Original Research
Neuroradiology

White Matter Changes in Comatose Survivors of Anoxic Ischemic Encephalopathy and Traumatic Brain Injury: Comparative Diffusion-Tensor Imaging Study

Anke W. van der Eerden, MD, Omid Khalitazadeh, MD, MPH, Vincent Petberg, PhD, Julien Dinkel, MD, PhD, Paola Sanchez, MD, Pieter E. Vos, MD, PhD, Charles-Edouard Luyt, MD, PhD, Robert D. Stevens, MD, PhD, Nicolas Menjot de Champfleur, MD, PhD, Christine Delmaire, MD, Eleonore Tollard, MD, Rajiv Gupta, MD, PhD, Didier Dormont, MD, PhD, Steven Laureys, MD, PhD, Habib Benali, MD, PhD, Audrey Vanhaudenhuyse, PhD, Damien Galanaud, MD, PhD, Louis Puybasset for the NICER (Neuro Imaging for Coma Emergence and Recovery) Consortium, MD, PhD

From the Department of Neuroradiology (A.W.v.d.E., D.D., D.G.), the Neurosurgical ICU (P.S., L.P.), and the Medical ICU (C.E.L.), Hôpital Pitié-Salpêtrière, Assistance Publique-Hôpitaux de Paris; 47-83 boulevard de l'Hôpital, 75651 Paris Cedex 13, France; Departments of Radiology (A.W.v.d.E.) and Neurology (P.E.V.), Radboud University Nijmegen Medical Centre, Nijmegen, the Netherlands; INSERM, UMRS 678, Université Pierre et Marie Curie-Paris 6, Paris, France; and Department of Radiology, Massachusetts General Hospital, Boston, Mass (O.K., J.D., R.G.); Division of Neurosciences Critical Care, Department of Anesthesiology Critical Care Medicine, Johns Hopkins University School of Medicine, Baltimore, Md (R.D.S.); Department of Neuroradiology, Guy de Chauliac Hospital, Montpellier, France (N.M.D.C.); Department of Neuroradiology, Roger Salengro Hospital, Lille, France (C.D.); Department of Neuroradiology, Centre Hospitalier Universitaire, Rouen, France (E.T.); and Cyclotron Research Center, University of Liège, Liège, Belgium (S.L., A.V.).

DOI: http://dx.doi.org/10.1148/radiol.13122720

Abstract Full Text Figures References Supplemental Materials Cited by PDF

Show Conflicts of Interest and Funding
Show Author Contribution
Show Abbreviations

Cardiac arrest and traumatic brain injury (TBI) may lead to similar clinical presentations that include prolonged impaired consciousness, even though these two types of insult have vastly different pathophysiological mechanisms. These differences are reflected in the spatial distribution of abnormalities over the brain. In TBI, shearing and acceleration-deceleration forces lead to diffuse axonal injury mostly in the central structures such as the brainstem and corpus callosum, often associated with contusions in the cerebral hemispheres \( I \). In cardiac arrest, the areas most vulnerable to damage are the watershed areas of the cerebral hemispheres \( II \).

Diffusion-tensor (DT) imaging provides information not only on lesion localization but also on the nature of white matter damage. The DT imaging parameter axial diffusivity (\( A \)) depends chiefly on the diffusibility of water molecules parallel to a tract, whereas radial diffusivity (\( R \)) assesses water diffusion perpendicular to the tract(4). Thus, changes in >\( R \) are thought to be associated primarily with axonal damage, while changes in \( R \) are thought to be related to myelin injury (8-10). These parameters tend to provide greater anatomy and functional information than scalar DT imaging parameters such as fractional anisotropy and the apparent diffusion coefficient (2,11,12), which have been more extensively evaluated than \( A \) and \( J \). These constructs have been validated in animal models (8,11,12), their meaning in humans has been less studied.

