Whole-Brain Perfusion CT Using a Toggling Table - Technique to Predict Final Infarct Volume in Acute Ischemic Stroke

CT-Ganzhirnperfusionsmessung durch „Toggling-Table-Technik“ zur Infarktvolumenvorhersage beim akuten ischämischen Schlaganfall

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Key words
- CT perfusion
- stroke
- toggling table
- MDCT

Abstract

Purpose: To evaluate how accurately final infarct volume in acute ischemic stroke can be predicted with perfusion CT (PCT) using a 64-MDCT unit and the toggling table technique.

Materials and Methods: Retrospective analysis of 89 patients with acute ischemic stroke who underwent CCT, CT angiography (CTA) and PCT using the “toggling table” technique within the first three hours after symptom onset. In patients with successful thrombolytic therapy (n = 48) and in those without effective thrombolytic therapy (n = 41), the infarct volume and the volume of the penumbra on PCT were compared to the infarct size on follow-up images (CT or MRI) performed within 8 days. The feasibility of complete infarct volume prediction by 8 cm cranio-caudal coverage was evaluated.

Results: The correlation between the volume of hypoperfusion on PCT defined by cerebral blood volume reduction and final infarct volume was strongest in patients with successful thrombolytic therapy (n = 48) and in those without effective thrombolytic therapy (n = 41), the infarct volume and the volume of the penumbra on PCT were compared to the infarct size on follow-up images (CT or MRI) performed within 8 days. The feasibility of complete infarct volume prediction by 8 cm cranio-caudal coverage was evaluated.

Conclusion: Using PCT and the “toggling table technique” allows accurate quantification of the infarct core and penumbra.

Key Points:
- Using PCT and the “toggling table technique” allows accurate quantification of the infarct core and penumbra.
- It is possible to record dynamic perfusion parameters quickly and easily of almost the entire supratentorial brain volume on a 64-slice MDCT unit.
- The technique allows identification of those patients who could profit from thrombolytic therapy outside the established time intervals.

Citation Format:
Schrader I et al. Whole-Brain Perfusion CT Using a Toggling Table - Technique to Predict Final Infarct Volume in Acute Ischemic Stroke. Fortschr Röntgenstr 2013; 185: 975–982
min.a. Zudem untersuchten wir, ob die Infarkte innerhalb eines 8 cm langen kranio-kaudalen Scanbereichs vollständig abgebildet werden konnten.

**Ergebnisse:** Die Übereinstimmung zwischen den Volumina mit reduziertem Cerebral Blood Volume (CBV) in der PCT und den definitiven Infarktvolumina war bei Patienten nach erfolgreicher Rekanalisation am größten. Dabei wurde das finale Infarktvolumen im Mittel um 8,5 ml unterschätzt. In der Patientengruppe ohne Rekanalisation wurde das endgültige Infarktvolumen im Vergleich zu den Volumina mit verlängerter MTT in der PCT im Mittel um 12,1 ml überschätzt. Alle Infarkte waren fast vollständig mittels der PCT erfasst. Es gab keine falsch positiven oder falsch negativen Befunde.

**Schlussfolgerung:** Der Einsatz der „Toggling-Table-Technik“ bei der Perfusion-CT ermöglicht beim akuten Schlaganfall eine schnelle und genaue Quantifizierbarkeit des Mindestvolumens des irreversibel geschädigten Hirnparenchyms und liefert somit einen prognostischen Parameter, der innerhalb zukünftiger Studien in Bezug auf die Therapieentscheidung evaluiert werden sollte.

### Materials and Methods

**Patients**


**Computed tomography**

nCCT und PCT wurden auf einer 64-Slice CT-Unit mit einem Detektorbereich von 40 mm (Brilliance 64 CT, Philips Medizin Systeme, Hamburg) durchgeführt. Die Toggling-Table-Technik wurde eingesetzt, um die Volumina in klinisch erheblichen Zeitfenstern zu bestimmen. Die Messung der Volumina erfolgte mit einem 8.4-MeV-Kollimator, um eine hohe Qualität der Scanergebnisse zu gewährleisten.
Follow-up MRI
The examinations were performed on a 1.5 Tesla MRI unit (Achieva, Philips Medical Systems) using a protocol consisting of a diffusion-weighted sequence, T1 and T2-weighted TSE sequences, T2-weighted flair scans, and a 3D time-of-flight (TOF) MRA of the intracranial arteries.

