Cerebral Oxygen Metabolic Stress, Microstructural Injury, and Infarction in Adults With Sickle Cell Disease

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ABSTRACT

Objective

To determine the patient- and tissue-based relationships between cerebral hemodynamic and oxygen metabolic stress, microstructural injury, and infarct location in adults with sickle cell disease (SCD).

Methods

Control and SCD participants underwent brain MRI to quantify cerebral blood flow (CBF), oxygen extraction fraction (OEF), mean diffusivity (MD), and fractional anisotropy (FA) within normal-appearing white matter (NAWM), and infarcts on FLAIR. Multivariable linear regression examined the patient- and voxel-based associations between hemodynamic and metabolic stress (defined as elevated CBF and OEF, respectively), white matter microstructure, and infarct location.

Results

Of 83 control and SCD participants, adults with SCD demonstrated increased CBF (50.9 vs 38.8 mL/min/100g, \( p<0.001 \)), increased OEF (0.35 vs 0.25, \( p<0.001 \)), increased MD (0.76 vs 0.72 x \( 10^{-3} \) mm² s⁻¹, \( p=0.005 \)), and decreased FA (0.40 vs 0.42, \( p=0.021 \)) within NAWM compared to controls. In multivariable analysis, increased OEF (β=0.19, \( p=0.035 \)), but not CBF (β=0.00, \( p=0.340 \)), independently predicted increased MD in the SCD cohort, while neither were predictors in controls. On voxel-wise regression, the SCD cohort demonstrated widespread OEF elevation, encompassing deep white matter regions of elevated MD and reduced FA, which spatially extended beyond high density infarct locations from the SCD cohort.

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Conclusion

Elevated OEF, a putative index of cerebral oxygen metabolic stress, may provide a metric of ischemic vulnerability which could enable individualization of therapeutic strategies in SCD. The patient- and tissue-based relationships between elevated OEF, elevated MD, and cerebral infarcts suggest that oxygen metabolic stress may underlie microstructural injury prior to the development of cerebral infarcts in SCD.
INTRODUCTION

Sickle cell disease (SCD) is a group of inherited hemoglobinopathies that affects one in 1000 individuals worldwide.\textsuperscript{1} The abnormal erythrocytes have decreased oxygen carrying capacity and increased rigidity, leading to microvascular obstruction and multi-organ ischemia. In the brain, pathological consequences of these mechanisms include ischemic strokes and cognitive impairment. While the incidence of overt strokes has decreased in the era of transcranial Doppler screening and prophylactic transfusion therapy,\textsuperscript{2} the prevalence of “silent” cerebral infarcts continues unabated. On brain MRI, over 50\% of adults with SCD demonstrate silent infarcts by age 32.\textsuperscript{3} Regardless of clinical presentation, cerebral infarcts are associated with cognitive deficits in children and young adults with SCD.\textsuperscript{4,5}

Cerebral infarcts in SCD may result, in part, from oxygen supply-demand mismatch. We and others have shown that global cerebral blood flow (CBF) and the fraction of oxygen that diffuses from blood to tissue (OEF) are increased in patients with SCD.\textsuperscript{6–8} Such elevation in CBF and OEF compensate for decreased arterial oxygen content in SCD and to meet cerebral oxygen metabolic demand. However, the brain’s compensatory capacity is heterogeneous and demonstrates regional vulnerability to ischemic-hypoxic insult.\textsuperscript{9} Cerebral infarcts most commonly occur in the physiologic watershed territory, characterized by low white matter CBF compared to the rest of the brain.\textsuperscript{6,7} We have previously shown that elevated watershed OEF is associated with increased infarct density from an independent SCD cohort,\textsuperscript{7} suggesting that regional CBF and OEF may represent “hemodynamic and oxygen metabolic stress”, respectively, and may hold promise as markers of increased stroke risk.

With a goal of identifying cerebral ischemic injury at its earliest stages, diffusion tensor imaging (DTI) has allowed the assessment of white matter microstructural integrity in SCD.\textsuperscript{10–12} Microstructural impairment in patients with SCD has been associated with slower processing
speed, independent of infarcts.\textsuperscript{13,14} Likewise, several studies in non-SCD sporadic cerebral small vessel disease have shown that changes in microstructure may predict progression of white matter hyperintensities and cognitive decline.\textsuperscript{15,16}

While quantifying degree of microstructural impairment has been of interest in SCD, both the pathomechanisms underlying its disruption and its spatio-temporal relationship to developing infarcts, are not well understood. In this study, we examined the impact of hemodynamic and oxygen metabolic stress on white matter microstructure within normal-appearing white matter (NAWM), unaffected by infarcts, in adults with SCD compared to healthy controls. We hypothesized that: (1) elevated CBF and OEF would be independently associated with impairment in NAWM microstructure, and (2) regions of greatest microstructural impairment would be located in and nearby regions of peak infarct density, suggesting microstructural impairment may be a precursor to cerebral infarcts in SCD.

\textbf{METHODS}

\textbf{Standard protocol approvals, registrations, and patient consents}

The Institutional Review Board at Washington University in St. Louis approved this study, and written informed consent was obtained from all participants.

