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Author: **Michele CERRA**
Supervisor: **Benoît MACQ**
Reader: **Alexandre BERGER**
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Abstract

Acknowledgments

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Introduction

Chapter 1

Theoretical background

1.1 Magnetic Resonance Imaging

1.1.1 Magnetic properties of nuclei

Biological organisms and tissues are naturally abundant of *Hydrogen* atoms, mostly in water and fats. Thanks to the magnetic properties of Hydrogen atoms it is possible to build anatomical images of the human body.

From a classical point of view an atomic nucleus can be assumed as sphere rotating around its axis 1.1. This rotation is called spin and it is a fundamental property of nucleus. The *spin* is the intrinsic angular momentum of the nucleus and can be an integer or a half-integer depending of the mass number¹ and the atomic number². In the particular case of the Hydrogen it is present only a proton and the spin can take only the values $1/2$ and $-1/2$.

Since the nucleus is a charged particle, a rotation of it creates a magnetic field. From this point of view the particle behaves like a small magnetic dipole 1.1: $\vec{\mu} = i\vec{S}$ where $\vec{\mu}$ is the intrinsic magnetic momentum that is aligned on its spin \vec{S} .

Figure 1.1:

Normally orientation of $\vec{\mu}$ is completely random due to thermal random motion, therefore the sum of the magnetic fields is null ($\sum_i \mu_i = 0$).

In a magnetic dipole, when an external magnetic field \vec{B}_0 is applied, the individual orientation can take two possible orientations: *parallel* or *anti-parallel*. This phenomena in the particles is different, since the particle is rotating, the external magnetic field creates a *precession* around \vec{B}_0 like a spinning top 1.2: $\vec{\Gamma} = \vec{\mu} \times \vec{B}_0$ where $\vec{\Gamma}$ is the *torque*.

Figure 1.2:

The axis rotates around the area of a "cone", with an angular speed proportional to the applied field following the *Larmor's Law*:

$$f_0 = \frac{\gamma}{2\pi} B_0 \quad (1.1)$$

¹Mass number: number of protons and neutrons

²Atomic number: number of protons

γ is the gyromagnetic ratio and it is a characteristic of the nucleus. The frequency of precession is called *Larmor frequency*.

From a global point of view, the populations of protons moments create a macroscopic magnetization, with the direction equal to the external field 1.3.

$$\vec{M} = \frac{1}{V} \sum_i \vec{\mu}_i \quad (1.2)$$

While the transversal magnetization in xy plane is null, since the components μ_{xy} rotate with different phases and overall they nullifying themselves 1.3.

Figure 1.3:

In terms of energy, without the magnetic field, it doesn't exist any difference between the two orientations (parallel and anti-parallel), because they are equiprobable. With the application of the static magnetic field the anti-parallel orientation will have a higher energy ($N \downarrow$) than the parallel with lower energy ($N \uparrow$), since it has to be the opposite of the external field. The *occupation ratio* of the two energy levels is described by the *Boltzmann distribution*.

$$\frac{N_{\uparrow}}{N_{\downarrow}} = e^{-\frac{\Delta E}{kT}} \quad (1.3)$$

where k is the Boltzmann's constant and T is the absolute temperature in [K]. The energy of a magnetic dipole in a magnetic field \vec{B}_0 can be defined by:

$$E = -\vec{\mu} \cdot \vec{B}_0 = -\mu_z B_0 \Rightarrow$$

where $\mu_z = \gamma \frac{h}{2\pi} I$

$$\Rightarrow E_I = -\gamma \frac{h}{2\pi} I B_0$$

where h is the Planck's constant and I is the spin orientation for the Hydrogen. Knowing that:

$$\Delta E = E_{-\frac{1}{2}} - E_{\frac{1}{2}} = h \frac{\gamma}{2\pi} B_0 = hf_0$$

we find that there are more spins in E_{\uparrow} (lower energy) state than E_{\downarrow} (higher energy) state 1.3.

The equilibrium macroscopic magnetization is non-zero and is defined by:

$$M_0 = \frac{(\frac{\gamma}{2\pi})^2 h^2 \rho B_0 I(I+1)}{3kT} \quad (1.4)$$

where ρ is the spin density³ and $I = 1/2$ for Hydrogen.

³Spin density: number of spins per unit volume

1.1.2 Radiofrequency pulse

Since the intensity of the macroscopic magnetization (M_0) is several orders of magnitude smaller than the main field (B_0), is impossible to measure it directly⁴.