Analysis of the CT perfusion data sets
A venous sinus with the greatest density integral was marked for determining the venous output function. Analogously, the further analysis for the basilar artery, the middle cerebral artery, and the anterior cerebral artery of each hemisphere was performed separately. By comparing the flow dynamics, it was ensured that there was no significant delay in the arterial inflow in any of the arteries available for additional analysis. For the further analysis, the reference vein and reference artery with the greatest density integral of the vessel cross-section were selected. With the help of evaluation software, color-coded cards showing the MTT, CBV, CBF, and the time-to-peak (TTP) were created using the principle of deconvolution [15] for every pixel (see Fig. 2). For the determination of the physiological CBF and CBV values, all brain perfusion values of the unaffected brain hemisphere for every included patient were shown in a histogram and an analysis of the two maxima of the bimodal distribution (one maximum for the gray matter and one for the white matter) was performed. Standard deviations and average values were calculated via the maxima and a group comparison was performed via t-test. The calculation of the percentage of the infarct area in the maximally cranial slice and the maximally caudal slice in the imaging area made it possible to make a statement about the scanned portion of the infarct area.

CT and MRI analysis
In the CT or MRI follow-up examinations, the definitive infarct volumes were determined on the basis of the hypodense areas in CCT or the areas with a diffusion restriction in MRI. The corresponding regions were manually encircled in all slices in consensus by two experienced neuroradiologists on an imaging workstation (Impax, Agfa-Gaevert, Mortsel, Belgium), whereby the enclosed surface was determined directly. A typical evaluation result is shown in Fig. 3. The volume could then be calculated via the particular slice thickness of the sectional images and the determined total surface of the infarct areas. The infarct volume calculated on the basis of the follow-up examinations was then compared to the infarct volume predicted on the basis of PCT.

Statistical evaluation
Statistical analysis was performed with Aabel 3.05 (Gigawiz Ltd. Co.). If not otherwise specified, the calculated numbers are noted as mean +/- standard deviation. The maximum brain perfusion values for the gray and white matter in the hemisphere not affected by stroke were analyzed for significant differences via t-test for the patient group with recanalization and the patient group without recanalization. A p-value of <0.05 was defined as the significance level.

Results

Patients
Of a total of 189 patients who underwent a CT perfusion examination in the study period, this examination was indicated in 152 patients on the basis of an acute ischemic stroke. In 35 patients the PCT examination was performed due to a suspicion of cerebral vasospasms after subarachnoidal hemorrhage.
noidal bleeding. PCT was performed to differentiate between Todd’s palsy and stroke in the two remaining patients.

The following exclusion criteria reduced the number from 152 to $n=89$ patients included in this study: 23 patients had ICB, 16 patients had substantially delayed contrast wash-in so that the arterial inflow function and the venous outflow function could not be fully visualized, the contrast agent bolus was insufficient in another 10 patients due to the low cardiac output, the remaining 14 patients had scans with significant overlapping primarily due to motion artifacts as well as foreign material artifacts. More precise details regarding the epidemiology of the included patients are provided in Table 2. The distribution of male and female patients is not significantly different ($p=0.39$).

**CBF and CBV values of the unaffected brain hemisphere**

Non-physiological cerebral blood flow and blood volume values in the gray and white matter of the sections of the brain not affected by stroke were not detected in any of the included patients.

In the group of successfully recanalized patients, the CBF and CBV values were $62.3 \pm 5.4\, \text{ml/min/100 g}$ and $6.8 \pm 0.5\, \text{ml/100 g}$, respectively, in the gray matter and $23.8 \pm 4.7\, \text{ml/min/100 g}$ and $1.9 \pm 0.4\, \text{ml/100 g}$, respectively, in the white matter. In the group of patients who could not be recanalized, the CBF and CBV values were $66.8 \pm 6.5\, \text{ml/min/100 g}$ and $6.9 \pm 0.4\, \text{ml/100 g}$, respectively, in the gray matter and $21.6 \pm 4.9\, \text{ml/min/100 g}$ and $2.1 \pm 0.5\, \text{ml/100 g}$, respectively, in the white matter. The t-test for the group comparison does not result in a significant difference ($p=0.32$).

