Remodeling of Saccular Cerebral Artery Aneurysm Wall Is Associated With Rupture
Histological Analysis of 24 Unruptured and 42 Ruptured Cases

Juhana Frösen, MD; Anna Piippo, MB; Anders Paetau, MD, PhD; Marko Kangasniemi, MD, PhD; Mika Niemelä, MD, PhD; Juha Heresniemi, MD, PhD; Juha Jääskeläinen, MD, PhD

Background and Purpose—The cellular mechanisms of degeneration and repair preceding rupture of the saccular cerebral artery aneurysm wall need to be elucidated for rational design of growth factor or drug-releasing endovascular devices.

Methods—Patient records, preoperative vascular imaging studies, and the snap-frozen fundi resected after microsurgical clipping from 66 aneurysms were studied. Immunostainings for markers of smooth muscle cell (SMC) phenotype, proliferation, and inflammatory cell subtypes and TUNEL reaction were performed.

Results—Unruptured (24) and ruptured (42) aneurysms had similar dimensions (median diameter in unruptured 6 mm; median in ruptured 7 mm; \( P = 0.308 \)). We identified 4 basic types of aneurysm wall that associated with rupture: (1) endothelialized wall with linearly organized SMCs (17/66; 42% ruptured), (2) thickened wall with disorganized SMCs (20/66; 55% ruptured), (3) hypocellular wall with either myointimal hyperplasia or organizing luminal thrombosis (14/66; 64% ruptured), and (4) an extremely thin thrombosis-lined hypocellular wall (15/66; 100% ruptured). Apoptosis, de-endothelialization, luminal thrombosis, SMC proliferation, and T-cell and macrophage infiltration associated with rupture. Furthermore, macrophage infiltration associated with SMC proliferation, and both were increased in ruptured aneurysms resected <12 hours from rupture, suggesting that these were not just reactive changes.

Conclusions—Before rupture, the wall of saccular cerebral artery aneurysm undergoes morphological changes associated with remodeling of the aneurysm wall. Some of these changes, like SMC proliferation and macrophage infiltration, likely reflect ongoing repair attempts that could be enhanced with pharmacological therapy. (Stroke. 2004;35:000-000.)

Key Words: cerebral aneurysm ■ inflammation ■ intracranial aneurysm ■ rupture
TABLE 1. Monoclonal Mouse Anti-Human Antibodies Used in the Study

<table>
<thead>
<tr>
<th>Antigen</th>
<th>Clone</th>
<th>Dilution</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>CD31 (PECAM 1) [platelet endothelial cell adhesion molecule 1]2⁰</td>
<td>JC70A</td>
<td>1:200</td>
<td>DAKO</td>
</tr>
<tr>
<td>Alpha-smooth muscle actin2¹</td>
<td>1A4</td>
<td>1:500</td>
<td>Sigma</td>
</tr>
<tr>
<td>Myosin heavy chain2²</td>
<td>SMMS-1</td>
<td>1:200</td>
<td>DAKO</td>
</tr>
<tr>
<td>Fibroblast marker2³</td>
<td>5B5</td>
<td>1:200</td>
<td>DAKO</td>
</tr>
<tr>
<td>K672⁴</td>
<td>MIB-1</td>
<td>1:250</td>
<td>DAKO</td>
</tr>
<tr>
<td>CD45 (LCA [leukocyte common antigen])2⁵</td>
<td>2B11+PD7/26</td>
<td>1:200</td>
<td>DAKO</td>
</tr>
<tr>
<td>CD3 (T-cell receptor)</td>
<td>PC3/188A</td>
<td>1:200</td>
<td>DAKO</td>
</tr>
<tr>
<td>CD11b (MAC 1 [macrophage adhesion molecule 1])²⁶</td>
<td>2LPM19c</td>
<td>1:200</td>
<td>DAKO</td>
</tr>
<tr>
<td>CD68 (macrophage marker)2⁷</td>
<td>PG-M1</td>
<td>1:200</td>
<td>DAKO</td>
</tr>
<tr>
<td>CD163 (macrophage marker)²⁸</td>
<td>Ber-MAC3</td>
<td>1:200</td>
<td>DAKO</td>
</tr>
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</table>

Clinical and Radiological Data
Clinical data were collected from the patients’ medical records. Dimensions of the aneurysms were measured from preoperative vascular imaging studies: computed tomography, magnetic resonance angiography, or digital subtraction angiography.

Statistics
Statistics were calculated using the NCSS 2000 (NCSS Statistical Software). For categorical variables, proportions were calculated and χ² independence test was used. For numeric variables, median and range were calculated, and Mann–Whitney U test and Kruskall–Wallis multiple comparison test were used. Logistic regression and multiple linear regression were used in multivariable analysis. α-Level was 0.05.

Results
Patients and SCAA
Patients with unruptured (n=24) or ruptured (n=42) SCAAs did not differ by age or gender (Table 2). The aneurysm neck and fundus sizes were similar (Table 2), and the most frequent locations were middle cerebral artery (67% in unruptured versus 41% in ruptured) and anterior communicating artery (AComA; 8% in unruptured versus 21% in ruptured). Secondary pouches in preoperative angiographies were seen in 30% of unruptured and in 67% of ruptured SCAAs (P=0.005).