The idea is to induce controlled oscillations of the spin system in order to generate a measurable signal. If a RF pulse is applied at the Larmor frequency ($f_{RF} = f_0$) we observe a *condition of resonance* 1.4, and if the system resonates with the pulse it starts to absorb energy 1.5.

$$B_1(t) = 2B_1(t) \cos(2\pi f_{RF}t + \phi) \vec{1}_{xy} \quad (1.5)$$

Figure 1.4:

Figure 1.5:

The *flip angle* from the initial direction of the magnetization is defined by:

$$\theta = \gamma B_1 T_{RF}$$

where T_{RF} is the duration of the RF-pulse.

Now the magnetization vector can be represented as:

$$\vec{M} = M_z \vec{1}_z + M_{xz} \vec{1}_{xy} \quad (1.6)$$

1.1.3 Relaxation

After applying the RF-pulse tends to go back to the initial state, these phenomena are called *relaxation*.

$$M_z \rightarrow M_0$$

$$M_{xy} \rightarrow 0$$

The first is the *longitudinal relaxation* (*spin-lattice relaxation* or *T1-relaxation*) in which the magnetization recovers to its original M_0 , because the energy state after the RF-pulse is unstable it will create a transition of spins from high energy to low energy 1.6.

$$M_z(t) = M_0 + (M_z(0) - M_0) e^{-\frac{t}{T_1}} \quad (1.7)$$

Where T_1 is the time needed to M_z to reach the 63% of the initial value M_0 1.7.

Figure 1.6:

In the T_1 -weighted image the signals must depend on the T_1 relaxation. Therefore the time between the RF-pulses have to be brief, but sufficient to differentiate the different tissues 1.7. In these scans, the white matter is represented in light grey, the grey matter in a darker shade of grey and the fluids in black.

⁴Even if is impossible to measure directly the M_0 , it is proportional to the field, therefore an higher B_0 allows to generate higher signals with higher SNR and less acquisition times.

Figure 1.7:

The second phenomenon is the *transverse relaxation* (*spin-spin relaxation* or *T2-relaxation*) and it is characterized by a loss in coherence of the spin phases 1.8.

$$M_{xy}(t) = M_{xy}(0)e^{-\frac{t}{T_2}} \quad (1.8)$$

Where T_2 is the time needed to M_{xy} to reduce itself to 37% of the initial value 1.9.

Figure 1.8:

Figure 1.9:

In the T_2 -weighted imaged the signals must depend only from the T_2 relaxation. Therefore is needed to wait that the T_1 relaxation effects are exhausted before reading the signal and send a new one. In these scans, the white matter is in dark grey, the grey matter is in light grey and the cerebrospinal fluid is in white 1.10.

In real conditions of an imperfect homogeneity of the field B_0 we see the *effective relaxation time*:

$$\frac{1}{T_2^*} = \frac{1}{T_2} + \gamma\Delta B_0 \quad (1.9)$$

Where ΔB_0 are the inhomogeneities in the magnetic field.

1.1.4 Spin-echo sequence

To obtain images with different type of contrast is needed to control the time between RF-pulses and the time of between readings of the signal.

The first sequence utilized for clinical purpose is the *spin-echo*. It introduces two main parameters: *Echo time (TE)* and the *Repetition time (TR)*. The time between two 90° RF-pulses is defined as TR , while the time between the RF-pulse and the first echo is defined as TE .

The strength of this sequence is the capacity of reading the T_2 -weighted signals and not the T_2^* 1.11.

The spin-echo sequence is composed of two type of RF-pulses: a 90° pulse and many 180° pulses. These last pulses have a double intensity and are called *echo impulses*. An echo impulse mirror all the spins of 180°, therefore the faster spins and the slower are inverted of position, creating the possibility that all the spins are refocused at time TE 1.12.

Contrast

By varying TE and TR , three types of contrast behavior can be obtained 1.13:

- $TE \ll T_2$ and $TR = T_1$: T_1 -contrast
- $TE = T_2$ and $TR \gg T_1$: T_2 -contrast
- $TE \ll T_2$ and $TR \gg T_1$: ρ -contrast (proton density)

Figure 1.10:

Figure 1.11:

1.1.5 Spatial coding

To reconstruct the image it is needed selecting a definite volume of tissue called *voxel*⁵, three operations are needed to localize them in the tissue: selecting the layer (in the z-direction), selecting the column of the voxel (in the x-direction) and selecting the row (in the y-direction). These selections are done by linear variations of the magnetic field along a specific direction called *Gradient fields*. They can change the static magnetic field B_0 and thus change the precession frequency of protons.

