be safe, easily accomplished when one knows the technique, and results in no neuropathological changes at the site of the omental transposition.

Note
(See Letter to the Editor: Omental Transposition To Human Brain, p. 272.)

References

SUMMARY Continuous-wave Doppler sonography is a reliable method for detecting severe subclavian stenosis and occlusion as well as subclavian steal. Intermediate stages leading to subclavian steal can also be detected. These are characterized by a cardiac-phase-dependent alternating flow direction in the vertebral artery. Some cases of proximal subclavian or proximal vertebral artery stenosis produce a systolic deceleration of flow in the vertebral artery. Stenosis and occlusion of the subclavian artery as well as stenosis of the subclavian and vertebral arteries can be distinguished. The pulse curve changes described can be reversed by a vascular by-pass.

REVERSE FLOW in the vertebral artery resulting from occlusion of the proximal subclavian artery (subclavian steal) which was first described in an angiographic study, can be demonstrated by transcutaneous Doppler sonography. Since occlusion of the proximal subclavian artery usually develops slowly with progression of arteriosclerotic stenosis, it is to be expected that intermediate, previously undescribed, flow patterns of forward and reverse flow will be found in flow studies of the vertebral artery. The results presented in this paper show it is possible to demonstrate such intermediate forms (incomplete steal) by means of Doppler sonographic examination of the subclavian and vertebral arteries. Characteristic changes are also described in patients with high-grade proximal stenosis of the vertebral artery, which could not previously be differentiated with certainty from hypoplasia and occlusion.

Material and Methods
The transcutaneous semiquantitative measurement of velocity and direction of blood flow was carried out with a directional continuous wave Doppler device, "Débitmètre Ultrasonique Delalande," at a frequency of 4 MHz. The Doppler pulse curves and the ECG were simultaneously registered on a direct-writing recorder (Cardirex 4-channel, Siemens and Brush 2-channel).

Recordings of flow in the subclavian artery are made in the supraclavicular fossa. Medial or lateral alignment of the probe allows examination of the proximal or distal portion of the vessel. The vertebral artery is examined at the level of the atlas slope, but it is not possible to determine by transcutaneous examination whether the afferent (flow to probe) or efferent (flow away from probe) section of the atlas slope is reached by the ultrasonic beam. The upward or downward direction of the pulse curves in relation to the zero line gives no clear indication of forward or reverse flow in this artery. This can only be determined by functional tests. With reverse (armward) flow, raising peripheral resistance to flow (compression of the upper arm or closure of the fist) causes deceleration of flow followed by raised flow velocity in the vertebral artery (postischemic hyperemia). With forward flow in the vertebral artery upper arm compression usually causes no significant change in flow velocity. The pulse curves of the vertebral artery for antegrade and retrograde flow, which show distinct differences, are illustrated in figure IA and ID, together with the effect caused by upper arm compression. In this study, for the purpose of simplification, the Doppler device was...
Vertebral A.

A

B

C

D

5 sec 0.5 sec

![Diagram](https://example.com/diagram)

Figure 1. Development of subclavian steal: Doppler pulse curve from the vertebral artery with forward flow (A), systolic deceleration (B), alternating flow (C), complete reversal of flow (D), in each case occurring on the side of subclavian occlusion. The horizontal bars above the pulse curves indicate the duration of the ipsilateral upper arm compression. The continuous straight line corresponds to zero flow velocity. The apparatus was so adjusted that an upward deviation of the pulse curve in relation to the zero line indicated forward flow. Ordinate: calibration signal of apparatus = 30 cm/sec.

poled to show an upward deviation of the Doppler pulse curve in relation to the zero line for forward flow. The differentiation of the vertebral artery from the occipital and other neck arteries has been described previously. In order to measure the temporal relationship of Doppler pulse curves to the ECG, 10 disturbance-free pulse curves were averaged by measuring the latency between the R-peak and 6 to 10 defined points of the Doppler pulse curve, including in each case the arise point of systolic acceleration and the 10% and 90% arising and falling values.

