

measured by using a saturation recovery method with a variable repetition time (TR) SE imaging sequence (16): TR 600, 1000, 2000, 4000, 8000 ms; echo time (TE) 10 ms; bandwidth (BW) 16 kHz; field of view (FOV) 40 × 30 mm; matrix size 256 × 160; slice thickness 1 mm; slice gap 1 mm; number of slices 16; number of excitations (NEX) 1; coronal plane. An 8-cm polyvinyl chloride tube with an outer diameter of 2.7 mm was inserted into the animal's trachea, and the rats were ventilated with an average of 2–3 ml per breath of a mixture of O<sub>2</sub>, N<sub>2</sub>, and air (2:1:10) using a small animal ventilator (CWE SAR-830/AP Ventilator; CWE, Inc., Ardmore, Pa., USA) at an average of 80 breaths per minute. Body temperature was monitored rectally (36.0 ± 0.5°C).

T1 values were estimated on a pixel-by-pixel basis using the non-linear least-square fit of the signal intensity measured for each TR value. In the obtained T1 images, regions of interest (ROIs) were placed on the thalamus, hippocampus, olfactory bulb, cerebral cortex, corpus callosum, midbrain, cerebellum, pons, cerebrospinal fluid, and muscle. Mean T1 values were calculated from each ROI. A mean and a standard deviation of the mean values obtained from three rats were calculated.

#### Phantom study

**Phantom preparation.** Gd-DTPA (Magnevist; Bayer Schering Pharma, Osaka, Japan) was diluted with saline to obtain 19 solutions with different concentrations (0, 0.01, 0.03, 0.05, 0.07, 0.1, 0.15, 0.2, 0.25, 0.3, 0.5, 0.7, 1, 3, 5, 7, 10, 30, and 50 mM). Each solution was encapsulated in separate polypropylene vials with a diameter of 27 mm, which were set in agar.

**T1 measurement.** T1 values of each Gd-DTPA solution were measured at room temperature using the same pulse sequence as the T1 measurement in normal rats: TR 34, 100, 200, 400, 600, 800, 1000, 1200, 1400, 1600, 1800, 2000, 4000, 6000, 8000, 11,000, 15,000 ms; TE 9 ms; BW 16 kHz; FOV

210 × 158 mm; matrix size 256 × 192; slice thickness 3 mm; number of slices 1; NEX 1. A standard quadrature birdcage head coil was used.

Circular ROIs with 70–80% of the diameter of a vial were placed on a homogeneous signal portion of each phantom image. T1 values were estimated by non-linear least-square fit of the average signal intensity of all voxels in the ROI measured for each TR value. Five measurements were performed for phantoms, and the mean and standard deviation of measured T1 values were calculated.

**Choice of pulse sequences.** We used a Gd-DTPA saline solution (0.1 mM) with a T1 value close to that in the normal thalamus as a corresponding solution to the glioma in the thalamus region before contrast. We hypothesized that T1 in the glioma would not be so different from that in normal tissue. Saline solutions with a higher concentration of Gd-DTPA were regarded as a corresponding solution to the glioma after contrast.

T1W images of each phantom were acquired at room temperature (approximately 21°C) using four clinically available pulse sequences (SE, fast SE [FSE], IR-FSE [T1FLAIR], and fast spoiled GRE [FSPGR]) (Table 1). A standard quadrature birdcage head coil was used for the imaging of phantoms.

Circular ROIs with 70–80% of the diameter of the vial were placed on a uniform signal portion of each phantom. Mean signal intensities were calculated from each ROI. For each sequence, signal enhancements of each Gd-DTPA solution ( $E_P$ ) were calculated as  $E_P = S/S_0$ , where S is the signal intensity of each solution and  $S_0$  is that of 0.1 mM of the solution. The pulse sequences showing high  $E_P$  were used for the imaging of C6 glioma model rats and were compared based on Gd-DTPA-induced signal enhancements in brain tumors, delineated by histopathology.

#### Rat brain C6 glioma model study

**Preparation of rat brain C6 glioma models.** C6 glioma cells (CCL-107 cell line, ATCC; Summit Pharmaceuticals International Corporation, Tokyo,

Table 1. Pulse sequences and imaging parameters used for imaging of saline phantoms containing gadopentetate dimeglumine (Gd-DTPA)

| Pulse sequence | TR, ms | TE, ms | TI, ms | FA, ° | ETL | BW, kHz | NEX | Acquisition time, min:s |
|----------------|--------|--------|--------|-------|-----|---------|-----|-------------------------|
| SE             | 1400   | 14     | —      | —     | —   | 16      | 1   | 4:46                    |
| FSE            | 1400   | 16     | —      | —     | 3   | 32      | 1   | 1:52                    |
| T1FLAIR        | 3000   | 16     | 1300   | —     | 3   | 32      | 1   | 4:00                    |
| FSPGR          | 20     | 3.2    | —      | 30    | —   | 32      | 10  | 0:39                    |

For all pulse sequences, FOV was 210 × 158 mm, matrix was 256 × 192, the number of slices was 1, and the slice thickness was 3 mm. SE: spin echo; FSE: fast spin echo; T1FLAIR: inversion recovery fast spin echo; FSPGR: fast spoiled gradient echo; TR: repetition time; TE: echo time; TI: inversion time; FA: flip angle; ETL: echo train length; BW: bandwidth; NEX: number of excitations.

