Association Between CT Angiogram Collaterals and CT Perfusion in the Interventional Management of Stroke III Trial

Achala Vagal, MD, MS; Bijoy K. Menon, MD; Lydia D. Foster, MS; Anthony Livorine, MD; Sharon D. Yeatts, PhD; Emmad Qazi, BS; Chris d’Esterre, PhD; Junzi Shi, MD; Andrew M. Demchuk, MD; Michael D. Hill, MD, MSc; David S. Liebeskind, MD; Thomas Tomsick, MD; Mayank Goyal, MD

Background and Purpose—Collateral flow can determine ischemic core and tissue at risk. Using the Interventional Management of Stroke (IMS) III trial data, we explored the relationship between computed tomography angiogram (CTA) collateral status and CT perfusion (CTP) parameters.

Methods—Baseline CTA collaterals were trichotomized as good, intermediate, and poor, and CTP studies were analyzed to quantify ischemic core, tissue at risk, and mismatch ratios. Kruskal–Wallis and Spearman tests were used to measure the strength of association and correlation between CTA collaterals and CTP parameters.

Results—A total of 95 patients had diagnostic CTP studies in the IMS III trial. Of these, 53 patients had M1/M2 middle cerebral artery–intracranial internal carotid artery occlusion, where baseline CTA collateral grading was performed. CTA collaterals were associated with smaller CTP measured ischemic core volume ($P=0.0078$) and higher mismatch ($P=0.0004$). There was moderate negative correlation between collaterals and core ($r_s=−0.45$; 95% confidence interval, −0.64 to −0.20) and moderate positive correlation between collaterals and mismatch ($r_s=0.53$; 95% confidence interval, 0.29–0.71).

Conclusion—Better collaterals were associated with smaller ischemic core and higher mismatch in the IMS III trial. Collateral assessment and perfusion imaging identify the same biological construct about ischemic tissue sustenance.

(Stoke. 2016;47:535-538. DOI: 10.1161/STROKEAHA.115.011461.)

Key Words: carotid artery, internal § collateral circulation § perfusion imaging § stroke § tomography, x-ray computed
testing for ischemic core did not show a significant difference between good and intermediate ($P=0.3950$) or between intermediate and poor collateral grade ($P=0.0728$).

### Discussion

We found that, among patients with M1/M2±internal carotid artery occlusions, better collaterals are associated with smaller ischemic cores and greater mismatch. The CTA collaterals correlated moderately well with CTP measured core with an inverse relation. The strength of our study is that we have demonstrated association between CTA collateral status and CTP parameters in a randomized trial setting.

It is well established that patients with better collaterals have smaller infarcts and better functional outcomes.$^6,8,9$ Using this premise, the recent ESCAPE trial used collateral assessment using multiphasic CTA for patient selection without additional CTP acquisition.$^1$ Although the EXTEND IA$^7$ and SWIFT PRIME$^8$ trials used CTP for patient selection utilizing automated software for CTP processing, it is important to note that there are numerous challenges for CTP imaging when performed outside of a well-controlled trial environment. These include variability in CTP acquisition and postprocessing methodology, as well as controversy, regarding readiness of CTP for prime time usage.$^{10}$

Because of the positive endovascular trials, baseline CTA has become standard of care for acute stroke workup. Although, concurrent assessment of collateral status is relatively straightforward and can provide a good estimate of ischemic core, CTA collateral evaluation is a relatively new imaging tool with heterogeneity in CTA acquisition of backfilling pial arteries in distal occlusions using single-phase CTA is technically difficult.$^6$ Because of significant topographical variability in CTA,$^7$ the collaterals were divided into 2 groups, namely anterior cerebral artery–middle cerebral artery and posterior cerebral artery–middle cerebral artery. The pial artery grading in each group used a 6-point scale (0=absent, 1=minimal, 2=significantly decreased prominence and extent with regions of no vessels, 3=moderately decreased prominence and extent, 4=mildly decreased prominence and extent, and 5=normal or increased prominence and extent) when compared with the opposite normal hemisphere.$^5$ Total CTA collateral score, calculated by summing the 2 regional scores, ranged from 0 to 10.

### Statistical Analysis

Collateral status was trichotomized as good (8–10), intermediate (6–7), and poor (0–5).$^9$ Association of collateral status with CTP parameters was assessed using the Kruskal–Wallis test; if significant at $\alpha=0.05$, pairwise tests were conducted to identify differences. Spearman correlation was used to measure strength of association between CTA collateral score (using total score of 0–10) and CTP parameters.