We hypothesized that the different pathophysiological events occurring in the subacute phase after cardiac arrest and TBI have different effects on \( R \) and \( A \). The purpose of this study was to analyze the anatomic distribution of white matter pathologic abnormalities by using DT imaging in a multicenter prospective cohort of patients with impaired consciousness following cardiac arrest or TBI.

Materials and Methods

The Institutional review boards of the participating institutions approved this prospective study. All patients’ next of kin and healthy control subjects gave informed consent. The patients and healthy control subjects were recruited during a study on the relevance of DT imaging biomarkers in the prediction of recovery of consciousness in patients after cardiac arrest and after TBI. In that study, the researchers used the same inclusion and exclusion criteria, the same clinical data and the same methods of magnetic resonance.
(MR) imaging acquisition and MR imaging analysis as were used in the present study. The study on the relevance of DT imaging biomarkers in the prediction of recovery of consciousness led to two articles. 1 for cardiac arrest ([1]), and the other for TBI ([7]). and the design is reported in more detail in those two previous articles ([1],[7]). Two authors (V.P., a computer scientist with 10 years of experience, and D.G., a neuroradiologist with 15 years of experience) processed the DT imaging acquisitions. They had no access to the clinical information and outcome of the patients.

Patients

Consecutive patients were enrolled prospectively in eight intensive care units in Paris, Lille, Lyon, Montpellier, Nancy, Rouen, and Bordeaux in France and in Liège in Belgium following cardiac arrest or TBI between October 2006 and February 2010. Patients were eligible if they (a) were between 18 and 85 years old, and (b) had severe brain damage, as expressed by (i) inability to follow simple commands 7-28 days after the incident, unexplained by sedation, and (ii) a Glasgow Outcome Scale (11) score of 1 or 2 at 12 months after the injury or a Glasgow Outcome Scale score of 3 that was explained by cognitive and not purely physical impairment. On the basis of these inclusion criteria, 57 patients with cardiac arrest and 55 patients with TBI were eligible. Patients were excluded if they (a) had a central neurologic disease prior to cardiac arrest or TBI (n = 2); (b) had a penetrating head injury (n = 1); (c) were born (expected survival off-24 hours) (n = 4); (d) had an contraindication to MR imaging (n = 4); or (e) were too unstable to be transported and to undergo MR imaging (n = 0). On the basis of these criteria, we enrolled 54 patients with cardiac arrest and 51 patients with TBI. Of these, the MR imaging data of 5 patients with cardiac arrest and in 11 patients with TBI could not be evaluated because of a suboptimal MR imaging acquisition, as a result of motion (four cardiac arrest patients, five TBI patients), other artifacts (zero cardiac arrest patients, one TBI patient), or deviation in the MR imaging protocol (one cardiac arrest patient, one TBI patient), or because an insufficient number of healthy control subjects were imaged (zero cardiac arrest patients, four TBI patients). Finally, we included 49 of 57 patients with cardiac arrest (86%) and 40 of 55 patients with TBI (73%) with sufficient quality normalized DT imaging data. Demographic and clinical characteristics of the patients are summarized in Table 1.

Cardiac Arrest

The cause of the cardiac arrest was primarily cardiac (cardiac arrest originating in the heart [e.g., myocardial infarction]) in 39 of 49 patients (80%) and secondarily cardiac (cardiac arrest resulting from disease outside the heart [e.g., severe hypoxia or hyperkalemia]) in 10 of 49 patients (20%). The mean duration of no flow before cardiopulmonary resuscitation was 5 minutes (interquartile range, 0-10 minutes). Iltok a median 0120 minutes (interquartile range, 10-36 minutes) for the circulation to become fully effective under cardiopulmonary resuscitation. Hypothermia was induced in 29 of 49 patients (59%). At admission, the mean serum troponin I level was 0.48 n/g/L (0.48 µg/L), with an interquartile range of 0.1-4.4 ng/mL (0.1-4.4 µg/L).