To select a slice, it is applied a gradient along the z-direction, here the magnetic field change raising from a minimum to a maximum, and in the point in which the gradient is null the magnetic field is exactly B_0 . Therefore only the nuclei in the condition of resonance will generate a signal 1.14.

Using a gradient on the x-direction (G_x) creates a signal that is the *sum of the associated signals with different frequencies*. This gradient is called *Gradient of frequency encoding*, because the spins assume a precession frequency depending on the gradient. Successively, is applied a gradient along the y-direction (G_y), called *Gradient of phase encoding*, it change the spin phase depending on the gradient 1.15. In this way each element of the section is different from the other by phase or frequency.

The raw data from these signals are collected in matrices that represent the *k-space* in the frequency domain, in which G_y selects the row and G_x scans it and save it in the matrix. This sequence must be repeated n times for each line of the k-space to fill it 1.15. After, is applied the *Inverse Fourier transform* to retrieve the image in the spacial domain.

1.1.6 Artifacts

In MRI artifacts is everything that is represented in the image without any correlation with the real anatomy of the tissues analyzed.

Motion artifacts

The most common artifacts are the *movement artifacts* due to the involuntary movements of the patient. In general the movements can be divided in random and periodic movements. Random movements create a blurring of the image, while periodic movements create *ghost images*⁶. The first can be reduced using techniques that reduce the acquisition time. The periodic movements artifacts can be reduced through *gating*, a technique where the acquisition of the data is synchronized with the periodic movement of the tissue.

⁵A voxel is the 3D expansion of a pixel

⁶Ghost images: periodic copies of some structures of the image

Figure 1.12:

Figure 1.13:

Magnet susceptibility artifacts

The presence of ferromagnetic materials create local inhomogeneities in the magnetic field which result in distortion artifacts called *magnetic susceptibility artifacts*. The signals can change generating zone bright or dark with some distortions in the surrounding tissues. These artifacts can be reduced using spin-echo sequence instead of gradient-echo, and reducing the TE .

Chemical shift

In the interface between tissues of different molecular characteristics can occur a *chemical shift*. It is a result of different resonance frequencies of adjacent tissues. Possible solutions are the reducing of the voxel dimension, increasing the bandwidth or using fat-suppressed imaging.

Gibb's artifacts

Gibb's artifacts are due to the reconstruction from k-space, since it is performed through a finite sampling. In hedges of high-contrast the Fourier transform truncate some frequencies, for this they are also named *truncation artifacts*, creating the effect of fine parallel lines ("ringing") adjacent to such interfaces. Increasing the matrix size or applying smoothing filters can reduce the artifacts.

Aliasing

Aliasing artifacts are visible when the tissue is outside the field-of-view (FOV), meaning that there was an under-sampling in the k-space. The only solution is to increase the size of the FOV or using techniques of foldover suppression.

Eddy currents

The Faraday-Lenz Law of electromagnetism states that electrical currents (*Eddy currents*) are induced in nearby conductors by a changing magnetic field. Since MRI uses rapidly changing magnetic fields, eddy currents are always produced. The conductive material in which eddy currents are induced may be any metallic component of the MRI scanner and the patient as a whole. These latter may generate a distortion of the magnetic field. Several techniques are available to minimize the effects including image post-processing [QeA,].

1.2 Diffusion-Weighted MRI

Sequences of *Diffusion-Weighted MRI* (DW-MRI) can provide motion-dependent contrast of water molecules in tissues, which can significantly alter in some brain

Figure 1.14:

Figure 1.15:

diseases. These sequences are also known as *Diffusion Weighted Imaging* (DWI) or *diffusion MRI* (dMRI).

1.2.1 Pulse Gradient Spin Echo (PGSE)

The *Pulse Gradient Spin Echo* (PGSE) sequence is the main diffusion-weighted sequence used, it is composed of two magnetic gradients, before and after the 180° RF-pulse of the classic spin echo sequence. When the first diffusion gradient is applied, the water molecules are dephased, the second gradient, after the 180° RF pulse, will rephase the magnetization 1.17. The difference of gradient intensity which is subject the water molecule is proportional to the distance traveled on the time between the two gradients and also the gradient intensity. Therefore, the protons that are moved faster will have a greater dephase.

