Stratification of Heterogeneous Diffusion MRI Ischemic Lesion With Kurtosis Imaging

Evaluation of Mean Diffusion and Kurtosis MRI Mismatch in an Animal Model of Transient Focal Ischemia

Jerry S. Cheung, PhD; Enfeng Wang, MD; Eng H Lo, PhD; Phillip Zhe Sun, PhD

Background and Purpose—Ischemic tissue damage is heterogeneous, resulting in complex patterns in the widely used diffusion-weighted MRI. Our study examined the spatiotemporal characteristics of diffusion kurtosis imaging in an animal model of transient middle cerebral artery occlusion.

Methods—Adult male Wistar rats (N=18) were subjected to 90 minutes middle cerebral artery occlusion. Multiparametric MR images were obtained during middle cerebral artery occlusion and 20 minutes after reperfusion with diffusion-weighted MRI obtained using 8 b-values from 250 to 3000 s/mm² in 6 diffusion gradient directions. Diffusion and kurtosis lesions were outlined in shuffled images by 2 investigators independently. T₂ MRI was obtained 24 hours after middle cerebral artery occlusion to evaluate stroke outcome.

Results—Mean diffusion lesion (23.5%±8.1%, percentage of the brain slice) was significantly larger than mean kurtosis lesion (13.2%±2.0%) during middle cerebral artery occlusion. Mean diffusion lesion decreased significantly after reperfusion (13.8%±4.3%), whereas mean kurtosis lesion showed little change (13.0%±2.5%) with their lesion size difference being insignificant.

Conclusions—We demonstrated that mean diffusion/mean kurtosis mismatch recovered reasonably well on reperfusion, whereas regions with concurrent mean diffusion and mean kurtosis deficits showed poor recovery. Diffusion kurtosis imaging may help stratify heterogeneous diffusion-weighted MRI lesions for enhanced characterization of ischemic tissue injury. (Stroke. 2012;43:00-00.)

Key Words: acute ischemia ▪ diffusion ▪ kurtosis

Diffusion-weighted imaging (DWI) detects severely damaged ischemic tissue that is likely to infarct and has been widely used in stroke imaging.¹,² However, tissue damage within DWI deficit is heterogeneous, which may partially recover with prompt treatment. There have been no well-established techniques capable of stratifying heterogeneously damaged DWI lesion.³,⁴ Diffusion kurtosis imaging is an emerging MRI technique that measures the degree of the non-Gaussian water diffusion and is sensitive to microscopic structural changes.⁵ Indeed, diffusion kurtosis imaging has been shown capable of detecting microstructural cerebral tissue changes in aging brains, acute stroke, and tumor.⁶–⁸ We postulated that diffusion kurtosis imaging could stratify heterogeneous DWI lesions, improving characterization of tissue injury. Our study examined the spatiotemporal characteristics of mean diffusion (MD) and kurtosis (MK) MRI using a transient filament middle cerebral artery occlusion (MCAO) rodent model.

Materials and Methods

Animal Model

Transient MCAO was induced in 18 adult male Wistar rats (Charles River Laboratory, Wilmington, MA), anesthetized under 1.5% to 2.0% isoflurane with heart rate and saturation of peripheral oxygen monitored online, following institution-approved guidelines. Animals were reperfused by withdrawing filament 95 minutes post-MCAO. One rat died during MRI and was excluded from analysis.

Magnetic Resonance Imaging

MR imaging was obtained using a Bruker 4.7-T small-bore scanner (5 slices, 2 mm/slice, field of view=25×25 mm², matrix size=64×64). Multiparametric MR imaging was obtained during MCAO (20–90 minutes post-MCAO), after reperfusion (120–190 minutes post-MCAO). DWI was acquired with b-values of 250, 500,
Results

Figure 1 shows that MD lesions were significantly larger than MK deficits during MCAO. After reperfusion, MD lesions decreased to approximately the size of MK lesions, which showed negligible change. Notably, MD and ADC maps showed very similar lesion, as expected. Stroke outcome was confirmed using follow-up T2 MRI and histology. ADC indicates apparent diffusion coefficient; MD, mean diffusion; MK, mean kurtosis; MCAO, middle cerebral artery occlusion.

Discussion

Our study found that the MD/MK mismatch recovered reasonably well on reperfusion, whereas areas with concurrent MD and MK deficits during MCAO. After reperfusion, MD lesions significantly larger than acute MD and MK lesions (P<0.01), likely due to severe ischemia and reperfusion injury.