\textbf{Participants}

Adult participants with SCD and healthy controls were prospectively enrolled in a longitudinal MRI study. A subset of participants returned for follow-up MRI at three years after the baseline MRI scan. Participants with SCD included hemoglobin SS (HbSS), HbSbeta-thalasemia\textsuperscript{\textregistered}, and hemoglobin SC (HbSC). Control participants included siblings, partners, or friends of participants with SCD to minimize imbalances in socioeconomic status and parental education level, which have been shown to impact cognitive function in SCD.\textsuperscript{17} In an effort to include
sibling controls, the control cohort included both participants with (HbAS) and participants without (HbAA) sickle cell trait. Exclusion criteria were: history of stem cell transplantation, cerebral vasculopathy, cerebral infarct volume > 5mL, or intracerebral hemorrhage. Controls were additionally excluded for any history of neurologic disease or chronic medical condition (i.e. hypertension) which is associated with stroke. A board-certified neuroradiologist (M.R.), blinded to cohort, diagnosis, and baseline characteristics, reviewed all MRIs and magnetic resonance angiograms (MRAs) for evaluation of cerebral infarcts or vasculopathy. Participants with infarcts were classified as: (1) overt strokes, defined as a clinical history of non-hemorrhagic stroke associated with clinical symptoms, or (2) silent cerebral infarcts (SCIs), defined as non-overt strokes with cerebral lesions ≥3 mm in diameter on axial plane of fluid-attenuated inversion recovery (FLAIR) images.18

Labs including venous hemoglobin, capillary gel electrophoresis to quantify percentage of Hb isoforms, and venous co-oximetry, and vital signs including oxygen saturation by pulse oximetry (SpO2) were obtained just before each MRI. Dyshemoglobins were missing in two controls and five SCD participants. Arterial oxygen content (CaO2) was calculated as: 1.36 x hemoglobin (g/dL) x SpO2. Hemoglobin used in CaO2 calculation was adjusted according to the following formula: Hb = [total measured Hb] – [total Hb x % carboxyhemoglobin] – [total Hb x % methemoglobin]. Dyshemoglobins (carboxyhemoglobin and methemoglobin), which are elevated in SCD, do not participate in oxygen exchange and were subtracted from total hemoglobin.19

MRI protocol and imaging analysis

All participants underwent brain MRI on a 3 Tesla Siemens MR system (Erlangen, Germany), including three scanner types: Magnetom Trio, Magnetom Prisma, and Biograph mMR. The MRI protocol included T1 3D Magnetization Prepared Rapid Gradient Echo (MPRAGE)
(TE/TR=2.95/1800ms, TI=1000ms, flip angle=8°, resolution=1.0x1.0x1.0mm), FLAIR
(TE/TR=93/9000ms, TI=2500ms, resolution=1.0x0.9x3.0mm), DTI (TE/TR=89/10100ms,
resolution=2.0x2.0x2.0mm, 25 directions, b=0-1400 s/mm²), pseudocontinuous arterial spin
labeling (pCASL) (TE/TR=12/3780ms, resolution=3.0x3.0x5.0mm, labeling duration=2000ms,
post-labeling delay=1500ms, background suppression not performed), and a double-echo
asymmetric spin echo (ASE) sequence (TE/TR=64.0/4400ms, FOV 220mm,
resolution=1.7x1.7x3.0mm, acquisition time=7:16).

For each participant, a “white matter mask”, “gray matter mask”, and “infarct mask” were
generated to respectively represent the total white matter region, gray matter region, and
infarcted region of that participant. To generate a “normal appearing white matter (NAWM)
mask”, all voxels within the infarct mask were excluded from white matter mask. First, cerebral
infarcts were identified by a board-certified neuro-radiologist (M.R.) and delineated on FLAIR
images by a board-certified vascular neurologist (A.L.F.) using the Medical Image Processing
Analysis and Visualization (MIPAV, https://mipav.cit.nih.gov/) application to create one “infarct
mask” per participant. MIPAV includes a semi-automated approach to delineating infarct
lesions, allowing the user to hover over an infarct lesion with the cursor, and the bright region is
automatically outlined based on contrasting signal intensity. Both the identification and
delineation of infarct masks were performed in a blinded fashion without knowledge of the
participant’s cohort. Second, to generate white and gray matter masks, MPRAGE images were
skull-stripped and segmented using statistical parametric mapping software (SPM12, Wellcome
Institute of Neurology, London, UK). To limit partial volume effects, voxels with a probability
<0.9 of being classified correctly as white or gray matter were excluded and a one-voxel
morphological erosion of gray and white matter was applied to segmented images. The
generation of NAWM mask allowed for regional measurements of CBF, OEF, and DTI metrics
within NAWM unaffected by infarcts.
CBF was measured with pCASL. Blood T1, required for CBF quantification, varies with hematocrit, and thus was measured individually to improve CBF reproducibility. Blood T1 was measured using an inversion-recovery echo planar imaging sequence, with an adiabatic nonselective inversion pulse, in the superior sagittal sinus and estimated using a four-parameter model. Blood T1 was not acquired in six scans and was imputed based on a larger dataset of SCD patients and controls in which we performed a multivariable analysis examining clinical predictors (such as age, sex, and hematocrit) on blood T1. This model demonstrated hematocrit as the main predictor of T1, which has been found in other studies. ASE measured tissue deoxyhemoglobin, permitting OEF quantification as described previously. Censorship of voxels exhibiting abnormal $\chi^2$ residuals, as a metric of high error when calculating OEF, was required to prevent spurious results. An a priori nonparametric unidirectional exclusion of all data producing residuals above the 65th percentile of the white matter, as a result of the Gibbs artifact affecting primarily gray matter, was applied. Representative CBF and OEF maps were showed in figure e-1 from Dryad: https://doi.org/10.5061/dryad.79cnp5hv5. Individual mean CBF and OEF within whole brain, gray matter, and NAWM were calculated.

DTI images were processed using the FMRIB Software Library (www.fmrib.ox.ac.uk/fsl, v6.0). Briefly, for each scan, diffusion images were corrected for eddy current distortion and head motion using the b=0 reference image. A binary brain mask in DTI space was then calculated using FSL’s Brain Extraction Tool on the same b=0 image. DTIfit was then applied to fit the diffusion tensor model, generating the three principle eigenvalues $\lambda_1$, $\lambda_2$, $\lambda_3$ at each voxel. Finally, measures of white matter microstructure, average fractional anisotropy (FA) and mean diffusivity (MD) in NAWM were calculated.

To create an infarct “heatmap” demonstrating the location and density of infarcts, all infarct masks from the SCD cohort were aligned to the Montreal Neurological Institute (MNI) 152...
standard space. Infarct density was defined as the number of participants with infarct in the voxel divided by total number of participants. Three participants were excluded due to poor registration of the lesion mask to the atlas, thus 31 participants with SCD were included in the infarct heatmap.

