



HAL
open science

Impaired cerebrovascular reactivity assessed by BOLD hypercapnic fMRI is associated with increased risk of stroke in patients with symptomatic intracranial atherosclerotic stenosis

Jérémie Papassin

► **To cite this version:**

Jérémie Papassin. Impaired cerebrovascular reactivity assessed by BOLD hypercapnic fMRI is associated with increased risk of stroke in patients with symptomatic intracranial atherosclerotic stenosis. Human health and pathology. 2017. dumas-01623795

HAL Id: dumas-01623795

<https://dumas.ccsd.cnrs.fr/dumas-01623795>

Submitted on 13 Nov 2017

HAL is a multi-disciplinary open access archive for the deposit and dissemination of scientific research documents, whether they are published or not. The documents may come from teaching and research institutions in France or abroad, or from public or private research centers.

L'archive ouverte pluridisciplinaire **HAL**, est destinée au dépôt et à la diffusion de documents scientifiques de niveau recherche, publiés ou non, émanant des établissements d'enseignement et de recherche français ou étrangers, des laboratoires publics ou privés.



AVERTISSEMENT

Ce document est le fruit d'un long travail approuvé par le jury de soutenance et mis à disposition de l'ensemble de la communauté universitaire élargie.

Il n'a pas été réévalué depuis la date de soutenance.

Il est soumis à la propriété intellectuelle de l'auteur. Ceci implique une obligation de citation et de référencement lors de l'utilisation de ce document.

D'autre part, toute contrefaçon, plagiat, reproduction illicite encourt une poursuite pénale.

Contact au SID de Grenoble :
bump-theses@univ-grenoble-alpes.fr

LIENS

Code de la Propriété Intellectuelle. articles L 122. 4
Code de la Propriété Intellectuelle. articles L 335.2- L 335.10

<http://www.cfcopies.com/juridique/droit-auteur>

<http://www.culture.gouv.fr/culture/infos-pratiques/droits/protection.htm>

UNIVERSITE GRENOBLE ALPES
FACULTE DE MEDECINE DE GRENOBLE

Année : 2017

N°

Altération de la vasoréactivité cérébrale en IRMf hypercapnique chez
les patients présentant une sténose artérielle intracrânienne
symptomatique d'origine athéromateuse à haut risque de récurrence.

THESE
PRESENTEE POUR L'OBTENTION DU DOCTORAT EN MEDECINE
DIPLOME D'ETAT

PAPASSIN Jérémie

[Données à caractère personnel]

THESE SOUTENUE PUBLIQUEMENT A LA FACULTE DE MEDECINE DE GRENOBLE*

Le : 12 Octobre 2017

DEVANT LE JURY COMPOSE DE

Président du jury : M. le Professeur Mikael MAZIGHI

Membres

M. le professeur Tae-Hee CHO

M. le Docteur Olivier DETANTE

M. le Professeur Alexandre KRAINIK, directeur de thèse

**La Faculté de Médecine de Grenoble n'entend donner aucune approbation ni improbation aux opinions émises dans les thèses ; ces opinions sont considérées comme propres à leurs auteurs.*

Doyen de la Faculté : Pr. Jean Paul ROMANET

Année 2017-2018

ENSEIGNANTS A L'UFR DE MEDECINE

CORPS	NOM-PRENOM	Discipline universitaire
PU-PH	ALBALADEJO Pierre	Anesthésiologie réanimation
PU-PH	APEL Florent	Ophthalmologie
PU-PH	ARVIEUX-BARTHELEMY Catherine	Chirurgie générale
PU-PH	BAILLET Athan	Rhumatologie
PU-PH	BARONE-ROCHETTE Gilles	Cardiologie
PU-PH	BAYAT Sam	Physiologie
PU-PH	BENHAMOU Pierre Yves	Endocrinologie, diabète et maladies métaboliques
PU-PH	BERGER François	Biologie cellulaire
MCU-PH	BIDART-COUTTON Marie	Biologie cellulaire
MCU-PH	BOISSET Sandrine	Agents infectieux
PU-PH	BONAZ Bruno	Gastro-entérologie, hépatologie, addictologie
PU-PH	BONNETERRE Vincent	Médecine et santé au travail
PU-PH	BOREL Anne-Laure	Endocrinologie, diabète et maladies métaboliques
PU-PH	BOSSON Jean-Luc	Biostatistiques, informatique médicale et technologies de communication
MCU-PH	BOTTARI Serge	Biologie cellulaire
PU-PH	BOUGEROL Thierry	Psychiatrie d'adultes
PU-PH	BOUILLET Laurence	Médecine interne
PU-PH	BOUZAT Pierre	Réanimation
MCU-PH	BRENIER-PINCHART Marie Pierre	Parasitologie et mycologie
PU-PH	BRICAULT Ivan	Radiologie et imagerie médicale
PU-PH	BRICHON Pierre-Yves	Chirurgie thoracique et cardio-vasculaire
MCU-PH	BRIOT Raphaël	Thérapeutique, médecine d'urgence
MCU-PH	BROUILLET Sophie	Biologie et médecine du développement et de la reproduction
PU-PH	CAHN Jean-Yves	Hématologie
PU-PH	CARPENTIER Françoise	Thérapeutique, médecine d'urgence
PU-PH	CARPENTIER Patrick	Chirurgie vasculaire, médecine vasculaire
PU-PH	CESBRON Jean-Yves	Immunologie
PU-PH	CHABARDES Stephan	Neurochirurgie
PU-PH	CHABRE Olivier	Endocrinologie, diabète et maladies métaboliques
PU-PH	CHAFFANJON Philippe	Anatomie
PU-PH	CHARLES Julie	Dermatologie
PU-PH	CHAVANON Olivier	Chirurgie thoracique et cardio-vasculaire
PU-PH	CHIQUET Christophe	Ophthalmologie

PU-PH	CHIRICA Mircea	Chirurgie générale
PU-PH	CINQUIN Philippe	Biostatistiques, informatique médicale et technologies de communication
MCU-PH	CLAVARINO Giovanna	Immunologie
PU-PH	COHEN Olivier	Biostatistiques, informatique médicale et technologies de communication
PU-PH	COURVOISIER Aurélien	Chirurgie infantile
PU-PH	COUTURIER Pascal	Gériatrie et biologie du vieillissement
PU-PH	CRACOWSKI Jean-Luc	Pharmacologie fondamentale, pharmacologie clinique
PU-PH	CURE Hervé	Oncologie
PU-PH	DEBILLON Thierry	Pédiatrie
PU-PH	DECAENS Thomas	Gastro-entérologie, Hépatologie
PU-PH	DEMATTEIS Maurice	Addictologie
MCU-PH	DERANSART Colin	Physiologie
PU-PH	DESCOTES Jean-Luc	Urologie
MCU-PH	DETANTE Olivier	Neurologie
MCU-PH	DIETERICH Klaus	Génétique et procréation
MCU-PH	DOUTRELEAU Stéphane	Physiologie
MCU-PH	DUMESTRE-PERARD Chantal	Immunologie
PU-PH	EPAULARD Olivier	Maladies Infectieuses et Tropicales
PU-PH	ESTEVE François	Biophysique et médecine nucléaire
MCU-PH	EYSSERIC Hélène	Médecine légale et droit de la santé
PU-PH	FAGRET Daniel	Biophysique et médecine nucléaire
PU-PH	FAUCHERON Jean-Luc	Chirurgie générale
MCU-PH	FAURE Julien	Biochimie et biologie moléculaire
PU-PH	FERRETTI Gilbert	Radiologie et imagerie médicale
PU-PH	FEUERSTEIN Claude	Physiologie
PU-PH	FONTAINE Éric	Nutrition
PU-PH	FRANCOIS Patrice	Epidémiologie, économie de la santé et prévention
MCU-MG	GABOREAU Yoann	Médecine Générale
PU-PH	GARBAN Frédéric	Hématologie, transfusion
PU-PH	GAUDIN Philippe	Rhumatologie
PU-PH	GAVAZZI Gaétan	Gériatrie et biologie du vieillissement
PU-PH	GAY Emmanuel	Neurochirurgie
MCU-PH	GILLOIS Pierre	Biostatistiques, informatique médicale et technologies de communication
MCU-PH	GRAND Sylvie	Radiologie et imagerie médicale
PU-PH	GRIFFET Jacques	Chirurgie infantile
PU-PH	GUEBRE-EGZIABHER Fitsum	Néphrologie
MCU-PH	GUZUN Rita	Endocrinologie, diabétologie, nutrition, éducation thérapeutique
PU-PH	HAINAUT Pierre	Biochimie, biologie moléculaire
PU-PH	HENNEBICQ Sylviane	Génétique et procréation
PU-PH	HOFFMANN Pascale	Gynécologie obstétrique
PU-PH	HOMMEL Marc	Neurologie
PU-MG	IMBERT Patrick	Médecine Générale
PU-PH	JOUK Pierre-Simon	Génétique
PU-PH	JUVIN Robert	Rhumatologie

PU-PH	KAHANE Philippe	Physiologie
MCU-PH	KASTLER Adrian	Radiologie et imagerie médicale
PU-PH	KRACK Paul	Neurologie
PU-PH	KRAINIK Alexandre	Radiologie et imagerie médicale
PU-PH	LABARERE José	Epidémiologie ; Eco. de la Santé
MCU-PH	LABLANCHE Sandrine	Endocrinologie, diabète et maladies métaboliques
MCU-PH	LANDELLE Caroline	Bactériologie - virologie
MCU-PH	LAPORTE François	Biochimie et biologie moléculaire
MCU-PH	LARDY Bernard	Biochimie et biologie moléculaire
MCU-PH	LARRAT Sylvie	Bactériologie, virologie
MCU - PH	LE PISSART Audrey	Biochimie et biologie moléculaire
PU-PH	LECCIA Marie-Thérèse	Dermato-vénéréologie
PU-PH	LEROUX Dominique	Génétique
PU-PH	LEROY Vincent	Gastro-entérologie, hépatologie, addictologie
PU-PH	LEVY Patrick	Physiologie
PU-PH	LONG Jean-Alexandre	Urologie
PU-PH	MAGNE Jean-Luc	Chirurgie vasculaire
MCU-PH	MAIGNAN Maxime	Thérapeutique, médecine d'urgence
PU-PH	MAITRE Anne	Médecine et santé au travail
MCU-PH	MALLARET Marie-Reine	Epidémiologie, économie de la santé et prévention
MCU-PH	MARLU Raphaël	Hématologie, transfusion
MCU-PH	MAUBON Danièle	Parasitologie et mycologie
PU-PH	MAURIN Max	Bactériologie - virologie
MCU-PH	MC LEER Anne	Cytologie et histologie
PU-PH	MERLOZ Philippe	Chirurgie orthopédique et traumatologie
PU-PH	MORAND Patrice	Bactériologie - virologie
PU-PH	MOREAU-GAUDRY Alexandre	Biostatistiques, informatique médicale et technologies de communication
PU-PH	MORO Elena	Neurologie
PU-PH	MORO-SIBILOT Denis	Pneumologie
PU-PH	MOUSSEAU Mireille	Cancérologie
PU-PH	MOUTET François	Chirurgie plastique, reconstructrice et esthétique ; brûlologie
MCU-PH	PACLET Marie-Hélène	Biochimie et biologie moléculaire
PU-PH	PALOMBI Olivier	Anatomie
PU-PH	PARK Sophie	Hémato - transfusion
PU-PH	PASSAGGIA Jean-Guy	Anatomie
PU-PH	PAYEN DE LA GARANDERIE Jean-François	Anesthésiologie réanimation
MCU-PH	PAYSANT François	Médecine légale et droit de la santé
MCU-PH	PELLETIER Laurent	Biologie cellulaire
PU-PH	PELLOUX Hervé	Parasitologie et mycologie
PU-PH	PEPIN Jean-Louis	Physiologie
PU-PH	PERENNOU Dominique	Médecine physique et de réadaptation
PU-PH	PERNOD Gilles	Médecine vasculaire
PU-PH	PIOLAT Christian	Chirurgie infantile
PU-PH	PISON Christophe	Pneumologie