Japan) were implanted into the region of the thalamus in the left hemispheres of the brains of 20 rats (8 weeks old,  $292.8 \pm 14.8$  g). The implantation procedures were performed under general anesthesia using an intramuscular injection of ketamine (33 mg/kg; Sankyo Co., Ltd., Tokyo, Japan) and xylazine (7 mg/kg; Bayer AG, Leverkusen, Germany). A burr hole was made 3 mm lateral and 2 mm posterior to the bregma using a dental drill. A needle with an outer diameter of 0.3 mm was inserted 4 mm below the outer table of the skull through the burr hole. A 10- $\mu$ l solution containing  $10^7$  cells/ml was infused over 5 min at a constant rate using a microsyringe (Hamilton Co., Reno, Nev., USA) and infusion pump (Eicom Corp., Kyoto, Japan).

**MR imaging.** Two weeks after implantation, all 20 rats underwent screening by T1W imaging after Gd-DTPA administration. Developed glioma was confirmed in only five out of 20 rats. Those five rats were used for experiments for the comparison of pulse sequences. Three weeks after implantation, when the glioma was fully developed, T1W brain images of the selected five rats (11 weeks old,  $301.3 \pm 29.0$  g) were acquired before and after Gd-DTPA administration using three pulse sequences determined by the phantom study (Table 2) in the coronal plane. Rats were given general anesthesia with an intramuscular injection of a ketamine (33 mg/kg) and xylazine (7 mg/kg) mixture, and allowed to breathe spontaneously during preparation and imaging. First, precontrast T1W images were acquired. Then, a dose of 0.1 mmol/kg of Gd-DTPA was administered by hand injection followed by a 3.0-ml saline flush through a 22G indwelling needle placed in a tail or femoral vein. Postcontrast T1W imaging started 1 min after Gd-DTPA administration with identical settings to the precontrast imaging. Each rat was examined using all three pulse sequences (Table 2). In order to eliminate the effect of previously administered Gd-DTPA, three scans using different pulse sequences

were performed on three separate days, at 22- to 26-hour intervals, in a randomized order.

**ROI analysis.** Based on the results of histopathology (see below), ROIs were placed on a portion of each glioma. Areas of necrosis or hemorrhage were excluded from the ROI. Mean signal intensities in the pre- and postcontrast T1W images were calculated from each ROI. For each sequence, signal enhancement of each glioma ( $E_T$ ) was calculated as  $E_T = S_{\text{post}}/S_{\text{pre}}$ , where  $S_{\text{post}}$  is signal intensity in the glioma after contrast and  $S_{\text{pre}}$  is that before contrast.

#### Histopathology

One day after MR imaging, rat brains were removed and fixed in formalin. All brains were completely coronally sectioned. Sections were stained with hematoxylin and eosin (HE) in order to delineate areas of glioma, hemorrhage, and necrosis.

#### Statistical analysis

All parameters assessed were given as means  $\pm$  standard deviations. Pair-wise comparison among pulse sequences was performed using the Tukey-Kramer test. A *P* value of  $<0.05$  was considered statistically significant.

## Results

#### T1 in normal rat brains

Fig. 2 shows images from one of the three normal rats used to quantitate T1 values in the brain. Table 3 summarizes the T1 values of typical brain structures. The T1 value in the thalamus was  $1405 \pm 32$  ms.

#### T1 of Gd-DTPA solutions

Fig. 3 shows selected images from a series of 17 images obtained with different TR values. Table 4 summarizes T1 values in the Gd-DTPA solutions

Table 2. Pulse sequences and imaging parameters used for imaging of rat brains with C6 glioma cell implants

| Pulse sequence | TR, ms | TE, ms | FA, ° | ETL | BW, kHz | NEX | Acquisition time, min:s |
|----------------|--------|--------|-------|-----|---------|-----|-------------------------|
| SE             | 1400   | 13     | —     | —   | 16      | 1   | 4:46                    |
| FSE            | 1400   | 18.6   | —     | 3   | 32      | 3   | 4:32                    |
| FSPGR          | 20     | 4.7    | 30    | —   | 32      | 8   | 5:40                    |

For all pulse sequences, FOV was  $60 \times 45$  mm, matrix was  $256 \times 192$ , the number of slices was 11, and the slice thickness was 2.5 mm (0.5-mm gap). SE: spin echo; FSE: fast spin echo; FSPGR: fast spoiled gradient echo; TR: repetition time; TE: echo time; FA: flip angle; ETL: echo train length; BW: bandwidth; NEX: number of excitations.



Fig. 2. Images from one of three rats used for the measurement of T1 values in normal rat brain. One of 16 slices acquired is shown. The images are arranged from left to right in ascending order of repetition time. All five images are set with equal window width and equal window level.

Table 3. T1 relaxation time in normal rat brain at 3T

|                     | T1, ms     |
|---------------------|------------|
| Thalamus            | 1405 ± 32  |
| Hippocampus         | 1779 ± 151 |
| Olfactory bulb      | 1613 ± 117 |
| Cerebral cortex     | 1506 ± 13  |
| Corpus callosum     | 1389 ± 43  |
| Midbrain            | 1329 ± 50  |
| Cerebellum          | 1726 ± 356 |
| Pons                | 1343 ± 80  |
| Cerebrospinal fluid | 3460 ± 737 |
| Muscle              | 1529 ± 99  |

Mean and standard deviation of values obtained from three rats.

ranging from 0 to 10 mM. In 30 and 50 mM solutions, an accurate T1 value could not be measured because of extensive signal loss due to T2 decay. The 0.1-mM solution showed a T1 value ( $1302 \pm 54$  ms) closest to that in the normal thalamus ( $1405 \pm 32$  ms).