Eighty-five patients have been found with proximal obstructions of the subclavian artery with complete reversal of vertebral flow. Angiographic examination was carried out in 34 of these patients confirming the findings in every patient.

Results

I. Doppler Sonography

Since the angle of transmission, particularly in the region of the atlas slope, is unknown, the amplitude reduction of the flow velocity curve of the vertebral artery is not a reliable sign of obstruction to flow. On the other hand, in the presence of high-grade stenosis of the subclavian or vertebral artery, we found typical changes in flow patterns as shown in figure 1. The development from proximal subclavian stenosis to occlusion, for example, produces changes in the pulse curves of the ipsilateral vertebral artery occurring in the order in which they are presented in figures 1B to D.

The well-known pulse curves in normals and those resulting from complete reversal of flow in the vertebral artery (subclavian steal, fig. 1D) will first be discussed, and then the pulse curves of partial reversal of flow or intermediate forms (fig. 1B, C).

1) Normal Flow Patterns of Vertebral and Subclavian Arteries

The Doppler pulse curve of the subclavian and vertebral arteries of a healthy subject and the relationship to the ECG are shown in figure 2. The R wave of the ECG denotes the onset of ventricular systole and the end of the T wave marks, approximately the beginning of diastole. The flow pattern of the subclavian artery shows a steep systolic wave and shortly after the onset of diastole a brief reverse flow phase. During later diastole no significant flow is present. In contrast to this, the normal pulse curve of the vertebral artery with forward flow shows less amplitude modulation. The decrease in late systole and in diastole is continuous and during the whole of diastole there is forward flow. The differences in the pulse curves are due to the low peripheral flow resistance in the vertebral artery which supplies the brain and the high resistance in the subclavian artery supplying skin and muscle. The latency of the arise point and the peak of the flow velocity curve of the vertebral artery are approximately 10 msec longer than those of the subclavian artery (pulse wave propagation velocity about 10 mm/ms). It is dependent on the pulse frequency and the state of the vessel walls.

FIGURE 2. Doppler pulse curve of the subclavian and vertebral artery from a healthy 30-year-old man, and their temporal relationship to the ECG. A = the onset of R-wave, B = the arise point of the systolic wave in the subclavian artery, C = the end of the T-wave which indicates approximately the beginning of diastole.
2) Reverse Flow in Vertebral Artery with Proximal Occlusion of Subclavian Artery

The pulse curve in figure 1D is characteristic for completely reversed flow in the vertebral artery, which is usually due to complete occlusion of the subclavian artery. The flow direction is reversed during systole and diastole. Since the vertebral artery contributes to the blood supply of the arm, the flow pattern is changed. The amplitudes vary considerably from patient to patient. In a typical patient the arise points of the systolic wave lie near the zero-line, due to the higher peripheral resistances to flow in the arm vessels than in the cerebral vessels.

For an analysis of the temporal relationship between the cardiac cycle and Doppler pulse curves the latter were averaged using the R-wave of the ECG as a trigger signal. This is shown in figure 3 for a patient with complete occlusion of the right subclavian artery (diagram of his vessels is seen in fig. 4).

A comparison of the arise point and peak of the right and left subclavian arteries shows a definitely longer latency on the side of the collaterally supplied subclavian artery as a result of the increased distance traversed by the pulse wave. In this patient the difference in latency of the arise points of the systolic wave in the subclavian arteries measured 41 msec. The difference in latency of the arise point of the systolic wave of the vertebral arteries is shorter, in this case 18 msec. This difference can be explained by the shorter distance between the points of measurement (atlas slopes of the vertebral arteries). The reason for the different latencies of the systolic peak of the vertebral and subclavian arteries on the unaffected (left) side is not clear (see also figs. 5, 6). Possible causes are a compensatory increase in flow with slight turbulence or transmission conditions and flow anomalies in a vessel loop. In addition, the latency values of the systolic peaks are more variable potentially resulting in a greater statistical error.