**Statistical analysis**

*Patient-based Analysis.* Data are presented as median (interquartile range). Clinical characteristics, laboratory parameters, and baseline imaging parameters were compared between healthy controls and SCD participants using Mann-Whitney *U* or Fisher’s exact test for continuous and categorical variables, respectively. Given the significant age and sex imbalance between the two cohorts, baseline imaging parameters were compared between the two cohorts before and after adjusting for age and sex using multivariable linear regression analysis. To account for multiple testing, significance was adjusted to maintain a family-wise error rate < 5% using the Benjamini-Hochberg procedure.

To measure the univariate relationships between oxygen metabolic and hemodynamic stress and microstructural impairment, bivariate correlations between OEF/CBF and MD/FA in NAWM were performed with Pearson correlation coefficients. To evaluate OEF and CBF as independent predictors of impaired NAWM microstructure, all imaging time-points (a subset of participants had two scans) were included in a mixed-model multivariable linear regression with random participant intercept. Additionally, for the mixed-model, NAWM OEF/CBF, age, and scanner type were entered as predictor variables, while NAWM MD and NAWM FA were the outcome variables. Scanner type was included as a predictor variable given inter-scanner variation in DTI metrics has been observed.\(^{31,32}\) Effect plots demonstrate the relationships between NAWM OEF/CBF and DTI metrics, while controlling for age, participant effect with multiple MRI scans,
and scanner type. Significance was set at $p < 0.05$. Patient-based analyses were performed with SAS (v9.4, SAS Institute Inc, Cary, NC).

**Voxel-wise analysis.** Each subject’s baseline OEF, MD, and FA images were aligned to individual MPRAGE images using FMRIB’s Linear mage Registration Tool (FLIRT) and transformed into MNI-152 space using non-linear registration methods. CBF was not included as it was not an independent predictor of NAWM microstructure in the patient-based analysis. For each MR modality, a 4D image was created by merging individual images. The 4D image was then fed into FSL Randomise to perform voxel-wise statistics.

Voxel-wise differences between SCD and controls in FA, MD, and OEF were tested over the white matter using permutation-based FSL Randomise \[^{33,34}\] with Threshold-Free Cluster Enhancement \[^{35}\] and 10,000 random permutations to adjust for multiple statistical comparisons. This method produced non-parametric permutation, two-sample, unpaired t-tests of MR metrics in participants with SCD compared to controls, adjusted for age and scanner type. Results were considered significant for $p < 0.05$.

**Data availability**

Data are available on request to the corresponding author.

**RESULTS**

**Patient characteristics**

Eighty-three participants (34 adults with SCD and 49 healthy controls) underwent brain MRI. Each participant had one MRI scan except for 4 controls and 16 SCD participants who had two MRI scans. All SCD participants had HbSS genotype except two with HbSC. The control cohort consisted of 26 participants with HbAA and 23 with HbAS. Participant characteristics are
included in Table 1. Due to imbalance in age between controls and SCD cohorts, all analyses were performed before and after adjusting for age. No significant univariate associations were found between age and DTI parameters examined in the study (figure e-2 from Dryad: https://doi.org/10.5061/dryad.79cnp5hv5). As sickle cell trait was permitted in the control cohort, we compared the imaging parameters (OEF, CBF, MD, and FA) between HbAA and HbAS. We found no differences or statistical trends between the control participants with and without sickle cell trait (data not shown).

**Cerebral OEF and CBF within NAWM were increased in adults with SCD**

To determine if cerebral oxygen metabolic and hemodynamic stress were elevated within NAWM, we compared baseline OEF and CBF in NAWM between adults with and without SCD. Cerebral OEF and CBF in NAWM were elevated in the SCD cohort compared to controls (Table 2). This elevation in OEF persisted in the SCD cohort after adjusting for age and sex (SCD cohort: $\beta$ [95% CI] = 0.13 [0.11, 0.15], $p \leq 0.001$; age: $\beta$ [95% CI] = -0.0003 [-0.002, 0.001], $p=0.70$; male: $\beta$ [95% CI] = -0.05 [-0.07, -0.03], $p \leq 0.001$). Likewise, CBF remained elevated in the SCD cohort after adjusting for age and sex on multivariable linear regression analysis (SCD cohort: $\beta$ [95% CI] = 19.41 [12.61, 26.21], $p \leq 0.001$; age: $\beta$ [95% CI] = 0.29 [-0.14, 0.71], $p=0.18$; male: $\beta$ [95% CI] = 0.16 [-6.08, 6.39], $p=0.96$). Similar patterns of OEF and CBF elevation in the SCD cohort were identified in whole-brain and gray matter regions (Table 2).

**Adults with SCD demonstrated impairment in NAWM microstructure**

To examine the microstructural integrity of NAWM in SCD, baseline DTI metrics (MD, FA) were compared between the two cohorts before and after adjusting for age and sex. Compared with controls, NAWM MD was higher (0.76 [0.74, 0.78] vs 0.72 10 [0.70, 0.77] $\text{mm}^2\text{s}^{-1}$, $p = 0.005$) and NAWM FA was lower (0.40 [0.40, 0.42] vs 0.42 [0.40-0.43], $p = 0.021$) in participants with SCD (Table 2), suggesting impaired white matter microstructure despite the
younger age of the SCD cohort. The microstructural integrity of NAWM remained altered in the SCD cohort after adjusting for age and sex on multivariable analysis: MD remained elevated (SCD cohort: $\beta$ [95% CI] = 0.029 [0.010, 0.048], $p = 0.003$; age: $\beta$ [95% CI] = 0.00009 [-0.001, 0.001], $p = 0.87$; male: $\beta$ [95% CI] = -0.008 [-0.025, 0.008], $p = 0.33$); and FA remained decreased (SCD cohort: $\beta$ [95% CI] = -0.016 [-0.027, -0.005], $p = 0.005$; age: $\beta$ [95% CI] = -0.0004 [-0.001, 0.0002], $p = 0.23$; male: $\beta$ [95% CI] = 0.007 [-0.003, 0.017], $p = 0.15$).