PU-PH	PLANTAZ Dominique	Pédiatrie
PU-PH	POIGNARD Pascal	Virologie
PU-PH	POLACK Benoît	Hématologie
PU-PH	POLOSAN Mircea	Psychiatrie d'adultes
PU-PH	PONS Jean-Claude	Gynécologie obstétrique
PU-PH	RAMBEAUD Jacques	Urologie
PU-PH	RAY Pierre	Biologie et médecine du développement et de la reproduction
PU-PH	REYT Émile	Oto-rhino-laryngologie
PU-PH	RIGHINI Christian	Oto-rhino-laryngologie
PU-PH	ROMANET Jean Paul	Ophthalmologie
PU-PH	ROSTAING Lionel	Néphrologie
MCU-PH	ROUSTIT Matthieu	Pharmacologie fondamentale, pharmaco clinique, addictologie
MCU-PH	ROUX-BUISSON Nathalie	Biochimie, toxicologie et pharmacologie
MCU-PH	RUBIO Amandine	Pédiatrie
PU-PH	SARAGAGLIA Dominique	Chirurgie orthopédique et traumatologie
MCU-PH	SATRE Véronique	Génétique
PU-PH	SAUDOU Frédéric	Biologie Cellulaire
PU-PH	SCHMERBER Sébastien	Oto-rhino-laryngologie
PU-PH	SCHWEBEL-CANALI Carole	Réanimation médicale
PU-PH	SCOLAN Virginie	Médecine légale et droit de la santé
MCU-PH	SEIGNEURIN Arnaud	Epidémiologie, économie de la santé et prévention
PU-PH	STAHL Jean-Paul	Maladies infectieuses, maladies tropicales
PU-PH	STANKE Françoise	Pharmacologie fondamentale
MCU-PH	STASIA Marie-José	Biochimie et biologie moléculaire
PU-PH	STURM Nathalie	Anatomie et cytologie pathologiques
PU-PH	TAMISIER Renaud	Physiologie
PU-PH	TERZI Nicolas	Réanimation
MCU-PH	TOFFART Anne-Claire	Pneumologie
PU-PH	TONETTI Jérôme	Chirurgie orthopédique et traumatologie
PU-PH	TOUSSAINT Bertrand	Biochimie et biologie moléculaire
PU-PH	VANZETTO Gérard	Cardiologie
PU-PH	VUILLEZ Jean-Philippe	Biophysique et médecine nucléaire
PU-PH	WEIL Georges	Epidémiologie, économie de la santé et prévention
PU-PH	ZAOUI Philippe	Néphrologie
PU-PH	ZARSKI Jean-Pierre	Gastro-entérologie, hépatologie, addictologie

PU-PH : Professeur des Universités et Praticiens Hospitaliers
MCU-PH : Maître de Conférences des Universités et Praticiens Hospitaliers
PU-MG : Professeur des Universités de Médecine Générale
MCU-MG : Maître de Conférences des Universités de Médecine Générale

REMERCIEMENTS

Aux membres du jury,

Au Professeur Mikael Mazighi, chercheur hors pair et neurologue interventionnel. Vous m'avez fait l'honneur de quitter la capitale pour venir présider ce jury.

Au Professeur Tae-Hee Cho, neurologue et excellent pédagogue. Je tenais absolument à ce que vous fassiez parti de ce jury pour apporter votre expertise à ce travail. Vos présentations en congrès ou en cours de DES sont toujours claires et pertinentes.

Au Docteur Olivier Detante, neurologue, show-man et chercheur passionné. Merci pour tes enseignements neurologiques et extra-neurologiques, tu as su me transmettre ton intérêt pour la science ainsi que ton dynamisme.

Au Professeur Alexandre Krainik, neuroradiologue et chercheur polyglotte. Toujours le mot pour rire. Merci pour la confiance que tu m'as accordé pour ce projet. Tu as su à la fois me laisser indépendant et être présent lorsqu'il le fallait.

Aux collègues et amis,

A Olivier Casez, ancienne star des terrains de foot, maintenant amateur de vin et d'arabica. Tu aurais fait aussi un excellent directeur de thèse. A tes côtés, j'ai appris à être médecin et (presque) neurologue, depuis le début de l'externat.

A Mathieu Vaillant. Les personnes qui t'ont élu neurologue le plus gentil du monde n'ont sûrement jamais couru ou monter à ski de rando avec toi, la cadence est insoutenable. Merci pour tes conseils et ta bienveillance.

A Gérard Besson. Homme érudit et musicien acharné vous avez façonné une véritable légende. J'ai hâte d'être CCA chez vous et d'apprendre à écrire mon prénom en hiéroglyphe.

A Katia Garambois. Je scrute maintenant avec attention le moindre ostium vertébral.

A Isabelle Favre « la dominatrice », assistante méticuleuse et avisée, tu aurais dû lire nos courriers d'hospitalisation jusqu'au bout...

A Anne So, archétype de la femme du XXIème, capable de tout faire en même temps et très bien, à mes yeux (et à ceux de bon nombre d'hommes), c'est une chose incroyable.

A l'équipe médicale de neurologie A, merci de votre soutien pendant ces semestres au pays des stimulés et des implantés.

A l'équipe médicale de psychiatrie. Stage très enrichissant alors que je venais à reculons. J'ai appris les rudiments de la psychopathologie en abandonnant ma blouse de « somaticien » et mes objets contraphobiques (marteau réflexe et sthété).

A l'équipe 5 du GIN dirigée par Emmanuel Barbier. Merci pour l'accueil que vous m'avez réservé dans le monde parallèle de la recherche. Pensées particulières à Claire, Nora et Ligia.

A Monsieur Tarel, neurologue passionné et homme juste, vous êtes un exemple pour moi. Merci pour les leçons du soir, vos expressions Shadoks et vos répliques à la Audiard.

A Marie Barre, une neurologue toujours classe en chaussures à paillettes. Jamais de fashion faux pas, Cristina Cordula serait fière de toi.

A Julien Gere. Merci à toi je sais dorénavant ce qu'est un waketeu.

A Nicolas Miret. Ton sens clinique aiguisé et ton bronzage de ski de rando m'ont toujours énervé (ceux sont plus des aveux que des remerciements, désolé...).

A toute les équipes paramédicales et secrétaires, merci pour votre attention et soutien tout au long de ces années. On s'est bien marré !!

Aux co-internes et amis,

Dans l'ordre d'apparition, Anne cath' ou Bernard pour les intimes, tu as donné le ton et le rythme (au pas de course) à cet internat ! Marine alias mariiiiiinnnnneeee a ensuite apporté sa douceur et son sourire. Alors que le bon Moumoun faisait semblant d'être un clinicien, mais tu ne trompes personne, on s'est que tu bluffes Martonni. Sérieusement, merci mec pour les bons et mauvais moments qu'on a passé ensemble. Formation par la suite du duo de choc avec Pauline, une co-interne brillante, esthète et championne toutes catégories confondues du radio-potin, j'ai hâte de reformer la team. Descente d'un étage et changement de pays, on se retrouve avec Emma (pulcino de la Basilicata) sous l'œil attentif de Raul, à parler rigidité, voyages et fromages. Puis transfert chez l'ennemi voisin. Pendant que Bibi le bo goss, venu à Grenoble pour faire ses preuves en mouvement (pour finalement faire plomberie à Dijon), l'ami Seb assurait l'intendance... Qui aurait parié qu'avec ce zigoto chevelu nous allions trouver un remède miracle pour tous les zinzins, notre classique valium-tercian. La Ponce quant à elle affinait sa technique pour repousser les avances de nombreux prétendants et la Maze élaborait un sujet d'étude sur les trans-genres (bref des psychiatres, des vraies). Pour continuer sur le rythme effréné de la psychiatrie, rien de mieux qu'une année recherche. C'est avec Ligia (Lig' Lig') que j'apprenais à dompter les rongeurs. A l'écart du tumulte grenoblois, la bande de joyeux lurons composée d'Aurèle le mélanchoniste, Juju la présidente, la grosse Margo, Hélène IPA, Elo-psy et Louise le fou du volant collectionnaient les histoires de dingues !! Tout ça pour qu'au final, on décide de me faire redoubler... Heureusement, Catalina et Hugo bite de fer tiennent la boutique pendant que je finalise ce manuscrit. Pensées à tous les autres petits copains : Clem la pile électrique, Col-Col, le bon Gab', Marie la rêveuse, Nasty l'autobus, Anne la cycliste, Gio le plus grand neurologue, Rig', Thomas (je te prends quand tu veux au squash gros), la bonne Hélène, Guillaume et son baobab, Salma, Loïc le babyfooteux et Lucie (et son absence de second degré). Merci d'avoir été là, l'histoire aurait été moins drôle sans vous !

Aux copains,

Aux pedz', Badar, Vinc', Bilou, Malik et Valer, au plaisir de se matter une énième fois le pari et les 3 frères, ou de se retrouver pour un petit resto chinois à volonté et aux copines des bancs de l'école, Sophie, Mytien, Sandar' et Aurore. Amies de toujours et pour toujours.

Aux colocs de l'île verte. La bière, les nouilles chinoises, les cloisons en polystyrène et Fifa n'auront pas eu raison de nous. Alex&Aude vous êtes toujours prêts à m'accueillir sur Paris pour un F.I.E.A.L.D. ou un concert mais pour ce qui est de la grimpe... on a parlera à Peter. Ciol&Poupette, même en déménageant on arrive à être voisins, c'est con mais c'est très sympa. Merci Amel' pour ce que t'as fait pour la Grande et la Petite Jojo, et merci Gros pour la relecture de la thèse, je pense que tu seras la seule personne, peut être avec les membres du jury, à avoir lu ce papier.

Aux colocs de SMH. Nico l'Œdipe et Flo le poulpe, merci votre reprise de Toujours pas d'amour de Priscilla et vos fouines empaillées. Moumoun t'as bien essayé de incruster dans cette magnifique maison, on s'est que la moquette aux murs ça donne du cachet !

A la fine équipe, Ludo, Astrid, Yohan, Marjo', Flo & Flo, Martin, Jess, Nico, Krousti-Bat' et à tous les potes de promo, Marie Peg', la brune, Rom' et ses crocodiles, Z, Sof', Jean Luc, Manon, Jano, Simon. Je ne sais toujours pas pourquoi j'ai choisi neuro, à vous voir le cerveau n'est clairement pas un organe essentiel.

Pensée spéciale à Ludobite et la grosse Dièg', vous formez une excellente base arrière et de très bons con-pagnons de révision. « On s'est pas comment ça va finir, mais au moins on aura bien rigolé »

A la bande de mecs (et meufs) sympas, Reda et Isle 187, La truite et MauMaud la Milf, Le nain et Bébéeééé, Max et Alizée les petites personnes, Mat' Taïchi et Popo, Fred le romantique & Eva la teutonne. Vous êtes de grands malades ! Unis dès la P1 puis dispersés aux 4 coins de l'Europe et de la Savoie, nos retrouvailles donnent toujours mal au crâne.

A ma famille,

A Poup' et Mum, je ne serais pas là sans vous mais surtout je n'aurai jamais été celui que je suis sans votre soutien et votre amour. Je vous dois tout.

A ma tante Vivi, tu es la personne la plus drôle et aimante que je connaisse. Je te considère comme ma deuxième maman.

Aux frérots, Raph' et Small T, mes complices. A courir derrière un ballon ou à de se mettre sur la gueule, je n'ai que de bons souvenirs avec vous.

A mes tantes, oncles, cousins et cousines et à tous les moments partagés ensemble. D'avoir une si belle famille est, à mes yeux, la plus grande des richesses.

A mes grands-parents, qui doivent sûrement me regarder d'où ils sont. Je pense souvent à vous, j'espère vous rendre fier.

A belle famille, qui me traîne à ski en haut de la Saulire ou dans les arcos. C'est toujours un plaisir de partager votre table! Vous faites beaucoup pour nous. Merci.

A Philippine.