The intensity of a voxel resulting from the signal will be equal to the intensity of a T₂-weighted image, lowered by a quantity that depends on the diffusion of the molecules.

$$I = I_0 \times \exp(-b_{PGSE} \times D) \quad (1.10)$$

Where I is the intensity of received signal, I_0 is the intensity of base signal (T₂-weighted), b_{PGSE} is the factor of sensibility (parameters of PGSE sequence) and D is the coefficient of diffusivity (intrinsic characteristic of the tissue).

$$b_{PGSE} = (\gamma G \delta)^2 \left(\Delta - \frac{\delta}{3} \right) [s/mm^2] \quad (1.11)$$

Where G is the diffusion gradient intensity, δ is the duration of the diffusion gradient and Δ is the time between the first diffusion and the second.

The diffusion can be affected even to pressure, temperature and molecular interactions and the DW-MRI can not distinguish between these different causes. Furthermore, if the followed path during the diffusion is random rather than linear, the signal will be only a measure between the starting point and the end point 1.18.

In the brain, the diffusivity of the water molecules is *anisotropic*, it is not equal in each direction of the space. For example the diffusion in the white matter will be higher along the direction of the axons rather than the perpendicular direction. While, if the diffusion does not have any preferential direction, such as in the CSF, the diffusion is called *isotropic* 1.19.

1.2.2 Diffusion Tensor Imaging (DTI)

$$D = \begin{pmatrix} D_{xx} & D_{xy} & D_{xz} \\ D_{yx} & D_{yy} & D_{yz} \\ D_{zx} & D_{zy} & D_{zz} \end{pmatrix} \quad (1.12)$$

Figure 1.16:

Figure 1.17:

$$D = \begin{pmatrix} D_{xx} & D_{xy} & D_{xz} \\ D_{yx} & D_{yy} & D_{yz} \\ D_{zx} & D_{zy} & D_{zz} \end{pmatrix} \quad (1.13)$$

$$E(b_{PGSE}, \mathbb{R}^n) = e^{-b_{PGSE} \hat{g}^T \vec{D} \hat{g}} \quad (1.14)$$

$$E(b_{PGSE}, \mathbb{R}^n) = e^{-b_{PGSE} D} \quad (1.15)$$

$$\Lambda = \begin{pmatrix} \lambda_1 & 0 & 0 \\ 0 & \lambda_2 & 0 \\ 0 & 0 & \lambda_3 \end{pmatrix} \quad (1.16)$$

$$MD = \frac{Tr(D)}{3} = \frac{\lambda_1 + \lambda_2 + \lambda_3}{3} \quad (1.17)$$

$$AD = \lambda_1 \quad (1.18)$$

$$RD = \frac{\lambda_2 + \lambda_3}{2} \quad (1.19)$$

$$FA = \sqrt{\frac{3}{2} \frac{\sqrt{(\lambda_1 - MD)^2 + (\lambda_2 - MD)^2 + (\lambda_3 - MD)^2}}{\sqrt{\lambda_1^2 + \lambda_2^2 + \lambda_3^2}}} \quad (1.20)$$

1.2.3 Tractography

1.3 DW-MRI Microstructural models

1.3.1 DIAMOND

1.3.2 NODDI

1.3.3 Microstructure fingerprintign

Figure 1.18:

Figure 1.19:

Chapter 2

Epilepsy

2.1 Overview of Epilepsy

Epilepsy is a disorder of the brain characterized by a lasting predisposition to generate spontaneous epileptic seizures, and has a numerous neurobiological, cognitive, and psychosocial consequences [Fisher et al., 2014]. Epilepsy affects over 50 million people worldwide, making it one of the most common neurological diseases globally [WHO, 2023]. Over 75% of those with active epilepsy are untreated [Saxena and Li, 2017].

Epilepsy incidence is bimodally distributed with two peaks: the first in the pediatric population less than 5 years old, and the second in people over the age of 50 years. The incidence is higher in low-income countries than high-income countries, thanks a contribution of poor hygiene, poor basic sanitation and higher risk of infection [Thijs et al., 2019]. Regardless the geographical location, the prevalence of active epilepsy is usually between 4 and 12 per 1000, with a risk factor that varies with age [Fiest et al., 2017].

The risk of death for a person with epilepsy is increased compared with the risk for the general population. Mortality in epilepsy can be divided into direct (eg, status epilepticus, injuries, SUDEP [Langan et al., 2000]) or indirect (eg, suicide, drowning) disease-related death [Devinsky et al., 2016].