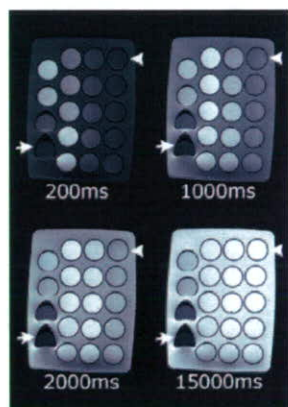


Fig. 3. Images obtained in the measurement of T1 values of 19 saline solutions with different concentrations of gadopentetate dimeglumine (0, 0.01, 0.03, 0.05, 0.07, 0.1, 0.15, 0.2, 0.25, 0.3, 0.5, 0.7, 1, 3, 5, 7, 10, 30, and 50 mM). The four selected images from a series of 17 images obtained with different TR values are shown. Each solution was encapsulated in separate polypropylene vials, which were set in agar. The concentration of gadopentetate dimeglumine decreases from bottom to top and from left to right. Arrows and arrowheads denote the 50-mM and 0-mM solutions, respectively. All four images are set with equal window width and equal window level.

Table 4. T1 of saline with different concentrations of Gd-DTPA at 3T

| Gd-DTPA concentration, mM | T1, ms     |
|---------------------------|------------|
| 0                         | 3026 ± 121 |
| 0.01                      | 2652 ± 96  |
| 0.03                      | 2245 ± 108 |
| 0.05                      | 1970 ± 92  |
| 0.07                      | 1775 ± 103 |
| 0.1                       | 1302 ± 54  |
| 0.15                      | 993 ± 57   |
| 0.2                       | 820 ± 52   |
| 0.25                      | 737 ± 51   |
| 0.3                       | 666 ± 63   |
| 0.5                       | 389 ± 17   |
| 0.7                       | 284 ± 12   |
| 1                         | 209 ± 9    |
| 3                         | 84 ± 4     |
| 5                         | 58 ± 2     |
| 7                         | 36 ± 1     |
| 10                        | 27 ± 1     |
| 30                        | —          |
| 50                        | —          |

Mean and standard deviation of values obtained from five measurements.

#### Choice of pulse sequences

Fig. 4 shows  $E_p$  in the Gd-DTPA solutions ranging from 0.1 to 50 mM. In Gd-DTPA solutions ranging from 0.15 to 30 mM, a higher  $E_p$  was obtained as follows: FSPGR > SE > FSE > T1FLAIR. Because  $E_p$  for T1FLAIR was lowest at all concentrations, T1FLAIR was not used for the imaging of rat brain tumors.

Based on our preliminary experiments, the T1 value in the glioma in the thalamus region after contrast was about 90% of that before contrast. Therefore, we regarded the 0.15-mM solution as a corresponding solution to glioma after contrast, and compared  $E_p$  values at 0.15 mM obtained using different sequences (Fig. 5).  $E_p$  at 0.15 mM was  $1.10 \pm 0.02$  for FSE,  $1.16 \pm 0.01$  for FSPGR,  $1.16 \pm 0.01$  for SE, and  $1.06 \pm 0.01$  for T1FLAIR. The Tukey-Kramer test showed significant differences ( $P < 0.05$ ) between all pairs except for FSPGR–SE.  $E_p$  for FSPGR was significantly higher than that for FSE and T1FLAIR and comparable to that for SE.

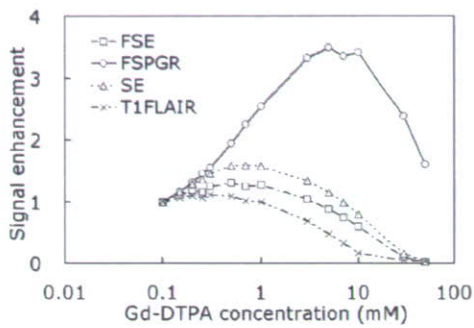


Fig. 4. Signal enhancements in saline solutions containing gadopentetate dimeglumine (Gd-DTPA) obtained by the following pulse sequences: spin echo (SE); fast spin echo (FSE); inversion recovery fast spin echo (T1FLAIR); fast spoiled gradient echo (FSPGR). Signal enhancement was the signal intensity scaled by that of a 0.1-mM Gd-DTPA solution whose T1 value was closest to the average T1 value in the brain parenchyma of normal rats.

Signal enhancement in rat brain C6 glioma

Fig. 6 displays typical pre- and postcontrast T1W images of brains of C6 glioma model rats, together with an example of ROIs placed on the glioma and HE-stained slices. Fig. 7 shows the comparison between  $E_T$  values for FSE, SE, and FSPGR.  $E_T$  values were  $1.12 \pm 0.05$  for FSE,  $1.26 \pm 0.11$  for FSPGR, and  $1.20 \pm 0.11$  for SE. The Tukey-Kramer test showed the significant superiority of FSPGR over FSE. There was no significant difference between FSPGR and SE.