Histological Types of SCAA Walls
SCAA walls of the 6 familial aneurysm patients did not differ from the 60 sporadic ones. Lack of elastic laminas was a common feature in the SCAAs studied. Atherosclerotic calcifications were seen in only 5 unruptured and 2 ruptured cases. However, pads of MH or MH-like disorganized wall structure occurred in both groups (Table 2). Four basic types of SCAA wall structure were distinguished (Figure 1A through 1D): type A (n=17), endothelialized wall with linearly organized SMC; type B (n=20), thickened wall with disorganized SMC; type C (n=14), hypocellular wall with either MH or OT; and type D (n=15), an extremely thin thrombosis-lined hypocellular wall. The prevailing wall type in the sample significantly associated (P=0.004) with rupture: 42% (7/17) in type A; 55% (11/20) in type B; 64% (9/14) in type C; and 100% (15/15) in type D. Symptoms suggestive of minor leaks2⁹ before diagnosed SAH were recorded in 12 patients (29%), and minor leaks were associated with the D-type wall (P=0.011). Several aneurysm walls were heterogeneous with gradual change from types A or B to types C or D, mostly in the neck to fundus direction. The wall type was not associated with aneurysm size (P>0.384) or location (P=0.426) or presence of secondary pouches (P=0.795), but patients with B-type walls were younger (median 47 years) than patients with A-type (median 61 years) or C-type (median 58 years) walls (P=0.021).

Thrombosis and Fibrosis
Fresh thrombosis (Figure 1D) or OT (Figure 1C) lined the luminal aspect in 25% of unruptured and in 70% of ruptured SCAAs (Table 2). SMCs were seen more frequently in luminal OT of ruptured SCAAs (Figure 2, Table 2). OT often had areas so fibrotic that it was difficult to
distinguish them from neighboring intimal hyperplasia pads, and they are collectively termed as MH/OT areas in further analysis.

Factors Associated With Rupture
Ruptured SCAA walls showed increased de-endothelialization, fresh and organizing luminal thrombosis, proliferation ratio in MH/OT areas, apoptosis ratio outside MH/OT areas, and leukocyte infiltration (CD45, CD3, CD11b, CD68, and CD163) in both areas of the wall (Table 2, Figure 3). These histological changes were not associated with minor leaks. Leukocyte density in MH/OT areas and OT were independent risk factors in logistic regression analysis ($R^2=0.46; P<0.001$ for the model). Fibroblast antigen+ cells occurred equally in the walls of unruptured (39%) and ruptured (46%) SCAs.

Leukocyte Infiltration and Cell Proliferation in the SCAA Wall After Rupture
Of the 42 ruptured SCAs, 35 had been resected between 3.5 and 48 hours after rupture (Table 2). Proliferation ratio, T-cell density (CD3+), and macrophage density (CD163+) were increased in MH/OT areas already before 12 hours from rupture but remained stable in other areas of the wall (Figures 3 and 4). Density of CD11b+ cells and CD163+ cells in the MH/OT areas and density of CD68+ cells in other parts significantly associated with proliferation in MH/OT areas in multiple linear regression analysis ($R^2=0.82; P<0.001$ for the model).

Discussion
The cellular mechanisms of SCAA rupture have to be elucidated for development of locally delivered or systemic drug therapies. We describe in a series of 66 SCAA fundi morphological changes of the SCAA wall that correlate with rupture, association of inflammatory cell infiltration, and SMC proliferation with rupture, and association of macrophage infiltration with SMC proliferation in ruptured SCAA walls.

Morphological Changes in SCAA Wall Preceding Rupture
SCAs tend to grow over the years. Therefore, the SCAA wall has to undergo morphological changes that likely differ in unruptured and ruptured SCAs. In a previous series of 27 unruptured and 44 ruptured SCAA fundi, Kataoka et al found that thick intima-like walls are mostly unruptured, and very thin and degenerated walls with hyaline deposits mostly ruptured. Other previous studies on SCAA walls describe inflammatory cells, signs of complement activation, increased protease activity, variations in SMC phenotype, and apoptosis. We identified 4 histological SCAA wall types that likely reflect consecutive stages (A through D) of wall degeneration proceeding to rupture. As Kataoka did, we also found