SUDEP (Sudden Unexpected Death in Epilepsy) is one of the causes of epilepsy-related death, it refers to a death in a patient with epilepsy that is not due to trauma, drowning, status epilepticus, or other known causes but for which there is often evidence of an associated seizure [Nashef, 1997]. The rate of SUDEP increases with the duration and severity of epilepsy, and most cases happen during or right after a seizure [Devinsky, 2011].

Epilepsy rarely stands alone and the presence of comorbidities is the norm: more than 50% of people with epilepsy have one or several additional medical problems [Thijs et al., 2019]. These comorbidities not only include psychiatric conditions (e.g. depression, anxiety disorder, psychosis, autism spectrum disorder, dementia), but even somatic conditions (e.g. type 1 diabetes, arthritis, digestive tract ulcers) [Yuen et al., 2018].

Definitions

Epilepsy

The given definition of Epilepsy is usually practically applied as having two unprovoked seizures occurring more than 24h apart. But the International League Against Epilepsy (ILAE) proposed that epilepsy be considered to be a disease of the brain by any of the following conditions: [Fisher et al., 2014]

- At least two unprovoked seizures occurring more than 24h apart;
- A single unprovoked seizure if recurrence risk is high ($>60\%$ over the next 10 years);
- Diagnosis of an epilepsy syndrome.

Seizure

An epileptic seizure is the clinical manifestation of an abnormal, excessive, purposeless and synchronized electrical discharge in the neurons, that leads to brief episodes of involuntary movement that may involve a part of the body (partial) or the entire body (generalized) and are sometimes accompanied by loss of consciousness and control of bowel or bladder function. [WHO, 2023]

Pathophysiology

A seizure can be conceptualized as occurring when there is a distortion of the normal balance between excitation and inhibition within a neural network [Fisher et al., 2005].

In focal epilepsies, focal functional disruption results in seizures beginning in a localized fashion in one hemisphere, commonly limbic or neocortical, which then spread by recruitment of other brain areas. The site of the focus and the speed and extent of spread determine the clinical manifestation of the seizure [Duncan et al., 2006, Fisher et al., 2017]. For generalized epilepsies, epileptogenic networks are widely distributed, involving thalamocortical structures bilaterally [Fisher et al., 2017].

The imbalance between excitation and inhibition resulting in epileptogenic networks is not necessarily only an increase of excitation or a loss of inhibition; an aberrant increase in inhibition can also be pro-epileptogenic in some circumstances, such as absence seizures [Pinault and O'brien, 2005] or limbic epilepsies in the immature brain. [Galanopoulou, 2008]

Types of epilepsy

Classification is made at three levels: seizure type, epilepsy type, and epilepsy syndromes. [Fisher et al., 2017]

Seizure type

Seizures are first classified by onset as either focal, generalized or unknown 2.1.

- **Focal Onset:** Usually limited to a specific region of the brain, called the focus. Level of awareness subdivides focal seizure in those with retained awareness and impaired awareness. Retained awareness means that the person is aware of self and environment during the seizure, even if immobile. In addition, focal seizures are sub-grouped as those with motor and non-motor manifestation.
- **Generalized Onset:** Affects most or all of the brain. Typically congenital and occurs simultaneously in both hemispheres of the brain. They are almost always accompanied by impaired awareness. Generalized seizures are divided into motor and non-motor (absence) seizures.
- **Unknown:** It is the case in which the onset is missed or obscured.

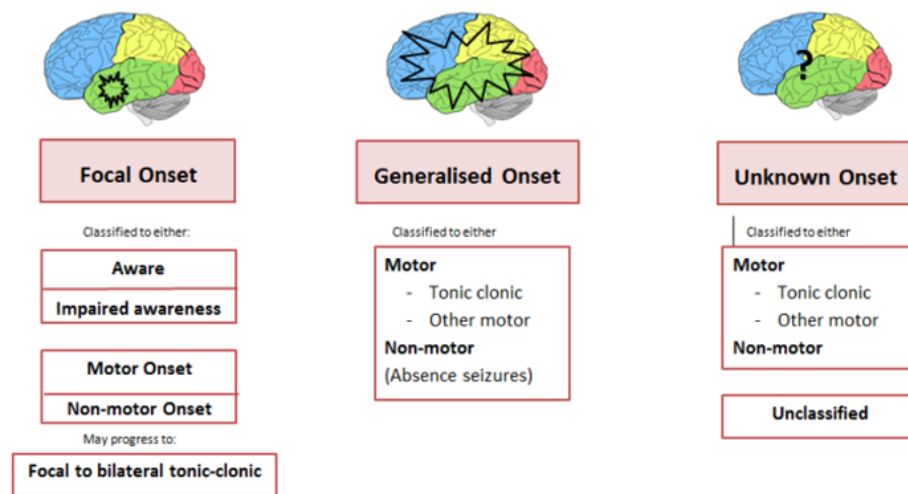


Figure 2.1: The International League Against Epilepsy.[Scheffer et al., 2017]