Traumatic Brain Injury

TBI was caused by a motor vehicle accident in 26 of 40 cases (65%) (20 drivers or passengers [50%] and six pedestrians [15%]) by a fall in nine of 40 cases (23%), and by another mechanism in five of 40 cases (13%). On a computed tomography (CT) scan obtained within 48 hours of the TBI, six of 40 TBI patients (15%) had an epidural hematoma, 14/40 patients (35%) had a subdural hematoma, 34 of 40 patients (85%) had a subarachnoid hemorrhage, 27 of 40 patients (68%) had one or more contusions, and nine of 40 patients (23%) had a midline shift greater than 6 mm. None of the TBI patients had signs of ischemia on this early CT scan. Of 40 patients, 18 (45%) had a Marshall classification diffuse injury (1-11, five (13%) had a Marshall classification diffuse injury III, one (3%) had a Marshall classification diffuse injury IV, and 15 (38%) had a mass lesion (eight patients had an evacuated mass lesion and seven patients had a nonevacuated mass lesion) (11). Fourteen of 40 TBI patients (35%) underwent neurosurgical intervention.

Healthy Control Subjects

To control for multisite variability in DT imaging data, in each center we compared the patients’ DT imaging values with those of a total of 11 healthy volunteers, with four to five control subjects per center. 60 of 111 (54%) were men and 51 (46%) were women (mean age, 33 years ± 3 [standard deviation]). These control subjects underwent MR Imaging with the same acquisition parameters as the patients. Volunteers were recruited by the local principal investigator among staff members of each center. They gave written informed consent to study participation. Individuals with no history of neurologic disease requiring medical attention were eligible. We excluded volunteers with abnormalities in the morphologic sequences, as occurred in two individuals (two of 113, 2%) one with mild atrophy and another with asymptomatic white matter disease.

Clinical Data Collection

Data were prospectively collected by using standardized case report forms and a Web-based, encrypted, and centrally managed data management system. Specific data included the following: patient demographics; initial clinical status and cranial CT scan; and 1-year outcome, including the Glasgow Outcome Scale score on a five-point scale (11) and cognitive and physical impairment as assessed by the investigating team at each participating center via a telephone interview or via an in-person visit. A central study monitor verified all data for accuracy, consistency, and completeness.

MR Imaging Acquisition

MR imaging was performed after enrollment and as soon as MR imaging was clinically feasible, which was a mean of 23.2 days (range, 7-57 days) after TBI and a median of 13.1 days (range, 5-47 days) after cardiac arrest. Vital signs were continuously monitored during imaging. Sedation, if any, was maintained. MR imaging was performed in eight centers using nine imaging units from three manufacturers (Siemens Erlangen, Germany), GE Healthcare Milwaukee, WI, and Philips Healthcare Eindhoven, the Netherlands) and included units with both 1.5- and 3.0-T magnetic field strengths. The imaging protocol has been described in previous publications ([1],[7]). The DT imaging acquisition parameters were optimized for each MR unit with minimal specification of a pixel size of at most 3 x 3 mm, a B value of 1000 mT/m, and at least 12 gradient directions. The clinical team did not have access to the DT imaging results, while the investigators processing the DT imaging acquisitions (P.O. and D.G.) had no access to the clinical information and outcome of the patients. No adverse events related to MR imaging were reported.
The pre- and postprocessing of the DT imaging data are described in Appendix E1 (online). This process uses nonlinear registration of A1 and A1c maps into a standard space, as implemented in software (FLIRT/FNIRT procedures; FSL Software Technologies. New Delhi, India). The averaged A1 and A1c values were then extracted in 19 predefined white matter regions of interest (ROIs) (Table 1), which were selected from the white matter atlas. To account for intercenter and intersequence variability, these values were normalized to values of healthy control subjects by scaling each value of a patient to the mean of the corresponding parameter calculated from the healthy control subjects who underwent imaging by using the same acquisition parameters in the same center, as previously described (8,9). We tested the effects of three factors (acquisition center, ROIs, groups) on the mean of the regional fractional anisotropy calculated in the patients and control subjects by using a three-way analysis of variance. The results showed that, before normalization, the three factors were significant (F < .05), and after normalization, only the group effect significantly explained the data variability. We did not adjust for the center-specific standard deviation. The intraclass coefficient of variation (ratio of the standard deviation and the mean) ranged from 2% (within the splenium of the corpus callosum) to 10% (within the body of the corpus callosum) with homogeneous variance across centers (Wilcoxon signed rank test). For exploratory analyses, the 19 ROIs were gathered into five groups: lower brainstem region, cerebral peduncles region, corpus callosum region, right hemisphere, and left hemisphere (Figure 1). The statistical analyses of raw MR data were performed by a computer scientist (V.P., with 10 years of experience) and a mathematician (H.B., with 30 years of experience). Image analysis and quality control of MR images were performed by two neuroradiologists (D.G., with 15 years of experience, and E.T., with 10 years of experience). Data consistency and data integrity were checked by an anesthesiologist (L.P., with 20 years of experience).

