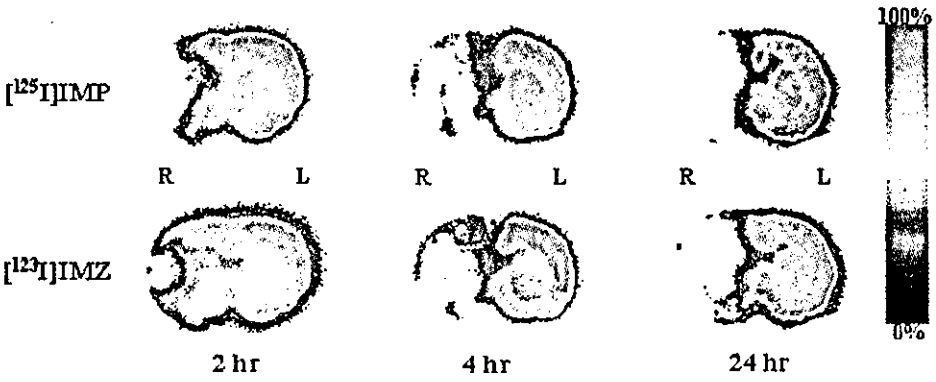

Fig. 3. Representative autoradiograms for [125I]IMP and [123I]IMZ

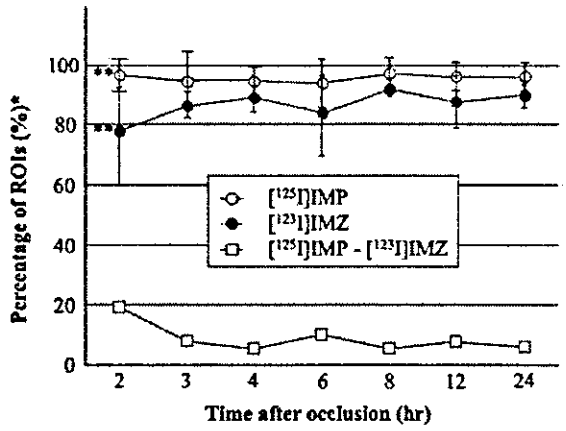

Fig. 4. Time course of the percentage of ROIs with impaired [125I]IMP or [123I]IMZ accumulation. *(Number of ROIs with LNRs less than 0.8)/(Number of total ROIs at each time point) ×100. ROIs with impaired [125I]IMP and [123I]IMZ accumulation were defined as those with LNRs less than 0.8. Significant uncoupling of accumulation between the two tracers was observed 2 h after occlusion (**P<0.01)

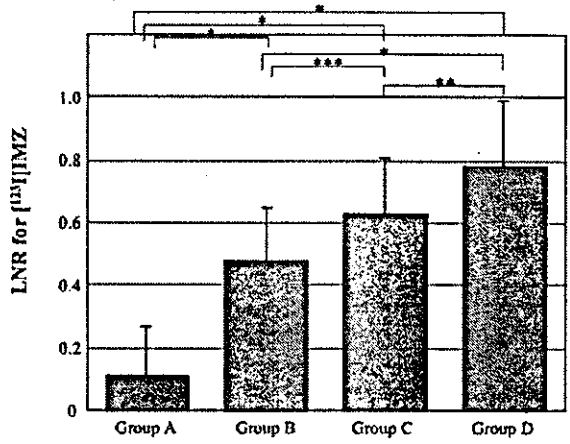

Fig. 5. The LNRs for [123I]IMZ in the four ROI groups classified on the basis of histological findings. Group A, impaired MAP-2 immunostaining; group B, preserved MAP-2 immunostaining and positive dUTP incorporation; group C, preserved MAP-2 immunostaining, negative dUTP incorporation and positive COX-2 immunostaining; group D, no histological evidence of ischaemic injury. Significant differences in LNRs between two groups: *P<0.0001, **P<0.001, ***P<0.01

decreased [123I]IMZ accumulation was smaller than that with decreased [125I]IMP accumulation (P<0.01). Uncoupling between [125I]IMP and [123I]IMZ accumulation was observed in regions surrounding the ischaemic core 2 h after occlusion, but such uncoupling reduced with time. The percentage of ROIs with impaired [123I]IMZ accumulation was significantly lower than that with decreased [125I]IMP accumulation at 2 h after occlusion (P<0.01), but not at other time points (Fig. 4).

Positivity for COX-2 was observed in 16.7% of the ROIs in the ischaemic lesions with preserved [123I]IMZ distribution (group 2) and 33.2% of the ROIs in the ischaemic lesions with decreased [123I]IMZ distribution (group 3), whereas no positivity for COX-2 was seen in non-ischaemic lesions (group 1) (Table 1). Neither positivity for dUTP incorporation nor decreased immunostaining of MAP-2 was observed in the ROIs in the lesions with preserved [123I]IMZ distribution (groups 1 and 2). Positivity for dUTP incorporation and impaired MAP-2 immunostaining were observed in 24.8% and 73.9% of the ROIs, respectively, in the lesions with decreased [123I]IMZ distribution (group 3) (Table 1).

When the ROIs were divided into four groups based on the histological findings (Fig. 5), the LNRs for [123I]IMZ in the lesions with preserved MAP-2 immunostaining (groups B, C and D) were significantly higher than those in the lesions with impaired MAP-2 immunostaining (group A; P<0.0001). The LNRs for [123I]IMZ in the lesions with preserved MAP-2 immunostaining and positive for dUTP incorporation (group B) were significantly lower than those in the lesions with preserved MAP-2 immunostaining and negative for dUTP incorporation (groups C; P<0.01, group D; P<0.0001). The LNRs for [123I]IMZ in the lesions with preserved MAP-2 immunostaining, negative for dUTP incorporation and positive for COX-2 (group C) were significantly lower

than those in the lesions with no histological evidence of an ischaemic injury (group D; $P<0.001$).

Discussion

In order to characterise [^{123}I]IMZ as a marker of neuronal viability, we compared the brain distribution of [^{123}I]IMZ with the expression of COX-2, DNA fragmentation and cellular integrity. Neither DNA fragmentation nor MAP-2 denaturation was detected in the ischaemic regions with preserved [^{123}I]IMZ accumulation. These results clearly demonstrate that neuronal DNA is still intact and cellular integrity is maintained in the ischaemic regions with preserved [^{123}I]IMZ accumulation. COX-2 expression was often observed in these regions. In addition, semiquantitative analysis based on the histological findings showed that [^{123}I]IMZ accumulation was significantly impaired in regions where DNA fragmentations were observed. Thus, [^{123}I]IMZ distribution can be an indicator that predicts the extent of neuronal damage after an ischaemic stroke.

In the present study, we compared the brain distribution of [^{123}I]IMZ with (1) CBF, (2) the expression of COX-2, a prostanoid synthesising enzyme that contributes to the progression of ischaemic damage [13, 14, 15, 16, 17], (3) fragmentation of DNA and (4) cellular integrity. The regions with preserved [^{123}I]IMZ accumulation and decreased [^{125}I]IMP accumulation, namely, uncoupling between CBF and BZR function, were observed 2 h after occlusion in regions surrounding the ischaemic core, which became smaller with time. Such uncoupling has been observed in the acute phase by several authors [9, 24, 25]. The BZR function in these regions can be regarded as intact in spite of hypoperfusion. Clinically, it was reported that the hypoperfused regions with preserved [^{123}I]IMZ accumulation do not develop infarction as determined in a follow-up evaluation with magnetic resonance imaging [3]. The uncoupling between [^{125}I]IMP and [^{123}I]IMZ accumulation may help determine the ischaemic penumbra.

Some authors [6, 10, 11] have compared [^{123}I]IMZ distribution with histological findings obtained using the haematoxylin-eosin stain. They suggested the potential of [^{123}I]IMZ for evaluating the extent of neuronal damage. The brain distribution of [^{123}I]IMZ, however, has not been correlated with the cellular response at the molecular level. The present results on the relationship between [^{123}I]IMZ accumulation and dUTP incorporation clearly demonstrate that neuronal DNA is still intact in the ischaemic regions where [^{123}I]IMZ accumulation is preserved. In addition, our results indicate the potential of [^{123}I]IMZ to significantly detect the region with DNA scission as a reduction in LNRs. It was reported that COX-2 is expressed early after an ischaemic insult and leads ischaemic neurons to apoptotic cell death [17, 26]. In the present study, COX-2 expression was often observed in the ischaemic regions with preserved [^{123}I]IMZ accumulation. COX-2 expression may precede impairment of [^{123}I]IMZ accumulation. On the other hand, the COX-2 protein was also observed in the regions where [^{123}I]IMZ accumulation decreased. The LNRs for [^{123}I]IMZ accumulation in group C (0.626±0.186) were significantly lower than those in group D (0.783±0.213). The role of the COX-2 protein may begin before the impairment of BZR function and it may continue even after this impairment, although further investigations are required to clarify this point. These results indicate that impairment of [^{123}I]IMZ accumulation may begin as early as the COX-2 expression after an acute stroke.