Cerebral oxygen metabolic stress was associated with microstructural impairment in adults with SCD, but not in healthy controls

To examine whether cerebral oxygen metabolic or hemodynamic stress were associated with disruption in NAWM microstructure, we performed univariate and multivariable linear regression evaluating NAWM OEF and CBF as independent predictors of NAWM MD and FA. In the total cohort, on univariate analysis, NAWM OEF was significantly correlated with NAWM MD ($r=0.306$, $p=0.002$) and FA ($r=-0.267$, $p=0.007$). On multivariable analysis, after adjusting for age and scanner type, OEF remained an independent predictor of NAWM MD and FA (Table 3). On univariate analysis, NAWM CBF was non-significantly correlated with NAWM MD ($r=0.186$, $p=0.072$) and not correlated with FA ($r=-0.148$, $p=0.152$). On multivariable analysis, CBF was not a predictor of MD and FA (Table 3).

To determine if the association between cerebral oxygen metabolic stress and NAWM microstructure was cohort dependent, we performed the same regression within SCD and control cohorts separately. On univariate analysis, NAWM OEF was significantly correlated with MD ($r=0.35$, $p=0.014$) and FA ($r=-0.318$, $p=0.026$) in the SCD cohort, but not in controls (MD: $r=-0.116$, $p=0.407$; FA: $r=0.112$, $p=0.425$). On multivariable analysis, after adjusting for age and scanner type, OEF remained associated with MD ($\beta$ [95% CI] = 0.19 [0.02, 0.36], $p=0.035$) and was non-significantly associated with FA ($\beta$ [95% CI] = -0.11 [-0.23, 0.01], $p=0.065$) in the SCD
cohort (Figure 1A-B, Table 3). On univariate analysis, NAWM CBF was associated with MD ($r=0.34$, $p=0.026$) and non-significantly associated with FA ($r=-0.262$, $p=0.089$) in the SCD cohort, but not in controls (MD: $r=-0.197$, $p=0.161$; FA: $r=0.201$, $p=0.153$). On multivariable analysis, after adjusting for age and scanner type, CBF was not a predictor of MD and FA in either cohort (Figure 1C-D, Table 3).

**Spatial locations of elevated cerebral oxygen metabolic stress and altered white matter integrity in adults with SCD**

To locate the white matter regions with highest oxygen metabolic stress and greatest microstructural disruption in adults with SCD compared to controls, we performed voxel-wise multivariable regression, using threshold-free cluster enhancement to identify significant voxels, after adjusting for age and scanner type. Participants with SCD demonstrated significantly higher OEF relative to controls throughout the majority of white matter, with loss of significance in the juxta-cortical regions and voxels adjacent to the lateral ventricles (Figure 2A). Compared to controls, participants with SCD had higher MD (Figure 2B) and lower FA (Figure 2C) in the deep white matter.

**Regions of oxygen metabolic stress include and surround deep white matter regions of impaired microstructure, which in turn, extend beyond regions of peak infarct density**

The infarct density map from the SCD cohort demonstrated infarcts in a small, deep, white matter region of the frontal and parietal lobes with maximal infarct density of 20% (Figure 3A). First, we investigated the spatial relationship of disrupted white matter microstructure and cerebral oxygen metabolic stress by overlaying the map of voxels with significantly elevated MD onto the map of voxels with significantly elevated OEF (Figure 3B). Regions of OEF elevation colocalized with and extended beyond regions of impaired white matter microstructure. Next, we examined the spatial relationship between infarct location and white matter microstructure by
overlying the infarct density map onto the map of voxels with elevated MD. Regions of significant MD elevation in the deep white matter surrounded and extended beyond cerebral infarcts. Together, these findings suggest that oxygen metabolic stress may underlie disruption in white matter microstructure, the latter which appears at the leading edge of developing cerebral infarcts.

**DISCUSSION**

In adults with SCD, we found that cerebral oxygen metabolic stress, defined as elevated OEF, was associated with microstructural impairment in radiographically normal white matter. Hemodynamic stress, defined as elevated CBF, was associated with NAWM microstructural disruption on univariate analysis only. Importantly, associations between OEF, CBF, and impaired white matter microstructure were absent in healthy controls where blood flow and oxygen metabolism are normal. In the voxel-wise analysis comparing the SCD cohort to the control cohort, a region of elevated MD was located in the deep supraventricular white matter, and was surrounded by a larger region of elevated white matter OEF that extended towards the cortex. The region of peak infarct density within the SCD cohort was centered within the region of elevated MD, suggesting that white matter microstructural impairment is located at the leading edge of cerebral infarct development in SCD. We are currently performing longitudinal studies to determine if impairment in white matter microstructure temporally progresses from NAWM to cerebral infarct.

Microstructural disruption and radiographic infarcts may be viewed as part of a continuum, determined by the magnitude and duration of ischemia. Mild and intermittent reduction in cerebral oxygen supply may result in interstitial fluid shifts and demyelination, causing reversible microstructural injury, while prolonged, severe decrease may result in irreversible cell death.36 While the spatial-temporal progression from white matter microstructural disruption to
cerebral infarct has been demonstrated in non-SCD sporadic cerebral small vessel disease,\textsuperscript{16,37,38} such evolution has not been studied in SCD. In the absence of longitudinal data, we examined the spatial relationship between microstructural integrity and infarct location in the early stages of SCD using a young adult cohort with low infarct burden. Consistent with previously published research,\textsuperscript{10–12} we found evidence for microstructural injury, defined by elevation in MD and reduction in FA, in the deep white matter tracts. Expanding on prior investigations, we found that a penumbra of microstructural disruption surrounds and extends beyond the borders of peak cerebral infarct density. Similarly, studies in non-SCD sporadic small vessel disease have shown that white matter hyperintensities are surrounded by a “penumbra” of reduced cerebral perfusion and compromised white matter microstructural integrity that normalized with increasing distance from the white matter hyperintensity “core”.\textsuperscript{39,40} Identifying tissue with microstructural injury but without infarction, presents an opportunity for intervention to prevent future infarct and progression in cognitive impairment.