**Predictability of the infarct area on the basis of PCT**

The prediction of the size of the infarct area on the basis of PCT depends on the success of the thrombolytic therapy: In the case of successful recanalization, the volume of the area with a decreased CBV should be used as a prognostic value for the volume of the infarct, while the infarct can ex-
tend to the entire hypoperfused area, i.e., the region with a significantly prolonged MTT, in the case of failed recanalization [16]. The volume of the infarct regions (CBV decreased in the initial perfusion measurement) of all patients with successful recanalization is compared to the volume of the infarct area in the follow-up examination in a Bland-Altman diagram in Fig. 4. This shows that the value predicted on the basis of PCT underestimates the infarct volume by 8.5 ml on average. For the deviation from this mean value, a 95 % confidence interval of 6.7 ml is calculated. The Bland-Altman diagram (Fig. 5) with respect to the unsuccessfully recanalized stroke patients shows that the MTT measurement provides a significantly less accurate prediction of the final infarct volume compared to the CBV measurement in the recanalized patients. Therefore, the volume measurement of the prolonged MTT overestimates the final infarct volume by an average value of 12.1 ml. The 95 % confidence interval is also greater with ± 15.2 ml. The final infarct volumes only exceed the volume of the areas with MTT extension determined in the PCT data in the case of significant hypoperfusion above a hypoperfused volume of approximately 80 ml as was the case in 4 patients. These patients developed malignant infarcts.

**Location of the infarct in the scanning area**

The above-described PCT measurement covers a scanning area of 8 cm (consisting of 8 individual slices). Fig. 6 shows the percentage distribution of hypoperfused brain volume for the 8 sectional images. Only approximately 3 % of the total hypoperfused volume is located in the maximally cranial slice and 5 % in the maximally caudal slice so that the total hypoperfused brain tissue was almost fully visualized in our collective.

**Discussion**

PCT provides prognostic information regarding the volume of the infarct core and penumbra so that it is possible to quickly and reliably select patients presenting outside of the established time interval but who would still profit from recanalization treatment [8, 17–19]. At the same time patients with a high risk for a malignant infarct can be identified [20].

Due to the ready availability and quick and uncomplicated implementation of PCT compared to MRI, PCT is currently being used in numerous hospitals [19, 21]. Compared to examination via MRI perfusion, the main disadvantage of PCT using 4 and 16-slice MDCT units is the small scanning area due to the narrow detector width so that complete scanning of hypoperfused areas and infarcts in cranial sections of the cerebrum is not reliably ensured [11, 22, 23]. The attempt to resolve this issue by increasing the examination area by scanning different sections of the brain in succession resulted in increased radiation exposure for the patient and the use of a greater contrast agent quantity due to the repeated applications [3, 24, 25]. PCT using a 256-slice or 320-slice MCDT unit recently made it possible to record hemodynamic data for the entire brain after only one contrast agent application and with a relatively low radiation dose [12, 23]. However, most hospitals use MDCT units with significantly

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**Table 2** Epidemiology of the patients.

<table>
<thead>
<tr>
<th>Patients</th>
<th>Total</th>
<th>Recanalized</th>
<th>Not recanalized</th>
</tr>
</thead>
<tbody>
<tr>
<td>all (n)</td>
<td>89</td>
<td>48</td>
<td>41</td>
</tr>
<tr>
<td>gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>female (n)</td>
<td>45</td>
<td>22</td>
<td>23</td>
</tr>
<tr>
<td>male (n)</td>
<td>44</td>
<td>26</td>
<td>18</td>
</tr>
<tr>
<td>age (years)</td>
<td>67,9 ± 12,8</td>
<td>66,8 ± 14,2</td>
<td>68,5 ± 11,1</td>
</tr>
<tr>
<td>recanalization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>follow-up group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TCD (n)</td>
<td>62</td>
<td>34</td>
<td>28</td>
</tr>
<tr>
<td>MRA (n)</td>
<td>12</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>CTA (n)</td>
<td>15</td>
<td>11</td>
<td>4</td>
</tr>
</tbody>
</table>

The patients with and without successful recanalization are listed according to gender and age, and according to the selected imaging methods.

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Fig. 4 Bland-Altman diagram for the comparison of the extent of the infarct volume predicted by decreased CBV and final infarct volume in case of arterial recanalization.

Fig. 5 Bland-Altman diagram for the comparison of the extent of the infarct volume predicted by decreased MTT and final infarct volume described by decreased CBV in case of persistent arterial occlusion.
fewer slices and thus a narrower detector width. To be able to scan the entire brain volume with a 64-slice MDCT unit, the toggling table technique is now used for PCT in numerous hospitals [14, 26]. In this process two adjacent sections of the brain are scanned in a specific sequence and an imaging field with a width of approximately 8 cm is examined. Almost the complete volume of the infarct area in all patients was scanned in our study. All infarct areas were large since PCT was only performed in patients with suspicion of a larger (territorial) ischemia and thus who were potential candidates for thrombolytic therapy. Accordingly, the lower sensitivity of PCT compared to MRI with regard to the detection of smaller or infratentorial infarcts as shown in the studies of other authors [14, 25, 27] does not play a role in our collective.