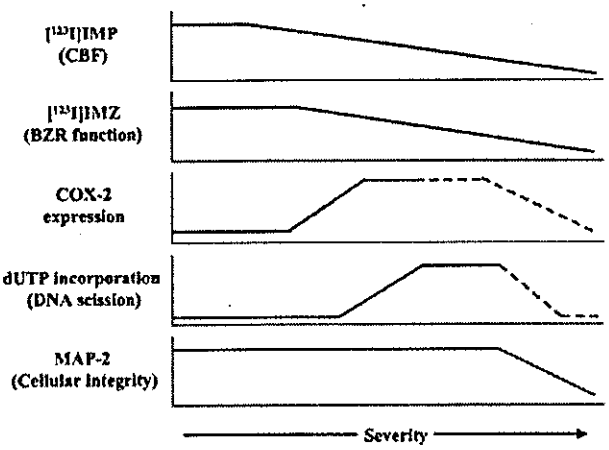

Fig. 6. Schematic representation of possible relationship between tracer accumulation and pathophysiological changes

From our results, a possible relationship between tracer accumulation and pathophysiological changes can be summarised as shown in Fig. 6. Namely, [^{125}I]IMP accumulation decreases concurrently with CBF after an ischaemic insult. COX-2 expression is often observed early after the ischaemic insult. [^{123}I]IMZ accumulation, namely, the BZR function, was impaired at a similar stage to COX-2 expression. DNA scission and impairment of cellular integrity follow the reduction in [^{123}I]IMZ accumulation.

Methodological considerations

In a clinical setting, an interval of several hours is required to sufficiently characterise BZR distribution after the [^{123}I]IMZ injection. In this study, however, rats were sacrificed 60 min after [^{123}I]IMZ administration, according to the method reported by Toyama et al. [10]. Their kinetic study indicated that specific binding of [^{123}I]IMZ can be evaluated 60 min after [^{123}I]IMZ injection in a rat model of cerebral ischaemia. Specific distribution of [^{123}I]IMZ can be achieved in a shorter period of 60 min in rats.

The relationship between tracer distribution and histological findings was evaluated simultaneously using all samples obtained from rats sacrificed at variable time intervals after the ischaemic insult, in order to characterise [^{123}I]IMZ distribution in regions with ischaemic injury of various extent. Regional analysis in rats subjected to the same period of MCA occlusion may provide more precise information on the relationship. The relatively narrow penumbra in rats, however, may restrict such evaluation and require a higher number of rats. Thus, in the present study, the relationship was evaluated simultaneously in rats sacrificed at variable time intervals.

The average LNR for [^{123}I]IMZ in histologically normal regions was not higher than 0.8. Although, in this study, we chose 0.8 as the threshold value of the LNRs for [^{123}I]IMZ, further examinations may be needed to determine a more suitable threshold value of LNR for [^{123}I]IMZ.

In the present study, we used a dual-tracer autoradiographic technique to evaluate the blood flow and [^{123}I]IMZ binding in the same individuals. Consequently, we could not perform quantitative assessment of the blood flow and [^{123}I]IMZ binding, as it is methodologically difficult to quantitatively assess flow and IMZ binding using the dual-tracer autoradiographic technique. Further studies, especially on quantitative measurement of flow and [^{123}I]IMZ binding, are required to confirm the present results and to obtain relevant information on the flow and [^{123}I]IMZ binding in relation to the histopathological findings.

Clinical implications

The routine use of nuclear medicine for the clinical assessment of neuronal viability has been limited exclusively to the determination of CBF, oxygen and/or glucose consumption, and CBF reactivity to acetazolamide. Oxygen and glucose metabolism and CBF reactivity to acetazolamide, however, do not provide direct information on neuronal viability. Rather, these techniques yield information not only on neurons but also on astrocytes and Schwann cells. On the other hand, [^{123}I]IMZ, a central-type BZR ligand, can be a specific marker of neuronal viability. Heiss et al. suggested that imaging of BZR receptors could distinguish between irreversibly damaged and viable penumbra tissues immediately after an acute stroke using carbon-11 flumazenil and positron emission tomography [27, 28]. The present study in the rat model demonstrated that [^{123}I]IMZ can also be a marker for neuronal viability. In addition, [^{123}I]IMZ does not require in-house cyclotrons and positron emission tomography, and can be commercially supplied. The availability of this procedure is expected to favour the clinical application of [^{123}I]IMZ.

Conclusion

The present study demonstrated for the first time that impairment of [^{123}I]IMZ accumulation precedes DNA fragmentation and denaturation of cellular integrity. Our results provide the molecular basis of [^{123}I]IMZ distribution. [^{123}I]IMZ accumulation can be a clue to predicting the severity of ischaemic neuronal injury.

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SHORT REPORT

Isolated pulmonary arteriovenous fistula without Rendu-Osler-Weber disease as a cause of cryptogenic stroke

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There has been uncertainty as to whether a right to left shunt through an isolated pulmonary arteriovenous fistula (P-AVF) without Rendu-Osler-Weber (ROW) disease can cause paradoxical brain embolism. A population of 747 acute ischaemic stroke patients was examined to determine the frequency and clinical characteristics of those patients who had an isolated P-AVF. The presence of a P-AVF was determined as follows. On patients with a stroke of undetermined cause, both transoesophageal echocardiography and transcranial Doppler with saline contrast medium was performed to detect a right to left shunt. If a P-AVF was then suspected, selective pulmonary angiography and enhanced chest CT was performed to confirm the presence of the P-AVF. Four patients (0.5%) were diagnosed as having a stroke associated with an isolated P-AVF. All the patients were middle-aged women (mean age 61 years). In all these patients, the P-AVF could not have been suspected on physical findings or chest x ray. The P-AVF was always single and located in the lower lobe. All the patients had asymptomatic deep venous thrombosis, and three patients developed pulmonary embolism. As D-dimer and thrombin–antithrombin complex were elevated in all patients, this indicated an activation of both fibrinolytic and thrombin activity. Our results show that an isolated P-AVF without ROW disease can cause paradoxical brain embolism. Thus, the existence of an isolated P-AVF as a right to left shunt in patients with a stroke of unknown origin should not be overlooked, even if a P-AVF is not suggested by the initial physical findings or chest x ray.

Rendu-Osler-Weber (ROW) disease is characterised by multiple dermal, mucosal, and visceral telangiectasia that are associated with recurrent bleeding, and by a pulmonary arteriovenous fistula (P-AVF) in 15% of patients.[1] The right to left shunt caused by P-AVF with ROW disease can cause paradoxical brain embolism.[1 2] To the best of our knowledge, however, only four cases of paradoxical brain embolism associated with an isolated P-AVF without ROW disease, including our one previous case, have been reported.[3–6] Therefore, the question remains as to whether an isolated P-AVF is associated with ischaemic stroke, and, in particular, with paradoxical brain embolism. The aims of this study were to investigate the frequency of brain infarction associated with an isolated P-AVF, to evaluate the salient clinical characteristics of this condition, and to elucidate a mechanism for the development of ischaemic stroke in these patients.

SUBJECTS AND METHODS

We reviewed the records of 747 consecutive ischaemic stroke patients who were admitted to our division within 7 days of stroke onset between August 1998 and December 2002. We identified those patients with a brain infarction that was associated with an isolated P-AVF without ROW disease. The diagnosis of ROW disease was made clinically based on the "classic triad" of telangiectasia, recurrent epistaxis, and a family history of the disorder. The presence of a P-AVF was determined as follows. When we had a patient with a stroke of undetermined cause, we always performed both a transoesophageal echocardiography (TOE) with saline contrast medium and a transcranial Doppler (TCD) with saline contrast medium so as to detect a right to left shunt, such as a patent foramen ovale (PFO) or a P-AVF. A patient with a stroke of undetermined cause was defined as a patient who did not have a lacunar stroke; did not have more than a 50% stenosis in the cerebral artery irrigating the affected lesions; and had no potential cardiac sources of emboli (such as atrial fibrillation, acute myocardial infarction, old myocardial infarction with intraventricular thrombus, mitral valve disease, prosthetic valve, implantation of a pacemaker, or a dilated cardiomyopathy). If a P-AVF was suspected based on the findings of the TCD study with saline contrast medium that detected microembolic signals (MES) through the middle cerebral artery or the basilar artery, and the TEE did not demonstrate a PFO,[7] we then always performed selective pulmonary angiography and enhanced chest CT so as to confirm the presence of the P-AVF. Pulmonary embolism was diagnosed by lung perfusion scintigraphy, and deep venous thrombosis (DVT) was diagnosed by venography and/or ultrasonography.

RESULTS

ROW disease was not observed in the 747 patients studied. However, seven patients were suspected as having a P-AVF by TCD and TEE studies. Pulmonary angiography and chest CT studies could not confirm a P-AVF in three of these patients. Therefore, four patients (0.5%), including our previously reported patient (case 1),[6] were diagnosed as having an embolic stroke associated with an isolated P-AVF. TCD studies in all these patients showed that MES were detected during normal breathing without having to perform a Valsalva manoeuvre or a cough. The clinical characteristics of all four patients are shown in the table. None of the patients had clinical evidence of hypoxia, such as cyanosis, dyspnea, and erythrocytosis. We could not auscultate vascular sounds in the lung fields, and the chest

Abbreviations: DVT, deep venous thrombosis; MES, microembolic signals; P-AVF, pulmonary arteriovenous fistula; PFO, patent foramen ovale; ROW, Rendu-Osler-Weber; TCD, transcranial Doppler; TOE, transoesophageal echocardiography

Table 1 Clinical characteristics of four patients with P-AVF without Rendu-Osler-Weber disease

	Case 1	Case 2	Case 3	Case 4
Gender	Female	Female	Female	Female
Age (years)	62	59	50	68
Location of brain infarction	Left MCA Territory	Thalamus	Cerebellum	Cerebellum
Medication before stroke onset	–	Ticlopidine (200 mg)	–	Aspirin (80 mg)
History of TIA or brain infarction	+	+	+	+
Risk factor	–	HT, HL	–	HT, HL
Chest *x* ray	Normal	Normal	Normal	Normal
Location of P-AVF in lung	Right lower	Right lower	Right lower	Left lower
Single or multiple P-AVF	Single	Single	Single	Single
Size of P-AVF (mm) on CT	5	7	2	4
DVT	+	+	+	+
Pulmonary embolism	+	+	+	–
RBC count×10 000/μl	377	404	383	327
Hg (g/dL)	11.1	12.0	8.2	10.6
Ht (%)	30.2	38.0	26.8	32.3
PaO_2 (mmHg)	76	85	88	83
TAT μg/L	4.2	3.7	2.7	2.3
D-dimer μg/L	2.4	1.5	3.9	1.1
After embolisation of P-AVF				
Medication	Free	Warfarin	Warfarin	Warfarin
Recurrent stroke	–	–	–	BH
Observation interval (months)	57	45	14	13

MCA, middle cerebral artery; TIA, transient ischaemic attack; HT, hypertension; HL, hyperlipidaemia; BH, brain haemorrhage; TAT, thrombin–antithrombin III complex; P-AVF, pulmonary arteriovenous fistula; DVT, deep venous thrombosis; RBC, red blood cell

x rays did not demonstrate any abnormality, such as a nodular density in the bilateral lung lobes, which would have led us to suspect P-AVF. The P-AVF found on lung CT and pulmonary angiography was always single and located in the lower lobe. The mean size of the P-AVF on CT was 4.5 mm. All patients had pulmonary embolism, and three had asymptomatic deep venous thrombosis. D-dimer and thrombin–antithrombin complex were elevated in all patients, indicating the activation of both fibrinolytic and thrombin activity.