The association between elevated OEF and DTI abnormalities within NAWM suggests that oxygen metabolic stress may play a role in white matter microstructural impairment prior to frank infarction. Consistent with our prior research in the pediatric population and expanding upon the findings by Jordan \textit{et al.}, which showed global elevation of OEF in an adult SCD population, we found elevated tissue-type specific cerebral OEF and CBF in adults with SCD relative to controls.\textsuperscript{6,8,41} While we are currently evaluating global and regional OEF as predictors of infarct progression in SCD, we postulate that OEF may risk stratify microstructural impairment prior to irreversible structural damage. In support of our findings showing a relationship between oxygen metabolic stress and microstructural integrity, Fields \textit{et al.} identified an association between oxygen metabolic stress and diminished functional connectivity in white matter unaffected by infarcts in children with SCD.\textsuperscript{42} In non-SCD sporadic small vessel disease, impairment in cerebrovascular reactivity, a metric of cerebral
autoregulation, has been associated with disruption in microstructural integrity. Together, these studies contribute to the notion that inadequate oxygen delivery and elevation in oxygen metabolic stress may underlie the pathophysiology of microstructural disruption in SCD.

In contrast, CBF elevation was not associated with microstructural impairment. Potential explanations include, first, CBF may be a less sensitive marker of hypoxia than OEF. In contrast to acute ischemic stroke where cerebral perfusion pressure and CBF precipitously drop, CBF in SCD is chronically elevated and plateaus with maximal arterial dilation. OEF may subsequently increase to provide additional oxygen reserve and responds more readily to fluctuations in oxygen availability. Second, CBF is highly variable, even in healthy individuals. We have recently measured the repeatability of pCASL CBF in healthy adults, finding substantially worse (higher coefficient of variation) repeatability than that of ASE OEF (manuscript in preparation). Lastly, CBF measurements in the white matter are limited by the low signal-to-noise ratio (SNR) using pCASL. Thus, we postulate that both biological and methodological reasons explain a lower association of CBF and microstructural integrity in SCD.

Our study has several strengths. For the patient-based analysis, we excluded regions of prior infarct permitting quantification of cerebral oxygen metabolic stress as an independent predictor of microstructural impairment within radiographically-normal white matter. We employed tissue-based MR measures of CBF and OEF, which allowed us to perform a voxel-wise analysis across white matter to examine the spatial relationships between regional cerebral oxygen metabolic stress, white matter microstructure, and infarct location at the voxel-level. An additional strength of our cohort was the ability to include participants with small infarct volumes to evaluate the microstructural impairment in close proximity to infarct location. While the prevalence and volume of infarcts in the control cohort were significantly smaller than those of the SCD cohort, 39% of the control cohort had evidence of silent cerebral infarcts on MRI.
The results underscore the importance of including a control group when examining infarct prevalence in SCD given non-specific white matter lesions are common in adults outside of SCD.

Our study has several limitations. We performed a cross-sectional analysis of prospectively collected MRI data which limits our ability to assess causality. While our data show that microstructural ischemic injury is adjacent to and more extensive than cerebral infarcts, we are following participants longitudinally to measure the temporal relationship between oxygen metabolic stress, microstructural disruption, and infarct development. We have not measured the association of our findings with cognitive consequences of SCD, which represent a major cause of disability and loss of independence for individuals with SCD. We have recently started performing full cognitive assessments to prevent this limitation in future studies. The cohorts are imbalanced with respect to age and sex between the two cohorts, in part due to difficulty in our ability to recruit younger, male healthy controls from the SCD clinic. As our SCD cohort was younger than the controls, we anticipated perhaps smaller differences in the DTI metrics, yet we found impairment in NAWM microstructure in the younger SCD cohort, even prior to adjusting for age. Further, we continued to find differences in all baseline imaging parameters between the two cohorts, after adjusting for age and sex imbalance. Due to logistics of scheduling, participants were scanned on one of three research scanners at our institution, whereas a single scanner would have been optimal. Indeed, we identified a significant effect of scanner type on the DTI values as has been found in other studies. Our control cohort included sibling controls when possible to balance the two cohorts across socioeconomic status, thus controls with HbAS were permitted. While the impact of sickle cell trait on multiple organ systems is debated, in a separate analysis, we found no differences in the CBF, OEF, and microstructural integrity in controls with HbAS compared to HbAA. If there was an effect of sickle cell trait
towards our findings in the SCD cohort, this would lessen the differences between the control and SCD cohorts.

Lastly, there are specific limitations with respect to the OEF and CBF measurements. The OEF values measured using the ASE technique are lower from that measured by $^{15}$O-PET, in part due to water diffusion effects which impact extravascular signal.\textsuperscript{48,49} In a preclinical study, we found a highly linear correlation of cerebral oxygen saturation measured via ASE MRI and blood gas oximetry across a wide range of global cerebral oxygenation in rats.\textsuperscript{26} While the absolute OEF differs between the MRI and PET methods, the relative differences between control and SCD cohorts and the significant association between OEF and white matter microstructure should remain valid. We are comparing MR-measured and $^{15}$O-PET-measured OEF in healthy participants within a separate study. Further sources of error in OEF quantification include background susceptibility effects and Gibb’s artifact which are accounted for by \textit{a priori} exclusion of voxels with poor model fit, as described in the methods. As discussed above, white matter CBF using pCASL may be limited by the relatively low SNR and poor repeatability, as well as, varying arterial transit times between gray and white matter and between healthy adults and adults with SCD. Previous studies, however, have suggested that using a protocol and post-label delay similar to one employed in this study will likely yield adequate labelling and SNR to permit accurate measures of white matter CBF.\textsuperscript{46}