3) Alternating Flow in Vertebral Artery with Proximal Stenosis of Subclavian Artery

Figure 1C shows a cardiac-phase-dependent change in the direction of flow in the vertebral artery, from reverse to forward flow.

This flow pattern is found with high-grade stenosis of the ipsilateral subclavian artery (fig. 7). It could be constantly elicited on examination with various probe positions and was not an artifact due to superimposed venous or arterial flow.

Figure 5 shows the latency measurements in a patient with severe left-sided subclavian stenosis. The peak velocities of
FIGURE 5. Incomplete subclavian steal with high-grade proximal stenosis of the left subclavian artery (for angiogram see fig. 7). Cardiac phase dependent alternating flow in left vertebral artery is seen. Note the same latency of the arise points of the systolic wave in the right and left vertebral arteries and in the right and left subclavian arteries.

FIGURE 6. Proximal stenosis of the right vertebral artery and systolic deceleration of flow in the part distal due to the high-grade stenosis. Note the same latency of the arise points of the systolic wave in the right and left subclavian arteries and in the right and left vertebral arteries. With only slight differences in the pulse curves of the subclavian arteries there is no indication of a hemodynamically relevant right subclavian stenosis. For the angiogram of another patient with corresponding pulse curves see figure 8.
SONOGRAPHY FOR SUBCLAVIAN STENOSES/von Reutern et al.

FIGURE 7. Left proximal subclavian stenosis. Right side (A-C) and left side (D-F) brachial angiography (for the Doppler pulse curves of the same patient see fig. 5). Serial pictures (exposure frequency 3/sec) indicate an inconstant vertebro-vertebral collateral flow (→). The temporary non-filling of the left vertebral artery in B proves that this was not an artifact due to injection technique. On the other hand, the initial filling of the whole left vertebral artery in the forward direction (D) is a result of a high-pressure injection in the left brachial artery. Later pictures (E, F) show slow emptying of the left vertebral artery armwards.

FIGURE 8. Stenosis at origin of the left vertebral artery. (For Doppler pulse curves of a corresponding case see fig. 6). The section of aortic arch angiography* (R) shows no significant constriction of the right vertebral artery (→). The selective catheterization of the left subclavian artery* (L) shows a hypoplastic left vertebral artery with extreme constriction at its origin (→).

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After operation.

artery (reduced amplitude, no reverse flow phase at the beginning of diastole) before operation.

FIGURE 9. Postoperative normalization in Doppler pulse curves of vertebral artery and subclavian artery in high-grade stenosis of brachiocephalic trunk. Note the pathological flow profile in the vertebral artery (systolic flow deceleration) and the subclavian artery (reduced amplitude, no reverse flow phase at the beginning of diastole) before operation.

Table 1: Frequency of Doppler diagnoses with complete reverse flow, alternating flow and systolic deceleration of flow in the vertebral artery. (In parentheses, the number of patients examined angiographically). The Doppler diagnoses were confirmed without exception. In two cases of alternating flow, high-grade stenosis of the subclavian artery was associated with stenosis of the vertebral artery. (For further explanation see text.)

<table>
<thead>
<tr>
<th>Pulse curve of the Vertebral A.</th>
<th>n</th>
<th>Occlusion Subclavian A</th>
<th>Stenosis Subclavian A</th>
<th>Stenosis Vertebral A.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete reverse flow</td>
<td>85 (34)</td>
<td>76 (30)</td>
<td>9 (4)</td>
<td>0</td>
</tr>
<tr>
<td>Alternating flow</td>
<td>42 (15)</td>
<td>5 (2)</td>
<td>37 (13)</td>
<td>2 (2)</td>
</tr>
<tr>
<td>Systolic flow deceleration</td>
<td>27 (9)</td>
<td>0</td>
<td>15 (4)</td>
<td>12 (5)</td>
</tr>
</tbody>
</table>