The P-AVFs were occluded with catheter embolisation within 2 months of stroke onset. Our follow up was conducted for an average of 32 months (range 13–57 months), and no recurrent ischaemic strokes were documented, but one patient (case 4) had a thalamic haemorrhage 8 months after catheter embolisation of the P-AVF. This patient had been treated with warfarin and her international normalised ratio was 2.2 at the onset of the brain haemorrhage.

Fig 1 shows the findings of case 2: a pulmonary angiography with a P-AVF; a venogram of the lower limbs showing a DVT; and lung perfusion scintigraphy showing pulmonary embolism.

DISCUSSION

We have presented four acute ischaemic stroke patients with P-AVF not associated with ROW disease. None of the patients had cardiac or arterial sources for the emboli. Furthermore, all the patients had DVTs and three patients developed pulmonary embolism. Therefore, we diagnosed all these patients as having had paradoxical brain embolism through a P-AVF. We conclude that an isolated P-AVF can cause paradoxical brain embolism.

It is of interest to note that the size of the P-AVFs differed between previously reported cases and our patients. The previously reported cases, due to the large size of the P-AVFs,[3–5] had physical findings, such as auscultate vascular sounds, or abnormalities on chest *x* ray. In contrast, in all of our patients the P-AVFs could not be suspected on physical findings or chest *x* ray, because of their small size. Therefore, the presence of P-AVF in stroke patients who have normal physical findings and no chest *x* ray abnormalities cannot be excluded.

A TCD with saline contrast medium performed on all patients was useful in identifying the presence of a P-AVF during the acute phase of the stroke. As a persistent right to left shunt occurs in a P-AVF, micro air bubbles can be detected in the cerebral arteries using TCD with saline contrast medium during normal breathing without the need to use provocative methods, such as a Valsalva manoeuvre or a cough.[7] Therefore, in patients who have had an embolic

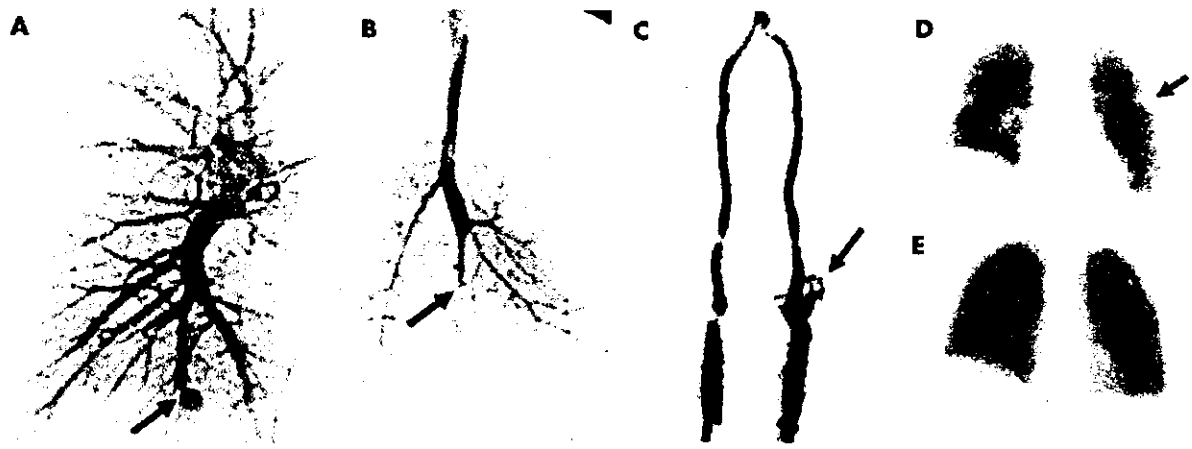

Figure 1 The pulmonary angiography (A, B), venogram of the lower limbs (C), and the ventilation–perfusion lung scintigraphy (D, E) of case 2. (A) Selective pulmonary angiography 30 days after stroke onset shows a P-AVF (arrow) in the right lower lobe. (B) After embolisation therapy with a metal coil, the feeding vessels to the P-AVF are completely occluded. (C) Venogram of the left lower limbs 4 days after stroke onset shows the abnormal collateral flow (arrow) in the leg veins, indicating a deep venous thrombus. (D) Lung perfusion scintigram 4 days after stroke onset shows the defect (arrow) in the left upper lung, indicating a pulmonary embolism. (E) The follow-up study taken 24 days after stroke onset shows no perfusion defect in the left upper lung.

stroke of undetermined cause and cannot perform a Valsalva manoeuvrer or a cough because of aphasia or a disturbance of consciousness, TCD with saline contrast medium can help detect a P-AVF in the acute phase of stroke.

Catheter embolisation is a safe and effective treatment for P-AVF.[8] All four patients had a history of ischaemic stroke or TIA prior to the present stroke. After catheter embolisation of their P-AVF, none of these patients had a recurrent ischaemic stroke. Thus, catheter embolisation of a P-AVF appears to be an effective method of preventing recurrent ischaemic stroke in such patients.

In conclusion, an isolated P-AVF without ROW disease can cause cryptogenic stroke. Thus, one should not overlook an isolated P-AVF as a right to left shunt in patients with a stroke of unknown origin, even when physical findings or chest *x* ray findings are not suggestive of a P-AVF.

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Temporal and topographic profiles of cyclooxygenase-2 expression during 24 h of focal brain ischemia in rats

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Abstract

Substantial increases in cyclooxygenase-2 (COX-2) mRNA and protein levels were demonstrated in the peri-infarct and focal ischemic areas after 3–24 and 12–24 h, respectively, in rats. In the ischemic core, significant increases in COX-2 mRNA followed 6 h of ischemia, though the peak level was about one-third of that in the peri-infarct area. Increases in COX-2 protein in the ischemic core were not observed during ischemic periods. Diffuse, neuronal COX-2 staining was found in peri-infarct areas as well as in discrete, immunoreactive neurons in the ischemic core. Robust increases in prostaglandin E_2 levels in the peri-infarct area were demonstrated following 24 h of ischemia. Prostaglandin production as well as COX-2 expression in ischemic tissues depended on the degree and duration of the reduction in cerebral blood flow.

Keywords: Cyclooxygenase-2; Focal brain ischemia; Prostaglandin E_2; 6-keto-PG $F_{1\alpha}$; Cerebral blood flow; Rat

Cyclooxygenase-2 (COX-2), a rate-limiting enzyme in prostaglandin synthesis, is rapidly induced by proinflammatory cytokines in vitro and has been shown to mediate the induction of prostaglandin synthesis during the inflammatory response in vivo [17]. Accumulating evidence suggests that inflammatory processes play a role in the development and progression of atherosclerosis [2,8,14] and COX-2 in particular has become the focus of attention as a therapeutic target enzyme in acute coronary syndromes [1] and Alzheimer's disease [16]. We previously reported that neuronal COX-2 was induced within potentially viable hypoperfused brain areas after a 24 h ischemic period in non-human primates [20]. The role of neuronal COX-2 within such peri-infarct areas, however, is still unclear. Several reports using various rodent models suggested that COX-2 played a role in the development of ischemic injury [3,4,12]. A few postmortem reports suggested that the production of prostanoids by COX-2 after acute ischemia could contribute to the remodeling of neural networks that is seen after focal infarction [15]. The objective of the present study was to elucidate the topography and time course of COX-2 expression and prostaglandin (PG) E_2 (the major prostanoid involved in inflammation) production, as well as the production of the prostacyclin metabolite 6-keto-PG $F_{1\alpha}$ [11,13] during 24 h of focal brain ischemia.

Male Sprague–Dawley rats (300–350 g, $n = 40$) were used in this study. All procedures were approved by our Institutional Animal Research Committee and were performed in accordance with the standards published by the National Research Council. Rats were anesthetized with chloral hydrate (400 mg/kg body weight i.p.) and focal brain ischemia was produced by the intraluminal occlusion of the ostium of the right middle cerebral artery with nylon monofilaments, as previously described [7,9]. Rectal temperatures were monitored and maintained at around 37

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°C with the aid of heating pads. Rats were sacrificed under chloral hydrate anesthesia at time 0 and at different times points after arterial occlusion (1, 2, 3, 4, 6, 8, 12, and 24 h, $n = 4$-5/time point) and their brains immediately immersed in ice-cold saline. The brains were then cut into four coronal sections (blocks A–D) as shown in Fig. 1A. Several blocks were frozen in isopentane-dry ice and stored at − 80 °C until use, whereas others (from C) were embedded in paraffin for immunohistochemistry. Analysis of COX-2 expression (mRNA, protein), and measurement of the concentrations of PGE_2 and the prostacyclin metabolite 6-keto-PG $F_{1\alpha}$ in the peri-infarct areas and the ischemic core were performed using blocks A and C, respectively.

