Latency Relationships Between Cerebral Blood Flow Velocity and Intracranial Pressure

Shadnaz Asgari, Paul M. Vespa, Marvin Bergsneider, and Xiao Hu

Abstract Pulsatile intracranial pressure (ICP) is a key to the understanding of several neurological disorders in which compliance is altered, e.g., hydrocephalus. A recently proposed model suggests that ICP pulse is a standing wave and not a transmitted wave. The present work, aimed at obtaining a better understanding of the pulsatility in the cranium, tries to test the following hypotheses: first, ICP pulse onset latency would be lower than that of cerebral blood flow velocity (CBFV) pulses measured at a distal vessel; second, CBFV pulse at different intracranial arteries will have different pulse onset latencies, and hence they are not generated as a standing wave. The dataset used in the present study consists of ICP and CBFV signals collected from 60 patients with different diagnoses. The results reveal that the ICP pulse leads CBFV for 90% of the patients regardless of the diagnosis and mean ICP value. In addition, we show that CBFV pulse onset latency is roughly determined by the distance of the measurement point to the heart. We conclude that the ICP signal is not generated as a standing wave and that ICP pulse onset may be related to the arteries proximal to the heart.

Keywords Intracranial pressure • Cerebral blood flow velocity • Pulse onset latency • Pulsatility

Introduction

For three decades, many clinical investigators have indicated that abnormalities of intracranial pulsations could play an important role in the pathophysiology of several neurological conditions (e.g., hydrocephalus) and have consequently employed the intracranial pressure (ICP) response to cardiac pulsations for characterization of compliance [5, 7, 10, 20]. In 1981, Foltz underlined the significance of intraventricular cerebral spinal fluid (CSF) pulsatility as the cause of hydrocephalus by showing that the power of intraventricular CSF pulsations is augmented by four times in chronic hydrocephalus [13, 14]. Since then, several interesting models of normal CSF pulsations have been proposed that relate CSF pulsatile flow to ICP, cerebral blood flow (CBF) or arterial blood pressure (ABP). While each model has its own specific set of assumptions, all of them suggest a major role of pulsatility in the cranium [4, 12, 14].

In 2000, Bateman reported decreased pulsatility at the cortical veins; measured for the first time in hydrocephalus patients, using magnetic resonance imaging (MRI) [3]. He suggested that reversible elevation in cortical vein pressure and reversal of the normal absorption pathway for CSF may be behind the pathophysiology of normal pressure hydrocephalus (NPH). Other studies have also employed the advanced magnetic resonance measurements of the transfer function between vascular pulsations and the pulsatile response of CSF to characterize intracranial mechanical factors [2, 8, 9, 18].

A recently proposed pulsatile CSF model postulates that the ICP pulse is a standing pulse and hence could even lead the carotid arterial pressure pulse if the mean ICP value is not high [11]. This theory has been shown to be valid to certain degree in animal data. To shed some light on the issue of timing of the ICP pulse, we test the following hypotheses in the present work, using a dataset of ICP and cerebral blood flow velocity (CBFV) signals collected from 60 patients with different neurological disorders: first, the ICP pulse onset latency would be lower than that of CBFV pulses measured at a distal vessel, regardless of mean ICP value; and second,
the CBFV pulse at different intracranial arteries will have different pulse onset latencies (proportional to the distance of the measurement point to the heart). This study may help us to re-evaluate our current understanding of the way in which the ICP pulse is generated and processed. Consequently, it may affect the management of several neuropathological conditions not limited to hydrocephalus, e.g., traumatic brain injury (TBI) and arteriosclerosis.

**Materials and Methods**

**Definition of Pulse Latency and Its Importance**

To develop clinically viable tools that are capable of continuously assessing the cerebral vasculature, a focus of our laboratory has been to explore novel methods of extracting physiological information by analyzing continuously acquired signals of intracranial origin [16, 17]. Latency of the onset of a vascular pulse relative to an extracranial timing signal (i.e., time delay between the electrocardiogram (ECG) QRS peak and the initial inflection in the resulting blood pressure pulse) is one of the parameters that could be continuously extracted from an intracranial signal.