Epilepsy type

Epilepsies are divided into: focal, generalized, combined generalized and focal, and unknown 2.2. The category combined epilepsy is used for those presenting both seizure types.

Causes of epilepsy

Epilepsy can have both genetic and acquired causes, with the interaction of these factors in many cases. Established acquired causes include serious brain trauma, stroke, tumours, and brain problems resulting from a previous infection.

Treatments

For most of the people with epilepsy Antiepileptic Drug(AEDs) constitute the first line treatment. However, it has been reported that AEDs are effective in only 60-70% of individuals, a percentage that is further reduced in low-income countries. [Duncan et al., 2006].

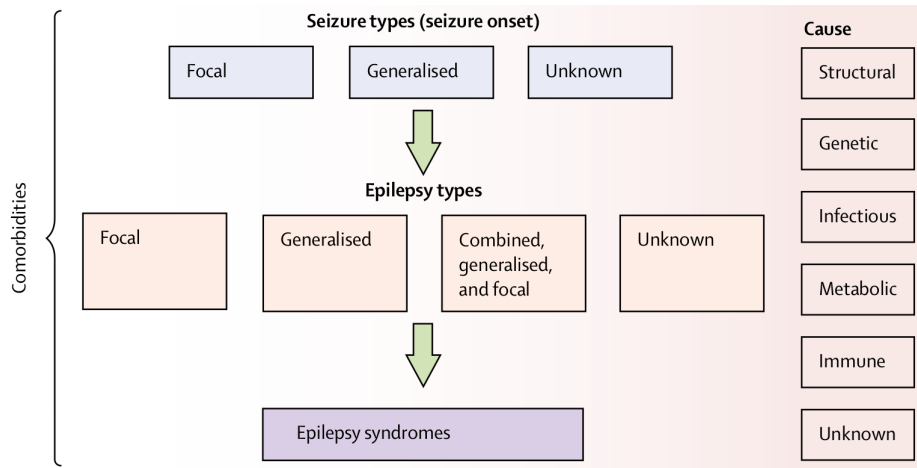


Figure 2.2: The International League Against Epilepsy.[Thijs et al., 2019, Fisher et al., 2017]

Up to a third of all individuals with epilepsy are refractory to AEDs [Spencer and Huh, 2008]. Drug-resistant epilepsy is assumed after the "failure of adequate trials of two tolerated, appropriately chosen and used at correct dosage antiseizure drug schedules to achieve sustained seizure freedom" [Kwan et al., 2010]. In those cases alternative non-pharmacological treatments including surgery and neurostimulatory interventions should be considered. When surgery is not possible because of the presence of multifocal or generalized epilepsy or whenever the epileptogenic focus lies in eloquent cortex that cannot be removed, neurostimulation techniques are palliative options [Englot et al., 2013].

Three neurostimulation devices are approved by the Food and Drug Administration (FDA) for the treatment of drug resistant epilepsy [Kiriakopoulos et al., 2018, Wong et al., 2019].

- VNS is approved for treatment of epilepsy when surgery is not possible or does not work. It is not a brain surgery and it is placed under skin on the top left section of the chest and uses wire coils to connect to the left Vagus nerve, located in your neck. It sends intermittent electrical continuously. The response rate after a year is 55%.
- RNS is a device that can record seizure activity directly from the brain and delivers stimulation to stop seizures. RNS is implanted near the seizure focus and is flush with the skull, it connects to electrodes that are placed inside your brain. It delivers pulses only when it detects abnormal activity in the seizure focus. RNS is not compatible with RNS. The response rate after a year is 45% and grows to 60% in long-term.
- DBS sends signals to the brain electrode to stop signals that trigger a seizure. The connected DBS electrodes are typically placed inside the thalamus, and the electrical pulses are delivered constantly or not. The response rate after a year is 45% and rises to 74% in long-term. Side effects include depression and memory.