Discussion

T1W imaging using SE results in a corresponding restriction in the number of slices as a result of the

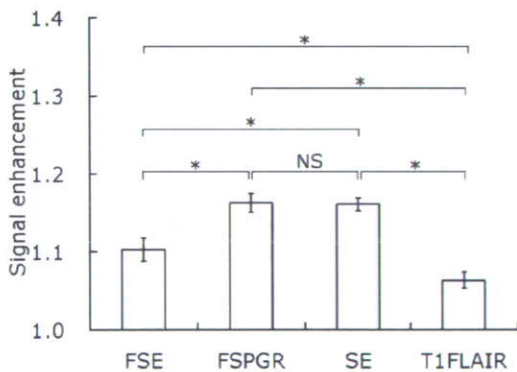


Fig. 5. Signal enhancement of saline solution with 0.15 mM Gd-DTPA obtained using different pulse sequences: spin echo (SE); fast spin echo (FSE); inversion recovery fast spin echo (T1FLAIR); fast spoiled gradient echo (FSPGR). Signal enhancement was defined as the signal intensity of a 0.15-mM solution scaled by that of a 0.1-mM solution. The Tukey-Kramer test was performed for pair-wise comparison among four pulse sequences. The asterisk and NS denote significant difference ( $P < 0.05$ ) and no significant difference ( $P > 0.05$ ), respectively.

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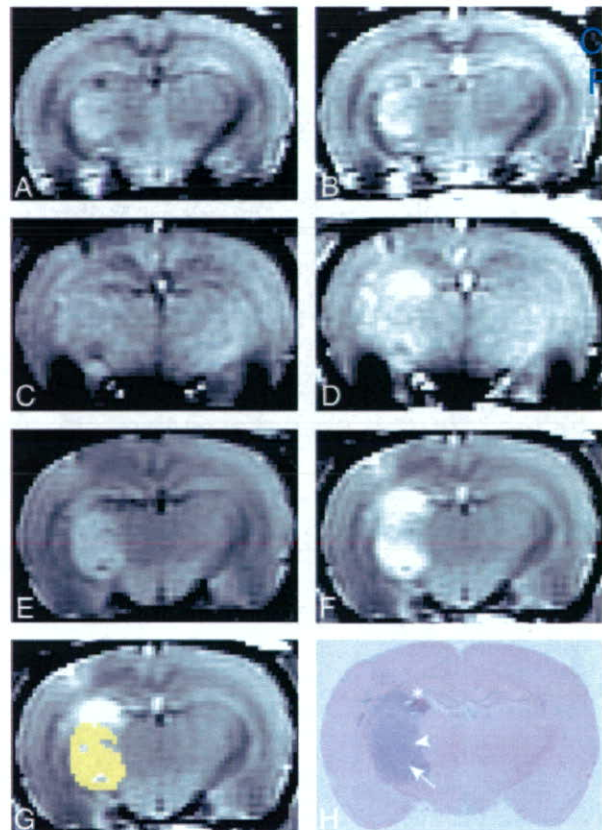


Fig. 6. Examples of pre- (A, C, E) and post-contrast (B, D, F) coronal T1-weighted images obtained using fast spin-echo (FSE) (A, B), fast spoiled gradient-echo (FSPGR) (C, D), and spin-echo (SE) (E, F) sequences. A region of interest (ROI) placed on the glioma (G) and a slice stained using hematoxylin and eosin (HE) (H). T1-weighted images were acquired 3 weeks after the implantation of C6 glioma cells. Areas of necrosis or hemorrhage, which were delineated based on histopathology, were excluded from ROIs. In the HE-stained slice, small-cell glioma (arrowhead), hemorrhage (asterisk), and necrosis (arrow) were found.

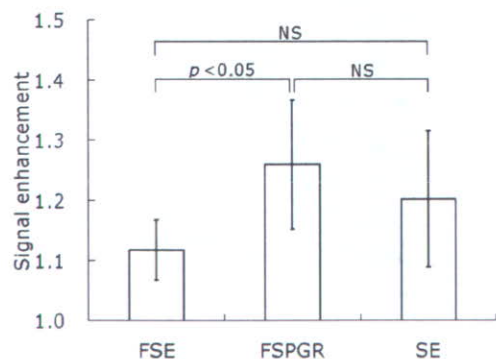


Fig. 7. Signal enhancement in rat brain C6 glioma obtained with different pulse sequences: spin echo (SE); fast spin echo (FSE); fast spoiled gradient echo (FSPGR). Signal enhancement was defined as the signal intensity after Gd-DTPA administration scaled by that before administration. The pair-wise comparison among pulse sequences was performed using the Tukey-Kramer test. NS denotes no significant difference ( $P > 0.05$ ).

specific absorption rate (SAR) at 3T. The use of FSE makes radiofrequency heating more serious. Compared to SE and FSE, FSPGR provides relatively low radiofrequency heating and, if the NEX of FSPGR can be reduced, relatively short acquisition time. This depends on the signal-to-noise ratio, and we thought it possible based on our rat brain images (Fig. 6). Therefore, we examined the characteristics of signal enhancement in FSPGR. FSPGR provided significantly higher signal enhancement than FSE and comparable signal enhancement to SE, both in the 0.15-mM Gd-DTPA solution and in rat brain C6 glioma in the thalamus region. We speculate that FSPGR may be superior to FSE and comparable to SE in its ability to delineate brain tumors, although, in order to verify this speculation, several studies would be required using different cell types and various transplantation sites. Considering the advantage of FSPGR in terms of acquisition time and SAR limit, FSPGR may be more suitable for contrast-enhanced TIW imaging of brain tumors in clinical 3T scanners than SE. Additionally, high-resolution 3D images can be obtained by using FSPGR with a reasonable acquisition time so that small lesions may be better visualized. On the other hand, FSPGR was more sensitive to magnetic susceptibility artifacts than SE (Fig. 6). SE could therefore be more suitable than FSPGR for delineation of tumors in regions with susceptibility artifacts, such as the base of the skull.