Ravissante, pétillante, candide, tu es plus que ma moitié, je n'irai pas bien loin sans toi. Même s'il nous a fallu plus de 7 ans pour se rencontrer, j'espère ne plus perdre un seul instant et passer le restant de mes jours à tes côtés. Je t'aime ma belle.

A Agathe, MA fille.

TITLE:

Impaired cerebrovascular reactivity assessed by BOLD hypercapnic fMRI is associated with increased risk of stroke in patients with symptomatic intracranial atherosclerotic stenosis

AUTHORS:

Jérémie Papassin^a, Olivier Heck^{bc}, Naïla Boudiaf^{cd}, Eric Condamine^e, Isabelle Favre^a, Sébastien Marcel^f, Kamel Boubagra^b, Katia Garambois^a, Florence Tahon^b, Johan Pietras^e, Olivier Detante^{ac}, Alexandre Krainik^{bce}

Stroke Unit, University Hospital Grenoble Alpes, 38000 Grenoble, France^a

Department of Neuroradiology, University Hospital Grenoble Alpes, 38000 Grenoble, France^b

Univ. Grenoble Alpes, Inserm, Grenoble Institute of Neurosciences, 38000 Grenoble, France^c

Univ. Grenoble Alpes, CNRS, LPNC, 38000 Grenoble, France^d

Univ. Grenoble Alpes, Inserm, CNRS, University Hospital Grenoble Alpes, IRMaGe, 38000 Grenoble, France^e

Stroke Unit, Hospital Savoie Metropole, 73000 Chambéry, France^f

*corresponding author: alexandre.krainik@univ-grenoble-alpes.fr

Key words: brain; stroke; intracranial arterial stenosis; DSC perfusion; BOLD fMRI; hypercapnia; cerebrovascular reserve

LIST OF ABBREVIATIONS

ACA: anterior cerebral artery
AIF: arterial input function
ASL: arterial spin labelling
BOLD: blood oxygenation level dependent
CBF: cerebral blood flow
CBV: cerebral blood volume
CVR: cerebrovascular reactivity
EPI: echo-planar imaging
fMRI: functional magnetic resonance imaging
FOV: field of view
GM: gray matter
GRE: gradient recalled echo
IAS: intracranial atherosclerotic stenosis
ICA: internal carotid artery
LDLc: low-density lipoprotein cholesterol
LI: laterality index
MCA: middle cerebral artery
MNI: Montreal Neurologic Institute
mRS: modified Rankin scale
MTT: Mean Transit Time
NIHSS: National Institutes of Health Stroke Scale
PCA: posterior cerebral artery
PET: positron emission tomography
PetCO₂: end-tidal CO₂ pressure
RECURRENT: recurrent ipsilateral ischemic event
ROI: regions of interest
SINGLE: single ischemic qualifying event
SPECT: single-photon emission computed tomography
TDS: transcranial Doppler sonography
TIA: transient ischemic attack
WI: weighted images

ABSTRACT:

Introduction: Despite intensive medical management, intracranial atherosclerotic stenosis (IAS) remains at risk of recurrent ischemic events. Impaired cerebrovascular reserve is suggested to explain hemodynamic stroke. Cerebrovascular reactivity assessed by hypercapnic challenge using BOLD functional MRI (CVR BOLD fMRI) has been proposed to estimate cerebrovascular reserve and to identify patients at higher risk. To discuss patients' selection for additional therapy such as intracranial angioplasty and stenting, we studied the relationships between baseline characteristics of patients with unilateral symptomatic IAS, recurrence of ischemic events, and CVR BOLD fMRI.

Subjects and methods: Nineteen patients with symptomatic unilateral IAS of middle cerebral artery (MCA) or internal carotid artery were selected. We calculated statistical relationships between individual clinical and biological baseline characteristics, recurrent ischemic events, basal perfusion estimated by dynamic susceptibility contrast MRI, and CVR BOLD fMRI measured in MCA territories (CVR_{MCA}), and reported using laterality indices (LI).

Results: Eight patients (42%) had an abnormal LI CVR_{MCA} ($|LI| CVR_{MCA} \geq 0.08$). During a mean follow-up of 3.6 years, recurrent ischemic events occurred within the first year. They were more frequent in impaired CVR_{MCA} group (n=6/8) than in normal CVR_{MCA} group (n=1/11), with different survival curves (log rank, $p=0.003$). Baseline characteristics were similar in both groups.

Conclusion: Impaired CVR assessed by BOLD hypercapnic fMRI is associated with increased risk of stroke in patients with symptomatic IAS. CVR mapping should be proposed to select high-risk patients in order to discuss additional treatment.

INTRODUCTION:

Intracranial atherosclerotic stenosis management

Intracranial atherosclerotic stenoses (IAS) account for approximately 10% of cerebrovascular ischemic strokes, and up to 50% in Asian populations¹⁻³. IAS are associated with high rates of recurrent ischemic event and cerebrovascular mortality when compared with other stroke subtypes^{4,5}. The recurrence rate of ischemic events in the territory of the stenotic artery remains high^{6,7}, with a major risk of subsequent disabling stroke⁸, despite optimal medical treatment.

Large randomized trials demonstrated better outcomes with aggressive medical management compared to IAS recanalization using intracranial stenting^{9,10} or surgical extracranial-intracranial bypass^{11,12} to prevent recurrent stroke because of the high rate of procedural complications. Actually, a combination of antiplatelet therapies (aspirin 325mg per day plus clopidogrel 75mg per day for 90 days) is recommended with an intensive medical management of risk factors: high blood pressure, elevated low-density lipoprotein cholesterol (LDLc) levels, diabetes, smoking, overweight, and insufficient exercise¹³. When life style adaptation is insufficient, antihypertensive drug and statin should be used to obtain a systolic blood pressure below 140 mmHg and LDLc level below 0.7g/l, respectively.

Vitamin K antagonists were associated with higher rates of adverse events and without benefit over aspirin⁴. No clinical benefit was demonstrated for direct oral anticoagulant (direct IIa and Xa factor inhibitors) or other anti-platelet agents such as cilostazole or dipyridamole.

Despite optimal medical management, IAS remains associated with a recurrence rate of stroke events at 2 years of 15-25%^{4,9}. The identification of risk factors of stroke recurrence among IAS patients under aggressive medical management would be helpful to consider alternative therapy^{14,15}. Indeed, old infarct in the territory of the stenosis, new stroke presentation, and absence of statin use at enrollment were independently associated with high recurrence rates of stroke events in the medical group in the SAMMPRIS trial¹⁶. Additionally, impaired cerebrovascular reserve was suggested as a risk factor of stroke recurrence¹⁷.

Cerebrovascular functions

The cerebral vasomotricity leads to active changes of vessels resistance, through dilation and contraction, in order to adjust cerebral blood flow (CBF) in response to variations of neural activity (neurovascular coupling), to cerebral perfusion pressure (autoregulation), and to circulating gases and metabolites (vasoreactivity).

The neurovascular coupling adapts the cerebral blood flow to local neuronal activity providing oxygen, glucose and adenosine triphosphate to neurons and glia, and removing heat and catabolites¹⁸.

The cerebral autoregulation refers to the ability of vasculature to maintain CBF constant, despite changes of perfusion pressure, to prevent ischemia-related brain damage. Combination of myogenic, humoral and neurogenic feedback mechanisms are implicated in the regulation of adequate CBF maintaining constant distal perfusion pressure in brain capillaries during large arterial pressure variations^{19,20}.

The cerebrovascular reactivity (CVR) modulates CBF in response to changes of circulating stimulus. Circulating gases such CO₂ and O₂ elicit vascular dilation and contraction, respectively, to maintain brain oxygenation.

Magnitude of the cerebrovascular properties is modulated by physiological changes (e.g. age, sex, hypoxia, arterial pressure, basal perfusion...), brain diseases (e.g. Alzheimer's disease; stroke,...), and structural vascular damage such as atherosclerosis (chronic arterial hypertension, diabetes,...)^{18,21}.

CVR assessment

When perfusion pressure decreases downstream the IAS, autoregulation may maintain CBF by vasodilation and cerebral blood volume increase. This additional dilation, known as cerebrovascular reserve, might be insufficient to compensate further perfusion pressure decrease. When cerebrovascular reserve is exhausted, patients are at risk of low grade ischemia and recurrent hemodynamic events^{22,23}. Thus, the estimation of the cerebrovascular reserve using perfusion measures before and after vasodilatory stimulus has been proposed to identify patients at risk of ischemia^{17,24}.

While Positron Emission Tomography (PET) remains the “gold standard” technique²⁵, non-invasive alternative methods have been advocated, such as transcranial Doppler sonography (TDS)²⁶, xenon-enhanced computed tomography²⁷, single-photon emission computed tomography (SPECT)²⁸, and more recently by functional magnetic resonance imaging (fMRI) using blood oxygenation level dependent (BOLD) contrast or arterial spin labelling (ASL)²⁴. Most common vasodilatory stimuli are acetazolamide and CO₂^{17,18}.

Among these techniques, BOLD CVR fMRI is an accessible, non-invasive, and reproducible whole brain imaging method^{29,30}. Among vasoactive stimuli, CO₂ challenge is safer when compared to hypotensive provocation. Intravenous acetazolamide administration is exposed to side effects, contraindications, and large inter-subject variability³¹. Thus, well tolerated CO₂ inhalation with immediate and transient vasodilation is now advocated to be the most suitable stimulus²⁹⁻³¹.

Objectives

Our objective was to investigate the relationships between clinical and biological characteristics of patients with unilateral symptomatic IAS, recurrence of ischemic events, basal perfusion parameters, and individual CVR mapping using BOLD hypercapnic fMRI. The study allowed to estimate: 1°) CVR and basal perfusion characteristics among patients with recurrent ischemic event, and 2°) occurrence of recurrent ischemic event in patients with CVR impairment.

SUBJECTS AND METHODS

Study participants

We conducted an observational study on adult patients referred at the University Hospital Grenoble Alps between February 2011 and August 2016 for transient ischemic attack (TIA) or non-disabling stroke that was attributed to 50–99% unilateral IAS of internal carotid (ICA) or first segment of the middle cerebral artery (MCA) assessed by catheter angiography or brain CT angiography³². Optimal medical treatment, consisting of dual antiplatelet therapy aspirin (75-300 mg per day) plus clopidogrel (75 mg per day), and management of risk factors (high blood pressure, hypercholesterolemia, diabetes, smoking, overweight) was implemented for each patient.

We excluded patients with tandem extracranial stenosis (70–99%) or occlusion, intraluminal thrombus proximal to or at the target lesion, any hemorrhagic infarct within 14 days before enrolment, non-atherosclerotic causes of intracranial stenosis, presence of a cardiac source of embolus, history of stent placement, cervical endarterectomy or extra-intracranial bypass surgery, contraindication to MRI and Gadolinium-Dota intravenous administration. We also excluded patients with incomplete MRI protocol due to excessive head motion (translation or rotation >2mm or >2° in any direction, respectively) or inappropriate hypercapnic stimulus. The study protocol was approved by our institute's committee on human research (B120620-10).

Clinical data collection and follow-up

Qualifying ischemic event-related data was obtained from medical records and included stroke risk factors, medical history, National Institutes of Health Stroke Scale (NIHSS; 0 to 42,

higher score indicating greater severity) at hospital admission, modified Rankin Scale (mRS; 0: no symptom to 6: death) at discharge, serum creatinine, glycosylated haemoglobin and lipid testing. Clinical follow-up period ranged from qualifying event until death, loss of follow-up or study end. All patients were seen yearly or more frequently if needed. Recurrent stroke or TIA, adverse events and assessment of the patient's functional abilities and mobility using the mRS were conducted by a neurologist (JP, IF, KG, SM, OD) during visits or by telephone interview. Any stroke or TIA in the territory of the qualifying artery was considered to be a recurrent ischemic event. Ischemic events out of the territory of the qualifying artery or death were also analyzed.

MRI Protocol

All participants were scanned using a 3T ACHIEVA TX MR scanner (Philips Healthcare®, the Netherlands) at University Hospital Grenoble Alps, using a whole-body RF transmit and 8 channels head receive coils. All participants had anatomical, basal perfusion, and BOLD CVR studies.