### Statistical Analysis

Data were analyzed by using statistical software (StatView 5.0, SAS Institute, Cary, NC; and SPSS 18, SPSS, Chicago, IL). Values are expressed as means and standard errors of the mean unless otherwise stated. Differences in demographic and clinical variables were tested by using the Student t test and the F test, as appropriate. DT imaging variables had normal distribution (according to the Kolmogorov-Smirnov test); therefore, we used parametric tests. We used the method of general linear modeling (analysis of variance with Bonferroni post hoc) for within- and between-group comparison of DT imaging variables in healthy control subjects, TBI patients, and cardiac arrest patients. Multivariate analyses were performed to evaluate the results after adjustment for age and sex. The interaction between variables was also assessed. We calculated Pearson correlation coefficients between the DT imaging parameters in each left-sided ROI and the corresponding right-sided ROI. P values were corrected for multiple testing by multiplication of the P values by the number of tested hypotheses; for example, P values were multiplied by 19 when we compared DT imaging values among the groups in the 19 ROIs (Bonferroni method). Throughout the article, we present the corrected P values.

### Results

The A1 and A1c values in various brain regions of patients and healthy control subjects are illustrated in Figure 2, a-c.

**Figure 2:** Normalized values of A1 and A1c in the lower brainstem region of patients and healthy control subjects. Box plots show the median (middle horizontal line in each box), interquartile range (25th to 75th percentiles), and the minimum (bottom of whisker) and maximum (top of whisker) values. Asterisks = P values for within- and between-group comparisons. When the combined ROIs were compared, P values with significant differences were as follows: For A1, TBI versus cardiac arrest patients, P < .01; for A1c, TBI versus healthy control subjects and cardiac arrest patients versus healthy control subjects, P < .01. There were no significant interactions between the anterior and posterior brainstem. NS = not significant.

**Figure 3:** Normalized values of A1 and A1c in the cerebral peduncles region of patients and healthy control subjects. Box plots show the median (middle horizontal line in each box), interquartile range (25th to 75th percentiles), and the minimum (bottom of whisker) and maximum (top of whisker) values. Asterisks = P values for within- and between-group comparisons. When the combined ROIs were compared, P values with significant differences were as follows: For A1c, TBI versus cardiac arrest patients, P < .01; for A1 and A1c, TBI patients versus healthy control subjects and cardiac arrest patients versus healthy control subjects, P < .01. There were no significant interactions between the left and the right cerebral peduncles. NS = not significant.
A1 and A2: in Patients versus Healthy Control Subjects