$E_T$  values obtained in our study (1.26 for FSPGR, 1.20 for SE, and 1.12 for FSE) were lower compared to previously reported values (1, 4, 5, 12). For example, RUNGE et al. reported that the  $E_T$  induced by Gd-DTPA was approximately 1.44 using SE in rat brain C6/LacZ glioma models at 3T (5). The difference between  $E_T$  in our study and that in previous reports may result from the difference in the type of tumor, in the degree of growth of brain tumors, or in TR. In our study, TR was adjusted to increase T1 contrast in the normal brain region for specification of more exact location of the glioma. Although the use of a shorter TR may increase signal enhancement in the glioma, contrast in the normal region would become unclear, and therefore it could become difficult to specify the location of the glioma exactly. Therefore, we used a longer TR than that in previous reports.

FISCHBACH et al. showed higher contrast in SE in patients, but they optimized the TR (600 ms) of SE by phantom experiments using a saline solution with a low concentration of Gd-DTPA (0.125  $\mu$ M) (12), whose T1 is extremely long compared to that in the brain. We quantified T1 in rat brains and chose a

proper TR (1400 ms) of SE to enhance normal brain contrast. Therefore, our comparison would be fairer and our results may be more closely extrapolated to human tumors.

One limitation of our work is our limited sample size. Although C6 glioma cells were implanted into 20 rats in our in-vivo study, only five rats could be used for the experiment, as C6 gliomas showed considerable individual variation in their growth and were fully developed only in five rats. Therefore, the number of test animals was relatively small, resulting in large standard deviations for  $E_T$ . A larger sample size may show a significant difference between FSPGR and SE.

In conclusion, FSPGR is superior to FSE and comparable to SE in its ability to delineate rat brain C6 glioma in the thalamus region using venous injection of Gd-DTPA.

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## Heart and Brain Circulation and CO<sub>2</sub> in Healthy Men

Ikuo Yokoyama M.D.<sup>a,e</sup>, Yusuke Inoue M.D.<sup>b</sup>, Toshibumi Kinoshita M.D.<sup>c</sup>, Hiroshi Itoh M.D.<sup>c,d</sup>, Iwao Kanno,<sup>c,d</sup> Hidehiro Iida PhD., Dsc<sup>d,e</sup>

<sup>a</sup> Department of Cardiovascular Medicine, Sanno Hospital, International University of Health and Welfare, Tokyo, Japan, <sup>b</sup> Department of Radiology, Institute of Medical Science, Graduate School of Medicine University of Tokyo, Tokyo, Japan, <sup>c</sup> Department of Radiology Akita Research Institute of Brain and Blood Vessels, Akita, Japan, <sup>d</sup> Brain Imaging Project, National Institute of Radiological Sciences, <sup>e</sup> Department of Radiology, the Research Institute of National Cardiovascular Center, Osaka, Japan.

Address for correspondence;

Ikuo Yokoyama M.D.

Correspondence to: Dr Ikuo Yokoyama, Department of Cardiovascular Medicine, Sanno Hospital, International University of Health and Welfare, 8-10-16 Akasaka, Minato-ku, Tokyo 107-0052, Japan

TEL: +81-3-3402-3151

FAX: +81-3-3404-3652

E-mail: yokochan-tky@umin.ac.jp

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**Abstract**

**Aim:** To compare blood flow response to arterial carbon dioxide tension change in the heart and brain of normal elderly men.

**Methods:** Thirteen healthy elderly male volunteers were studied. Hypercapnea was induced by carbon dioxide inhalation and hypocapnea was induced by hyperventilation. Myocardial blood flow ( $\text{mL} \cdot \text{minute}^{-1} \cdot [100 \text{ gram of perfusable tissue}]^{-1}$ ) and cerebral blood flow ( $\text{mL} \cdot \text{minute}^{-1} \cdot [100 \text{ gram of perfusable tissue}]^{-1}$ ) were measured simultaneously at rest, under carbon-dioxide gas inhalation and hyperventilation using the combination of two positron emission tomography scanners.

**Results:** Arterial carbon dioxide tension increased significantly during carbon dioxide inhalation ( $43.1 \pm 2.7 \text{ mmHg}$ ,  $p < 0.05$ ) and decreased significantly during hyperventilation ( $29.2 \pm 3.4 \text{ mmHg}$ ,  $p < 0.01$ ) from baseline ( $40.2 \pm 2.4 \text{ mmHg}$ ). Myocardial blood flow increased significantly during hypercapnea ( $88.7 \pm 22.4$ ,  $p < 0.01$ ) from baseline ( $78.2 \pm 12.6$ ), as did the cerebral blood flow (baseline:  $39.8 \pm 5.3$  vs. hypercapnea:  $48.4 \pm 10.4$ ,  $p < 0.05$ ). During hypocapnea cerebral blood flow decreased significantly ( $27.0 \pm 6.3$ ,  $p < 0.01$ ) from baseline as did the myocardial blood flow ( $55.1 \pm 14.6$ ,  $p < 0.01$ ). However normalized myocardial blood flow by cardiac workload ( $100 \text{ mL} \cdot \text{mmHg}^{-1} \cdot [\text{heart-beat}]^{-1} \cdot [\text{gram of perfusable tissue}]^{-1}$ ) was not changed from baseline ( $93.4 \pm 16.6$ ) during hypercapnea ( $90.5 \pm 14.3$ ) but decreased significantly from baseline during hypocapnea ( $64.5 \pm 18.3$ ,  $p < 0.01$ ).