The Moens–Korteweg equation (Pulse Wave Velocity $= \text{PWV} = \frac{Eh}{2\rho R}$), establishes a deterministic relationship between PWV (the velocity at which a blood pressure or a flow velocity pulse travels through the cerebral vasculature) and the basic properties of this vascular route, including Young’s elastic modulus $E$, wall thickness $h$, internal radius $R$, and the blood density $\rho$. As the changes in PWV would manifest with reciprocal changes in pulse waveform latency, the latency of a pulsatile intracranial signal could be considered to be a cerebrovascular index. Figure 1 shows an example of an ABP signal for one cardiac cycle and its extracted latency using the tangent intersect method [6].

**Patient Data**

The ECG, ICP, and CBFV data were collected from 60 inpatients including 20 female and 40 male, who were treated for various ICP-related conditions at UCLA Ronald Regan Medical Center; 21 cases of TBI, 21 cases of subarachnoid hemorrhage (SAH), 10 cases of hydrocephalus, 4 cases of intracerebral hemorrhage (ICH) and 4 cases of headaches. Patients’ ages ranged from 18 to 89 years with the mean and standard deviation of 48 and 20 respectively. No explicit criteria were used to select the aforementioned patients other than the availability of ECG, ICP, and CBFV signals. ICP was monitored continuously using Codman intraparenchymal microsensors (Codman and Schurteff, Raynnaud, MA, USA) placed in the right frontal lobe. Simultaneous cardiovascular monitoring was performed using the bedside GE monitors and CBFV was measured using transcranial Doppler (TCD) machines (Multi-Dop X, Compumedics DWL, Singen, Germany). ICP, CBFV, and lead II of the ECG signals were archived using either a mobile cart at the bedside that was equipped with the PowerLab SP-16 data acquisition system (ADInstruments, Colorado Springs, CO, USA) with sampling frequency of 400 Hz or the BedMaster system.
that collects data (sampling frequency of 240 Hz) from the GE Unity network to which the bedside monitors were connected. The use of these archived waveform data in an anonymous fashion has been granted a waiver of consent by the UCLA IRB.

To verify the hypothesis that CBFV pulse at different intracranial arteries will have different pulse onset latencies (and hence they are not generated as a standing wave), the CBFV signal was measured for two healthy subjects (subject 1: a 24-year-old woman and subject 2: a 29-year-old man), at the following vessels: intracarotid artery (ICA), vertebral (VERT), posterior cerebral artery (PCA), middle cerebral artery (MCA), anterior cerebral artery (ACA).

**Data Analysis**

All the signals were time synchronized and re-sampled at 400 Hz. ECG QRS detection was performed using a previously published algorithm [1] on lead II of the ECG. Then, an ECG-aided pulse detection algorithm [17] was used to delineate each pulse of ICP and CBFV. In addition, each detected ICP and CBFV pulse was saved and visualized using the custom software developed in-house to screen obvious noise or artifacts, so that only clean beats were further processed. Latencies were measured from the onset of each clean pulse relative to ECG QRS as described in the previous subsection. Then all extracted latencies were corrected based on the subjects’ heart rate using Weissler’s regression equation [15, 22, 23].

**Results**

The mean and standard deviation of the corrected ICP and CBFV latencies over all 60 patients were 120.85 ± 29.6(ms) and 160.1 ± 30.93(ms) respectively.

Figure 2 demonstrates the histogram of the corrected latency difference between CBFV and ICP (corrected CBFV latency – corrected ICP latency) over all 60 patients. The mean and standard deviation of this latency different is 40 ± 30(ms). As the histogram shows, only 6 out of 60 subjects had a negative latency difference. These subjects had a different diagnosis: two cases of TBI, two cases of ICH, one case of NPH, and one case of SAH. As a result, ICP pulse leads CBFV pulse measured at MCA for 90% of the patients in this study. A simple correlation analysis reveals that the amount of leading does not seem to be related to the mean ICP value \( (p = -0.16, p = 0.22) \).