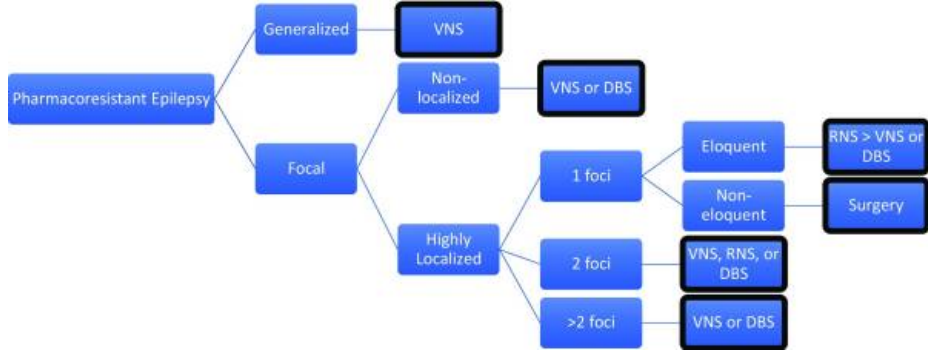


Figure 2.3: The following shows a general algorithm for efficacious device selection based on mechanism of action and focality. Other considerations (side effects, device features, and patient preferences) also drive device selection but are not captured in this flowchart. [Wong et al., 2019]

2.2 Vagus Nerve Stimulation

Vagus Nerve Stimulation (VNS) showed positive effects in multiple other medical conditions, including essential tremors gastroparesis [Krahl et al., 2004], chronic tinnitus, stroke, post-traumatic stress disorder [Hays et al., 2013], chronic pain, Parkinson’s disease, eating disorders, multiple sclerosis, migraine and Alzheimer’s disease [Broncel et al., 2020, Beekwilder and Beems, 2010].

VNS was implanted first time in four epilepsy patients by Penry and Dean in 1988 [Penry and Dean, 1990]. After several large clinical studies, it was approved for seizures by the European Community in 1994 and FDA in 1997. Clinical trials demonstrate that 24 to 48 months after the implantation of the device, 60% of patients were considered as responders and 8% of implanted patients became seizure free [Englot et al., 2016]. Responders to VNS will be defined as those who experience 50% or greater reduction in seizure frequency after VNS [Ibrahim et al., 2017]. Although VNS is used in clinical practice the exact mechanistic of its effect in modulating seizures remain poorly understood.

VNS consists of a device implanted in the upper left thoracic region with a helical electrode placed around the left cervical nerve, which delivers intermittent electrical impulses to activate the vagus nerve 2.4. Studies in the dog show that right-sided VNS results in a greater degree of bradycardia as compared to the left-sided VNS, because right vagus nerve innervates more densely in the heart [Ardell and Randall, 1986]. Because on those studies VNS is indicated for use only in stimulating the left vagus nerve.

Side effects of VNS are commonly limited to coughing and/or hoarseness of the voice. In a study, voice alternation was reported in 66% of patients on high stimulation and in 30% on low stimulation and cough was reported in 45% of patients. [Ben-Menachem, 2001] To avoid cardiac side effects, a cuff electrode in most cases is implanted on the left vagal nerve.