In conclusion, we found that elevated cerebral OEF was independently associated with microstructural impairment in NAWM in adults with SCD, but not in healthy controls. Within high OEF regions, we found disruption in white matter microstructure which spatially extended beyond cerebral infarcts. Longitudinal imaging studies with cognitive assessment will help to determine if cerebral oxygen metabolic stress temporally predicts microstructural and structural ischemic brain injury, as well as cognitive disability, in SCD. Recently, new SCD therapies
aimed to strengthen hemoglobin-oxygen binding could lower cerebral oxygen metabolic stress and maintain oxygen reserve; however, studies are required to measure neurological and safety outcomes after treatment. Cerebral metabolic stress may, therefore, serve as a potential therapeutic target, allowing physicians to tailor preventative strategies before microstructural injury and stroke occur.
APPENDIX 1. Authors

<table>
<thead>
<tr>
<th>Name</th>
<th>Location</th>
<th>Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yan Wang, MD</td>
<td>Washington University School of Medicine, St. Louis, MO</td>
<td>Designed the study, performed the analysis, interpreted the data, and drafted the manuscript</td>
</tr>
<tr>
<td>Slim Fellah, PhD</td>
<td>Washington University School of Medicine, St. Louis, MO</td>
<td>Acquired the data, performed the analysis, interpreted the data, and drafted the manuscript</td>
</tr>
<tr>
<td>Melanie E. Fields, MD, MSCI</td>
<td>Washington University School of Medicine, St. Louis, MO</td>
<td>Acquired the data and edited the manuscript</td>
</tr>
<tr>
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<td>Washington University School of Medicine, St. Louis, MO</td>
<td>Acquired the data and edited the manuscript</td>
</tr>
<tr>
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<td>Washington University School of Medicine, St. Louis, MO</td>
<td>Acquired the data, performed the statistical analysis, and edited the manuscript</td>
</tr>
<tr>
<td>Cihat Eldeniz, PhD</td>
<td>Washington University School of Medicine, St. Louis, MO</td>
<td>Acquired the data and performed the analysis</td>
</tr>
<tr>
<td>Joshua S. Shimony, MD, PhD</td>
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<td>Acquired the data and performed the analysis</td>
</tr>
<tr>
<td>Martin Reis, MD</td>
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<td>Acquired the data and performed the analysis</td>
</tr>
<tr>
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<td>Acquired the data and performed the analysis</td>
</tr>
<tr>
<td>Yasheng Chen, DSc</td>
<td>Washington University School of Medicine, St. Louis, MO</td>
<td>Acquired the data and performed the analysis</td>
</tr>
<tr>
<td>Jin-Moo Lee, MD, PhD</td>
<td>Washington University School of Medicine, St. Louis, MO</td>
<td>Conceived and designed the study</td>
</tr>
<tr>
<td>Name</td>
<td>Institution</td>
<td>Contribution</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Hongyu An, DSc</td>
<td>Washington University School of Medicine, St. Louis, MO</td>
<td>Conceived and designed the study</td>
</tr>
<tr>
<td>Andria L. Ford, MD, MSCI</td>
<td>Washington University School of Medicine, St. Louis, MO</td>
<td>Conceived and designed the study, performed the analysis, interpreted the data, and drafted the manuscript</td>
</tr>
</tbody>
</table>
REFERENCES


25. Hales PW, Kirkham FJ, Clark CA. A general model to calculate the spin-lattice (T1) relaxation time of blood, accounting for hematocrit, oxygen saturation and magnetic field


Table 1. Baseline participant characteristics

<table>
<thead>
<tr>
<th></th>
<th>Control Cohort</th>
<th>SCD Cohort</th>
<th>( p ) value</th>
</tr>
</thead>
<tbody>
<tr>
<td>( N = 49 )</td>
<td></td>
<td>( N = 34 )</td>
<td></td>
</tr>
<tr>
<td>Median (IQR)</td>
<td>Median (IQR)</td>
<td>( p )</td>
<td></td>
</tr>
<tr>
<td>Age, y</td>
<td>33.0 (28.5 - 37.0)</td>
<td>22.0 (19.0 - 28.0)</td>
<td>( \leq 0.001 )</td>
</tr>
<tr>
<td>Sex, female, N (%)</td>
<td>36 (73)</td>
<td>15 (44)</td>
<td>0.01</td>
</tr>
<tr>
<td>Race, African-American, N (%)</td>
<td>49 (100)</td>
<td>34 (100)</td>
<td>1.0</td>
</tr>
<tr>
<td>Hemoglobin, g/dl</td>
<td>12.5 (11.8 - 13.6)</td>
<td>9.0 (7.9 - 9.7)</td>
<td>( \leq 0.001 )</td>
</tr>
<tr>
<td>Hemoglobin S, ( % )^a</td>
<td>0 (0 - 37.3)</td>
<td>71.2 (49.6 - 84.0)</td>
<td>( \leq 0.001 )</td>
</tr>
<tr>
<td>Hemoglobin F, ( % )</td>
<td>0.4 (0.2 - 0.4)</td>
<td>3.8 (1.8 - 14.95)</td>
<td>( \leq 0.001 )</td>
</tr>
<tr>
<td>COHb, ( % )</td>
<td>1.0 (0.7 - 2.0)</td>
<td>2.9 (2.1 – 3.7)</td>
<td>( \leq 0.001 )</td>
</tr>
<tr>
<td>MetHb, ( % )</td>
<td>1.2 (0.6 – 1.6)</td>
<td>1.9 (1.5 – 2.6)</td>
<td>( \leq 0.001 )</td>
</tr>
<tr>
<td>SpO\textsubscript{2}, ( % )</td>
<td>99 (98 - 100)</td>
<td>98 (95 - 99.5)</td>
<td>0.001</td>
</tr>
<tr>
<td>CaO\textsubscript{2}, mL/dL</td>
<td>16.2 (15.5 -17.7)</td>
<td>11.29 (9.3 - 12.1)</td>
<td>( \leq 0.001 )</td>
</tr>
<tr>
<td>Radiographic infarct</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Present, N (%)</td>
<td>19 (39)</td>
<td>21 (62)^a</td>
<td>0.047</td>
</tr>
<tr>
<td>Overt stroke in SCD, N (%)</td>
<td></td>
<td>5 (24)</td>
<td>-</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>SCI in SCD, N (%)</th>
<th>-</th>
<th>16 (76)</th>
<th>-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infarct volume, mL</td>
<td>0 (0 - 0.09)</td>
<td>0.35 (0.03 - 1.10)</td>
<td>≤ 0.001</td>
</tr>
</tbody>
</table>