### Results

### Subject Characteristics

Of 656 subjects enrolled in IMS III, 104 patients had a CTP at baseline. Of these, 9 were excluded because of nondiagnostic CTP. Of the remaining 95 subjects, 85 (89.5%) had a concurrent baseline CTA, and 53 of 85 (62.4%) patients had M1/M2 middle cerebral artery±intracranial ICA occlusion where collateral status was measured (Table 1).

### CTA Collaterals and CTP

Subjects with good CTA collaterals had smaller CTP measured ischemic cores and larger mismatch than subjects with poor collaterals. (Table 2; Figure) There was a moderate negative correlation between collaterals and core volume ($r_s=−0.45$; 95% confidence interval, −0.64 to −0.20) and moderate positive correlation between collaterals and mismatch ($r_s=0.53$; 95% confidence interval, 0.29–0.71). There was insufficient evidence to conclude an association and correlation between collaterals and tissue at risk ($P=0.4484$ and $r_s=−0.14$, 95% confidence interval, −0.40 to 0.12), respectively. Pairwise

### Table 1. Subject Characteristics

<table>
<thead>
<tr>
<th>Variables</th>
<th>Total, n=53</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, y, median (minimum–maximum)</td>
<td>69 (33–83)</td>
</tr>
<tr>
<td>Men, n (%)</td>
<td>27 (50.9)</td>
</tr>
<tr>
<td>NIHSS, median (minimum–maximum)$^*$</td>
<td>18 (7–40)</td>
</tr>
<tr>
<td>ASPECTS, n (%)</td>
<td>6–10</td>
</tr>
<tr>
<td>0–5</td>
<td>16 (30.2)</td>
</tr>
<tr>
<td>6–10</td>
<td>37 (69.8)</td>
</tr>
<tr>
<td>Core volume, mL, median (minimum–maximum)</td>
<td>8.3 (0.0–81.6)</td>
</tr>
<tr>
<td>Hypoperfused volume, mL, median (minimum–maximum)</td>
<td>70.6 (2.1–383.4)</td>
</tr>
<tr>
<td>Mismatch ratio</td>
<td>4.9 (1.0–371.5)</td>
</tr>
<tr>
<td>Vessel occlusion, n (%)</td>
<td>ICAT</td>
</tr>
<tr>
<td>M1</td>
<td>37 (69.8)</td>
</tr>
<tr>
<td>M2</td>
<td>3 (5.7)</td>
</tr>
<tr>
<td>Randomized to endovascular therapy, n (%)</td>
<td>35 (66.0)</td>
</tr>
<tr>
<td>CTA collateral status, n (%)</td>
<td>Good (8–10)</td>
</tr>
<tr>
<td>Intermediate (6–7)</td>
<td>21 (39.6)</td>
</tr>
<tr>
<td>Poor (0–5)</td>
<td>15 (28.3)</td>
</tr>
<tr>
<td>17 (32.1)</td>
<td></td>
</tr>
</tbody>
</table>

$^*$ASPECTS indicates Alberta Stroke Program Early Computed Tomography score; CTA, computed tomography angiogram; ICAT, internal carotid artery terminus; and NIHSS, National Institutes of Health Stroke Scale.

$^*$Subject missing (n=1).
and collateral grading. Our study suggests that collaterals and perfusion are measuring similar aspects of the ischemic pathophysiology. This finding is clinically relevant as CTA collateral assessment may be an alternative for CTP, potentially obviating the need for an additional CTP study.

Our study adds to the accumulating body of evidence related to association of collaterals and perfusion in acute ischemic stroke. A malignant CTA collateral profile, specific for large core volume on baseline magnetic resonance diffusion study correlated with poor outcomes. Better collateral flow measured by magnetic resonance perfusion was associated with larger diffusion–perfusion mismatch and smaller baseline diffusion-weighted imaging lesion volume. However, Bang et al found no difference in the magnetic resonance mismatch depending on the angiographic collateral grade, but did show that patients with good collaterals had larger areas of milder perfusion delay than those with poor collaterals. Similarly, Marks et al showed a relationship between angiographic collaterals and severity of magnetic resonance perfusion deficit but did not show an association between collaterals and DWI core and mismatch. A key explanation for the conflicting findings is the fact that angiographic collaterals were used in these studies, which may not necessarily quantify posterior cerebral artery middle cerebral artery collaterals.

