Cerebral Hemodynamic Changes in Stroke During Sleep-Disordered Breathing

Fabio Pizza, MD, PhD; Martin Biallas, Dipl Ing; Ulf Kallweit, MD; Martin Wolf, DrScTech*; Claudio L. Bassetti, MD*

Background and Purpose—Sleep-disordered breathing (SDB) negatively impacts stroke outcome. Near-infrared spectroscopy showed the acute cerebral hemodynamic effects of SDB.

Methods—Eleven patients (7 men, age 61 ± 13 years) with acute/subacute middle cerebral artery stroke (National Institutes of Health Stroke Scale score 10 ± 7) and SDB (apnea–hypopnea index 32 ± 28/hour) were assessed with nocturnal polysomnography and bilateral near-infrared spectroscopy recording. Cerebral oxygenation and hemoglobin concentration changes during obstructive and central apneas were analyzed.

Results—During SDB, near-infrared spectroscopy showed asymmetrical patterns of cerebral oxygenation and hemoglobin concentrations with changes significantly larger on the unaffected compared with the affected hemisphere. Brain tissue hypoxia was more severe during obstructive compared with central apneas.

Conclusions—Profound cerebral deoxygenation effects of SDB occurred in acute/subacute stroke. These changes may contribute to poor outcome, arising in the possibility of a potential benefit of SDB treatment in stroke management. (Stroke. 2012;43:1951-1953.)

Key Words: acute stroke ■ cerebral hemodynamics ■ microcirculation ■ near-infrared spectroscopy ■ sleep apnea

Sleep-disordered breathing (SDB) independently increases the risk of cardiovascular events, stroke, and death. SDB is associated with worse clinical outcome in stroke, but the acute impact of repetitive brain hypoxia has never been documented.1 Cerebral near-infrared spectroscopy (NIRS) provides a noninvasive, bedside assessment of oxygen saturation and oxygenated, deoxygenated, and total hemoglobin concentrations at the cortical level.² Cerebral NIRS coupled with transcranial Doppler (TCD) during the breath-holding test in patients with carotid occlusion distinguished symptomatic patients for their insufficient cerebrovascular autoregulation.³ NIRS also proved the inability of cerebral autoregulation to prevent hypoxia in patients with severe obstructive SDB.⁴

Methods
Nocturnal polysomnography was coupled with bilateral cerebral NIRS performed with OxiplexTS. The study was approved by local ethic committee. All patients signed a written informed consent.

Patients were consecutively recruited (University Hospital of Zürich) over a period of 6 months with the following inclusion criteria: (1) first-ever ischemic stroke with unilateral involvement of areas supplied by middle cerebral artery (MCA); (2) stable clinical condition; and (3) TCD and neuroimaging studies performed after stroke treatment.

NIRS Recording and Signal Analysis
Our 2-wavelength system, based on a frequency-domain technology, provides absolute values of oxygen saturation, oxygenated hemoglobin, and total hemoglobin. The multisdistance approach subtracts superficial layers, thus yielding values of a cortical brain volume of a few cube centimeters.⁵ Two probes were calibrated, attached to corresponding frontal areas through a medical adhesive, and shielded from external light.

NIRS data underwent the signal analyses described before.⁴ NIRS and peripheral oxygen saturation (SpO₂) data associated with obstructive and central apneas occurring in different sleep stages of each patient were averaged for each of the 2 hemispheres (Figure). Respiratory event duration was defined from the first SpO₂ decrease to its return to baseline and SpO₂ signal was integrated. Averaged NIRS parameters were plotted together for each hemisphere to detect the first hemodynamic change occurring close to time 0 second. Synchronous integrals were compared using Wilcoxon test on the whole data set and independently for obstructive and central apneas. NIRS parameter (and SpO₂) changes of different event types were compared using the Mann–Whitney test.

Results
Patients
Fifteen patients were consecutively enrolled. Three patients lacking unilateral MCA involvement (one bilateral, one posterior, and one lacunar) and one because of a technical NIRS failure were excluded. Eleven patients (7 men, mean...
age 61±13 years) with unilateral MCA stroke and TCD evidence of stenosis/occlusion of intracranial arteries (n=5) or symmetrical MCA blood flow velocities (n=6), respectively, were analyzed. Their mean National Institutes of Health Stroke Scale score was 10±7 at admission, and their mean Rankin Scale score was 2±1 at discharge.

Nocturnal polysomnography, performed 7±5 days after symptom onset, showed a mean apnea–hypopnea index of 32±28/hour (range, 5–94/hour) with a predominant central and obstructive SDB in 5 and 3 patients, respectively and an apnea–hypopnea index >30/hour in 3.

**Bilateral Hemodynamic Patterns**

Averaged NIRS parameters occurring during respiratory events revealed an asymmetrical pattern of cerebral hemodynamics over the 2 hemispheres (Figure): a trend of decrease of oxygenated hemoglobin and an increase of deoxygenated hemoglobin, apparently of higher amplitude on the unaffected hemisphere followed by return to baseline values. Reduced oscillations of cerebral oxygen saturation on the affected side were the result of the 3 dynamic hemoglobins' concentration changes over the 2 hemispheres.