**Primary disease modification, SCD**

- None, N (%) - 9 (26)
- Hydroxyurea, N (%) - 18 (53)
- Chronic transfusion, N (%) - 9 (26)

**Abbreviations:** CaO2, arterial oxygen content; SCD, sickle cell disease; COHb, carboxyhemoglobin; MetHb, methemoglobin; SpO2, peripheral oxygen saturation; SCI, silent cerebral infarct

\(^a\) The control cohort included 26 participants with HbAA and 23 with HbAS.

\(^b\) Two participants received hydroxyurea and chronic transfusion therapy
Table 2. Baseline OEF, CBF, and DTI metrics in control and SCD cohorts

<table>
<thead>
<tr>
<th></th>
<th>Control (N = 49)</th>
<th>SCD (N = 34)</th>
<th>p value(^a)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Median (IQR)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whole brain</td>
<td>0.27 (0.25 - 0.28)</td>
<td>0.37 (0.32 - 0.42)</td>
<td>≤ 0.001</td>
</tr>
<tr>
<td>Gray matter</td>
<td>0.29 (0.26 - 0.30)</td>
<td>0.37 (0.34 - 0.43)</td>
<td>≤ 0.001</td>
</tr>
<tr>
<td>NAWM</td>
<td>0.25 (0.24 - 0.27)</td>
<td>0.35 (0.31 - 0.41)</td>
<td>≤ 0.001</td>
</tr>
<tr>
<td>Whole brain</td>
<td>62.0 (54.0 - 66.6)</td>
<td>81.2 (74.2 - 99.3)</td>
<td>≤ 0.001</td>
</tr>
<tr>
<td>Gray matter</td>
<td>68.6 (56.4 - 75.3)</td>
<td>90.4 (82.6 - 114.4)</td>
<td>≤ 0.001</td>
</tr>
<tr>
<td>NAWM</td>
<td>38.8 (32.8 - 42.4)</td>
<td>50.9 (43.9 - 62.6)</td>
<td>≤ 0.001</td>
</tr>
<tr>
<td><strong>MD</strong></td>
<td></td>
<td></td>
<td>0.005</td>
</tr>
<tr>
<td>NAWM</td>
<td>0.72 (0.70 - 0.77)</td>
<td>0.76 (0.74 - 0.78)</td>
<td></td>
</tr>
<tr>
<td><strong>FA</strong></td>
<td></td>
<td></td>
<td>0.021</td>
</tr>
<tr>
<td>NAWM</td>
<td>0.42 (0.40 - 0.43)</td>
<td>0.40 (0.40 - 0.42)</td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations: OEF, oxygen extraction fraction; CBF, cerebral blood flow, expressed in unit of mL/min/100g; DTI, diffusion tensor imaging; NAWM, normal appearing white matter; MD, mean diffusivity, expressed in unit of \(10^{-3}\)mm\(^2\)/s\(^{-1}\); FA, fractional anisotropy

\(^a\)Raw p values reported. Cohort differences OEF, CBF, MD, and FA remained significant after adjusting for age and sex, and correcting for multiple comparisons using Benjamini-Hochberg procedure.
Table 3. Mixed-model regression of cerebral hemodynamic (CBF) and oxygen metabolic (OEF) stress as independent predictors of white matter microstructure