In some animals, *N*-isoproryl-*p*-[^{125}I]-iodoamphetamine ([^{125}I]IMP) (2.22 MBq/kg body weight) was injected into the femoral vein 5 min before sacrifice and ex vivo autoradiography was performed to measure cerebral blood flow (CBF) using blocks B and D. For each frozen block, tissues that were adjacent to block C were serially sectioned (20 μm). Exposure was carried out for 7 days in order to visualize the distribution of [^{125}I]IMP. The autoradiograms were analyzed using a computerized imaging analysis system (Bio-imaging Analyzer BAS-5000, Fuji Photo Film, Tokyo, Japan). A total of four regions of interest (ROIs), as shown in Fig. 1B, were bilaterally and symmetrically positioned in the cerebral cortices in each coronal slice of blocks B and D. Asymmetry indices (AIs) were defined as the ratios of values for ROIs in the hemisphere ipsilateral to the arterial occlusion (right) to those of the contralateral homologous ROIs. AIs of the ischemic core were defined as a/d, whereas the AIs of the peri-infarct area were defined as b/c (Fig. 1B). An average AI value from blocks B and D was calculated for the CBF in each area of the ischemic core and peri-infarction areas.

RNA preparation and blot analysis were performed using cortices from blocks A (peri-infarct area) and C (ischemic core) as previously described [6]. For the immunoblot analyses, right cortical samples from block A (peri-infarct area) were obtained from each animal at time 0, and 3, 6, 12, and 24 h after ischemia ($n = 4$-5 for each period). The sample volumes, which were about 20 mg for each animal, were pooled together for each ischemic period. Right

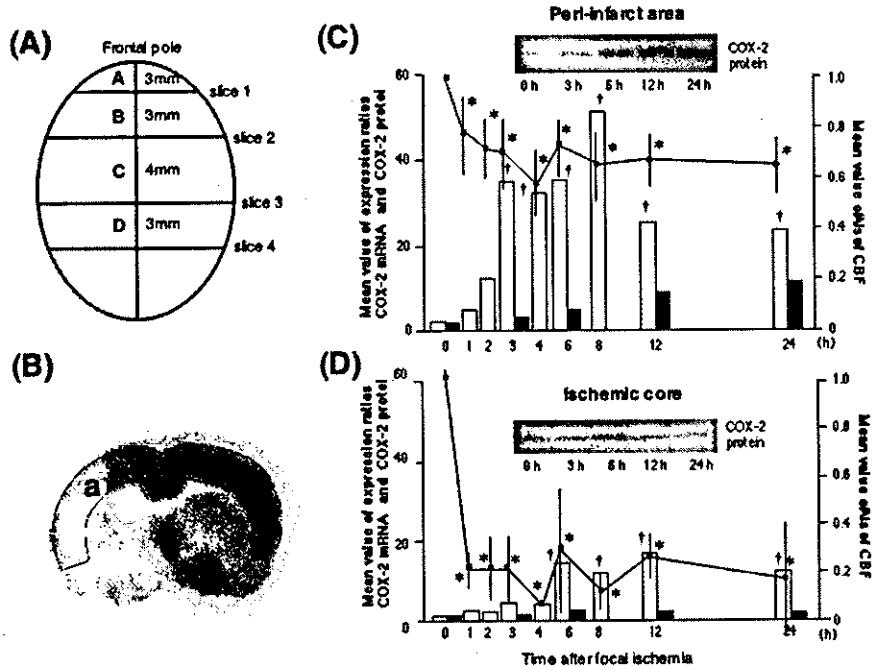

Fig. 1. Temporal profile of COX-2 expression associated with changes in CBF during 24 h of ischemia. (A) The brain was stereotaxically divided, on ice, into four coronal sections using a brain matrix. The first slice was made 3 mm from the frontal pole (block A), while the other three were cut at 3 mm (block B), 7 mm (block C), and 10 mm (block D) intervals posterior to the first slice. Determination of COX-2 expression levels (mRNA, protein) in the peri-infarct area and ischemic core was performed using blocks A and C, respectively. (B) To measure CBF in each animal, four regions of interest (ROIs) were bilaterally symmetrically placed on the cerebral cortices using coronal frozen slices from blocks B and D. Asymmetry indices (AIs) of the ischemic core were defined as a/d, whereas the AIs of the peri-infarct area were defined as b/c. (C,D) Lines indicate the mean AI values of CBF. The open and solid columns correspond to the mean expression ratios of COX-2 mRNA and COX-2 protein, respectively. Figures C and D show the time course of COX-2 expression in the peri-infarct area and ischemic core, respectively. A one-way ANOVA and post-hoc Fisher's tests were used to assess the differences in AIs and expression ratios of COX-2 mRNA between the different ischemic time points. CBF values in the peri-infarct area and ischemic core were significantly reduced compared to controls immediately after arterial occlusion ($^*P < 0.05$). The mean CBF values in the ischemic core and peri-infarct area were 0.19 ± 0.07 (mean ± SD) and 0.67 ± 0.06, respectively. The time course of COX-2 expression in the peri-infarct area was different from that in the ischemic core. Thus, the expression ratios of COX-2 mRNA increased significantly after 3 h of ischemia ($^\dagger P < 0.05$), with COX-2 protein also increasing with time in the peri-infarct area. On the other hand, significant increases in COX-2 mRNA were found 6 h after ischemia ($^\dagger P < 0.05$), and increases in COX-2 protein were not observed during the ischemic period in the ischemic core.

cortical samples from block C (ischemic core) for each ischemic period were also pooled together in this manner. Immunoblot analyses were then performed on each pooled sample as previously described [19]. COX-2 expression (mRNA, protein) in the ischemic cortices was calculated as expression ratios, defined as the ratio of the COX-2 mRNA or protein signals in the ischemic samples to their mean values in the corresponding control areas.

For immunohistochemistry, a mirror sectioning technique was used to colocalize COX-2 and microtubule-associated protein 2 (MAP-2), a neuronal skeletal protein, in sections from block C as previously described [19]. Negative controls consisted of sections that were incubated overnight without the primary antibody and processed as above.

Tissue concentrations of PGE_2 and 6-keto-PG $F_{1\alpha}$ in the right (ischemic) cortices of blocks A (peri-infarct area) and C (ischemic core) were determined using radioimmunoassay kits (Perkin-Elmer Life Sciences, Inc. MA, USA), and values were normalized for protein content.

Significant reductions in AIs for CBF in the peri-infarct area and ischemic core were demonstrated in animals at each ischemic time point compared to controls (Fig. 1C,D). The expression ratios of COX-2 mRNA increased significantly between 3 and 24 h of ischemia in the peri-infarct area compared to controls (Fig. 1C). In the ischemic core, significant increases in COX-2 mRNA were seen following 6 h of ischemia, which remained through 24 h (Fig. 1D). The peak value of the expression ratio of COX-2 protein in the peri-infarct area was 10.7 at 24 h of ischemia, while the peak expression ratio in the ischemic core was 2.0 at 6 h of ischemia.

COX-2 immunoreactive neurons were found predominantly in the peri-infarct area, though elevations in the immunohistochemical staining of discrete neuronal populations were also observed in the ischemic core (Fig. 2). Both COX-2 and MAP-2 immunoreactivity were abolished when the primary antibody was omitted.

Although no significant increases in PGE_2 and prostacyclin levels were observed in the peri-infarct and ischemic core areas following 3 h of ischemia, significant increases in prostaglandin levels were found in the ischemic hemisphere following 24 h of ischemia. In particular, PGE_2 levels in the peri-infarct area increased significantly (Table 1).

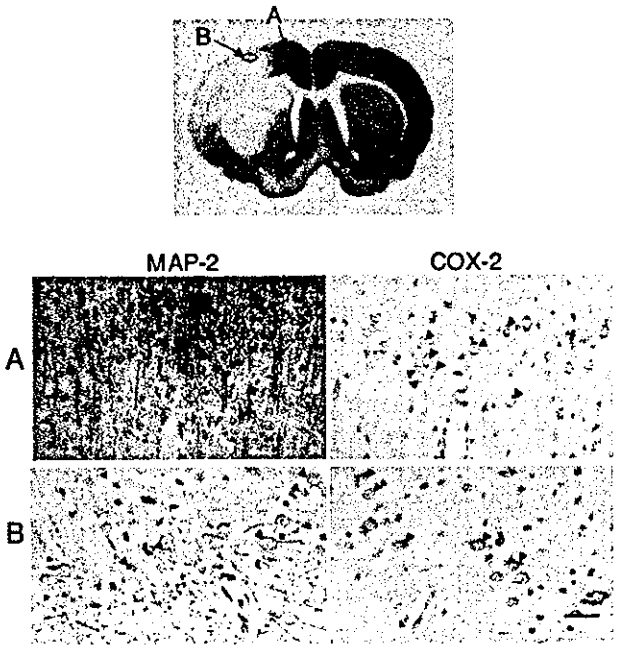

Fig. 2. Immunohistochemical analysis of COX-2. The single top figure shows a coronal slice of the brain of an animal that had undergone 3 h of ischemia, which was immunostained for microtubule-associated protein 2 (MAP-2). The bottom figures are sections that were immunostained for COX-2 and MAP-2 that were derived from either the peri-infarct area (region A in the top figure) or the ischemic core (B). Immunoreactive COX-2 and MAP-2 were localized in the same neurons in the ischemic core and peri-infarct area (arrow heads). Scale bar: 100 μm.