Figure 7 shows alternating flow direction in the left vertebral artery in the angiograms from a patient with high-grade proximal left subclavian stenosis. With rapid radiograph exposure frequency it was possible to demonstrate inconstant vertebo-vertebral collateral flow, which corresponds to the Doppler sonographic finding of a change in flow direction in the left vertebral artery dependent on cardiac phase (right brachial angiography A – C). In the left brachial angiogram from the same patient (D – F) the whole left vertebral artery was first completely filled in the antegrade direction as a result of the high-pressure injection, but it emptied gradually armwards.

Systolic deceleration of flow was mainly found on Doppler examination of patients with suspected high-grade proximal vertebral stenosis and no evidence of marked subclavian stenosis. It was also found with high-grade proximal stenosis of the subclavian artery and the brachiocephalic trunk. The angiogram in figure 8 shows an example with filiform stenosis at the origin of the left vertebral artery, demonstrated by selective catheterization at angiography (fig. 8B). In this example the Doppler pulse curves from the vertebral artery at the level of the atlas slope showed a typical systolic deceleration of flow, indicating a high-grade proximal stenosis. The right vertebral artery showed no stenosis (fig. 8A).

III. Restoration of Normal Pulse Curves by Vascular Surgery

Follow up observations proved that the pulse curves illustrated in figure 1B and C were, in fact, intermediate forms. In a patient with high grade subclavian stenosis which had caused alternating flow in the vertebral artery a carotid-subclavian by-pass operation was performed.* The pulse curves from the vertebral and subclavian arteries subsequently returned to normal. In another patient with systolic deceleration of flow in the right vertebral artery due to high grade stenosis of the brachio-cephalic trunk, similar postoperative normalization was seen (fig. 9).

In a patient with occlusion of the brachio-cephalic trunk we observed alternating flow in the homolateral common carotid artery similar to that described above in the vertebral artery of a patient with subclavian stenosis. After upper arm compression the flow was completely reversed (fig. 10 A). An aorto-subclavian by-pass operation was performed,f and after the operation (fig. 10 B) physiological flow was shown to be reestablished in the carotid artery.

IV. Experimentally Induced Alternating Flow in Radial Artery

In patients on renal dialysis who have an artificial arteriovenous fistula in the lower arm the portion of the radial
artery proximal (fig. 11 A) and distal (fig. 11 B) to the fistula may be compared to the right and left vertebral arteries. This is when the shunt also receives blood over the distal part of the radial artery supplied from the ulnar artery via the palmar arch. In this model the ulnar artery corresponds to the proximal subclavian artery. In this model, too, the pulse curve characteristics from the proximal and distal radial artery resemble those of forward flow in the vertebral artery due to the low peripheral resistance to flow. The pulse curve from the distal section of the radial artery in this situation is illustrated in figure 12 A. This pulse curve can be changed to alternating or retrograde flow by increasing compression on the ulnar artery (fig. 12 B–D). When compared to the subclavian-vertebral system this corresponds to increasing stenosis in the proximal subclavian artery.

Discussion
In the presence of occlusion of the subclavian artery the ipsilateral vertebral artery takes over the function of a collateral vessel (subclavian steal). The usual direction of flow is then reversed. In high grade stenosis of the subclavian artery there is usually not a complete reversal of flow in the vertebral artery but alternating flow dependent on the cardiac cycle. The basis for this is that the difference in pressure and the resistance to flow in the right and left subclavian-vertebral system change during the cardiac cycle. In all patients with alternating flow in the vertebral artery the latency measurement to the R-peak of the ECG showed a reversal of flow only during a part of systole, which can be explained as follows:

The hemodynamic effect of stenosis, a poststenotic fall in pressure, increases with rising flow velocity during systolic flow acceleration. It is thus understandable that the pressure gradient between the vertebral system and the poststenotic subclavian artery is only large enough to effect a reversal of the direction of flow in the ipsilateral vertebral artery at the peak range of systolic flow velocity, and not at the onset of systolic acceleration or during diastole. If the pressure gradient caused by proximal subclavian stenosis is not high enough during systole to cause a reversal of the direction of flow in the vertebral artery, only a systolic deceleration or cessation of flow may be seen. The Doppler pulse curves with systolic flow deceleration or alternating flow are, therefore, characteristic of intermediate forms leading to complete subclavian steal. It is common to them all that the watershed shifts in relation to the cardiac cycle, at times found in the region of the vertebral artery itself but shifting from the cranial direction downward and backward.

A displacement of the watershed can also occur as a result of an alteration in peripheral flow resistance. If there is alternating flow in the vertebral artery at rest it is possible to

FIGURE 11. Diagram of vessels of a patient with an artificial arterio-venous fistula. The fistula receives its blood supply over the palmar arch and the flow in the distal radial artery (B) is therefore reversed. This reversal can be abolished by compression on the ulnar artery (I).

FIGURE 12. Experimentally induced alternating flow in the radial artery. Doppler pulse curves from the radial artery (position of probe shown in fig. 11) and ECG in a patient with Cimino's fistula in the lower arm. The direction of flow in the radial artery is reversed. Note the unusually high diastolic flow. Increasing compression of the ulnar artery causes changes in the pulse curves from the radial artery as already shown in the example of the vertebral artery (systolic deceleration (B), alternating flow direction (C), or almost complete change of flow direction.)
effect displacement of the watershed toward the head with no reversal of flow by compression on the upper arm on the side of the subclavian stenosis, and displacement toward the arm i.e. complete reversal of flow due to reactive postischemic hyperemia (see fig. 1 C).

Figure 6 shows that high grade proximal vertebral stenosis as well as proximal subclavian stenosis may lead to systolic flow deceleration of the Doppler pulse curves of the distal vertebral artery. The hemodynamic situation in the region under examination, at the level of the atlas slope, is similar in both types. In contrast to subclavian stenosis, in vertebral stenosis no complete reversal of flow in the vertebral artery can be induced by reactive postischemic hyperemia of the arm (lowering of resistance). Moreover, the pulse curves from the subclavian artery are symmetrical, so that in typical cases there is no difficulty in differentiating between vertebral and subclavian stenosis. It is only in combined vertebral and subclavian stenosis that such problems are to be expected.

Alternating flow in the vertebral artery usually correlates with angiographic evidence of high-grade subclavian stenosis. In occlusion of the subclavian artery, which usually shows complete reversal of flow, alternating flow with minimal forward flow in diastole was a rarer finding. In two patients it was due to aortic valve insufficiency. It is possible to differentiate between stenosis and occlusion of the subclavian artery by measuring the latency of the arise point during systolic acceleration. A delay in latency is found only with occlusion. It is usually possible to make this differentiation without simultaneous ECG recording, since proximal stenosis of the subclavian artery leads to severe turbulence which may be conveyed to the supraclavicular fossa and be recordable there.

With alternating flow of approximately equal degrees of forward and reverse flow, the affected arteries may not be demonstrable by aortic arch angiography. In these instances patency and a beginning steal can only be proved by selective angiographic methods with simultaneous functional tests (upper arm compression and/or closure of fist).

In the hands of an experienced examiner directional continuous wave Doppler sonography is more than a simple screening method. It is often more useful than angiography for the evaluation of the hemodynamics of the extracranial cerebral vessels.14 The exact demonstration of the morphology of vascular changes can only be obtained with selective angiography in several planes. Aortic arch angiograms do not usually give sufficient information to supplement the Doppler diagnosis. Initial Doppler sonographic examination is followed by more precise formulation of the question at angiography, but often Doppler diagnosis is sufficiently reliable to be able to replace angiography.

Acknowledgment

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