<table>
<thead>
<tr>
<th>TABLE 2. Patients and SCAs</th>
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<tr>
<td>Variables</td>
</tr>
<tr>
<td>Age</td>
</tr>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>Familial background*</td>
</tr>
<tr>
<td>Patients with multiple SCAs (≥2)</td>
</tr>
<tr>
<td>Patients with prior aneurysmal SAH</td>
</tr>
<tr>
<td>Aneurysms resected for study</td>
</tr>
<tr>
<td>No. of known ruptures</td>
</tr>
<tr>
<td>Time from rupture to resection</td>
</tr>
<tr>
<td>Neck diameter</td>
</tr>
<tr>
<td>Width of fundus</td>
</tr>
<tr>
<td>Length of fundus</td>
</tr>
<tr>
<td>Histology of aneurysm wall</td>
</tr>
<tr>
<td>Atherosclerotic calcifications*</td>
</tr>
<tr>
<td>Intact elastic lamina</td>
</tr>
<tr>
<td>Remnants of elastic laminae</td>
</tr>
<tr>
<td>Endothelial lining absent*</td>
</tr>
<tr>
<td>Pads of intimal hyperplasia</td>
</tr>
<tr>
<td>Organizing thrombosis lining the wall*</td>
</tr>
<tr>
<td>Infiltrating myosin heavy chain + cells</td>
</tr>
<tr>
<td>Fresh thrombosis lining the wall*</td>
</tr>
</tbody>
</table>

Median and range are given for continuous variables. *P<0.05 (χ² or Mann–Whitney U test).
that aneurysms with thin hyalinized walls (D-type wall in our series) were ruptured. However, in our series, also as many as 55% (11/20) of thick intima-like walls (B-type) had ruptured. This may reflect differences in Finnish and Japanese SCAA populations. Interestingly, in our series, B-type (thick intima-like) walls occurred in younger patients than A-type (organized) or C-type (hypocellular with luminal thrombosis) walls. Possible association between age and SCAA wall maintenance and repair capacity warrants further studies.

**Maintenance and Repair of SCAA Wall**

The wall of unruptured SCAs may remain intact for years. Thus, strong maintenance and repair mechanisms are mandatory. Our results suggest that before rupture, the SCAA wall becomes unstable and undergoes morphological changes that start at an undefined time interval before rupture. These changes reflect the effect of risk factors that predispose to rupture as well as the maintenance and repair mechanisms trying to prevent rupture. The factors distinguishing unruptured and ruptured SCAs in our series were: decellularization, apoptosis, and degeneration of wall matrix; de-endothelialization; thrombus organization; proliferation; and inflammatory infiltration. Most of these are features related to MH (ie, the mechanism of how generally the arterial wall responds to injury or hemodynamic stress). During MH formation, the SMCs that migrate from the vascular wall to the luminal surface secrete matrix metalloproteinases that destroy parts of the wall matrix and make the migration of SMCs possible. The morphological changes that result from the MH and matrix destruction are collectively referred to as remodeling of the vascular wall. Although MH is an adaptation mechanism of arteries to hemodynamic stress, in SAH patients, for undefined reasons, vascular wall remodeling was insufficient to prevent SCAA rupture. Paradoxically, in SCAs, remodeling might even facilitate rupture because of increased matrix proteolysis. It would be important to study aneurysms at a few weeks after rupture, but in our series, all but 6 aneurysms were clipped within 48 hours.

**Inflammation in SCAA Wall**

Ruptured SCAA walls show inflammation. It is not known whether inflammation triggers the rupture of the SCAA wall.
causing SAH. However, it is known that infiltrating leukocytes, mainly T-cells and macrophages, stimulate SMC proliferation in areas of vascular wall thickening.\textsuperscript{18} We found that T-cell and macrophage infiltration associate with rupture, and furthermore, macrophage infiltration associates with SMC proliferation in the SCAA wall. Therefore, we hypothesize that in the SCAA wall, macrophages may stimulate SMCs to change phenotype and proliferate, thus promoting fibrosis. That SMC proliferation and T-cell and macrophage infiltration were increased in samples resected from rupture suggests that these changes were, to some extent, present before rupture because in healthy arterial wall, they occur in response to injury during the first 24 hours or later (T-cell and macrophage infiltration as well as SMC proliferation).\textsuperscript{17,32}

**Therapeutic Implications**

Only few diagnosed SCAAs will occlude spontaneously.\textsuperscript{30} It is not known why luminal thrombosis, SMC migration, and vascular wall remodeling fail to prevent rupture and occlude untreated SCAA pouches. Systemic or locally delivered selected agents that stimulate SMC proliferation and migration to luminal thrombus might promote the occlusion. Our data suggest that inflammatory cell infiltration and SMC proliferation increase in the SCAA wall before rupture, and we hypothesize that they are part of the adaptation and repair mechanism of the SCAA wall. Locally delivered selected proinflammatory agents stimulating SMC proliferation and matrix synthesis might reinforce the SCAA wall. In addition, matrix metalloproteinase inhibitors that reduce proteolysis in mechanical arterial...
wall injury models\textsuperscript{33,34} might inhibit harmful matrix degradation in the SCAA wall and prevent rupture.

**Acknowledgments**

This study was supported by the research funds of the Helsinki University Central Hospital, Finland, and by grants from the Bioclinicum Helsinki Foundation. We thank Ilse Pyy, MLT, and Tanja Erikson, MLT, for their excellent technical assistance.

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Stroke. published online August 19, 2004; Stroke is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231 Copyright © 2004 American Heart Association, Inc. All rights reserved. Print ISSN: 0039-2499. Online ISSN: 1524-4628

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