**Conclusion:** In normal elderly men, hypocapnea produces similar vasoconstriction in both heart and brain. Mild hypercapnea increased cerebral blood flow but did not have an additional effect to dilate coronary arteries beyond the expected range in response to an increase in cardiac workload.

**Key Words:** Carbon dioxide, Coronary circulation, Cerebrovascular circulation, Hypercapnea, Hyperventilation, Hypocapnea, Myocardial blood flow, Positron emission tomography



## **Introduction**

Correlation between arterial carbon dioxide tension and cerebral blood flow is well established [Kety & Schmidt 1948, Shimosegawa et al. 1995, Kuwabara et al. 1997]. However, responsiveness of myocardial blood flow to hypercapnea and hypocapnea has not been fully elucidated. These relationships were investigated in animal experiments [Feinberg et al. 1960, Love et al. 1965, Case & Greenberg 1976, Bos et al. 1979, Powers et al. 1986] and human clinical studies [Rowe et al. 1962, Neill & Hattenhauer 1975, Wilson et al. 1981, Kazmaier et al. 1998] with conflicting results. The inconsistencies observed should be attributable to differences in experimental conditions, such as the techniques used for measurement, or whether the studies were performed in animals or humans, or presence versus absence of ischemic heart disease.

In this study, we evaluated the responses of myocardial blood flow and cerebral blood flow to hypercapnea and hypocapnea in healthy elderly men. We employed a dual positron emission tomography (PET) scanner consisting of two scanners to measure myocardial blood flow and cerebral blood flow simultaneously in the same subject [Iida et al. 1998]. PET allows assessment of functional parameters under physiological conditions. Using this dual PET scan technique allowed simultaneous assessment of myocardial and cerebral circulations, noninvasively and reliably and enabled comparison of the two.

## **Materials and Methods**

### **Study Subjects**

Thirteen healthy men (age range 51-71 years; mean 59.4, standard deviation [5.5]) who had been the subjects of previously published studies with different objectives [Iida et al. 1998, Ito et al. 1999, Ito et al. 2000, Ito et al. 2002] took part in the study. These men had normal laboratory parameters, no signs or symptoms of ischemia in the heart or brain, and no abnormalities were found by brain magnetic resonance imaging, electrocardiography, cardiac echocardiography, and physical examination. All subjects provided written informed consent that data obtained from the PET studies could be used for research purposes. The study protocol was approved by the Ethics Committee of the Research Institute of Brain and Blood Vessels, Akita, Japan.

### **PET Procedures**

The Headtome V dual PET system (Shimadzu Corp., Kyoto, Japan), a combination of the two Headtome V PET scanners, was used for all studies [Iida et al. 1998]. The system allowed simultaneous imaging of the brain and heart and provided 47 sections for the brain and 31 sections for the heart with center-to-center distances of 3.125 mm. The intrinsic spatial resolution was 4.0 mm in-plane and 4.3 mm full-width at half-maximum axially. All PET data were acquired in 2D mode and reconstructed with a Butterworth filter, resulting in a final in-plane resolution of approximately 8 mm full-width at half-maximum.

After an overnight fast, subjects were placed in the supine position on the scanner bed. The blood-pool images were obtained 1 minute after continuous inhalation of  $^{15}\text{O}$ -CO gas (approximately 5 GBq total applied to the mouth). One minute after the end of  $^{15}\text{O}$ -CO gas inhalation,  $^{15}\text{O}$ -CO blood-pool images of the heart were obtained with an R-wave triggered electrocardiogram gated tomographic scan. A simultaneous gated static scan on both the heart and brain was done 4 minutes after the inhalation of  $^{15}\text{O}$ -CO gas. Three venous blood samples were taken during the  $^{15}\text{O}$ -CO scan, and the radioactivity concentration in the whole blood was measured using a NaI-well counter that was cross-calibrated with the PET scanner.  $^{15}\text{O}$ -CO blood-pool images were used to draw regions of interests on left ventricular cavity and left ventricular wall accurately to obtain time activity curves. The recovery of

coefficient of left ventricular cavity was given by the myocardial static blood volume image and was also used to determine myocardial blood flow [Iida et al. 1998]. After 12-15 minutes, to allow for decay of  $^{15}\text{O}$ -radioactivity to background levels, transmission scanning was undertaken over 10 minutes. Then,  $\text{H}_2^{15}\text{O}$  PET studies were performed at rest, and under hypercapnea and hypocapnea. The order of the studies was rest, hypercapnea, and hypocapnea studies in 7 subjects, and rest, hypocapnea, and hypercapnea studies in 6 subjects. The intervals between  $\text{H}_2^{15}\text{O}$  PET studies were at least 15 minutes to allow the decay of radioactivity. Following the continuous intravenous infusion of  $\text{H}_2^{15}\text{O}$  (1.1-1.4 GBq) over 2 minutes, 180-sec static imaging of the brain and 360-sec dynamic imaging of the heart were commenced. The dynamic data of the heart consisted of twelve 5- seconds frames, eight 15-seconds frames, and six 30- seconds frames. Hypercapnea was achieved by inhalation of 7%  $\text{CO}_2$  gas, beginning 1 minute before  $^{15}\text{O}$ -water injection and continuing until the end of the imaging of the heart. Hypocapnea was induced by hyperventilation. Three arterial blood samples were taken during each PET scan to measure arterial carbon dioxide tension and pH.