Our study limitations include those inherent in a post hoc analysis along with a small sample size. Another important limitation is that the IMS III trial was a multi-institutional trial with significant heterogeneity in the CTP acquisition technique, although this resembles real-world circumstances. Although CTP techniques have evolved during and beyond the trial period (2006–2012), a large proportion of subjects (86%) had CTP brain coverage of <4 cm, and 95% subjects had <90-s duration of CTP acquisition. The CTA studies obtained were all single-phase acquisitions, which are dependent on bolus characteristics and can underestimate collateral status when compared with the newer multiphasic CTA techniques.

**Conclusions**

Better collaterals were associated with smaller ischemic core and higher mismatch in the IMS III trial. CTA collateral assessment and perfusion imaging identify the same biological construct about ischemic tissue sustenance.

**Disclosures**

Dr Vagal received CTSA 8 UL1 TR000077-05 KL2 Grant and grant support from Genentech, Inc for Imaging Core Laboratory of Study of the Efficacy and Safety of Alteplase in Patients With Mild Stroke (PRISMS) Trial. Dr Menon has received grant support from Canadian Institutes of Health Research (CIHR) and Heart and Stroke Foundation of Canada. Dr Yeatts has received grant from NIH/National Institute of Neurological Disorders and Stroke (NINDS) U01 NS052220 and served as a consultant for Genentech Inc. Dr Liebeskind has received research grant from NIH/NINDS. Dr Demchuk has been on the speaker’s bureau for Medtronic CME events (Modest). Dr Goyal has received research grant from Covidien AG (Medtronic) for design and conduct of Solitaire with the Intention for Thrombectomy as Primary Endovascular Treatment (SWIFT PRIME) trial and has been on the

### Table 2. Associations Between CTA Collateral Grade and CT Perfusion Parameters

<table>
<thead>
<tr>
<th>CTA Collateral Status</th>
<th>Good (n=21)</th>
<th>Intermediate (n=15)</th>
<th>Poor (n=17)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core volume (mL), median (minimum–maximum)</td>
<td>4.0 (0.0–19.0)</td>
<td>6.0 (0.0–41.7)</td>
<td>24.1 (0.0–81.6)</td>
<td>0.0078</td>
</tr>
<tr>
<td>Hypoperfused volumes (mL), median (minimum–maximum)</td>
<td>60.3 (2.1–197.5)</td>
<td>80.5 (8.4–248.7)</td>
<td>84.5 (7.2–383.4)</td>
<td>0.4484</td>
</tr>
<tr>
<td>Mismatch ratio, median (minimum–maximum)</td>
<td>12.4 (1.7–371.5)</td>
<td>8.0 (1.0–314.2)</td>
<td>2.8 (1.1–8.4)</td>
<td>0.0004</td>
</tr>
</tbody>
</table>

CTA indicates computed tomography angiogram.
speaker’s bureau for Covidien (Significant). Dr Hill has received research grant from Covidien AG (Medtronic) to the University of Calgary for partial funding of the Endovascular Treatment for Small Core and Anterior Circulation Proximal Occlusion with Emphasis on Minimizing CT to Recanalization Times (ESCAPE) trial (Significant) and has ownership interest in Calgary Scientific Inc, Imaging company (Significant). The other authors report no conflicts.

References
Association Between CT Angiogram Collaterals and CT Perfusion in the Interventional Management of Stroke III Trial
Achala Vagal, Bijoy K. Menon, Lydia D. Foster, Anthony Livorine, Sharon D. Yeatts, Emmad Qazi, Chris d'Esterre, Junzi Shi, Andrew M. Demchuk, Michael D. Hill, David S. Liebeskind, Thomas Tomsick and Mayank Goyal

Stroke. 2016;47:535-538; originally published online December 10, 2015; doi: 10.1161/STROKEAHA.115.011461

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://stroke.ahajournals.org/content/47/2/535

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published in Stroke can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the Permissions and Rights Question and Answer document.

Reprints: Information about reprints can be found online at:
http://www.lww.com/reprints

Subscriptions: Information about subscribing to Stroke is online at:
http://stroke.ahajournals.org//subscriptions/