Data of other authors describing a relatively high sensitivity and specificity of PCT in connection with the toggling table technique is currently available. However, these studies either include study populations with disease entities other than cerebral ischemia [14] or examine ischemia in infratentorial sections of the brain [28]. In other cases, the technique applied by other workgroups differed in that a combination of CTA and PCT was used in one examination procedure [13]. Moreover, the precision of PCT was checked primarily visually and thus subjectively by comparison to follow-up MRI examinations [14, 28]. Although quantitative evaluations of the comparison of PCT to MRI perfusion are currently available [8, 17, 18], there are none for the perfusion data generated using the toggling table technique in the case of supratentorial ischemia. We examined this in our study on the basis of the comparability of the expected and definitive infarct volumes in PCT and in follow-up examinations. The results showed high predictability of PCT for patients both with and without successful thrombolytic therapy but we found greater agreement between the predicted and actual infarct volumes in patients with successful recanalization than in those without recanalization. This is probably related to the fact that the infarcted area extends beyond the initially calculated infarct core into the penumbra in the case of a lack of recanalization [29]. In the recanalized patients, the final infarct volume having the greatest concordance with the volume with decreased CBV [11, 16] is underestimated by 8.5 ml on average (95% confidence interval of 6.7 ml). Using the volume with prolonged MTT as the most suitable predictor for the final infarct volume in patients without successful thrombolytic therapy [3, 16] results in an underestimation of the final infarct volume by 12.1 ml on average (95% confidence interval ± 15.2 ml).

The toggling table technique used in our study has decreased temporal resolution. However, this is not a disadvantage since it was able to be shown in numerous studies that an extension of the scanning interval to up to 4 s does not result in any significant quantitative imprecision of the hemodynamic parameters (with simultaneous dose reduction) [10, 30].

A disadvantage of this necessary extension of the sampling interval is that individual images can no longer be excluded (e.g. due to motion artifacts) without invalidating the entire data set. This may be why the exclusion rate for technical/patient-related reasons in our study is extremely high (40 of 129 patients with acute cerebral ischemia). Other studies consistently report exclusion rates of < 10% for PCT [12, 24]. Other possible criticisms of our study are that both the follow-up examinations and the check for recanalization were not performed at a standardized time point so that the exact recanalization instant was not known. Moreover, two different methods (MRI and CT) were used in the follow-up examinations. The recanalization success was also verified via different methods (TCD, MRA, and CTA) since the intracranial basal arteries could not be visualized through the transtemporal bone window in approx. 15% of the stroke patients due to thickening of the skullcap [31]. Since the follow-up examination was not performed in any patient within the first 24 hours after the onset of symptoms, the infarct areas could be equally reliably visualized on the basis of the distinctive features in DWI MRI and the typical hypodense areas in CT.
The exact effect of the selection of the inflow function on the obtained perfusion data could not be examined in our study. Selecting inflow and outflow functions with a high integral value, i.e., only arterial and venous blood vessels with a large cross-sectional area were taken into consideration, made it possible to standardize the measurement method. The range of variation of blood flow was not fully taken into consideration since arterial vessels of both cerebral hemispheres were not compared. However, the cerebral volume principle used in our study to calculate the dynamic perfusion parameters which is based on the mathematical principle of deconvolution yields quantitative CBV, CBF, and MTT values at low injection speeds and thus independently of a delay of the contrast agent passage [15, 32] in contrast to the so-called maximum slope model, which is based on the assumption that no contrast agent exits the compartment via a venous path up to a certain point in time after arrival of the bolus in the tissue [33].

The average effective dose of our PCT protocol was 8.4 mSv and therefore differs only minimally from the dose of 7.6 mSv applied for PCT with a 320-slice MDCT unit [23]. As a result of the relatively high total dose of 4.7 – 9.5 mSv for an imaging protocol typically consisting of numerous CT examinations on a 64-slice MDCT unit [23, 34], possibly followed by catheter angiography, the indication for the individual examination and the selection of the follow-up examination method must be reviewed in each case. The benefit of the examination with respect to the survival and the least possible subsequent impairment of the stroke patient must be taken into consideration here.

It was already able to be shown in multiple studies that the use of the toggling table technique in perfusion CT makes it possible to quickly and easily record dynamic perfusion parameters of almost the entire supratentorial brain volume [13, 14]. On the basis of our quantitative analysis of the predicted and final infarct area, we were able to prove that the parameters acquired using the toggling table technique are precise. The technique allows accurate quantification of the infarct core and penumbra as the foundation for a safe and quick treatment decision.

Literatur


Schrader I et al. CT-Ganzhirnperfusionsmessung durch „Toggling-Table-Technik“... Fortschr Röntgenstr 2013; 185: 975 – 982

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