#### **Data Analysis**

Cerebral blood flow images were generated from the PET data as described previously [Iida et al. 1998], and a region of interest for the inside of the brain contour was drawn on a slice of the cerebral blood flow image that was at the level of the basal ganglia. The region of interest was determined on an image obtained at rest and applied to images obtained under stress conditions. The mean cerebral blood flow in the region of interest was calculated from  $^{15}\text{O}$ - $\text{H}_2\text{O}$  autoradiography method [Raichle ME et al. 1983] and used for the following analyses. The percent change in cerebral blood flow at hypercapnea was defined as  $100 \times (\text{cerebral blood flow at hypercapnea} - \text{cerebral blood flow at rest}) / \text{cerebral blood flow at rest}$ , and cerebral blood flow responsiveness to hypercapnea was calculated as percent change in cerebral blood flow at hypercapnea divided by arterial carbon dioxide tension at hypercapnea minus arterial carbon dioxide tension at rest. The percent change in cerebral blood flow at hypocapnea and cerebral blood flow responsiveness to hypocapnea were determined using similar calculations, but using hypocapnea values instead.

The region of interests for the left ventricular cavity and the whole anterolateral wall

of the left ventricle at mid ventricular level were drawn on a slice of the short-axis myocardial images. The region of interests for the image at rest were copied on the myocardial images under the stress conditions. The myocardial blood flow value was estimated using the regions of interests according to a previously validated method [Iida et al. 1998]. In summary, myocardial blood flow was calculated using a non-linear least squares fitting technique of the left ventricular tissue and arterial  $^{15}\text{O-H}_2\text{O}$  time activity curves [Iida H et al. 1988]. The input function was non-invasively determined from the time activity curve of left ventricular cavity [Iida H et al. 1992]. Time activity curve of the left ventricular cavity and that of the myocardial wall were fitted to the previously demonstrated tracer kinetic model equations to determine myocardial blood flow [Iida et al. 1998]. The percent change in myocardial blood flow at hypercapnea was defined as  $100 \times (\text{myocardial blood flow during hypercapnea} - \text{myocardial blood flow at rest}) / \text{myocardial blood flow at rest}$ , and myocardial blood flow responsiveness to hypercapnea was calculated as percent change in myocardial blood flow during hypercapnea divided by arterial carbon dioxide tension under hypercapnea minus arterial carbon dioxide tension at rest. The percent change in myocardial blood flow during hypocapnea and myocardial blood flow responsiveness to hypocapnea were determined using similar calculations but using hypocapnea values instead. In addition, normalized myocardial blood flow was calculated for the rate pressure product by the equation:

Normalized myocardial blood flow =  $10000 \times \text{myocardial blood flow} / \text{rate pressure product}$ , and percent change in normalized myocardial blood flow and normalized myocardial blood flow responsiveness were calculated.

### **Statistical Analysis**

Values were expressed as the mean  $\pm$  standard deviation. Comparisons were made by one-way analysis of variance followed by Fisher's least significant difference tests for parametric distributions and Kruskal-Wallis test followed by Scheffe's test for nonparametric distributions. A P value  $< 0.05$  was considered statistically significant.

## Results

### **Hemodynamics**

Blood pressures, heart rate, rate pressure product, arterial carbon dioxide tension and pH are summarized in Table 1. Blood pressures were measured in the thigh because arteries and veins in both arms were cannulated. Since the blood pressure measured in the thighs were on average 25 mmHg higher than those measured in the arms in our institution, blood pressures in the thigh were considered to be within normal range. Electrocardiogram findings under hypercapnea or hypocapnea did not change compared with those at rest. Arterial carbon dioxide tension significantly decreased during hypocapnea and significantly increased during hypercapnea. Blood pressures significantly increased during hypercapnea but remained unchanged during hypocapnea. Rate pressure product did not change significantly during hypocapnea but significantly increased during hypercapnea.

### **Cerebral blood flow**

Cerebral blood flow significantly decreased during hypocapnea and significantly increased during hypercapnea (Table2). The change in cerebral blood flow caused by hypocapnea was  $-32.2$  percent  $\pm$  11.3 percent, and the cerebral blood flow responsiveness to hypocapnea was  $3.0 \pm 1.1$  percent /mmHg. The change in cerebral blood flow caused by hypercapnea was  $21.0$  percent  $\pm$  15.5 percent, and the cerebral blood flow responsiveness to hypercapnea was  $8.2 \pm 5.3$  percent /mmHg.

### **Myocardial blood flow**

Hypocapnea caused a significant reduction in myocardial blood flow from baseline (Table 2). The percent change in myocardial blood flow caused by hypocapnea was  $-29.3$  percent  $\pm$  15.1 percent, and the myocardial blood flow responsiveness to hypocapnea was  $3.5 \pm 3.0$  percent /mmHg. Normalization for rate pressure product did not alter the percent change ( $-30.4$  percent  $\pm$  16.5 percent) and responsiveness ( $-2.2 \pm 11.2$  percent /mmHg) substantially. Under hypocapnea, the percent changes in cerebral blood flow, myocardial blood flow, and normalized myocardial blood flow were not significantly different compared with baseline. There were no significant differences in the responsiveness to hypocapnea between cerebral blood flow, myocardial blood flow, and normalized myocardial blood flow.