We previously demonstrated, in a small number of non-human primates, that post-ischemic COX-2 expression was regulated by the extent of CBF reduction [20]. In the present study, serial changes in the expression of COX-2 during focal ischemia were evaluated more closely in relation to the degree and duration of CBF reduction, and COX-2 reaction products (PGE_2 and prostacyclin), which were not analyzed in our previous study, were also examined. The time course of COX-2 expression in the ischemic core, characterized by a CBF of $<20\%$ of baseline values, was different from that seen in the peri-infarct area, where 70–80% of control CBF was observed following 24 h of ischemia. The upregulation

Table 1
Prostaglandin production (pg/mg total protein) in the right (ischemic) hemisphere

Prostaglandin	Duration of ischemia (h)	Peri-infarct area	Ischemic core
PGE_2	0	60.8 ± 16.6	21.4 ± 11.4
	3	156.6 ± 70.1	54.4 ± 22.3
	24	2609.0 ± 2522.0*†	414.6 ± 226.3*†
Prostacyclin metabolite (6-keto-PG $F_{1\alpha}$)	0	122.3 ± 47.6	47.6 ± 23.0
	3	200.8 ± 59.7	93.4 ± 43.5
	24	1143.0 ± 623.7*†	341.6 ± 84.5*†

*$P < 0.05$ vs. 0 h (control); †$P < 0.05$ vs. 3 h ischemia by ANOVA. The values are the mean ± SD.

of COX-2 mRNA in the peri-infarct area persisted for at least 24 h after ischemia, as did the production of COX-2 protein, which led to significant increases in prostacyclin as well as PGE_2 levels following 24 h of ischemia. In the ischemic core, increases in COX-2 mRNA persisted during the 24 h of ischemia, though significant increases in COX-2 protein were not observed. This latter finding was considered to be due to the severe ischemic injury that was caused by reduced CBF, which likely affected protein synthesis [5]. This assertion is supported by the work of Xie et al. [18] who reported that a CBF of <70% of controls suppressed protein synthesis. In spite of these effects on COX-2 protein, significant increases were seen in the concentration of prostaglandins in the ischemic core 24 h after ischemia. Local increases in neuronal COX-2 expression in the ischemic core, as determined by immunohistochemical analysis, could have accounted for this increase in prostaglandin concentration. Increases in PGE_2 in ischemic cortices after 24 h of ischemia, particularly in peri-infarct areas, were probably due to the upregulation of membrane-associated PGE_2 synthase (mPGES) activity as well as the induction of COX-2, which were reported to be essential components for delayed PGE_2 biosynthesis [10].

The induction of neuronal COX-2 is important for the regulation of prostaglandin signaling in post-ischemic regions, and the magnitude of COX-2 activity and prostaglandin production is determined by the degree and duration of CBF reduction. Before novel therapeutic options for stroke patients can be developed, further clarification of the effects of COX-2 during and after ischemia will be required.

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Long-Term Prognosis, by Stroke Subtypes, after a First-Ever Stroke: A Hospital-Based Study over a 20-Year Period

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Key Words
Stroke recurrence · Recurrence-free survival · Risk factors · Japan

Abstract
Background and Purpose: The influence of stroke subtype on recurrence, and determinants of recurrence-free survival after a first-ever stroke are not fully understood. We aimed to clarify the long-term prognosis by stroke subtypes and to identify determinants for recurrence and death after a first-ever stroke. ***Methods:*** We enrolled 1,732 consecutive patients (men/women = 1,134/598, mean age of 65 years) with a first-ever acute stroke who were admitted to our Stroke Care Unit during a period of 20 years. Stroke subtypes were classified as atherothrombotic brain infarction, lacunar infarction, cardioembolic infarction, other type of infarction, and brain hemorrhage. The prognosis was assessed by stroke subtypes. ***Results:*** During the hospital stay (mean 61 days), 99 patients died: 73 died directly from stroke. A total of 198 patients had recurrent strokes, and 286 died within 3 years after the index stroke. The overall recurrence rate within the first year was 6.5%, which was different among stroke subtypes. Patients with cardioembolic infarction (9.0%) as well as other type of infarction (9.1%) had more recurrent strokes within the initial year compared with the other subtypes. A history of transient ischemic attack (relative risk = 1.38), atrial fibrillation (1.52), ischemic heart disease (1.40), and disability at discharge (2.64) were independent predictors for the recurrence and death within 3 years after the first-ever stroke. ***Conclusions:*** The recurrence rate was different among stroke subtypes within 1 year after the index stroke. Atrial fibrillation, ischemic heart disease, history of transient ischemic attack, and disability at discharge were important determinants for stroke recurrence and death.

Introduction

Stroke is a major cause of death and disability throughout the world. In Japan, stroke was the third leading cause of death after cancer and heart disease in 2000. Although stroke mortality in Japan has declined markedly since 1970 [1], the actual number of stroke patients has been increasing along with a rapid increase in the elderly population. As acute stroke events and disability among stroke survivors produce a great burden to the social and health care systems, the prevention and better treatment of stroke have a considerable public health significance. Un-

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derstanding the considerable heterogeneity in risk factors, stroke incidence, and mortality among different geographic and ethnic populations is important for advancing available prevention strategies for stroke in the world. However, little is known about the long-term outcome by stroke subtypes in Asians.

Our hospital, National Cardiovascular Center, is located in the second largest urban area (Osaka) in Japan. A Stroke Care Unit for acute stroke patients has been operating since 1978. The aim of this study was to determine whether stroke recurrence and mortality are different among stroke subtypes, and to determine whether conventional stroke risk factors and disability at discharge influenced recurrence-free survival after a first-ever stroke.

Subjects and Methods

Subjects

Out of 2,192 patients admitted to the Stroke Care Unit within 7 days of complete stroke onset from April 1, 1978 to March 31, 1997, 1,732 consecutive patients (1,134 men and 598 women, 12–96 years) with a first-ever stroke were enrolled in the present study. Patients with aneurysmal subarachnoid hemorrhages were not included.

Baseline Assessment

Baseline clinical characteristics were recorded, including age, sex, hypertension (HT), hyperlipidemia (HLP), diabetes mellitus (DM), ischemic heart disease (IHD), history of transient ischemic attack (TIA), and atrial fibrillation (AF). The information about conventional risk factors and past medical history were obtained from the hospital records (all medical records are being kept permanently in our hospital), or were inferred from a self-reported medical history or prescribed medication. HLP was defined as a total cholesterol level of >220 mg/dl or triglyceride level of >140 mg/dl, and HT was assessed from systolic blood pressure ≥140 mm Hg, or diastolic pressure ≥90 mm Hg at two independent measurements 2 weeks after stroke onset. DM was defined as a fasting blood glucose level ≥140 mg/dl, or ambient blood glucose ≥ 200 mg/dl after the initial 14 days. Patients who had been treated with insulin or oral hypoglycemic agents were also defined as diabetics. AF was diagnosed by electrocardiography, including 24-hour monitoring, during the hospital stay.

A baseline assessment was performed on every patient: brain CT, carotid ultrasonography (including Dopscan), electrocardiography, as well as standard blood and urine tests. In order to evaluate cerebral arteries, 63% of patients received the conventional cerebral angiography and 8% underwent magnetic resonance angiography in addition to the carotid ultrasonography. Two-dimensional echocardiography was performed on 353 patients with possible cardioembolic infarction to investigate a potential embolic source.

Diagnosis of Stroke Subtypes

The diagnosis of stroke subtypes, such as atherothrombotic brain infarction (ABI), lacunar infarction (LI), cardioembolic infarction (CEI), other type of infarction (OTI), and brain hemorrhage (BH), was made by taking into account all the available data described above, mainly according to the criteria in the Classification of Cerebrovascular Disease III [2].

A diagnosis of ABI was based on the presence of focal brain infarct(s) in the collection of evidence for occlusive lesions in the large cervical and intracranial arteries (either occlusion, ≥50% stenosis of the lumen diameter, or ulceration). In patients with ABI, the responsible vascular lesion for the index stroke was determined by the clinical data. The diagnosis of LI was made when a typical clinical syndrome was associated with a small infarct, ≤15 mm in diameter on CT, restricted to the territory of a perforating artery, and when no evidence of adjacent major artery occlusion or severe stenosis was found [3]. CEI was clinically diagnosed as described elsewhere [4]. If the patient had a combination of the above etiologies, or if the stroke had other causes, such as arterial dissection, cerebral venous thrombosis, or had undetermined etiologies, the index stroke was categorized as OTI. The diagnosis of BH was based on CT findings.

Patient Outcome and Medical Treatment at Discharge

Patient outcome at discharge was assessed with the modified Rankin Scale score [5], trichotomized to good (0–2), poor (3–5), or death. Patients who survived the initial hospitalization were defined as stroke survivors. Any uses of warfarin or antiplatelet agents at discharge were also noted.

Patient Follow-Up

Every effort was made to have in-person follow-up for a period of at least 3 years after the index stroke. The end point events of death or recurrent stroke, defined as a new neurological deficit fitting the definitions for ischemic or hemorrhage stroke, were assessed and recorded by experienced stroke physicians. The follow-up continued until March 31, 2000 or until the end point. Eighty-three percent (1,429 patients) were followed up completely for at least 3 years after the index stroke, or until the end point events. Postal surveys were conducted to identify recurrence or death for the remaining subjects, who moved out of the area or stopped visiting our outpatient clinic after their discharge, making it impossible to pinpoint the occurrence of their end point events within 3 years after the index stroke. In cases of death, medical records and death certificates were reviewed to determine causes of death.

Statistical Analysis

To evaluate changes in clinical characteristics during the 20-year study period, we performed subanalyses by the time trends, and by the two age groups. In the analysis by the time trends, subjects were divided into two groups: patients who were admitted in the initial decade (n = 894) and those admitted in the recent decade (n = 838). In the analyses by the two age groups, we compared patients who were 64 years or younger (younger group; mean age of 54 years, n = 821) with those who were 65 years or older (older group; mean age of 74 years, n = 911).