Anatomical study

Anatomical study consisted in a 3D gradient recalled echo (GRE) T1-weighted image (WI) (160 contiguous slices, slice thickness=1mm, TR/TE/ α : 9.9/4.6ms/8°, 256x256 matrix, field of view (FOV) of 256x160 mm for 4.5 min acquisition time).

Basal perfusion study

Perfusion-WI was performed using dynamic T2*-WI GRE echo-planar imaging (EPI) (25 contiguous slices, thickness=4mm, TR/TE/ α : 1660/40ms/75°, 112x112 matrix, FOV=224x184mm), tracking a bolus of 0.1mmol/kg of Gadolinium (Guerbet®, France), injected at a rate of 5mL/s with a MR compatible injector (MEDRAD®, USA). This injection

was flushed by a bolus of physiological saline (60mL). To obtain an accurate estimate of the baseline MR signal intensity $S(0)$ prior to the arrival of contrast agent an injection delay of 10 seconds was applied. Eighty single-shot, gradient-echo, echo-planar images, were obtained in each of the slices during the 2'11 minute acquisition time.

CVR study

CVR imaging consisted in BOLD sensitive T2* WI GRE EPI acquisition (32 axial slices, slice thickness=4mm, TR/TE/ α : 3000/35ms/90°, 64x64 matrix, FOV=256x256 mm, 240 dynamics) with a whole brain coverage. Hypercapnic challenge was conducted according to the following block-designed paradigm [air(1')–hypercapnia(2')–air(1')]x3, for a total duration of 12 minutes. Each participant was exposed alternatively to medical air and to a hypercapnic normoxic gas mixture (CO₂ (8%), O₂ (21%), and N₂ (71%)) through a non-rebreathing face mask. Physiological parameters, including end-tidal CO₂ pressure (PetCO₂), arterial oxygen saturation, breath frequency and heart rate were monitored using a MR compatible device (Maglife, Schiller medical). This protocol induces an increase PetCO₂ about 10 mm Hg, recorded via nasal cannula.

Images processing and analyses

Data analysis was performed with Amigo, an in-house post-processing suite written in Python 3.6 using Matlab (MathWorks, Inc., Natick, MA, USA) and SPM12 (SPM, Wellcome Department of Imaging Neuroscience).

Anatomical data

White and gray matters (GM) were segmented through the 3D GRE T1 sequence using the standard space tissue probability maps from SPM12. GM maps were spatially normalized to the Montreal Neurologic Institute (MNI) T1-weighted template and resampled at 2x2x2mm

resolution. GM maps were further smoothed with a 6-mm Gaussian Kernel for Regions of Interest (ROI) analyses.

Basal perfusion data

Basal perfusion images preprocessing consisted in coregistration, normalization, resampling onto anatomical images, and spatial smoothing with a 6-mm Gaussian Kernel. The arterial input function (AIF) was estimated by averaging 5 voxels from all slices of the perfusion scan during the dynamics. These 5 voxels were automatically detected by optimizing a function with a signal evolution characterized by the higher peak height, a faster dropout, concomitant to a smaller full-width-half-maximum and bolus arrival time (brain-feeding artery detection). Mean Transit Time (MTT) maps were then calculated pixel-wise with a deconvolution approach based on a singular value decomposition using a tracer arrival timing insensitive method and an automatic regularization of oscillations³³. The relative Cerebral Blood Volume (CBV) was estimated from the area under the curve of the voxel concentration. To obtain quantitative maps, the mean brain CBV was normalized to 5%. The MTT maps were estimated from the area under the curve and from the time to maximum of the deconvolved function respectively. CBF was calculated as the ratio CBV/MTT from the central volume theorem. The excluded voxels from the computation were averaged with the nearby voxels.

CVR data

BOLD CVR images preprocessing consisted in coregistration, normalization, resampling onto anatomical images, and spatial smoothing with a 6-mm Gaussian Kernel. Statistical analysis was conducted using a general linear model and the individual PetCO₂ in mmHg as a physiological regressor. CVR maps were expressed as percent change of BOLD signal per mmHg change of PetCO₂ (%BOLD/ PetCO₂ mmHg). Illustrative case is shown in Figure 1.

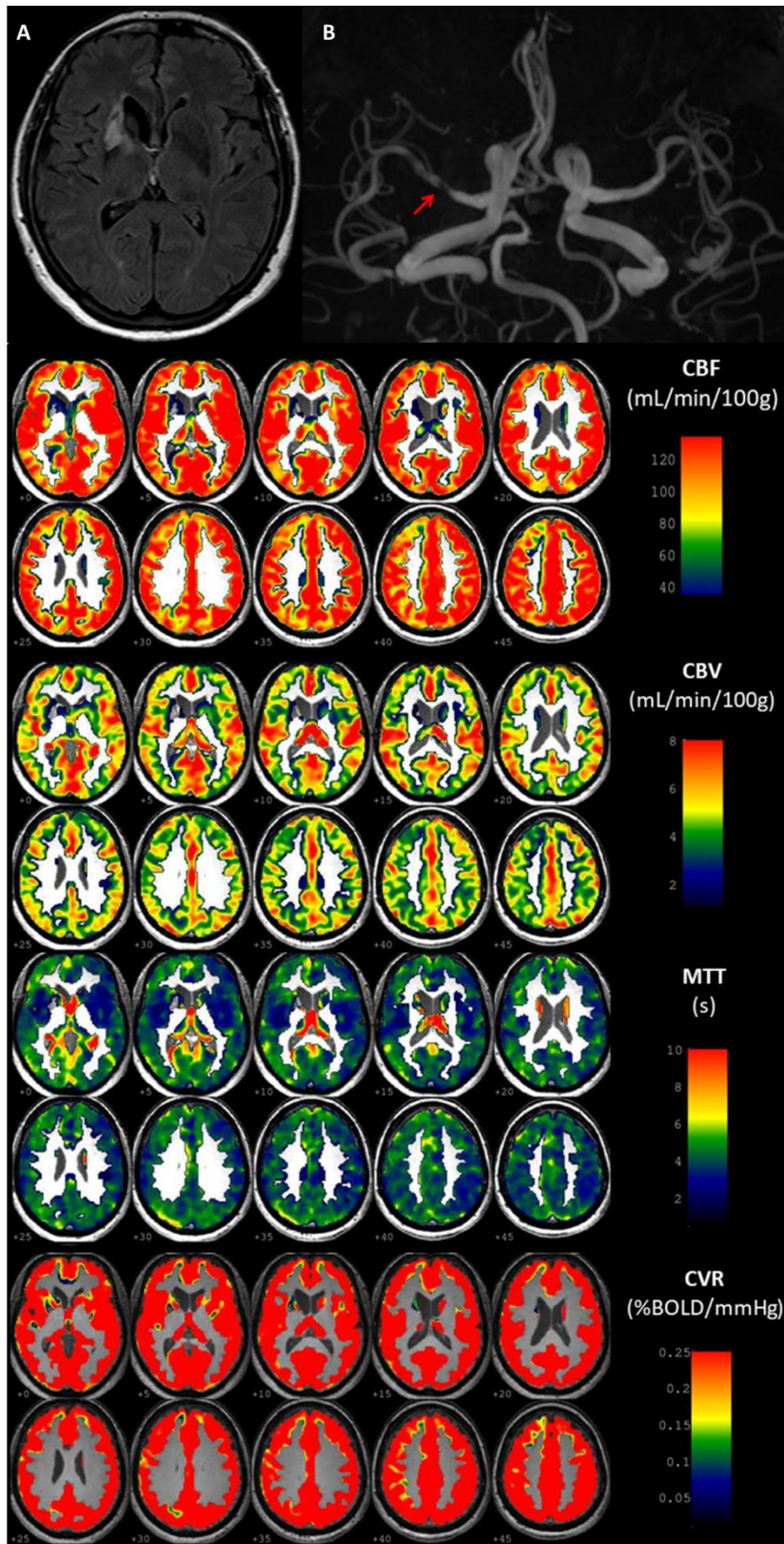


Figure 1: FLAIR-T₂ weighted image (A), Time-Of-Flight weighted image (B), basal perfusion parameters and CVR maps in 68-year woman referred for symptomatic right MCA stenosis in red arrow, without ischemic recurrence (radiological convention).

ROI analyses

Vascular territories ROIs were obtained by using a standard set of vascular ROIs³⁴ masked by smoothed GM maps, giving individual ROIs in the territories of the middle (MCA), anterior (ACA), and posterior (PCA) cerebral arteries (Figure 2).

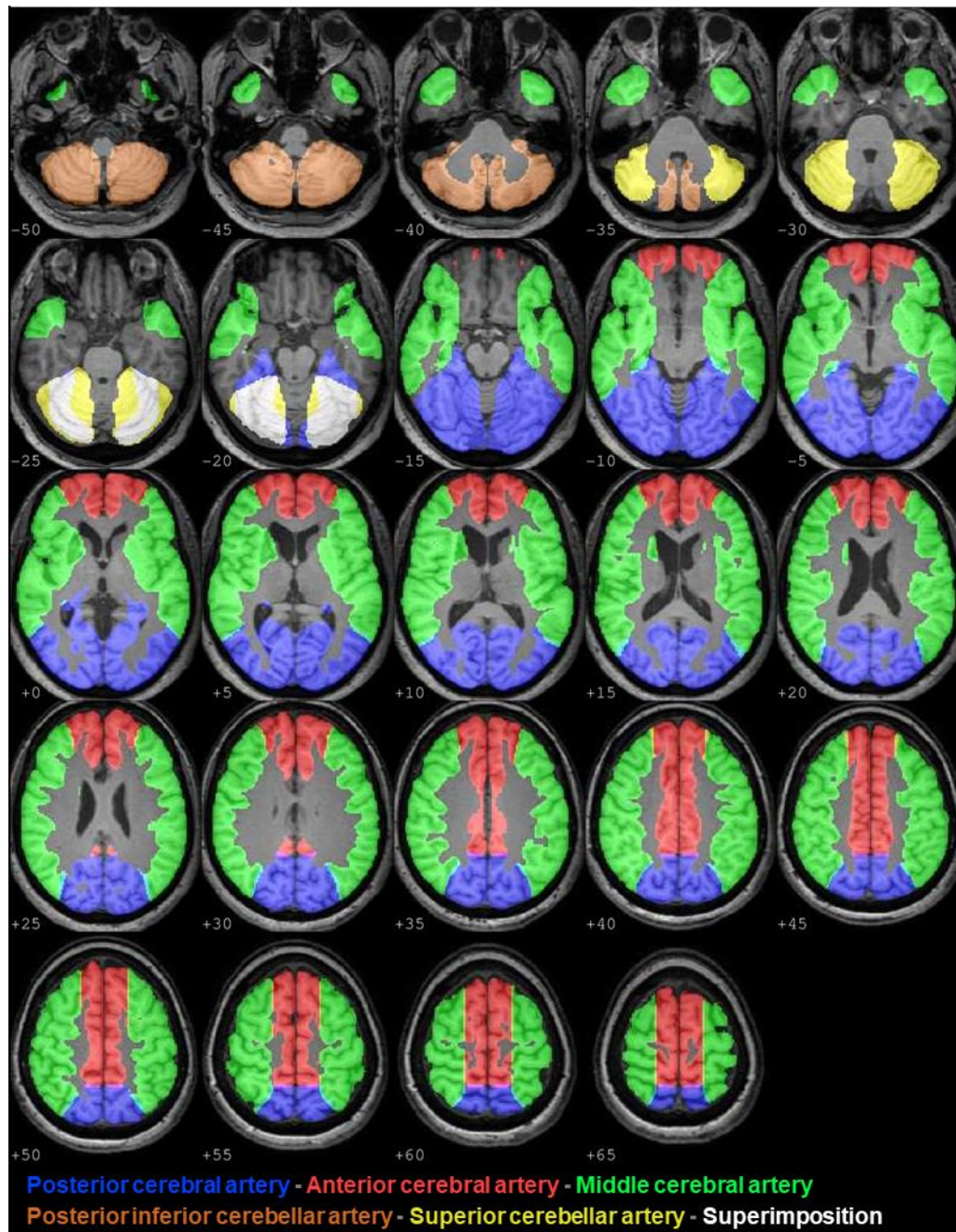


Figure 2: Individual regions of interest in major cerebral arteries territories.

