} values, with particular focus on the 70 and 100 mL cut-offs.3,4,11

Results

During the study period, 473 patients underwent intravenous and intra-arterial thrombolysis for acute stroke. Excluded patients (n=143; posterior circulation or pure anterior cerebral artery stroke, n=83 and no pretreatment MRI, n=60) did not differ from included patients on baseline characteristics (data not shown). The remaining 330 patients (178 [54%]

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men; median [interquartile range] age, 68 [56–79] years; admission National Institutes of Health Stroke Scale score, 15 [10–20]) had onset-to-MRI delay of 122 (90–164) minutes. Medians (interquartile range) for DWI-ASPECTS and VolDWI were 7 (6–8) and 23.3 mL (9.6–63.4), respectively. Weighted-κ and interobserver intraclass correlation coefficient were 0.94 (95% confidence interval, 0.91–0.96) and 0.98 (95% confidence interval, 0.98–0.99), respectively. There was a strong negative correlation between VolDWI and DWI-ASPECTS (ρ=−0.82; 95% confidence interval, −0.86 to −0.77; P<0.001). The Table shows that the highest VolDWI in the 207 patients with DWI-ASPECTS ≥7 was 67 mL, whereas the lowest VolDWI in the 34 patients with DWI-ASPECTS <4 was 93 mL (Figure). However, VolDWI values were extremely variable in the 88 patients with ASPECTS 4 to 6 (median [interquartile range], 66 [41–97]; range, 10–197 mL). Post hoc analysis showed similar results for VolDWI versus modified DWI-W-ASPECTS13 (142/330 [43%] patients had lesion in the corona radiata).

**Discussion**

Although each DWI-ASPECTS point corresponded to a wide range of VolDWI, all patients with extensive changes on DWI-ASPECTS (0–3) had large VolDWI whereas all patients with limited DWI-ASPECTS changes (≥7) had VolDWI <70 mL. DWI-ASPECTS is increasingly used for description or prognostic purposes in stroke populations. Although not designed to substitute for VolDWI, DWI-ASPECTS does provide some semiquantitative estimate of it. However, DWI-ASPECTS overlooks lesions within the striatocapsular region and only partially covers the middle cerebral artery territory. This explains the wide range of true lesion volumes for a given DWI-ASPECTS point found here, in line with other studies.2,7

Our finding that DWI-ASPECTS <4 invariably predicted VolDWI ≥93 mL is entirely consistent with 1 previous report7 and highly relevant to the Diffusion and perfusion imaging Evaluation For Understanding Stroke Evolution (DEFUSE)-2 malignant profile 100 mL cut point.4 However, patients with DWI-ASPECTS ≥7 all had VolDWI <70 mL, which corresponds to the cut point incorporated in the target mismatch definition.4 Although debated,11 these volume cut-offs are proposed to identify poor or good responders to reperfusion therapy,3 and particularly the 100-mL cut point serves as an exclusion criterion in several ongoing trials. However, fully automated softwares to calculate VolDWI are not yet commonly used and can fail in real time. This may lead to imbalanced groups on baseline characteristics in trials where randomization is based on automated MR-image segmentation.14 Failure of automated volumetry may also restrain patient’s inclusion in trials. To overcome these difficulties, DWI-ASPECTS <4 could replace the poorly reproducible greater than one third of the middle cerebral artery territory CT rule as an alternative exclusion criterion in MR-based trials.

The tight relationships between extreme DWI-ASPECTS values (ie, <4 or ≥7) and the >100- or <70-mL, respectively, cut points found here suggest that DWI-ASPECTS could serve as a surrogate for these volumes. This concerned almost 3 quarters (241/330) of the studied population and may have clinical relevance. However, in those patients with intermediate DWI-ASPECTS (4–6), VolDWI straddled widely across the above cut point volumes, indicating that intermediate DWI-ASPECTS cannot substitute for VolDWI to identify patients with target mismatch or malignant profile. Of note, no DWI-ASPECTS cut point identified lesion volume >145 mL,15 above which decompressive hemiecraniectomy is indicated.

Limitations of our study include its retrospective and single-center nature, and the focus on patients who underwent thrombolysis, which limits generalizability to nonthrombolized patients and may, in part, explain the low proportion of patients with large VolDWI and consequently the relative large 95% confidence interval for patients with low ASPECTS.

In conclusion, in the first 6 hours, each DWI-ASPECTS point corresponds to a wide range of VolDWI. However, extreme DWI-ASPECTS scores could serve as surrogates for important volume cut points. Further studies are needed prospectively to confirm this observation and to strengthen the value of existing VolDWI cut points in predicting outcomes after recanalization.11

**Table.** DWI-ASPECTS Cut Points and Corresponding Volumes

<table>
<thead>
<tr>
<th>DWI-ASPECTS</th>
<th>Volume on DWI, mL</th>
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<tr>
<td></td>
<td>n</td>
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<tr>
<td>&lt;4</td>
<td>34</td>
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<tr>
<td>≥4</td>
<td>296</td>
</tr>
<tr>
<td>&lt;5</td>
<td>52</td>
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<tr>
<td>≥5</td>
<td>278</td>
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<td>&lt;6</td>
<td>81</td>
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<tr>
<td>≥6</td>
<td>249</td>
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<td>&lt;7</td>
<td>123</td>
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<tr>
<td>≥7</td>
<td>207</td>
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<td>&lt;8</td>
<td>187</td>
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<td>≥8</td>
<td>143</td>
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DWI-ASPECTS indicates diffusion-weighted imaging-Alberta Stroke Program Early CT Score; and IQR, interquartile range.
Disclosures

None.

References

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