Statistics were performed using the SPSS package for Macintosh. The baseline clinical characteristics were assessed in a total of 1,732 patients. To determine the differences in clinical backgrounds among stroke subtypes, the χ^2 test, Student's t test, Fisher exact test, or one-way analysis of variance with a Scheffe's post hoc test were used as appropriate.

Table 1. Clinical characteristics of 1,732 patients with different subtypes of stroke

Characteristics	ABI	LI	CEI	OTI	BH	p
Cases	287 (17)	556 (32)	371 (21)	168 (10)	350 (20)	n.s.
Male	216	387	207	103	220	
Female	71	169	164	65	130	
Age (mean ± SD), years	67 ± 10	66 ± 11	64 ± 13	64 ± 16	61 ± 13	<0.05
History of TIA	60 (21)	82 (15)	33 (9)	25 (7)	4 (2)	<0.05
HT	244 (85)	417 (75)	127 (34)	98 (58)	284 (81)	<0.05
DM	103 (36)	149 (27)	67 (18)	40 (24)	56 (16)	<0.05
HLP	123 (43)	180 (32)	91 (25)	52 (31)	108 (31)	<0.05
IHD	53 (19)	51 (9)	54 (15)	29 (17)	16 (5)	<0.05
AF	19 (7)	24 (4)	287 (77)	19 (11)	12 (3)	<0.05
Hospital stay (mean ± SD), days	72 ± 45	43 ± 24	76 ± 58	63 ± 54	66 ± 51	<0.05

Figures in parentheses indicate percentages.

We analyzed long-term prognosis within 3 years after the index stroke. We excluded 167 patients (9.6%) from the analyses who provided no information about their outcome within 3 years after the index stroke in spite of postal surveys. Recurrence-free survival time for stroke survivors was calculated from the date of discharge. Recurrence-free survival rate by stroke subtypes was analyzed by the Kaplan-Meier method. Reasons for censoring included surgical operations, such as extracranial-intracranial bypass surgery and carotid endarterectomy, as well as subject dropout. The log-rank test was used to compare recurrence-free survival rates among stroke subtypes. We estimated the independent contribution of each risk factor to the risk of stroke recurrence or death within 3 years after the index stroke by Cox proportional hazard models. For all statistical analyses, a value of $p < 0.05$ was considered to indicate significant difference.

Results

Clinical Characteristics

Clinical characteristics were compared by stroke subtypes (table 1). Cardiac sources of emboli in 371 patients with CEI were as follows: nonvalvular AF in 144 patients (40%), rheumatic heart disease in 94 (25%), prosthetic valve in 38 (10%), dilated cardiomyopathy in 38 (10%), sick sinus syndrome or pacemaker implantation in 27 (7%), and others in 30 (8%). Two hundred and one patients with ABI (70%) had significant stenosis in the carotid system. Thirty-seven patients had ABI with carotid lesions (18%) associated with IHD: 31 patients had extracranial and 6 had intracranial lesions. In patients with BH, 223 patients (64%) had basal ganglionic, 26 (7%) had pontine, 13 (4%) had cerebellar, 55 (16%) had lobar, and the remaining (n = 33, 9%) had unclassified hematomas.

The distribution of stroke subtypes in the recent decade was significantly different from that in the initial decade. The frequency of patients with LI increased in the recent decade compared with that in the initial decade (35 vs. 29%), while the frequency of BH decreased in the recent decade (16 vs. 25%). The proportion of patients with ABI whose responsible vascular lesion was extracranial had increased significantly in the recent decade (63 vs. 40%). The duration of hospital stay became shorter in the second decade (median 42 days) than it was in the first decade (median 53 days). The proportion of stroke subtypes was also different in the age groups, particularly for ABI (13% in the younger vs. 19% in the older group), LI (31 vs. 34%), and BH (26 vs. 15%).

Patient Outcome at Discharge

During the hospital stay (mean 61 days), 99 patients (5.7%) died: 73 died directly from stroke (36 BH, 24 CEI, 6 ABI, 7 OTI). Sixty-two percent of patients were graded in a good outcome category at discharge. A total of 241 patients received warfarin at discharge, and 499 received antiplatelet agents.

Prognosis within 3 Years after the Index Stroke

Of the 1,565 patients with follow-up data (a follow-up rate of 90%), 198 patients had a recurrent stroke, and 286 patients died within 3 years after the index stroke. Carotid endarterectomy and extracranial-intracranial bypass surgery were performed on 9 and 11 patients, respectively.

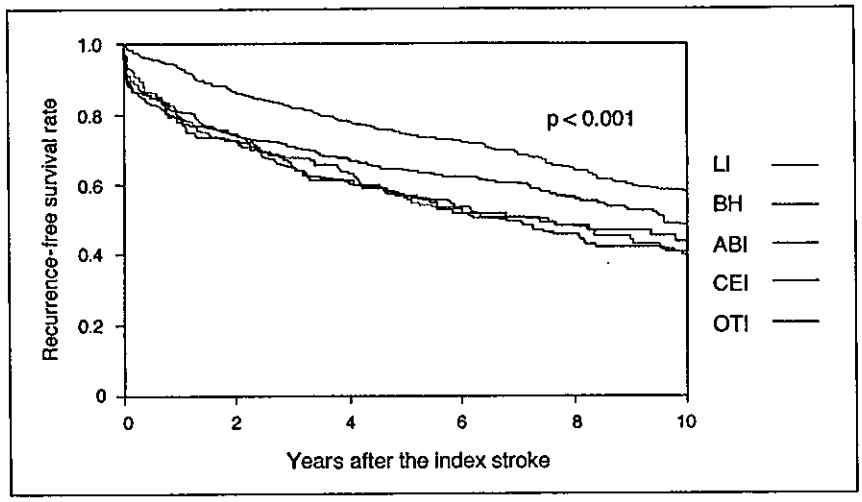

Fig. 1. Recurrence-free survival rate after the index stroke by subtypes. Kaplan-Meier analysis showed that significant differences were demonstrated in recurrence-free survival rates among stroke subtypes through the follow-up period as well as within 3 years after the stroke onset.

Table 2. Change in stroke subtype between the first and recurrent strokes within 3 years after the index stroke

Subtype of index stroke	Cases (n = 1,732)	Recurrence	Same subtype	Other subtype	
				ischemic	hemorrhagic
Ischemic stroke	1,382	172	105 (61)	56 (33)	11 (6)
ABI	287	37	24 (65)	11 (30)	2 (5)
LI	556	66	33 (50)	29 (44)	4 (6)
CEI	371	47	38 (81)	5 (11)	4 (8)
OTI	168	22	10 (45)	11 (50)	1 (5)
Hemorrhagic stroke, BH	350	26	12 (46)	14 (54)	–

$p < 0.05$. Figures in parentheses indicate percentages.

Significant differences in the recurrence-free survival rates were demonstrated among stroke subtypes (fig. 1). One hundred and one patients (6.5%) had the recurrent stroke within 1 year after the index stroke. The recurrence rate within the first year was significantly higher in CEI (9.0%) and OTI (9.1%) than in the other subtypes: 7.6% for ABI, 5.2% for LI, and 3.7% for BH. After the first year, the recurrence rate was not significantly different among the subtypes. A majority of the patients with stroke recurrences, particularly those with CEI, had a recurrent stroke of the same subtype as the index stroke (table 2). In time analyses, the recurrence-free survival within the initial year was not different during the initial and recent decades (84 vs. 86%). The recurrence-free survival within the first year was significantly lower in the older group than in the younger group (81 vs. 89%, $p < 0.05$).

Among a total of 1,466 stroke survivors, 199 patients died within 3 years after the discharge: 23 patients died of stroke, 42 of heart disease, 17 of cancer, and the remaining patients of other causes. In those survivors, a history of TIA, AF, IHD, and disability at discharge were significant predictors for recurrence or death after multivariate risk-adjusted estimation (table 3).

Discussion

This is the first hospital-based study in Japan that investigated long-term prognosis by stroke subtypes and identified the determinants of stroke recurrence or death in patients with a first-ever stroke.

Table 3. Age- and multivariate risk-adjusted relative risk (RR) of recurrence or death in 1,466 stroke survivors within 3 years after the onset

	Age-adjusted			Multivariate risk-adjusted		
	RR	95% CI	p	RR	95% CI	p
Sex (female/male)	1.04	0.84–1.30	0.71	1.13	0.90–1.41	0.31
History of TIA (no/yes)	1.33	0.98–1.80	0.063	1.38	1.02–1.88	0.031
HT (no/yes)	1.12	0.89–1.41	0.34	1.20	0.94–1.53	0.15
DM (no/yes)	1.27	1.00–1.60	0.042	1.17	0.92–1.49	0.21
HLP (no/yes)	1.07	0.85–1.35	0.55	1.05	0.83–1.34	0.68
IHD (no/yes)	1.38	1.04–1.83	0.026	1.40	1.04–1.87	0.024
AF (no/yes)	1.60	1.26–2.01	0.0001	1.52	1.19–1.95	0.001
Rankin scale (good: 0–2/poor: 3–5)	2.73	2.15–3.47	<0.0001	2.64	2.07–3.37	<0.0001

Multivariate risk-adjusted = adjusted for all other risk factors; CI = confidence intervals.

The present study involves several limitations, such as concerns for data consistency or observation bias associated with data collection over a long period of time, as well as biases related to the selection of patients in a hospital-based study. The number of admitted male patients was about twice that of females in this study in contrast to other studies [6, 7], which should be taken into account in the interpretation of the results. We re-examined risk profiles as well as diagnoses of stroke subtypes in all the patients based on the criteria described above.