The A1 and A2 in the anterior brainstem and A1 in the posterior brainstem were higher in cardiac arrest patients than in control subjects (all P < 0.01). The A1 was lower in the posterior brainstem, and A2 was higher. In the anterior brainstem in TBI patients compared with control subjects (all P < 0.01) (see file 3). The A1 was lower (P < 0.05) and A2 was higher (P < 0.05) in TBI patients and cardiac arrest patients than in control subjects in the left and right cerebral peduncles, body, genu, and splenium of the corpus callosum (except for A1 in the genu) (see file 3). Thus, in central white matter, A1 differed from that in control subjects in six of seven TBI ROIs and five of seven cardiac arrest ROIs (all P < 0.01). A1 differed from that in control subjects in all ROIs in both patient groups (P < 0.01) (see file 4). For the various ROIs in the cerebral hemispheres, Figure 5 shows the comparison of A2 and A2 in TBI patients versus control subjects. Thus, in hemispheres, A2 was decreased compared with that in control subjects in three of 12 TBI ROIs (P < 0.05) and nine of 12 cardiac arrest ROIs (P < 0.01). The A2 was increased in all TBI ROIs (P < 0.01) and in seven of 12 cardiac arrest ROIs (P < 0.05). Cerebral hemisphere A2 was lower in cardiac arrest than in TBI in six of 12 ROIs (P < 0.01), while A1 was higher in TBI than in cardiac arrest in eight of 12 ROIs (P < 0.01).

A1 and A1: in Cardiac Arrest versus TBI Patients

The major findings for the difference in A1 and A1 between TBI and cardiac arrest patients are reported in Figures 2–4. Table 2 presents the types and distribution of abnormalities in central regions (anterior and posterior brainstem, left and right cerebral peduncles, genu, body, and splenium of the corpus callosum) and in cerebral hemispheric regions (left and right sagittal strata, superior longitudinal fasciculus, anterior and posterior limb of internal capsule, external capsule, and corona radiata). In both central regions and cerebral hemispheres, A1 was higher (P < 0.05) in TBI patients than in cardiac arrest patients. In cerebral hemispheres, A1 was lower (P < 0.05) in cardiac arrest patients than in TBI patients.

Table 2. Types and Distribution of Abnormalities in TBI and Cardiac Arrest Patients

<table>
<thead>
<tr>
<th>Type of Abnormality</th>
<th>TBI</th>
<th>Cardiac Arrest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td>Increased</td>
<td>26%</td>
<td>66%</td>
</tr>
<tr>
<td>Decreased</td>
<td>44%</td>
<td>10%</td>
</tr>
</tbody>
</table>

The differences presented in Figures 2–4 remained significant after adjustment for age and sex.

A1 and A2: in the Left versus the Right Cerebral Hemisphere

Figure 3 shows a symmetrical pattern of DT imaging changes in the ROIs in the corresponding right and left hemispheres in patients with cardiac arrest and in control subjects. Indeed, there was a significant intercorrelation between DT imaging values of the ROIs in the corresponding right and left hemispheres in cardiac arrest patients (ranging from r = 0.81 in the external capsule to r = 0.95 in the frontal radiata for A1 and A2) (see file 3). In general, the correlation values were close to one for both types of ROIs. The values close to one for both types of ROIs. Thus, the asymmetry pattern of DT imaging changes was not seen in the most ROIs (see file 3).
Discussion

This article shows that DT imaging can help distinguish the different pathophysiologic mechanisms that underly similar states of impaired consciousness following TBI and cardiac arrest.