Hypercapnea significantly increased myocardial blood flow. The percent change in myocardial blood flow caused by hypercapnea was 12.5 percent  $\pm$  15.6 percent, and the myocardial blood flow responsiveness to hypercapnea was 5.2  $\pm$  9.9 percent /mmHg. However, the increase in myocardial blood flow disappeared after normalization for rate pressure product. The change in normalized myocardial blood flow under hypercapnea was -2.2 percent  $\pm$  11.2 percent, and the normalized myocardial blood flow responsiveness to hypercapnea was -1.7  $\pm$  8.8 percent /mmHg. As for hypercapnea, the percent change in normalized myocardial blood flow was significantly smaller than the change in cerebral blood flow ( $p < 0.05$ ), and the normalized myocardial blood flow responsiveness was significantly smaller than cerebral blood flow responsiveness ( $p < 0.05$ ).

## Discussion

We simultaneously measured myocardial blood flow and cerebral blood flow at rest, during hypocapnea, and during hypercapnea in healthy elderly men. During hypocapnea, cerebral blood flow was reduced significantly as expected, and myocardial blood flow also diminished significantly to a similar magnitude. Rate pressure product did not change significantly from baseline, and myocardial blood flow normalized for rate pressure product also decreased. These results indicate that hypocapnea depresses myocardial blood flow, independently of cardiac workload, in healthy elderly men. The responsiveness to hypocapnea was similar between cerebral blood flow and myocardial blood flow, suggesting that hypocapnea can induce vasoconstriction in both heart and brain in healthy elderly men.

Several studies of coronary vascular response to hypocapnea using experimental animals have been reported however, the results were inconsistent [Feinberg 1960, Love 1965, Case 1976]. In a study of humans **with** negligible coronary artery disease, hypocapnea with 30.6 percent reduction in arterial carbon dioxide tension resulted in a significant 30.3 percent reduction in myocardial blood flow with a wide range of variability [Rowe 1962]. The present results are consistent with these previous studies. However, in studies of patients with coronary artery disease, hypocapnea resulted in a mild but significant 12 percent reduction in myocardial blood flow [Neill & Hattenhauer 1975] or did not change significantly [Wilson et al. 1981, Kazmaier et al. 1998]. Therefore, myocardial blood flow response to hypocapnea is likely to be different between normal subjects and patients with coronary artery disease. Since myocardial blood flow response to hypocapnea did not differentiate regions with myocardial ischemia from regions of non-ischemic myocardium in these studies of coronary artery disease, further study is required to clarify whether myocardial blood flow response to hypocapnea would differ between ischemic myocardium and non-ischemic myocardium.

Myocardial blood flow response to hypercapnea remains controversial. A number of experimental animal studies showed that hypercapnea did not increase myocardial blood flow [Feinberg et al. 1960, Love et al. 1965, van den Bos et al. 1979], whereas other studies showed that hypercapnea could increase myocardial blood flow [Case & Greenberg 1975, Powers et al. 1986]. In a study of anesthetized patients with coronary artery disease before

surgery, elevation of arterial carbon dioxide tension (+10 mmHg) resulted in a 15 percent increase in myocardial blood flow [Kazmaier et al. 1998]. However, the study did not estimate normalized myocardial blood flow to exclude the influence of cardiac workload on myocardial blood flow measurement [Kazmaier et al. 1998]. In this study, hypercapnea significantly increased myocardial blood flow and cerebral blood flow but not normalized myocardial blood flow with rate pressure product in healthy elderly men. Myocardial blood flow responsiveness to hypercapnea was significantly lower than that in cerebral blood flow when myocardial blood flow was normalized with respect to rate pressure product. Increase in cardiac workload under hypercapnea could explain an increase in myocardial blood flow. However, hypercapnea did not have an additional direct effect to increase myocardial blood flow independent of an elevation in cardiac workload under mild hypercapnea. Since myocardial blood flow responsiveness to hypercapnea was significantly lower than that in cerebral blood flow when myocardial blood flow was normalized with respect to cardiac workload, vascular responsiveness to hypercapnea is expected to be different between heart and brain. In this study, the magnitude of increase in arterial carbon dioxide tension during hypercapnea was small (3 mmHg), contrasting with the magnitude of decrease in arterial carbon dioxide tension during hypocapnea (11 mmHg). Such difference in the magnitude of changes in arterial carbon dioxide tension may explain why hypocapnea was effective to decrease the normalized myocardial blood flow but hypercapnea had no effect to increase the normalized myocardial blood flow. However, even under such very small increase in carbon dioxide tension, significantly elevated myocardial blood flow without normalization in response to an increase in cardiac workload was seen. Therefore, the importance of the carbon dioxide tension changes in determining the response of heart and brain perfusion could be discussed more than is presently done. To resolve such issues, much stronger hypercapneic stress test at different hypercapnic levels to increase arterial carbon dioxide tension is required to clarify whether hypercapnea directly increases myocardial blood flow independent of an increase in cardiac workload. Use of beta-blockers to exclude an influence of increase in cardiac workload for the myocardial blood flow measurement during hypercapnea [van den Bos et al. 1979, Powers et al. 1986] would also be helpful to understand myocardial blood



flow responsiveness to hypercapnea. For future studies, it is of interest to test the effect of normalization with both cardiac workload and arterial carbon dioxide tension changes on the studies of myocardial blood flow.

#### Conclusion

In normal elderly men, hypocapnea produces similar vasoconstriction in both heart and brain. Mild hypercapnea increased cerebral blood flow but did not have an additional effect to dilate coronary arteries beyond the expected range in response to an increase in cardiac workload.

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## **Conflict of interest**

No conflict of interest exists in connection with this article.

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