Changes in the distribution of stroke subtypes in the two age groups were similar to those in the two time periods, indicating that an increase in the elderly population influenced the alteration in the distribution of stroke subtypes in the recent decade. Although the frequency of ABI in the recent decade was comparable with that in the initial decade, the responsible lesions were changed by the time trends. The higher frequency of extracranial lesions in the recent decade, which is consistent with the findings in patients with ABI in Western countries, would be due to recent changes in risk profiles in Japan. The proportion of underlying cardiac diseases in CEI has changed during the study period. The most frequent cardiac source of emboli was nonvalvular AF, and 25% of patients with CEI had rheumatic heart disease, which decreased in prevalence in recent years. Treatment strategies have also changed during these 20 years. Thrombolytic therapy has not been approved by the government in Japan. More patients were given antithrombotic agents early after the stroke onset in the recent decade compared with the initial decade. Besides, therapeutic measures against HT and HLP have been improved during these 20 years. Although the recurrence-free survival rate within the initial year was not significantly different between the initial and recent decades, it was difficult to clarify the net effects of the changes in those variables on the long-term prognosis.

We analyzed the long-term prognosis within 3 years, and calculated the recurrence rate within 1 year after the index stroke by each stroke subtype in order to avoid an observation bias. Although a selection bias of patients may exist in hospital-based stroke registries, they allow us to obtain precise clinical data in consecutive stroke patients. Potential embolic sources were intensively investigated in patients with possible CEI, and vascular evaluations were performed in every patient. Laboratory data or blood pressure readings considered normal at the time of data collection might now be at levels where treatment options would also be considered.

The distribution of stroke subtypes in the present study was quite different from that in North America and Europe [8–11], while risk profiles by stroke subtypes were not so different from those in Western countries. LI was the most common subtype in this study, which is similar to other previous observations in Asia [12, 13]. The mean hospital stay was much longer than that reported from Western countries [6, 7, 10]. The longer hospital stay in Japan was also reported by Yoneda et al. [14], which may be attributed to a social security system including universal health insurance, and to differences in medical care or health care systems. An increase in the elderly population and a decrease in the number of children in recent years in Japan are driving forces in the need to establish well-organized medical care systems with a policy of early hospital

discharge. The outcome at discharge in this study was close to those reported in studies in stroke units in Europe at 3 months [6, 7].

One third of recurrent strokes during the observation period occurred within 1 year after the index stroke. The stroke recurrence rate within 1 year after the index stroke was 5–10%, depending on the stroke subtype, which was lower than that in other reports [8, 11, 15]. In patients with BH, 26 out of 350 patients recurred within 3 years after the index stroke; this annual recurrence rate of 2.5% is comparable with that in a recent study [16].

We identified a history of TIA, IHD, AF, and disability at discharge as significant risk factors for recurrence or death. IHD and AF were reported to be significant risk factors for recurrence-free survival [17]. Several studies have demonstrated that stroke patients with AF had higher mortality after the index stroke [18, 19], probably due to more severe initial neurological impairment [19], which was also ascertained as an independent predictor for recurrence or death in the present study. Heart disease, rather than stroke, caused death in stroke survivors in our study, although we could not distinguish patients who died of IHD from those who died of other cardiac causes.

In conclusion, the recurrence rate was different among stroke subtypes within 1 year after the index stroke. IHD, presence of AF, a history of TIA, and disability at discharge were important determinants for stroke recurrence and death within 3 years after the first-ever stroke.

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Aortic Arch Atherosclerotic Lesions and the Recurrence of Ischemic Stroke

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Background and Purpose—Aortic arch atherosclerotic lesions are often associated with embolic brain infarction. We investigated the relationship between stroke recurrence and the characteristics of aortic arch atherosclerotic lesions.

Methods—Among 487 stroke patients who underwent transesophageal echocardiography, 283 patients with brain embolism diagnosed without significant occlusive lesions (≥50%) in their cerebral arteries were included in this study. We measured the intima-media thickness (IMT) and evaluated the extension and mobility of the aortic arch atherosclerotic lesions. During a mean follow-up period of 3.4 years, we investigated the relationship between stroke recurrence and the various characteristics of the aortic arch atherosclerotic lesions.

Results—An IMT ≥4.0 mm was found in 67 patients (25.3%). In 51 of these patients, the aortic lesions extended to the origin of the branches of the arch. Recurrences of cerebral ischemic events were found in 32 patients (recurrence group) and not in the other 251 (nonrecurrence group). Aortic atheroma ≥4.0 mm (41% versus 22%), aortic atheroma extending to the branches (63% versus 39%), and both (38% versus 16%) were more frequently seen in the recurrence group than in the nonrecurrence group ($P<0.05$, $P<0.1$, $P<0.01$, respectively). After adjustment for age and the presence of hypertension, an aortic atheroma that was ≥4.0 mm as well as extending to the branches was found to be an independent predictor of ischemic stroke recurrence (hazard ratio=2.42, $P<0.05$).

Conclusions—Stroke recurrence is associated with the severity of the atheroma (IMT ≥4.0 mm) and plaque extension to the branches. (***Stroke.* 2004;35:1426-1429.**)

Key Words: aorta ■ stroke ■ recurrence ■ echocardiography

Several studies using transesophageal echocardiography (TEE) reported that severe atherosclerotic lesions are frequently observed in the aortic arch in patients with brain infarction of unknown cause.[1-9] In these studies, a wall thickness ≥3 to 5 mm, the presence of ulceration, or the presence of a mobile aortic arch plaque was found to be associated with embolic brain infarction. Amarenco et al[8] found that ulcerated plaques at the aortic arch are independently associated with brain infarction of unknown cause. They also reported that the association between aortic plaques and ischemic stroke is particularly strong when the plaques are ≥4 mm in thickness.[9] Moreover, a previous study demonstrated that atherosclerotic plaques ≥4 mm thick at the aortic arch are significant predictors of recurrent brain infarction and other vascular events.[10] Jones et al demonstrated that a complex aortic atheroma ≥5 mm or an atheroma with mobile elements is an independent risk factor for ischemic stroke.[11] However, no study has yet evaluated the relationship between the extent of aortic arch atherosclerotic lesions and the occurrence of brain infarction.

Several studies reported the characteristics of aortogenic brain embolism. Otsubo et al[12] suggested that the size of brain infarction in aortogenic brain embolism was smaller than that in cardiogenic brain embolism. Mentel et al[13] reported that aortogenic brain embolism tends to occur relatively more commonly in the vertebrobasilar system. However, in addition to their aortic atheroma, many patients with embolic brain infarction also have heart disease or an occlusive disease in their cerebral arteries that can be an embolic source for their brain infarction. Therefore, it is difficult to determine the actual role of an aortic atheroma on an embolic brain infarction, especially in patients with other potential sources of emboli.

The purpose of the present study was to evaluate the relationship between the characteristics of aortic arch atherosclerotic lesions and brain infarction in a longitudinal follow-up study in patients both with and without heart disease as possible sources of emboli.

Materials and Methods

TEE studies were performed in 487 ischemic stroke patients from January 1995 to December 1998. Based on 4 vessel cerebral angiography, magnetic resonance angiography, and duplex carotid ultrasonography, 283 patients with brain embolism diagnosed and

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without significant occlusive lesions (≥50%) in the cerebral arteries were included in this study. There were 194 men and 89 women, with a mean age of 63.2±25 (mean±SD) years. Of the 283 patients, 239 had a completed ischemic stroke and 40 had transient ischemic attacks. The remaining 4 patients were admitted to our hospital because of headache, vertigo, dizziness, or head injury, and computed tomography revealed a silent territorial cortical infarction in all of them. TEE studies were performed for an embolic source. In addition to the TEE studies, electrocardiography or transthoracic echocardiography, or both, were performed to evaluate the heart for possible embolic sources, such as atrial fibrillation, sick sinus syndrome, mitral valve stenosis, prosthetic valves, cardiomyopathy, old myocardial infarction, atrial septal defect, patent foramen ovale, pulmonary arteriovenous fistula, and infectious endocarditis. At least 1 such heart disease was observed in 162 patients; the remaining 121 patients had no heart disease. The following cerebrovascular risk factors were investigated: hypertension (systolic blood pressure ≥140 mm Hg or diastolic blood pressure ≥90 mm Hg), diabetes mellitus (fasting plasma glucose ≥126 mg/dL or plasma glucose at any time ≥200 mg/dL), and hypercholesterolemia (plasma total cholesterol ≥220 mg/dL).

We used a commercially available real-time 2-dimensional echocardiography system (model SSD-2200; Aloka) equipped with a 5.0-MHz phased array biplane or omniplane transesophageal transducer. We observed the aortic arch with both transverse and sagittal views. Focal increases in intima-media thickness (IMT) ≥1.1 mm were regarded as atheromatous plaques. We evaluated the maximum IMT, extension of the aortic lesions, and presence of any mobile plaque at the arch. We observed the aortic arch from the distal to the proximal portion with a sagittal view and tried to identify the origin of the 3 branches. We carefully evaluated to which branches the atheroma reached. When all 3 branches were visible, they were labeled the left subclavian artery, left common carotid artery, and innominate artery, respectively, from the distal portion. When the atheromatous plaque of ≥1.1 mm extended to at least 1 origin of the branch, we defined it as an extending atheroma.

Patients were treated with antiplatelet therapy (114 patients), anticoagulant therapy (149 patients), or both (5 patients). In all 283 patients, we observed the recurrence of ischemic stroke and all death through the outpatient clinic until July 2000. The mean follow-up period was 3.4±1.4 (mean±SD) years and the minimum follow-up period was 1.4 years. When a patient could not go to our hospital regularly because of some circumstances such as removal, discontinuing visits to our outpatient clinic, and so on, we searched the status by phone. We investigated the relationship between the characteristics of the aortic arch atherosclerotic lesions and stroke recurrence.