**Hemisphere and Event-Type Comparison**

Relative changes of NIRS parameters showed a larger decrease of oxygen saturation, oxygenated hemoglobin, and, to a lesser extent, of total hemoglobin, associated with an increase of deoxygenated hemoglobin on the normal compared with the affected hemisphere (Table).

The comparison between different event types showed that obstructive events induced larger hemodynamic changes than central ones with statistical significance for oxygen saturation of the unaffected hemisphere (P=0.010), oxygenated hemoglobin of the affected hemisphere (P=0.027), and for $\text{SpO}_2$ (P=0.004) on the Mann–Whitney test.

The larger amplitude of the hemodynamic changes occurring on the unaffected versus affected hemisphere was confirmed for all NIRS parameters during obstructive apneas, but only for oxygen saturation and deoxygenated hemoglobin during central apneas (Table).

**Discussion**

We firstly explored the SDB effect on cerebral hemodynamics in acute/subacute stroke using bilateral NIRS. We improved the signal-to-noise ratio (averaging) and included the temporal dimension in NIRS measurements (integrals adjusted for duration). We disclosed that SDB acutely induces larger hemodynamic changes in the unaffected hemisphere than in the affected one and that obstructive apneas more profoundly impacted on cerebral hemodynamics than central apneas.

NIRS changes during SDB reflect the cortical balance between blood supply and metabolism. Positron emission tomography during cerebral ischemia revealed a complex interaction between cerebral perfusion and metabolic oxygen consumption that defines the dynamic evolution of an ischemic “core.”6 Once brain damage has occurred, cerebrovascular autoregulation fails, even if cerebral perfusion returns to normal.

The “paradoxical” observation of lower hemodynamic changes on the affected hemisphere induced by SDB cannot be explained by diminished blood perfusion, because additional analyses of 6 patients with normal or increased MCA blood flow velocities in the affected side yielded comparable results (data not shown). TCD studies during obstructive apneas showed repetitive, transient increases of MCA blood
Table. Mean (and SEM) Relative Changes of Peripheral Oxygen Saturation and Cerebral NIRS Parameters of the 2 Hemispheres With Side Comparison Significance on Wilcoxon Test

<table>
<thead>
<tr>
<th></th>
<th>Unaffected Mean</th>
<th>Unaffected SEM</th>
<th>Affected Mean</th>
<th>Affected SEM</th>
<th>Side Comparison P Value</th>
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<td>All apneas</td>
<td></td>
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<td></td>
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<tr>
<td>SpO2, %·s⁻¹</td>
<td>−3.24</td>
<td>0.28</td>
<td>−3.24</td>
<td>0.28</td>
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<tr>
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<td>0.08</td>
<td>−0.19</td>
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<td>0.03</td>
<td>−0.03</td>
<td>0.09</td>
<td>0.009</td>
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<td>0.04</td>
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<td>0.04</td>
<td>−0.14</td>
<td>0.11</td>
<td>NS</td>
</tr>
<tr>
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<td>0.03</td>
<td>−0.21</td>
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<td>−0.08</td>
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<td>0.008</td>
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<td>0.06</td>
<td>0.041</td>
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</table>

NIRS indicates near-infrared spectroscopy; SItO2, cerebral oxygen saturation; tHb, peripheral total hemoglobin; O₂Hb, oxygenated hemoglobin; HHb, deoxygenated hemoglobin; NS, nonsignificant.

Summary

We documented asymmetrical nocturnal cerebral hemodynamic changes induced by SDB during the acute/subacute phase of stroke. Lower hemodynamic fluctuations occurred over the affected hemisphere, and the oxygen desaturations on the unaffected side were more profound during obstructive SDB. Studies coupling different techniques (TCD and positron emission tomography) to NIRS in a larger sample of patients with and without stroke and different SDB severity will confirm our findings and their clinical relevance for stroke pathophysiology and recovery.

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Disclosures

None.

References

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Abstract

Bilateral Cerebral Hemodynamic Changes in Stroke During Sleep-Disordered Breathing

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Background and Objective: Sleep-disordered breathing (SDB) is a common complication of stroke..hypercapnia and hypocapnia during sleep-disordered breathing (SDB) are associated with impaired cerebral hemodynamics.

Methods: We studied 10 patients with acute stroke (NIHSS score 10 ± 7) and SDB (apnea-hypopnea index 32 ± 28 per hour) using near-infrared spectroscopy (NIRS) during sleep.

Results: In stroke patients with SDB, there were significant differences in cerebral hemodynamics compared to healthy controls. The mean cerebral oxygen saturation was significantly lower in the acute stage of stroke compared to healthy controls.

Conclusion: SDB during sleep is associated with impaired cerebral hemodynamics in stroke patients. This finding may have implications for the management of stroke patients with SDB.

Stroke 2012; 43: 1951-1953