We conducted ROI analyses on each basal perfusion parameter and CVR maps. For each parameter, we calculated mean values and a laterality index (LI), e.g. for CVR in MCA territory $LI_{CVR_{MCA}} = (Left_CVR_{MCA} - Right_CVR_{MCA}) / (Left_CVR_{MCA} + Right_CVR_{MCA})$. A positive value of LI representing left-hemisphere dominance and negative value a right-hemisphere dominance. The intermediate values reflect varying degrees of laterality. In our analyses we used the absolute values of LI ($|LI|$). We also defined 2 groups based on $|LI|$ CVR_{MCA} : NORMAL CVR_{MCA} for $|LI| CVR_{MCA} < 0.08$; IMPAIRED CVR_{MCA} for $|LI| CVR_{MCA} \geq 0.08$ ³⁵. Calculation of a LI was also used for all basal perfusion parameters (CBF, CBV, or MTT) and in other ROI.

Statistical analyses

Analyses were performed using the SPSS 20.0. Non-parametric statistics were conducted because of small sample sizes. Intergroup comparisons were conducted using Mann-Whitney U tests. Relationship between CVR_{MCA} status and recurrent ipsilateral ischemic event was determined using Kaplan–Meier analysis with log rank comparison. Correlations between basal perfusion parameters and CVR_{MCA} were assessed by Spearman’s ρ correlation coefficient. All tests were two-tailed and a p value < 0.05 was considered statistically significant.

RESULTS:

Twenty-one patients satisfied inclusion criteria. No adverse reaction to the Gadolinium-dota administration and to hypercapnic stimulus was reported. Two patients were excluded because of incomplete protocol realization secondary to discomfort due to the face mask within the head coil (n=1) and inappropriate hypercapnic stimulus (n=1), leaving 19 patients for further analyses. Finally, 13 men and 6 women were included, with a mean age of 61.0 years (SD \pm 12.5). Clinical and biological baseline characteristics are presented in Table 1. IAS were located on right MCA (n=9), left MCA (n=5), right ICA (n=3), left ICA (n=2). Qualifying events were stroke (n=15) and TIA (n=4).

	IAS patients (n=19)
Age in years	61.0±12.5
Men	13
History of hypertension	10
History of lipid disorder	11
Smoking	8
Diabetes	5
History of coronary artery disease	2
Low-density lipoprotein cholesterol (g/L)	1.1±0.4
High-density lipoprotein cholesterol (g/L)	0.5±0.3
Total cholesterol (g/L)	1.9±0.4
Triglycerid (g/L)	1.4±0.6
Glycosylated haemoglobin (%)	6.9±2.5
Overweigh or obesity (body-mass index > 25)	5
Qualifying event	
- Stroke	15
- TIA	4
NIHSS at entrance (median [IQR])	2 [0.5-3]
mRS at discharge (median [IQR])	2 [0-2]
On antithrombotic therapy at qualifying event	4
On antihypertensive therapy at qualifying event	9
On lipid-lowering therapy at qualifying event	5
On diabetic therapy at qualifying event	4
Symptomatic qualifying artery	
- ICA	5
- MCA	14
Follow-up duration in years	3.6±1.4
mRS follow-up (median [IQR])	1 [0-1.5]

Table 1: Clinical and biological baseline characteristics. Data are mean ±standard deviation. IAS=intracranial atherosclerotic stenosis, TIA=transient ischemic attack, MCA=first segment of middle cerebral artery, ICA=internal carotid artery, NIHSS=National Institutes of Health Stroke Scale, mRS=modified Rankin Scale, [IQR]=interquartile range.

During follow-up (mean±SD=3.57±1.43 years), we identified 2 groups: 12 patients had a single ischemic qualifying event (SINGLE), and 7 patients experienced a recurrent ipsilateral ischemic event (RECURRENT), of which 3 strokes and 4 TIA (Table 2). Overall annual risk of recurrent ipsilateral ischemic event was 18.4% per year. An ischemic event out of the qualifying IAS territory occurred in 3 patients (2 in RECURRENT group and 1 in SINGLE group). No intracranial hemorrhage was detected on follow-up. One death caused by acute pulmonary edema was reported at 3.5 years follow-up for a patient from SINGLE group. Annual risk of recurrent combination of all ischemic events and death was 24.2% per year.

N°	Age (years)	Sex	Qualifying event	Location of stenosis	LI CVR _{MCA}	Days to recurrent event	Details of recurrent event
1	80	F	Stroke	MCA	0.05	84	TIA
2	63	F	Stroke	MCA	0.12	182	TIA
3	63	M	Stroke	MCA	0.12	24	Stroke
4	72	M	TIA	ICA	0.13	110	TIA
5	64	M	Stroke	ICA	0.14	173	Stroke
6	84	F	TIA	MCA	0.19	2	TIA
7	62	M	Stroke	MCA	0.20	9	Stroke

Table 2: Summary details of RECURRENT patients. |LI|CVR_{MCA}=absolute value of laterality index of cerebrovascular reactivity in middle cerebral artery territories, other abbreviations are defined in Table 1.

Comparisons between SINGLE and RECURRENT groups

When compared with SINGLE, RECURRENT patients were older (69.5±9.1. vs 56.1±11.8 p=0.04). There were no differences among other clinical and biological data (Table 3).

	SINGLE group (n=12)	RECURRENT group (n=7)	p value
Age in years	56.1±11.8	69.5±9.1	0.04
Men	9	4	0.54
History of hypertension	5	5	0.3
History of lipid disorder	8	3	0.43
Smoking	6	2	0.48
Diabetes	3	2	0.9
History of coronary artery disease	1	1	0.84
Low-density lipoprotein cholesterol (g/L)	1.2±0.4	1±0.3	0.17
High-density lipoprotein cholesterol (g/L)	0.4±0.1	0.6±0.4	0.2
Total cholesterol (g/L)	1.9±0.5	1.9±0.3	0.86
Triglycerid (g/L)	1.4±0.6	1.5±0.7	0.84
Glycosylated haemoglobin (%)	7.0±2.9	6.9±1.7	0.48
Overweigh or obesity (body-mass index > 25)	4	1	0.54
Qualifying event			
- Stroke	10	5	0.71
- TIA	2	2	
NIHSS at entrance (median [IQR])	3[1-1.5]	1[0-2.5]	0.23
mRS at discharge (median [IQR])	2[0.8-2]	1[0-2]	0.3
On antithrombotic therapy at qualifying event	3	1	0.71
On antihypertensive therapy at qualifing event	5	4	0.59
On lipid-lowering therapy at qualifiying event	4	1	0.54
On diabetic therapy at qualifying event	2	2	0.71
Symptomatic qualifying artery			
- ICA	3	2	0.9
- MCA	9	5	
Follow-up duration in years	3.8±1.3	3.2±1.7	0.38
mRS follow-up (median [IQR])	0.5[0.5-1.3]	1[0.5-1.5]	0.59

Table 3: Clinical and biological baseline characteristics of SINGLE and RECURRENT groups. Patients who experient recurrent ipsilateral ischemic event are significantly older than SINGLE patients. Data are mean ± standard deviation. Abbreviations are defined in Table 1.

RECURRENT patients had higher $|LI| CVR_{MCA}$ (0.14 ± 0.05 vs 0.05 ± 0.03 , $p=0.001$). There were no differences among $|LI| CVR$ in other arterial territories. Subtle intergroup differences in basal perfusion parameters did not reach significance (Table 4).

		SINGLE group (n=12)	RECURRENT group (n=7)	<i>p</i> value
$ LI CVR$	MCA	0.05 ± 0.03	0.14 ± 0.05	0.001
	ACA	0.04 ± 0.04	0.05 ± 0.06	0.23
	PCA	0.04 ± 0.03	0.04 ± 0.02	0.54
$ LI CBF$	MCA	0.07 ± 0.05	0.11 ± 0.06	0.23
	ACA	0.07 ± 0.05	0.04 ± 0.02	0.38
	PCA	0.03 ± 0.02	0.02 ± 0.02	0.97
$ LI CBV$	MCA	0.04 ± 0.03	0.03 ± 0.03	0.54
	ACA	0.04 ± 0.03	0.03 ± 0.03	0.26
	PCA	0.03 ± 0.03	0.03 ± 0.02	0.97
$ LI MTT$	MCA	0.07 ± 0.03	0.10 ± 0.07	0.43
	ACA	0.05 ± 0.03	0.05 ± 0.04	0.65
	PCA	0.03 ± 0.03	0.02 ± 0.02	0.38

Table 4: Laterality indices between SINGLE and RECURRENT groups for each vascular ROI and each hemodynamic parameter (cerebrovascular reactivity, basal perfusion parameters). The $|LI| CVR_{MCA}$ is significantly increased in patients who experiment recurrent ipsilateral ischemic event, other hemodynamic parameters differ between these two groups. Data are mean \pm standard deviation. $|LI|$ =absolute value of laterality index, CVR =cerebrovascular reactivity, CBF =cerebral blood flow, CBV =cerebral blood volume, MTT =mean time transit, ACA =anterior cerebral artery territories, PCA =posterior cerebral artery territories, other abbreviations are defined in Table 1.

Illustrative cases are shown in Figure 3.

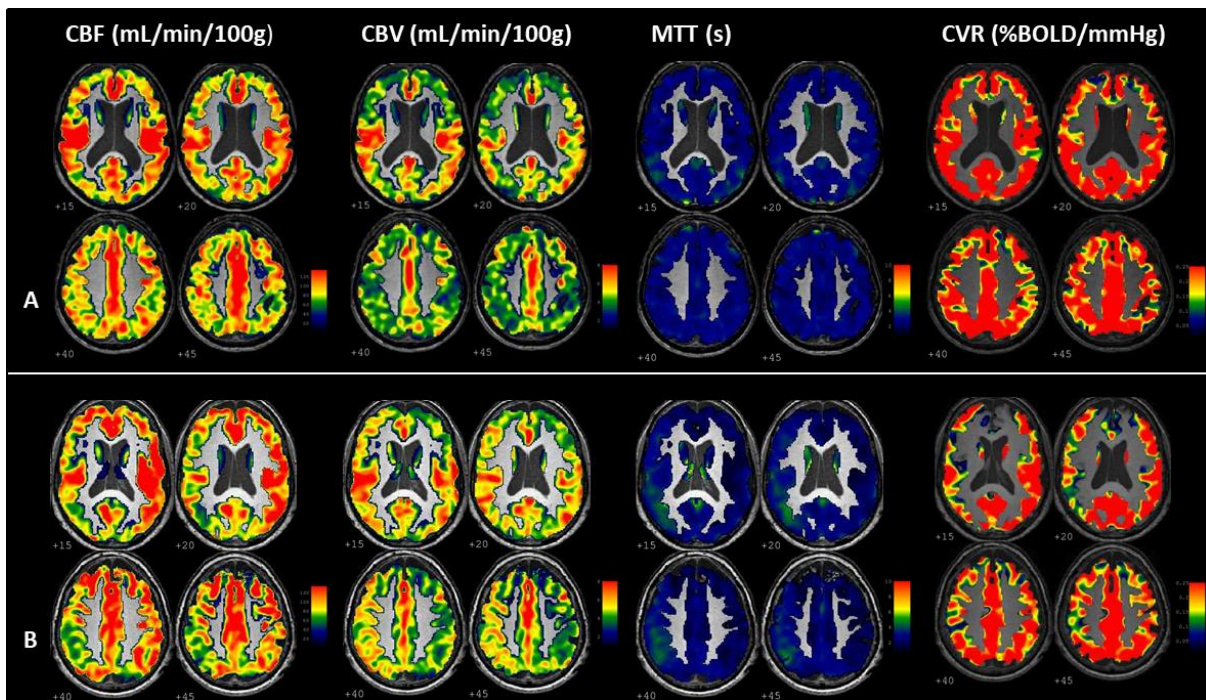


Figure 3: Basal perfusion parameters and CVR maps in patients referred for symptomatic right MCA severe stenosis (radiological convention). Upper row: 65-years man without ischemic recurrence (SINGLE group). Both basal perfusion (CBF, CBV, MTT) and CVR_{MCA} were symmetrical: $|LI| CBF_{MCA}=0.00$, $|LI| CBV_{MCA}=0.00$, $|LI| MTT_{MCA}=0.01$, $|LI| CVR_{MCA}=0.02$ (NORMAL CVR_{MCA}). Lower row: 83-years woman with 2 recurrent transient ischemic attacks (RECURRENT group). Autoregulation with increased CBV failed to maintain CBF symmetrical. Additionally, CVR decreased downstream MCA stenosis: $|LI| CBF_{MCA}=0.18$, $|LI| CBV_{MCA}=0.06$, $|LI| MTT_{MCA}=0.22$, $|LI| CVR_{MCA} = 0.19$ (IMPAIRED CVR_{MCA}).