Our main findings are a marked decrease in $\Delta \lambda$ in cardiac arrest patients and a marked increase in $\lambda$ in TBI patients. These findings are consistent with reported pathophysiologic concepts, a fact that supports the validity of DT imaging to help distinguish axonal and myelin damage in vivo in groups of patients. Thus, in cardiac arrest, the marked decrease in $\Delta \lambda$ is consistent with primary axonal damage (eq. 1Q i) related to energy depletion from anoxia/ischemia. Primary axonal damage induces changes in the fluid microenvironment of the central nervous system, to which in turn myelin is susceptible (Z. 1W). The moderate $\Delta \lambda$ increase in our cardiac arrest patients are consistent with secondary myelin damage (8). Conversely, the marked $\lambda$ increase in many areas of TBI patients suggests myelin damage, edema, and/or macrophage infiltration as the primary injury. The mechanical forces exerted on the brain in TBI probably cause more myelin damage than axonal damage. The smaller $\lambda$ decrease in TBI patients is consistent with axonal damage, caused either by direct trauma (axonotmesis) or by indirect ischemic damage secondary to extracranial traumatic injuries. In a later phase, brain swelling and increased intracranial pressure may further contribute to the axonal damage. In cardiac arrest, there is a gradient of injury severity from the cerebral hemispheres toward the medulla oblongata, with relative sparing of the central brain structures (11). The vascular anatomy in the cerebral hemispheres, characterized by widespread linear arteries with few anastomoses, increases the vulnerability of the hemisphere to hypoxic-ischemic injury (11). Conversely, in TBI patients, $\lambda$ was highly abnormal in both the central brain structures and the cerebral hemispheres. This finding is consistent with the distribution of diffuse axonal injury observed in the classic monkey model of axial trauma caused by rotational and acceleration–deceleration shearing forces (X). The $\lambda$ increase and, to a lesser extent, the $\lambda$ decrease were asymmetric, being more pronounced in the left cerebral hemisphere of our TBI patients. This predominance of left-sided abnormalities in TBI patients with poor clinical outcomes was expected, as left-sided lesions are more frequently symptomatic. The asymmetry was attributable to a left predominance of $\lambda$ abnormalities and, to a lesser extent, $\lambda$ abnormalities, suggesting greater asymmetry of edema and/or myelin damage than of axonal damage. This finding supports the hypothesis that edema and myelin damage are chiefly related to the mechanical trauma, which is an asymmetric assault, whereas axonal damage may be a combined effect of symmetric systemic processes and asymmetric local processes.

Our finding of greater $\lambda$ increase compared with $\Delta \lambda$ alterations in TBI patients is consistent with DT imaging findings in the key experimental mouse model of brain injury by MacDona et al (10). The researchers in all previous descriptive DT imaging studies in humans at the early subacute phase of TBI evaluated a later or longer time window than we did in our study Gl. 1. In included patients with milder brain injury (1.11,11), and/or did not specify separate diffusivity parameters in various ROIs (6,11,11). Although we can intuitively expect, $\lambda$ values and therefore myelin damage played a larger role than $\Delta \lambda$ in recent DT imaging-based and clinically based prognostic model in severe TBI (1). To our knowledge, no previous descriptive DT imaging studies in human cardiac arrest patients have been published.

To our knowledge, investigators in only one previous study have compared the use of DT imaging in cardiac arrest patients versus TBI patients. Our finding of greater sensitivity of central brain structure injury in TBI patients versus cardiac arrest patients is consistent with the findings in the comparative study at a later postinjury phase of Newcombe et al. Although an overall $\lambda$ decrease was our main finding in cardiac arrest patients, $\lambda$ in the lower brainstem and cerebral peduncles regions showed lesser decreases in TBI than in cardiac arrest. Similarly, in a study of 10 patients with severe TBI evaluated 8 weeks after trauma, $\lambda$ was decreased and $\Delta \lambda$ was increased in the deep brain regions and brainstem (1,11). Whereas we found large differences in the cerebral hemispheres between cardiac arrest and TBI, Newcombe et al (1) found broadly similar DT imaging abnormalities in TBI and ischemic-hypoxic brain injury. This discrepancy is ascribable to differences in patient populations and MR imaging timing, as well as to the relatively small number of patients studied by Newcombe et al.