We used 2-tailed t tests and χ^2 tests to compare proportions. A 2-tailed $P<0.05$ was considered to indicate statistical significance. The data were analyzed using Statview software. The incidence of stroke recurrence was expressed per 100 person-years of follow-up. We used the Kaplan–Meier method to evaluate the distribution of time to events. Kaplan–Meier curves were compared using the log-rank test to detect a trend. We also constructed a proportional hazards model, which included risk factors of cerebrovascular disease and the characteristics of the aortic atheroma. The characteristics of the aortic atheroma included: model 1, IMT ≥4 mm; model 2, extension to at least 1 branch (extending atheroma); and model 3, both of these.

Results

A wall thickness ≥4.0 mm was found in 67 (25.3%) of the 283 patients. In 51 of these 67 patients (76%), the aortic lesions were both ≥4.0 mm and extending to the origin of at least 1 branch. An aortic atheroma ≥4.0 mm was found to be statistically significantly more likely to extend to branches compared with an atheroma <4 mm ($P<0.01$). A mobile plaque was observed in 5 patients and all of them had an aortic atheroma that was both ≥4.0 mm and extending to at least 1 branch. The baseline characteristics according to the IMT are shown in Table 1. Patients with an aortic atheroma ≥4.0 mm were significantly older ($P<0.001$) and had hypertension more frequently ($P<0.0001$). There was no significant difference in follow-up period between patients with and without an aortic atheroma ≥4.0 mm.

TABLE 1. Baseline Characteristics of Patients According to the Thickness of the Aortic Atheroma

	Thickness of the Aortic Atheroma		
Characteristics	≥4 mm (n=67)	<4 mm (n=216)	P
Age (y)	65.5±9.5	61.9±11.8	<0.001
Males (%)	52 (78)	142 (66)	NS
Observation period (y)	3.17±1.58	3.50±1.41	NS
Hypertension (%)	59 (88)	128 (59)	<0.0001
Diabetes mellitus (%)	17 (25)	37 (17)	NS
Hypercholesterolemia (%)	29 (39)	52 (24)	NS
Heart disease (%)	34 (51)	128 (59)	NS
Treatment			
Antiplatelet (%)	33 (49)	81 (38)	NS
Anticoagulant (%)	30 (45)	119 (55)	NS
Follow-up period (y)	3.1±1.6	3.5±1.4	NS

NS indicates not significant.

Using TEE, we were able to identify all 3 branches of the aortic arch in 87 (31%) patients, 2 branches in 114 (40%), 1 branch in 78 (28%), and no branch was detected in 4 (1%) patients. Among the 87 patients in whom we were able to evaluate the origins of all 3 branches, heart disease as a possible embolic source was present in 48 patients. In the other 39 patients without heart disease, 14 (36%) patients had an aortic atheroma ≥4.0 mm. The initial ischemic lesions were shown to be in the vascular territories of the branch to whose origin the aortic atheroma extended in 10 (71%) of the 14 patients.

We observed 32 patients with stroke recurrence during the follow-up period. Of these 32 patients, 13 had an aortic atheroma ≥4.0 mm and 20 had an extending atheroma. In the 13 patients with an atheroma ≥4.0 mm and stroke recurrence, 12 patients had an extending atheroma and 2 of these patients also had a mobile plaque. Patients who had stroke recurrence had an aortic arch atheroma ≥4.0 mm or atheroma that was ≥4.0 mm as well as extending to at least 1 branch more frequently than those who had not ($P<0.05$, $P<0.01$, respectively). Patients with stroke recurrence were significantly older than those without stroke recurrence ($P<0.01$) (Table 2). No other significant differences in baseline characteristics were observed between these patients. Four patients died during the follow-up period, 1 because of stroke recurrence, 1 because of subarachnoid hemorrhage, and the other 2 because of heart attacks.

Of the 33 patients who had an atheroma ≥4.0 mm without any heart disease as a possible embolic source, 6 had a recurrent stroke and all of them were treated with antiplatelet therapy without anticoagulant therapy. The aortic arch atherosclerotic lesions in these 6 patients extended to at least 1 branch. In the 3 patients in whom we were able to evaluate all

TABLE 2. Comparison Between Patients With and Without Stroke Recurrence

Characteristics	Stroke Recurrence (+) (n=32)	(−) (n=251)	P
Age (y)	68.6±8.9	62.5±11.7	<0.01
Males (%)	22 (69)	172 (69)	NS
Hypertension (%)	26 (81)	161 (64)	<0.1
Diabetes mellitus (%)	7 (22)	47 (19)	NS
Hypercholesterolemia (%)	9 (28)	72 (29)	NS
Heart disease (%)	21 (66)	141 (56)	NS
Treatment			
Antiplatelet (%)	13 (41)	101 (40)	NS
Anticoagulant (%)	16 (50)	133 (53)	NS
Aortic atheroma (%)			
4≥4 mm (%)	13 (41)	54 (22)	<0.05
Extending atheroma (%)	20 (63)	98 (39)	<0.1
Both (%)	12 (38)	39 (16)	<0.01

the branches at the aortic arch by TEE, all the recurrent ischemic lesions occurred in the territory of the branch to whose origin the aortic atheroma extended. Five of the 6 recurrent ischemic lesions were observed in the same vascular territory as the initial lesion. One patient had a mobile plaque.

The incidence of stroke recurrence was 9.1% per person-year in patients with an aortic atheroma ≥4.0 mm in comparison with 2.3% per person-year in patients with an atheroma <4 mm. The incidence of stroke recurrence was 9.8% per person-year in patients with an aortic atheroma extending to at least 1 branch, compared with 2.9% per person-year in patients without an aortic atheroma extending to at least 1 branch.

Age and the presence of hypertension that showed $P<0.1$ in the univariate analysis for predicting stroke recurrence (Table 2) were included into the multivariate analysis with the characteristics of the aortic atheroma. After adjusting for age and hypertension, the multivariate analysis revealed that the presence of an aortic atheroma that was ≥4.0 mm or extending to at least 1 branch was not an independent predictor of stroke recurrence (models 1 and 2 in Table 3). However, the presence of an aortic atheroma that was both ≥4.0 mm and extending to at least 1 branch was an independent predictor of stroke recurrence (hazard ratio=2.42; 95% CI: 1.12 to 5.21; $P<0.05$) (model 3 in Table 3). Age was an independent predictor of stroke recurrence in all these multivariate analyses. Kaplan-Meier curve analysis revealed a significant difference in the recurrence-free survival between patients with an atheroma, both ≥4.0 mm and extending to at least 1 branch, and other patients ($P<0.001$ by log-rank test) (Figure). When we divided the 283 patients into 2 groups; patients with heart disease as a possible embolic source and those without heart disease as a possible embolic source, Kaplan–Meier curve analysis revealed a significant difference in the recurrence-free survival between patients with an atheroma ≥4.0 mm and patients with an atheroma <4 mm, both in patients with and without heart disease as a possible embolic source ($P<0.05$ by log-rank test in both).

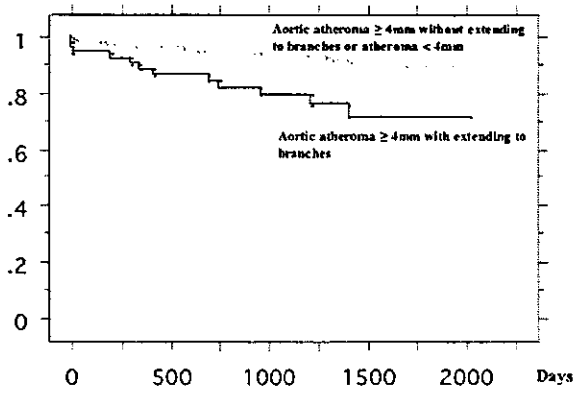
TABLE 3. Multivariate Analyses for Predicting Stroke Recurrence According to the Characteristics of Aortic Arch Atheroma

	Hazard Ratio	95% CI	P
Model 1			
Atheroma ≥4 mm	1.98	0.94–4.15	<0.1
Age	1.04	1.00–1.09	<0.05
Hypertension	1.44	0.57–3.68	NS
Model 2			
Atheroma extending to at least 1 branch	1.59	0.76–3.33	NS
Age	1.04	1.00–1.09	<0.05
Hypertension	1.53	0.60–3.85	NS
Model 3			
Aortic atheroma both ≥4 mm and extending to at least 1 branch	2.42	1.12–5.21	<0.05
Age	1.04	1.00–1.08	<0.05
Hypertension	1.37	0.53–3.52	NS.

Discussion

The present results show that an aortic atheroma ≥4.0 mm can be a significant predictor for recurrent ischemic stroke and are similar to those of The French Study of Aortic Plaques in Stroke Group. Our incidence of stroke recurrence was 9.1% per person-year in patients with an aortic atheroma ≥4.0 mm compared with 2.9% per person-year in patients with an atheroma <4.0 mm.

In univariate regression, an aortic atheroma ≥4.0 mm can be a significant predictor for recurrent ischemic stroke. We also evaluated the extension of the aortic atheroma using TEE. An association between the extension of the aortic atheroma to the branches and ischemic stroke has not previously been demonstrated. Our multiple regression analysis showed that an aortic atheroma ≥4.0 mm that also extended to at least 1 branch was a more significant predictor than an



Recurrence-free survival. Kaplan-Meier analysis of survival without stroke recurrence according to the thickness and extension of the aortic atheroma. A significant difference in recurrence-free survival was observed between patients with atheroma both ≥4.0 mm and extending to branches and those without ($P<0.001$ by log-rank test).