<table>
<thead>
<tr>
<th>Outcome variable</th>
<th>Predictor</th>
<th>Total cohort</th>
<th></th>
<th>Control</th>
<th></th>
<th>SCD</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(N = 103 MRIs)&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td>(N = 53 MRIs)</td>
<td></td>
<td>(N = 50 MRIs)</td>
<td></td>
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<tr>
<td>NAWM MD</td>
<td>NAWM</td>
<td>0.13 (0.03, 0.23)</td>
<td>0.013</td>
<td>0.10 (-2.54, 2.73)</td>
<td>0.72</td>
<td>0.19 (0.02, 0.36)</td>
<td>0.035</td>
</tr>
<tr>
<td></td>
<td>OEF</td>
<td></td>
<td></td>
<td>0.10 (-2.54, 2.73)</td>
<td>0.72</td>
<td>0.19 (0.02, 0.36)</td>
<td>0.035</td>
</tr>
<tr>
<td></td>
<td>Scanner&lt;sup&gt;b&lt;/sup&gt;</td>
<td>0.04 (0.03, 0.05)</td>
<td>&lt;0.001</td>
<td>0.04 (-0.01, 0.18)</td>
<td>0.16</td>
<td>0.04 (0.02, 0.05)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td></td>
<td>Age&lt;sup&gt;c&lt;/sup&gt;</td>
<td>0.00 (0.00, 0.00)</td>
<td>0.844</td>
<td>0.00 (-0.01, 0.01)</td>
<td>0.66</td>
<td>0.00 (0.00, 0.00)</td>
<td>0.51</td>
</tr>
<tr>
<td>NAWM FA</td>
<td>NAWM</td>
<td>-0.08 (-0.15, -0.02)</td>
<td>0.02</td>
<td>0.04 (-1.67, 1.75)</td>
<td>0.82</td>
<td>-0.11 (-0.23, 0.01)</td>
<td>0.065</td>
</tr>
<tr>
<td></td>
<td>OEF</td>
<td></td>
<td></td>
<td>0.04 (-1.67, 1.75)</td>
<td>0.82</td>
<td>-0.11 (-0.23, 0.01)</td>
<td>0.065</td>
</tr>
<tr>
<td></td>
<td>Scanner&lt;sup&gt;b&lt;/sup&gt;</td>
<td>-0.01 (-0.02, -0.01)</td>
<td>0.003</td>
<td>-0.01 (-0.01, 0.01)</td>
<td>0.33</td>
<td>-0.01 (-0.03, 0.00)</td>
<td>0.02</td>
</tr>
<tr>
<td></td>
<td>Age&lt;sup&gt;c&lt;/sup&gt;</td>
<td>0.00 (0.00, 0.00)</td>
<td>0.31</td>
<td>0.00 (-0.10, 0.08)</td>
<td>0.46</td>
<td>0.00 (0.00, 0.00)</td>
<td>0.71</td>
</tr>
<tr>
<td>NAWM MD</td>
<td>NAWM</td>
<td>0.00 (0.00, 0.00)</td>
<td>0.56</td>
<td>0.00 (-0.01, 0.01)</td>
<td>0.60</td>
<td>0.00 (0.00, 0.00)</td>
<td>0.34</td>
</tr>
<tr>
<td></td>
<td>CBF</td>
<td></td>
<td></td>
<td>0.00 (-0.01, 0.01)</td>
<td>0.60</td>
<td>0.00 (0.00, 0.00)</td>
<td>0.34</td>
</tr>
<tr>
<td></td>
<td>Scanner&lt;sup&gt;b&lt;/sup&gt;</td>
<td>0.04 (0.02, 0.05)</td>
<td>0.002</td>
<td>0.04 (0.10, 0.17)</td>
<td>0.18</td>
<td>0.03 (0.01, 0.05)</td>
<td>0.01</td>
</tr>
<tr>
<td></td>
<td>Age&lt;sup&gt;c&lt;/sup&gt;</td>
<td>0.00 (0.00, 0.00)</td>
<td>0.89</td>
<td>0.00 (-0.01, 0.01)</td>
<td>0.58</td>
<td>0.00 (0.00, 0.00)</td>
<td>0.76</td>
</tr>
</tbody>
</table>
| Abbreviations: NAWM, normal appearing white matter; MD, mean diffusivity; OEF, oxygen extraction fraction; FA, fractional anisotropy; CBF, cerebral blood flow; β, regression coefficient; CI, confidence interval.

<table>
<thead>
<tr>
<th>NAWM</th>
<th>FA</th>
<th>CBF</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00 (0.00, 0.00)</td>
<td>0.37</td>
<td>0.00 (0.00, 0.01)</td>
</tr>
<tr>
<td>Scanner&lt;sup&gt;b&lt;/sup&gt;</td>
<td>-0.01 (-0.02, 0.00)</td>
<td>0.01</td>
</tr>
<tr>
<td>Age&lt;sup&gt;c&lt;/sup&gt;</td>
<td>0.00 (0.00, 0.00)</td>
<td>0.72</td>
</tr>
</tbody>
</table>

<sup>a</sup> Each participant had one MRI scan except for 4 control participants and 16 SCD participants who had two serial scans per person.

<sup>b</sup> The most prevalent scanner type served as the reference.

<sup>c</sup> Age, per 1-year increase
Figure 1. White matter OEF is associated with white matter microstructural injury in participants with SCD. Relationships between normal-appearing white matter (NAWM) OEF/CBF vs. NAWM MD/FA are shown after performing linear mixed-model regressions adjusted for age, participants with multiple MRI scans, and scanner type. All effect plots were calculated at the median cohort age of 29.0 years and the most prevalent scanner type as the reference scanner. In participants with SCD, NAWM OEF was associated with MD (A) and non-significantly associated with FA (B), while no association was found between OEF and DTI metrics in controls. NAWM CBF was not associated with MD (C) or FA (D) in either cohort. 95% confidence intervals for control cohort were excluded for simplicity.
Figure 2. Adults with SCD demonstrate widespread oxygen metabolic stress and microstructural injury in deep white matter regions. Voxel-wise nonparametric statistical comparisons between the SCD and control cohorts were performed with corrections for multiple voxel-wise comparisons using threshold-free cluster enhancement and adjusted for age and scanner type. Voxels with statistically significant differences in oxygen extraction fraction (OEF), mean diffusivity (MD), and fractional anisotropy (FA) between SCD and control cohorts at $p < 0.05$ are displayed. (A) OEF was elevated throughout the white matter of adults with SCD, with significance lost in the juxtacortical regions and adjacent to the lateral ventricles. In addition, the SCD cohort demonstrated increased MD (B) and decreased FA (C) relative to controls, predominately in the deep white matter.
Figure 3. Spatial relationship between oxygen metabolic stress, white matter microstructural injury, and cerebral infarcts. (A) Infarct density map was calculated from FLAIR lesion maps in SCD cohort, defined as number of participants with infarcts in the voxel, divided by total number of participants, thresholded to include at least two participants with infarcts in the voxel. (B) To determine the spatial relationship between impairment in white matter microstructure and oxygen metabolic stress, the map of voxels with elevated MD was overlaid onto the map of voxels with elevated OEF. Regions of significant OEF elevation colocalized with and extended beyond regions of significant microstructural impairment. (C) To determine the spatial relationship between infarct location and white matter microstructural injury, the infarct density map was overlaid onto the map of voxels with elevated MD. The region of elevated MD surrounded and extended beyond the borders of the cerebral infarcts, suggesting that microstructural injury in NAWM may be a precursor to infarct development in SCD.
Cerebral Oxygen Metabolic Stress, Microstructural Injury, and Infarction in Adults With Sickle Cell Disease
Yan Wang, Slim Fellah, Melanie E. Fields, et al.
Neurology published online June 25, 2021
DOI 10.1212/WNL.0000000000012404

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