Our study has several limitations. As was inevitable with a multicenter design, the DT imaging data were acquired with different MR imaging machines. We corrected for this source of variability by normalizing the patient values to values in healthy control subjects who underwent imaging with the same parameters on the same machine. Because of the epidemiology of TBI and cardiac arrest, our TBI patients were younger and cardiac arrest patients had higher mortality rates. Differences in treatment-limitation decisions between the two patient groups cannot be ruled out. We followed up the patients for 1 year. Although improvements are unlikely to occur beyond this period, some degree of confounding bias cannot be ruled out. In both cardiac arrest and TBI, neurologic injury and recovery is a dynamic process. Therefore, our findings are only valid within the studied time (ie, the early subacute phase ). In TBI, the spatial distribution varies across patients as a result of variations in the direction of the impact on the head. Thighly significant results were found in our study despite this inevitable source of heterogeneity supports the general applicability of our findings.

Our results should be tested in future research evaluating the robustness and validity of $\lambda$ and or $\Delta \lambda$, preferably comparing the DT imaging results with postmortem pathologic findings.

Although the neurologic presentation is similar in patients with persistent consciousness impairments after TBI and cardiac arrest, DT imaging findings suggest substantial differences in white matter injury between these two causes. Our findings indicate differences at both the topographic and the cellular levels. The results in cardiac arrest patients are consistent with a primary axonal injury responsible for secondary myelin damage. In TBI in contrast, the chiefly mechanical primary mechanism results in myelin damage, which is followed by secondary ischemic injury. The consistency of our findings with current pathophysiologic concepts supports the validity of DT imaging for in vivo testing of pathophysiologic hypotheses in humans. DT imaging is a promising in vivo tool for separating myelin from axonal damage, a step that may prove important in the early prediction and understanding of patient outcomes.

**Advances in Knowledge**

- In cardiac arrest, the predominant finding at diffusion-tensor (DT) imaging is a marked decrease in axial diffusivity ($\Delta \lambda$) (-8.9% in central regions, -9.1% in cerebral hemispheres), whereas in traumatic brain injury (TBI), the predominant finding is a marked increase in radial diffusivity ($\lambda$) (37.5% in central regions, 24.9% in cerebral hemispheres).
* The central brain structures show lower A1 and higher AL values in TBI than in cardiac arrest (cardiac arrest TBI, P<.01 for A1 in the lower brainstem region and for AL in the cerebral peduncles region and corpus callosum region); in the cerebral hemispheres regions, A1 and AL are highly abnormal in both cardiac arrest and TBI, with the lowest A1 values occurring in cardiac arrest (cardiac arrests TBI, -9.1% vs -0.1%, P<.01) and the highest AL values in TBI (TBI vs cardiac arrest, 24.9% vs 9.7%; P<.01).

* The known predominance of left-sided damage in TBI patients with poor clinical outcomes is attributable to left-sided predominance of AL abnormalities and, to a lesser extent, A1 abnormalities (P<.05 for side-to-side correlations in five of six ROIs for AL and in three of six ROIs for A1); this finding suggests greater asymmetry of edema and isomyelination damage than of axonal damage in TBI.

**Implications for Patient Care**

* Our findings help physicians understand the mechanisms underlying chronic consciousness impairments after TBI and cardiac arrest.

* Our findings encourage physicians who interpret DT imaging studies to take into account not only scalar variables such as fractional anisotropy and apparent diffusion coefficient but also vector variables such as A1 and AL.

**Acknowledgment**

We acknowledge Ritse Mann for editing . . and .

Received December 18, 2012; revision requested February 20, 2013; final revision received May 20; accepted May 29; final version accepted August 12.

Supported by a grant from the French Ministry of Health (Projet Hospitalier de Recherche Clinique registration P051061 [20051], Paris, France, and from the Agence Nationale de la Recherche, Paris France, for the program "Investissements d’avenir" under agreementANR-10-IAIHU-06 for the Paris Institute of Translational Neurosciences-IHU-A-ICM.

**References**