Comparisons between IMPAIRED and NORMAL CVR_{MCA} groups

Among all patients, 11 patients had NORMAL CVR_{MCA}, and 8 had IMPAIRED CVR_{MCA}. There were no intergroup differences among clinical and biological baseline data (Table 5).

	NORMAL CVR _{MCA} group (n=11)	IMPAIRED CVR _{MCA} group (n=8)	p value
Age in years	58.3±13.1	64.8±11.4	0.27
Men	7	6	0.72
History of hypertension	5	5	0.55
History of lipid disorder	6	5	0.78
Smoking	5	3	0.78
Diabetes	2	3	0.49
History of coronary artery disease	0	2	0.4
Low-density lipoprotein cholesterol (g/L)	1.3±0.4	1.0±0.4	0.13
High-density lipoprotein cholesterol (g/L)	0.5±0.1	0.6±0.4	0.72
Total cholesterol (g/L)	2.0±0.4	1.9±0.4	0.76
Triglycerid (g/L)	1.4±0.5	1.6±0.8	0.60
Glycosylated haemoglobin (%)	6.3±1.5	6.5	0.21
Overweigh or obesity (body-mass index > 25)	4	1	0.4
Qualifying event			
- Stroke	9	6	0.84
- TIA	2	2	
NIHSS at entrance (median [IQR])	1 [0.5-3]	2 [0.8-2]	0.44
mRS at discharge (median [IQR])	2 [0-2]	1 [0.8-2.3]	0.66
On antithrombotic therapy at qualifying event	2	2	0.84
On antihypertensive therapy at qualifying event	5	4	0.9
On lipid-lowering therapy at qualifying event	3	2	0.97
On diabetic therapy at qualifying event	1	3	0.31
Symptomatic qualifying artery			
- ICA	2	3	0.49
- MCA	9	5	
Follow-up duration in years	3.6±1.4	3.5±1.6	0.78
mRS follow-up (median [IQR])	0 [0-1]	1 [0.8-2.3]	0.27

Table 5: Baseline characteristics of NORMAL and IMPAIRED CVR_{MCA} groups. Clinical and biological data are similar between patients with and without CVR impairment downstream the intracranial stenosis. Data are mean ± standard deviation. CVR_{MCA}=cerebrovascular reactivity on middle cerebral artery territories, other abbreviations are defined in Table 1.

The occurrence of recurrent ipsilateral ischemic event in IMPAIRED CVR_{MCA} (n=6/8) was more frequent than in NORMAL CVR_{MCA} group (n=1/11) with different survival curves (p=0.003) (Figure 4).

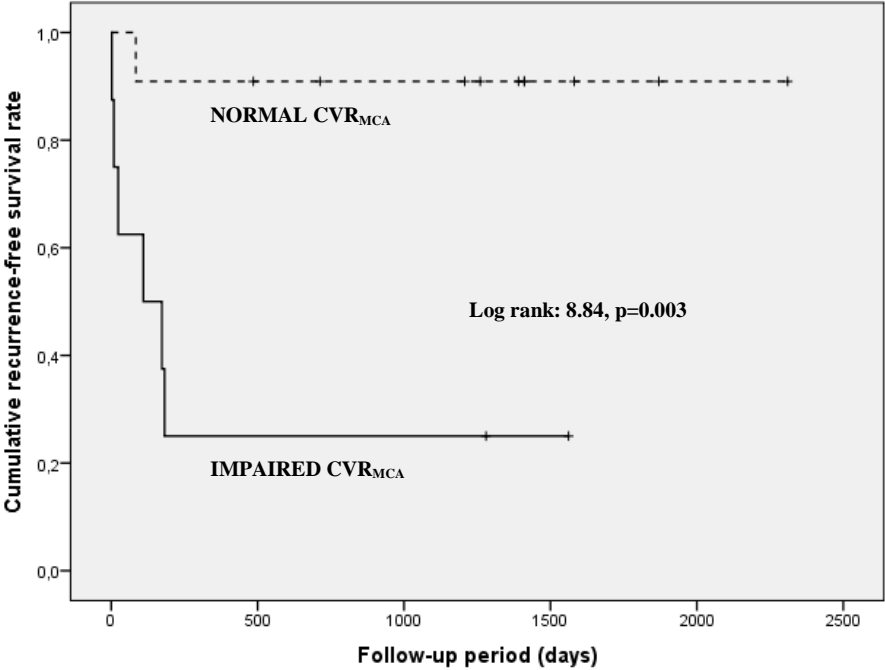


Figure 4: Kaplan-Meier survival curves illustrating the relationship between CVR_{MCA} and the occurrence of ipsilateral ischemic event. The vertical cross-lines indicates patient whose data were censored due to study end, death, or recurrent ischemic event.

The annual risk of recurrent ipsilateral ischemic event was higher in IMPAIRED CVR_{MCA} group compared to NORMAL CVR_{MCA} group (39.1%/year vs 3.4%/year, $p=0.012$). There were neither differences among |LI| CVR in other arterial territories nor in other basal perfusion parameters (Table 6).

		NORMAL CVR _{MCA} group (n=11)	IMPAIRED CVR _{MCA} group (n=8)	<i>p</i> value
LI CVR	MCA	0.04±0.02	0.14±0.04	<0.001
	ACA	0.04±0.04	0.06±0.05	0.44
	PCA	0.04±0.03	0.04±0.02	0.17
LI CBF	MCA	0.08±0.05	0.10±0.06	0.49
	ACA	0.07±0.05	0.04±0.02	0.55
	PCA	0.03±0.02	0.02±0.02	0.44
LI CBV	MCA	0.03±0.02	0.05±0.03	0.27
	ACA	0.04±0.03	0.03±0.03	0.78
	PCA	0.03±0.03	0.03±0.02	0.90
LI MTT	MCA	0.07±0.03	0.11±0.06	0.11
	ACA	0.06±0.03	0.04±0.04	0.24
	PCA	0.03±0.03	0.02±0.02	0.44

Table 6: Laterality indices between NORMAL and IMPAIRED CVR_{MCA} groups for each vascular ROI and each hemodynamic parameter (cerebrovascular reactivity, basal perfusion parameters). Except |LI| CVR_{MCA}, no other hemodynamic parameters differ significantly between these two groups. Data are mean ± standard deviation. Abbreviations are defined in Table 4.

CVR_{MCA} and basal perfusion parameters correlations

We found a positive correlations between LI CVR_{MCA} and LI CBF_{MCA} ($\rho=0.89$, $p=0.007$ vs $\rho=0.59$, $p=0.043$) for RECURRENT and SINGLE patients, respectively (Figure 5). A significant negative correlation was found between LI CVR_{MCA} and LI MTT_{MCA} in RECURRENT group ($\rho=-0.86$, $p=0.014$) but not significant in SINGLE group ($\rho=-0.47$, $p=0.12$). For both groups, LI CVR_{MCA} was not significantly correlated with LI CBV_{MCA}.

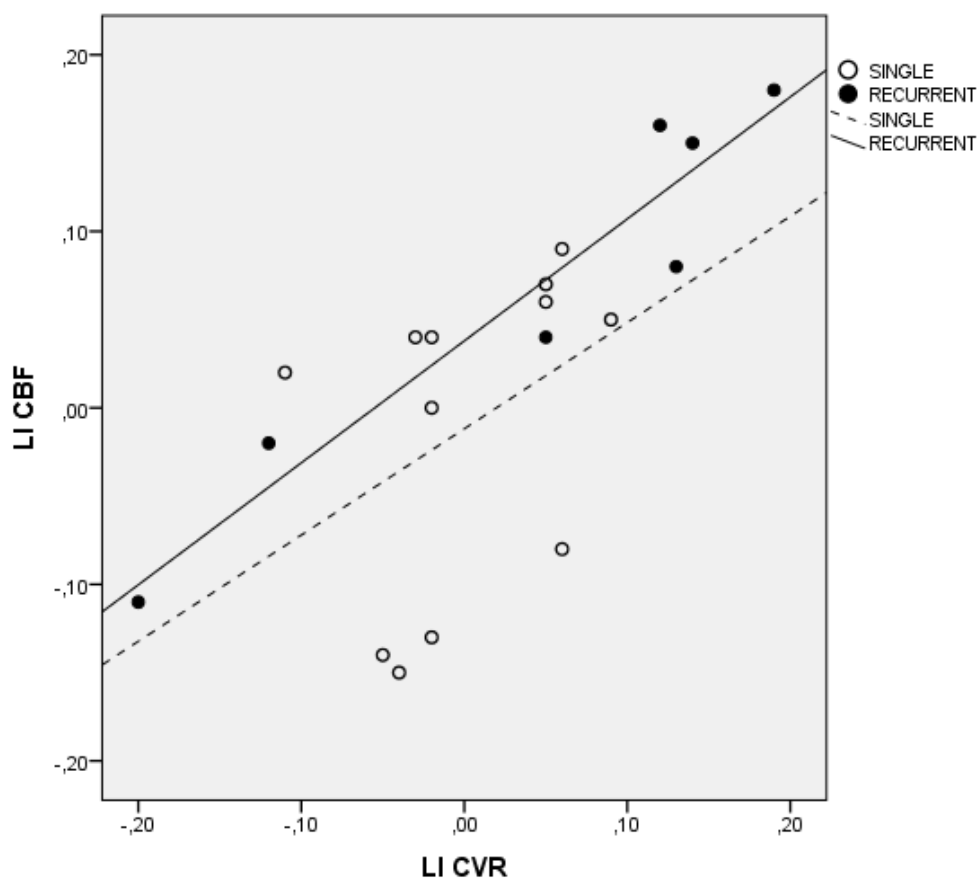


Figure 5: Positive correlations between LI CBF and LI CVR from middle cerebral artery territories ($\rho=0.89$, $p=0.007$ vs $\rho=0.59$, $p=0.043$) for RECURRENT and SINGLE patients with intracranial stenosis, respectively.

DISCUSSION:

In patients with symptomatic intracranial atherosclerotic stenosis, recurrent ischemic events occur despite optimal medical therapy. Additional treatments such as endovascular angioplasty and stenting are still not validated. Indeed, large trials failed to demonstrate significant clinical benefits when compared to higher risks of morbidity and mortality. To further address additional therapy, the estimation of cerebrovascular reserve may help to better identify patients at higher risk of stroke recurrence. In our observational study, we showed that 1°) patients with recurrent ischemic events have an impaired CVR downstream the IAS, using BOLD fMRI with hypercapnic challenge; 2°) patients with abnormal CVR defined by a laterality index ≥ 0.08 are at higher risk of recurrent ischemic events. These results emphasized the potential role of CVR fMRI to select patients for additional treatment.