Table 1 summarizes the results of the corrected CBFV pulse latencies measured at different intracranial arteries for

<table>
<thead>
<tr>
<th>Measured artery</th>
<th>Subject 1 (a 24-year-old woman)</th>
<th>Subject 2 (a 29-year-old man)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICA</td>
<td>Not measured</td>
<td>140.3 ± 4.4</td>
</tr>
<tr>
<td>VERT</td>
<td>155.7 ± 4.6</td>
<td>152.2 ± 4.1</td>
</tr>
<tr>
<td>PCA</td>
<td>172.8 ± 6.6</td>
<td>Not measured</td>
</tr>
<tr>
<td>MCA</td>
<td>175.9 ± 5.6</td>
<td>169.2 ± 8.3</td>
</tr>
<tr>
<td>ACA</td>
<td>194.7 ± 9.4</td>
<td>167.4 ± 8.5</td>
</tr>
</tbody>
</table>
the two healthy subjects. We observe that the latency results for each of the two subjects are consistent with the distances of the measurement points to the heart

\[(\text{Latency}_{\text{ICA}} \leq \text{Latency}_{\text{VERT}} \leq \text{Latency}_{\text{PCA}} \leq \text{Latency}_{\text{MCA}} \leq \text{Latency}_{\text{ACA}})\]

In other words, as the measurement point of CBFV at the ICA is closer to the heart than that of VERT, one would expect to have a shorter CBFV latency measured at ICA than at VERT. We also observe that the corrected CBFV latency measured at MCA for the two normal subjects is at least 12 ms longer than those of the patients (average of 160 ms). This observation is consistent with the fact that patients may have stiffer vessels and consequently a higher pulse wave velocity, which itself results in a shorter pulse latency.

As the mean of the corrected ICP latency for the patients was 120 ms; considering the latency difference between healthy subjects and the patients, we can conclude that the latency of ICP is close to the latency of the CBFV measured at the ICA; a point relatively closer to the heart than the MCA.

Discussion

While several clinical investigations have focused on studying the intracranial pulsations in hydrocephalus and the effect on treatment, there have only been a few studies that explain the underlying physiological causes [21]. In a recent study, Egnor et al. proposed that the ICP pulse is a standing wave and hence could even lead the carotid arterial pulse [11]. In addition, a negative correlation between mean ICP and the latency difference between the ICP and the carotid arterial pulse has been found in dogs when the mean ICP is not high.

Our results show that the ICP pulse leads CBFV measured at the MCA for 90% of the patients in the study and there is no significant correlation between the amount of leading and the value of mean ICP. Also, the results of a multi-vessel TCD study on two normal subjects revealed that CBFV pulse at different intracranial arteries have different pulse onset latencies that are proportional to the distance of the measurement point to the heart; hence, these pulsatile signals cannot be generated as standing waves.

The observation that the ICP pulse precedes the CBFV is counterintuitive, because, first, the location of the ICP measurement is further away from heart than that of the CBFV; and second, a flow pulse usually leads the pressure pulse [19]. We propose that the following factors could contribute to the observed leading phase of the ICP versus CBFV:

1. As the ICP pulse is the summation of all cerebral blood volume and CSF pulsations in the cranium, ICP pulse onset may be related to the arteries proximal to the heart.
2. The current definition of the onset of a pulse is not compatible for different pulses and needs to be modified accordingly.
3. Different analog filter settings on the amplifier of ICP and CBFV recording systems can affect the estimated latency of the pulses.

Conclusion

The latency relationship between the ICP and CBFV signals was described in studies in 60 patients with different neurological disorders. It was found that ICP pulse leads CBFV, but no significant correlation between mean ICP and the latency difference was observed. The leading phase of the ICP relative to the CBFV measured at the MCA could be explained by the fact that the ICP pulse is the summation of all cerebral blood volume and CSF pulsations in the cranium. As a result, ICP pulse onset may be related to the arteries proximal to the base of the skull rather than the MCA. An additional intracranial multi-vessel study on two normal subjects confirmed that the CBFV latency is roughly determined by the distance of the corresponding measurement site to the heart and thus intracranial pulsatile signal cannot be generated as a standing wave. Gaining a deeper insight into the mechanisms underlying the link between pulsations and hydrocephalus and other pathophysiological conditions involving the cerebral blood flow could be helpful in the design of therapies based on the regulations of intracranial dynamics.

Conflict of interest statement We declare that we have no conflict of interest.

References

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