Figure 3 compares reperfusion-induced change in multiparametric MRI values. During MCAO, MD in ischemic lesion decreased significantly from the contralateral normal region (0.55±0.03 versus 0.78±0.02 μm²/ms, P<0.01), whereas MK was elevated (0.98±0.04 versus 0.69±0.03, P<0.01). Using the contralateral region of interest as reference, the percentage difference between nonischemic and ischemic tissues was −29.0%±3.6% and 42.6%±4.8% for MD and MK, respectively. After reperfusion, the ischemic lesion MD improved (0.60±0.04 μm²/ms, P<0.01) but was still significantly less than the reference (P<0.01). Moreover, ischemic tissue MK decreased significantly, yet it was still elevated from the contralateral normal tissue (0.93±0.06 versus 0.70±0.03, P<0.01). The percentage differences between nonischemic and ischemic tissues were −22.7%±5.3% and 33.9%±10.9% for MD and MK, respectively.

Lesion (23.5%±8.1%) was larger than MK (13.2%±2.0%, P<0.01). MD lesion decreased significantly after reperfusion, and the difference between MD (13.8%±4.3%) and MK (13.0%±2.5%) lesion became insignificant. However, the follow-up T2 MRI showed infarction (28.1%±9.6%) significantly larger than acute MD and MK lesions (P<0.01), likely due to severe ischemia and reperfusion injury.

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Our study found that the MD/MK mismatch recovered reasonably well on reperfusion, whereas areas with concurrent MD and MK deficits during MCAO. After reperfusion, MD lesions decreased to approximately the size of MK lesions, which showed negligible change. Notably, MD and ADC maps showed very similar lesion, as expected. Stroke outcome was confirmed using follow-up T2 MRI and histology.

Figure 2 shows reperfusion-induced change in lesion size, calculated as the percentage of the brain. During MCAO, MD lesion (23.5%±8.1%) was larger than MK (13.2%±2.0%, P<0.01). MD lesion decreased significantly after reperfusion, and the difference between MD (13.8%±4.3%) and MK (13.0%±2.5%) lesion became insignificant. However, the follow-up T2 MRI showed infarction (28.1%±9.6%) significantly larger than acute MD and MK lesions (P<0.01), likely due to severe ischemia and reperfusion injury.

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MK deficits showed little recovery. In comparison, T1 and T2 MRI are not sensitive to ischemic tissue injury during acute stroke. Our results suggest that MD/MK mismatch may represent mildly damaged and potentially salvageable ischemic lesion, whereas areas with simultaneous MD and MK deficits likely indicate aggravated cellular damage. However, the mechanisms of diffusion and kurtosis deficits in acute stroke are complex. MD decreases in the MD/MK mismatch is likely due to cytotoxic edema.10,11 In contrast, MK is sensitive to intracellular tortuosity and viscosity changes subsequent to breakdown of cytoskeletal structures and swelling of mitochondria, likely indicating more severe tissue damage.5,7,12–14 Nevertheless, the filament stroke model used in our study is subject to severe ischemia and reperfusion injury, and the DWI renormalization was transient.15 Indeed, we found that cerebral blood flow decreased significantly in the ipsilateral hemisphere from the contralateral region of interest both during MCAO (0.88±0.27 versus 1.43±0.33 mL/g/min) and after reperfusion (1.15±0.23 versus 1.72±0.25 mL/g/min). Importantly, reperfusion induced significant cerebral blood flow increase in both hemispheres (P<0.01). Therefore, rodent embolic stroke models that more closely resemble human stroke may be more suitable to elucidate the mechanisms of stroke diffusion kurtosis imaging. Moreover, the study may be improved with remote reperfusion techniques to enable pixel-based analysis of MD and MK evolution. Furthermore, histology immediately after reperfusion may help characterize early tissue damage of MD and MK deficits, augmenting evaluation of stroke outcome currently assessed by follow-up MRI.

Conclusion

We showed that MD/MK lesion mismatch recovered reasonably well on reperfusion, whereas regions with concurrent MK and MD deficits responded poorly. Diffusion kurtosis imaging may augment DWI for improved characterization of ischemic tissue injury.

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Disclosures

None.

References

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SUPPLEMENTAL MATERIAL

MCAO | Reperfusion

20-90 min post MCAO

95 min post MCAO

120-190 min post MCAO

24 hr post MCAO

~20 min:
Loading animal into magnet + planning slices

~5 min:
Withdrawing filament

+ ~20 min:
Loading animal into magnet + planning slices

MRI

MRI

MRI

T₂ MRI