In our study, the global rate of recurrence of ischemic event was 37%, similar to 38% observed in GESICA study⁶. The annual rate of stroke downstream the qualifying IAS was also close to 18% reported in the severe IAS subgroup of WASID trial, but higher than 12% in the SAMMPRIS trial^{4,9}. We used identical restrictive inclusion and exclusion criteria. This led to analyze a much smaller population in our monocentric study. However, clinical baseline characteristics were similar. In SAMMPRIS, a more intensive control of cardiovascular risk factors, based on a tight clinical and biological follow-up and a lifestyle modification program may explain this difference⁹.

We identified a high-risk subgroup, i.e. patients with IMPAIRED CVR_{MCA} had a rate of ipsilateral recurrent ischemic event of 39%/year when compared to 3%/year in NORMAL

CVR_{MCA} patients. The 13x higher rate in patients with CVR impairment advocates for a tight relationship. Reduced CVR has been identified as a strong and independent predictor on stroke recurrence in steno-occlusive diseases, using multivariate analysis among other variables (cardiovascular risk factors, degree of stenosis)^{28,36,37}. Most of these CVR studies used TDS with several advantages, such as high temporal resolution, arterial velocity quantification, non-invasiveness, cost, and availability, and limitations such as insonation window access, interoperator variability, absence of parenchymal imaging. Functional brain imaging techniques using SPECT, and MRI have been proposed to explore whole brain CVR^{17,18}. However, fMRI studies on steno-occlusive diseases were heterogeneous with extracranial and/or stenosis or occlusion, and with different etiologies such as atheromatous or moya-moya^{15,24,29,30,38,39}. Our study is the first one to evaluate CVR using fMRI in a homogeneous group of patients with symptomatic atherosclerotic stenosis of a major intracranial artery, like in large randomized trials^{4,9}.

BOLD fMRI with hypercapnic challenge has been shown as a safe and reliable brain imaging technique to estimate cerebrovascular reserve^{29,30}. However BOLD signal, which reveals changes in blood oxygenation, remains an unclear combination of variation in oxygenation consumption, CBF, CBV, and vasomotricity. Perfusion MRI techniques such as ASL were also proposed to monitor quantitative CBF changes to vasomotor stimuli^{24,40}. In our experience, CVR fMRI using ASL remains difficult to implement in clinical work-flow, mostly limited by a poor signal to noise ratio, a lower temporal resolution (8 sec between 2 pairs of tag-control images), a critical sensitivity to labeling temporal parameters with aging and arterial transit time asymmetry *a fortiori* downstream IAS, sophisticated postprocessing that requires parametric assumptions and signal corrections for “absolute” CBF quantification^{41,42}.

Because of the variability of basal perfusion and CVR, we chose to estimate these parameters independently, to calculate LI to minimize interindividual amplitude effects, and to test their relationships²³. Using classical LI, as defined for hemispheric lateralization for language, we previously shown that 95% of 100 healthy subjects, had $CVR |LI| < 0.08$ ³⁵. In the present study, all RECURRENT patients but one had a $CVR |LI| \geq 0.08$. Based on both of these results, IMPAIRED CVR_{MCA} had a much higher risk of ischemic event, suggesting a reliable threshold to select patients at high risk in a future prospective study. However, the asymmetry characterization is less relevant and limits results interpretation in case of bilateral stenosis. Thus, absolute CVR quantification would be helpful to further address these limitations, although physiological and pathological confounds account for a large inter-individual variability^{18,24,35}.

In a previous study, basal CBF decrease and CVR impairment explained decreased parenchymal oxygenation, suggesting chronic low grade ischemia in patients with symptomatic IAS²³. Here, CBF and CVR asymmetry were correlated in both RECURRENT and SINGLE patients. The correlation coefficient was higher in the RECURRENT group. However the small groups' size did not allow to conduct appropriate statistical comparison. Despite these relationships, CVR asymmetry was the only significant parameter which differed across RECURRENT and SINGLE groups.

In fact, most recurrent ischemic events downstream IAS occurred during the first year after qualifying event, in line with large clinical trials^{4,9}. This observation suggests time-dependent changes of the plaque under aggressive medical management, collateral supply development, and adaptive cerebrovascular reserve increase. Indeed, IAS are dynamic and

degree of stenosis may progress or regress over time⁴³. The risk of new stroke is attenuated after 1 year by the stabilization of vulnerable plaque, and development of collateral circulation⁴⁴. Intensive medical management should therefore accelerate these different protective processes^{45,46}. Beside structural changes of vascularization, functional changes of arterial supply may also occur. Several cases of spontaneous improvement of cerebrovascular reserve were reported using SPECT⁴⁷. However, temporal changes of cerebrovascular reserve remain to be documented in larger studies. A systematic CVR mapping and basal perfusion imaging follow-up would be interesting in order to test spatial agreement between CVR impairment and recurrent stroke, and to monitor natural evolution of CVR and basal perfusion.

Additionally to hemodynamic ischemic event related to CVR impairment, artery-to-artery embolism, *in situ* thrombo-occlusion, and occlusion of perforating arteries are other key pathophysiological mechanisms underlying cerebral ischemia in patients with IAS⁴⁸. Dual antiplatelet therapy and restrictive medical management of cardiovascular factors decrease the risk of disability and death following recurrent stroke in and out the stenosis territory over extended follow-up⁹. Indeed, stroke out the qualifying artery territory and cardiovascular death also occurred, as in large trials^{4,6-9}, in 4 patients out of 19, independently of CVR_{MCA} status.

Given to our results, prevention of stroke recurrence within the first year remains the most critical therapeutic challenge after the acute stroke management. CVR fMRI would be useful to select high-risk patients and to may help to justify peri-procedural adverse events related to additional invasive treatment. We suggest that future therapeutic trials on endovascular

techniques using stents⁴⁹ or angioplasty alone⁵⁰, should be first conducted on IAS patients with CVR impairment, only.

CONCLUSION:

Symptomatic intracranial atherosclerotic stenosis is associated with high rates of subsequent stroke and cerebrovascular mortality. Prevention of recurrent ischemic events remains challenging. Using noninvasive CVR BOLD fMRI, LI CVR_{MCA} derived from asymmetric BOLD signal change, elicited by hypercapnic stimulus, shows that CVR impairment is observed in more than 40% of patients with unilateral symptomatic IAS. An increased |LI| CVR_{MCA} is associated with a major risk of ipsilateral recurrent ischemic event. CVR_{MCA} impairment is more frequent in patients with recurrent versus single event. CVR impairment significantly shortens event-free survival during the first year, despite optimal medical management. CVR status should be considered to identify among IAS patients those at a higher risk of recurrent ischemic event and to select those who may benefit from additional treatment, such as endovascular procedures.

BIBLIOGRAPHY

1. Sacco, R. L., Kargman, D. E., Gu, Q. & Zamanillo, M. C. Race-ethnicity and determinants of intracranial atherosclerotic cerebral infarction. The Northern Manhattan Stroke Study. *Stroke* **26**, 14–20 (1995).
2. White, H. *et al.* Ischemic stroke subtype incidence among whites, blacks, and Hispanics: the Northern Manhattan Study. *Circulation* **111**, 1327–1331 (2005).
3. Wong, L. K. S. Global burden of intracranial atherosclerosis. *Int. J. Stroke Off. J. Int. Stroke Soc.* **1**, 158–159 (2006).
4. Chimowitz, M. I. *et al.* Comparison of warfarin and aspirin for symptomatic intracranial arterial stenosis. *N. Engl. J. Med.* **352**, 1305–1316 (2005).
5. Holmstedt, C. A., Turan, T. N. & Chimowitz, M. I. Atherosclerotic intracranial arterial stenosis: risk factors, diagnosis, and treatment. *Lancet Neurol.* **12**, 1106–1114 (2013).
6. Mazighi, M. *et al.* Prospective study of symptomatic atherothrombotic intracranial stenoses: the GESICA study. *Neurology* **66**, 1187–1191 (2006).
7. Weber, R., Kraywinkel, K., Diener, H.-C. & Weimar, C. Symptomatic Intracranial Atherosclerotic Stenoses: Prevalence and Prognosis in Patients with Acute Cerebral Ischemia. *Cerebrovasc. Dis.* **30**, 188–193 (2010).
8. Famakin, B. M. *et al.* Causes and severity of ischemic stroke in patients with symptomatic intracranial arterial stenosis. *Stroke J. Cereb. Circ.* **40**, 1999–2003 (2009).
9. Chimowitz, M. I. *et al.* Stenting versus Aggressive Medical Therapy for Intracranial Arterial Stenosis. *N. Engl. J. Med.* **365**, 993–1003 (2011).
10. Zaidat, O. O. *et al.* Effect of a balloon-expandable intracranial stent vs medical therapy on risk of stroke in patients with symptomatic intracranial stenosis: the VISSIT randomized clinical trial. *JAMA* **313**, 1240–1248 (2015).

11. The EC/IC Bypass Study Group. Failure of extracranial-intracranial arterial bypass to reduce the risk of ischemic stroke. Results of an international randomized trial. The EC/IC Bypass Study Group. *N. Engl. J. Med.* **313**, 1191–1200 (1985).
12. Powers, W. J. *et al.* Extracranial-intracranial bypass surgery for stroke prevention in hemodynamic cerebral ischemia: the Carotid Occlusion Surgery Study randomized trial. *JAMA* **306**, 1983–1992 (2011).
13. Hoak, D. A. & Lutsep, H. L. Management of Symptomatic Intracranial Stenosis. *Curr. Cardiol. Rep.* **18**, 83 (2016).
14. Attyé, A. *et al.* Normalization of cerebral vasoreactivity using BOLD MRI after intravascular stenting. *Hum. Brain Mapp.* **35**, 1320–1324 (2014).
15. Mandell, D. M. *et al.* Quantitative Measurement of Cerebrovascular Reactivity by Blood Oxygen Level-Dependent MR Imaging in Patients with Intracranial Stenosis: Preoperative Cerebrovascular Reactivity Predicts the Effect of Extracranial-Intracranial Bypass Surgery. *Am. J. Neuroradiol.* **32**, 721–727 (2011).
16. Waters, M. F. *et al.* Factors Associated With Recurrent Ischemic Stroke in the Medical Group of the SAMMPRIS Trial. *JAMA Neurol.* 1–8 (2016).
doi:10.1001/jamaneurol.2015.4315
17. Gupta, A. *et al.* Cerebrovascular reserve and stroke risk in patients with carotid stenosis or occlusion: a systematic review and meta-analysis. *Stroke J. Cereb. Circ.* **43**, 2884–2891 (2012).
18. Krainik, A. *et al.* Functional imaging of cerebral perfusion. *Diagn. Interv. Imaging* **94**, 1259–1278 (2013).
19. Mchedlishvili, G. Physiological mechanisms controlling cerebral blood flow. *Stroke* **11**, 240–248 (1980).

20. Powers, W. J. Cerebral hemodynamics in ischemic cerebrovascular disease. *Ann. Neurol.* **29**, 231–240 (1991).
21. Krainik, A., Hund-Georgiadis, M., Zysset, S. & von Cramon, D. Y. Regional impairment of cerebrovascular reactivity and BOLD signal in adults after stroke. *Stroke J. Cereb. Circ.* **36**, 1146–1152 (2005).
22. Conklin, J. *et al.* Mapping white matter diffusion and cerebrovascular reactivity in carotid occlusive disease. *Neurology* **77**, 431–438 (2011).
23. Bouvier, J. *et al.* Reduced CMRO₂ and cerebrovascular reserve in patients with severe intracranial arterial stenosis: a combined multiparametric qBOLD oxygenation and BOLD fMRI study. *Hum. Brain Mapp.* **36**, 695–706 (2015).
24. Smeeing, D. P. J., Hendrikse, J., Petersen, E. T., Donahue, M. J. & de Vis, J. B. Arterial Spin Labeling and Blood Oxygen Level-Dependent MRI Cerebrovascular Reactivity in Cerebrovascular Disease: A Systematic Review and Meta-Analysis. *Cerebrovasc. Dis. Basel Switz.* **42**, 288–307 (2016).
25. Herold, S. *et al.* Assessment of cerebral haemodynamic reserve: correlation between PET parameters and CO₂ reactivity measured by the intravenous 133 xenon injection technique. *J. Neurol. Neurosurg. Psychiatry* **51**, 1045–1050 (1988).
26. Chen, J. *et al.* Impaired dynamic cerebral autoregulation and cerebrovascular reactivity in middle cerebral artery stenosis. *PloS One* **9**, e88232 (2014).
27. Pindzola, R. R., Balzer, J. R., Nemoto, E. M., Goldstein, S. & Yonas, H. Cerebrovascular Reserve in Patients With Carotid Occlusive Disease Assessed by Stable Xenon-Enhanced CT Cerebral Blood Flow and Transcranial Doppler. *Stroke* **32**, 1811–1817 (2001).

28. Ogasawara, K., Ogawa, A. & Yoshimoto, T. Cerebrovascular Reactivity to Acetazolamide and Outcome in Patients With Symptomatic Internal Carotid or Middle Cerebral Artery Occlusion. *Stroke* **33**, 1857–1862 (2002).
29. Donahue, M. J. *et al.* Routine Clinical Evaluation of Cerebrovascular Reserve Capacity Using Carbogen in Patients With Intracranial Stenosis. *Stroke* **45**, 2335–2341 (2014).
30. Spano, V. R. *et al.* CO₂ blood oxygen level-dependent MR mapping of cerebrovascular reserve in a clinical population: safety, tolerability, and technical feasibility. *Radiology* **266**, 592–598 (2013).
31. Fierstra, J. *et al.* Measuring cerebrovascular reactivity: what stimulus to use? *J. Physiol.* **591**, 5809–5821 (2013).
32. Samuels, O. B., Joseph, G. J., Lynn, M. J., Smith, H. A. & Chimowitz, M. I. A standardized method for measuring intracranial arterial stenosis. *AJNR Am. J. Neuroradiol.* **21**, 643–646 (2000).
33. Wu, O. *et al.* Tracer arrival timing-insensitive technique for estimating flow in MR perfusion-weighted imaging using singular value decomposition with a block-circulant deconvolution matrix. *Magn. Reson. Med.* **50**, 164–174 (2003).
34. Tatu, L., Moulin, T., Vuillier, F. & Bogousslavsky, J. Arterial territories of the human brain. *Front. Neurol. Neurosci.* **30**, 99–110 (2012).
35. Boudiaf, N. *et al.* BOLD fMRI of cerebrovascular reactivity in the middle cerebral artery territory: A 100 volunteers' study. *J. Neuroradiol. J. Neuroradiol.* **42**, 338–344 (2015).
36. Markus, H. & Cullinane, M. Severely impaired cerebrovascular reactivity predicts stroke and TIA risk in patients with carotid artery stenosis and occlusion. *Brain J. Neurol.* **124**, 457–467 (2001).

37. Reinhard, M. *et al.* Cerebrovascular reactivity predicts stroke in high-grade carotid artery disease. *Neurology* **83**, 1424–1431 (2014).
38. Goode, S. D., Altaf, N., Munshi, S., MacSweeney, S. T. R. & Auer, D. P. Impaired Cerebrovascular Reactivity Predicts Recurrent Symptoms in Patients with Carotid Artery Occlusion: A Hypercapnia BOLD fMRI Study. *Am. J. Neuroradiol.* **37**, 904–909 (2016).
39. Haller, S. *et al.* Reduced cerebrovascular reserve at CO₂ BOLD MR imaging is associated with increased risk of periinterventional ischemic lesions during carotid endarterectomy or stent placement: preliminary results. *Radiology* **249**, 251–258 (2008).
40. Villien, M. *et al.* Changes in cerebral blood flow and vasoreactivity to CO₂ measured by arterial spin labeling after 6days at 4350m. *NeuroImage* **72**, 272–279 (2013).
41. Vincent, T. *et al.* Bayesian joint detection-estimation of cerebral vasoreactivity from ASL fMRI data. *Med. Image Comput. Comput.-Assist. Interv. MICCAI Int. Conf. Med. Image Comput. Comput.-Assist. Interv.* **16**, 616–624 (2013).
42. Villien, M. *et al.* Per-subject characterization of bolus width in pulsed arterial spin labeling using bolus turbo sampling. *Magn. Reson. Med.* **69**, 1677–1682 (2013).
43. Akins, P. T., Pilgram, T. K., Cross, D. T. & Moran, C. J. Natural history of stenosis from intracranial atherosclerosis by serial angiography. *Stroke* **29**, 433–438 (1998).
44. Liebeskind, D. S. *et al.* Collaterals dramatically alter stroke risk in intracranial atherosclerosis. *Ann. Neurol.* **69**, 963–974 (2011).
45. Sander, K., Hof, U., Poppert, H., Conrad, B. & Sander, D. Improved Cerebral Vasoreactivity After Statin Administration in Healthy Adults. *J. Neuroimaging* **15**, 266–270 (2005).
46. Sterzer, P. *et al.* Pravastatin Improves Cerebral Vasomotor Reactivity in Patients With Subcortical Small-Vessel Disease. *Stroke* **32**, 2817–2820 (2001).

47. Hasegawa, Y., Yamaguchi, T., Tsuchiya, T., Minematsu, K. & Nishimura, T. Sequential change of hemodynamic reserve in patients with major cerebral artery occlusion or severe stenosis. *Neuroradiology* **34**, 15–21 (1992).
48. van den Wijngaard, I. R. *et al.* Treatment and imaging of intracranial atherosclerotic stenosis: current perspectives and future directions. *Brain Behav.* **6**, n/a-n/a (2016).
49. Ding, D., Starke, R. M., Crowley, R. W. & Liu, K. C. Role of stenting for intracranial atherosclerosis in the post-SAMMPRIS era. *BioMed Res. Int.* **2013**, 304320 (2013).
50. Dumont, T. M. *et al.* Submaximal angioplasty for symptomatic intracranial atherosclerosis: a prospective Phase I study. *J. Neurosurg.* 1–8 (2016).
doi:10.3171/2015.8.JNS15791

THESE SOUTENUE PAR :

PAPASSIN Jérémie

TITRE:

Altération de la vasoréactivité cérébrale en IRMf hypercapnique chez les patients présentant une sténose artérielle intracrânienne symptomatique d'origine athéromateuse à haut risque de récurrence.

RESUME :

Introduction: Malgré un traitement médical optimal, le risque de récurrence dans les sténoses artérielles intracrâniennes symptomatiques (SAIS) d'origine athéromateuse est élevé. Une altération de la vasoréactivité cérébrale (CVR) pourrait être impliquée. L'étude en IRM fonctionnelle BOLD hypercapnique de la CVR permettrait d'identifier les patients à haut risque de récurrence, afin de proposer des traitements complémentaires plus invasifs comme l'angioplastie transluminale percutanée avec stent intracrânien.

Méthodes: Nous avons étudiés les relations statistiques entre les données cliniques et biologiques individuelles, la récurrence d'évènement ischémique et la CVR dans les territoires de l'artère cérébrale moyenne (ACM) rapportée par un index de latéralité (IL), pour 19 patients avec une SAIS de l'ACM ou de l'artère carotide interne.

Résultats: Huit patients (42%) avaient un IL CVR_{ACM} anormal ($|IL| CVR_{ACM} \geq 0.08$). Avec un suivi moyen de 3.6 ans, la récurrence d'évènement ischémique était plus fréquente et plus précoce dans le groupe CVR_{ACM} altérée ($n = 6/8$) que dans le groupe CVR_{ACM} normale ($n = 1/11$) avec des courbes de survie significativement différentes (log rank, $p = 0.003$). Les caractéristiques cliniques étaient similaires entre les deux groupes.

Conclusion: Une altération de la CVR en IRMf hypercapnique est associée à un risque élevé de récurrence pour les patients avec une SAIS d'origine athéromateuse. La cartographie de la CVR pourrait être utilisée pour sélectionner les patients à haut risque de récurrence, afin de discuter un traitement complémentaire.


VU ET PERMIS D'IMPRIMER
Grenoble, le 21/09/2017

LE DOYEN

LE PRESIDENT DE LA THESE

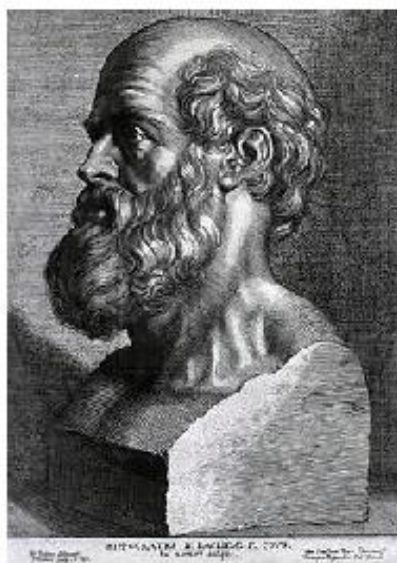
J.P. ROMANET

M. MAZIGHI



Pour la Présidente
et par délégation
Le Doyen de Médecine
Pr. Jean-Paul ROMANET





SERMENT D'HIPPOCRATE

En présence des Maîtres de cette Faculté, de mes chers condisciples et devant l'effigie d'HIPPOCRATE,

Je promets et je jure d'être fidèle aux lois de l'honneur et de la probité dans l'exercice de la Médecine.

Je donnerais mes soins gratuitement à l'indigent et n'exigerais jamais un salaire au dessus de mon travail. Je ne participerai à aucun partage clandestin d'honoraires.

Admis dans l'intimité des maisons, mes yeux n'y verront pas ce qui s'y passe ; ma langue taira les secrets qui me seront confiés et mon état ne servira pas à corrompre les mœurs, ni à favoriser le crime.

Je ne permettrai pas que des considérations de religion, de nation, de race, de parti ou de classe sociale viennent s'interposer entre mon devoir et mon patient.

Je garderai le respect absolu de la vie humaine.

Même sous la menace, je n'admettrai pas de faire usage de mes connaissances médicales contre les lois de l'humanité.

Respectueux et reconnaissant envers mes Maîtres, je rendrai à leurs enfants l'instruction que j'ai reçue de leurs pères.

Que les hommes m'accordent leur estime si je suis fidèle à mes promesses.

Que je sois couvert d'opprobre et méprisé de mes confrères si j'y manque.

Impaired cerebrovascular reactivity assessed by BOLD hypercapnic fMRI is associated with increased risk of stroke in patients with symptomatic intracranial atherosclerotic stenosis

Introduction: Despite intensive medical management, intracranial atherosclerotic stenosis (IAS) remains at risk of recurrent ischemic events. Impaired cerebrovascular reserve is suggested to explain hemodynamic stroke. Cerebrovascular reactivity assessed by hypercapnic challenge using BOLD functional MRI (CVR BOLD fMRI) has been proposed to estimate cerebrovascular reserve and to identify patients at higher risk. To discuss patients' selection for additional therapy such as intracranial angioplasty and stenting, we studied the relationships between baseline characteristics of patients with unilateral symptomatic IAS, recurrence of ischemic events, and CVR BOLD fMRI.

Subjects and methods: Nineteen patients with symptomatic unilateral IAS of middle cerebral artery (MCA) or internal carotid artery were selected. We calculated statistical relationships between individual clinical and biological baseline characteristics, recurrent ischemic events, basal perfusion estimated by dynamic susceptibility contrast MRI, and CVR BOLD fMRI measured in MCA territories (CVR_{MCA}), and reported using laterality indices (LI).

Results: Eight patients (42%) had an abnormal LI CVR_{MCA} ($|LI| CVR_{MCA} \geq 0.08$). During a mean follow-up of 3.6 years, recurrent ischemic events occurred within the first year. They were more frequent in impaired CVR_{MCA} group ($n=6/8$) than in normal CVR_{MCA} group ($n=1/11$), with different survival curves (log rank, $p=0.003$). Baseline characteristics were similar in both groups.

Conclusion: Impaired CVR assessed by BOLD hypercapnic fMRI is associated with increased risk of stroke in patients with symptomatic IAS. CVR mapping should be proposed to select high-risk patients in order to discuss additional treatment.