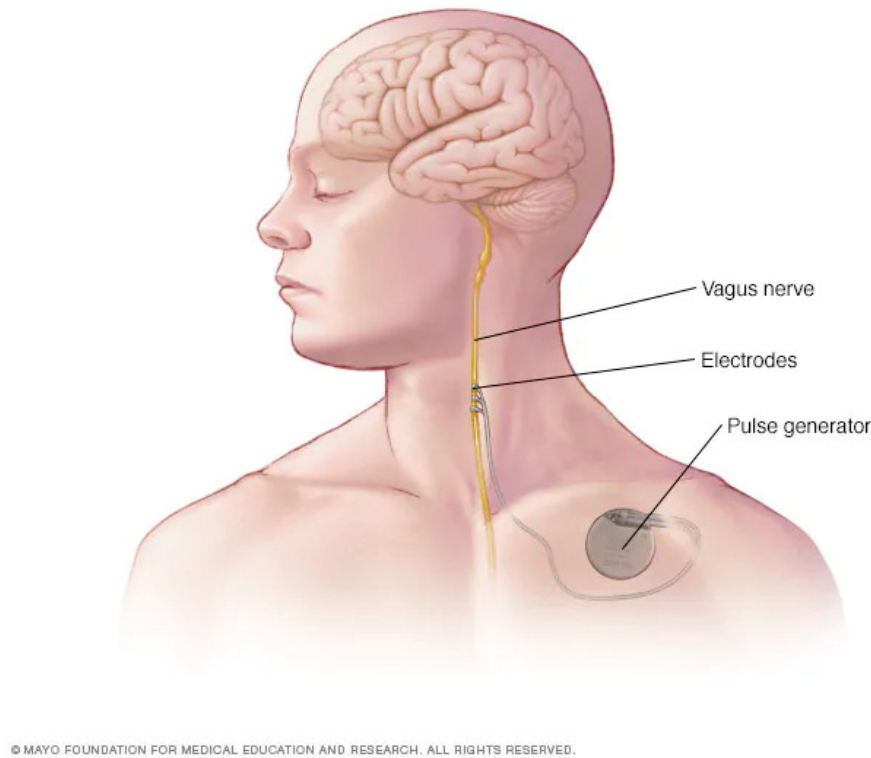


Figure 2.4: Components of the VNS system.

Vagus Nerve Anatomy and Connections

The vagal nerve (VN) is the longest cranial nerve and exerts a wide range of effects on the body. It comprises two nerves, the left and right vagus nerves and comprises both sensory and motor fibers. The vagal nerve is a mixed nerve made up of 75% sensory (afferent) fibers responsible for the side effects observed (e.g. coughing, difficulties of swallowing, voice modification effects), and 25% efferent fibers which mainly send feedback from heart, lungs, stomach and upper bowel. [Bonaz et al., 2017].

The majority of vagus nerve fibers are comprised of afferents and project to the nucleus tractus solitarius (NTS), which in turn sends fibers to other brainstem nuclei important in modulating the activity of subcortical and cortical circuitry. This vagus afferent network (VagAN) is thought to be the neural substrate of VNS efficacy [Hachem et al., 2018]. The NTS receives direct inputs from the VN and projects to other brainstem nuclei: the locus coeruleus (LC), dorsal raphe nucleus (DRN), and parabrachial nucleus (PBN) [Ricardo and Tongju Koh, 1978]. The functional importance of NTS connectivity in modulating seizure activity is further borne out by findings in rats that increased inhibitory gamma-aminobutyric acid (GABA) signaling or decreased excitatory glutamate signaling within the NST, reduces the susceptibility to chemically induced limbic motor seizures [Walker et al., 1999].

The LC is characterized by widely diffused projections to both subcortical and cortical structures. The projections of the LC are small unmyelinated fibers, forming a wide antero-posterior branching network to reach the raphe nuclei, the cerebellum, and almost all areas of the midbrain and forebrain regions. The LC is the main source of norepinephrine (NE) in the brain [Aghajanian et al., 1977]. NE is a neurotransmit-

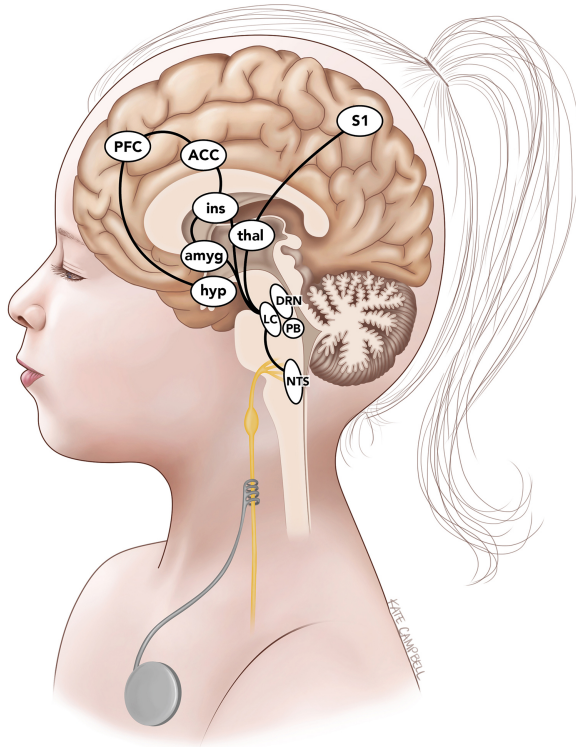


Figure 2.5: The vagus afferent network. Schematic diagram showing the important brainstem centers and subcortical and cortical structures. [Campbell, , Hachem et al., 2018]

ter that has been associated with the clinical effects of VNS by preventing seizure development and by inducing long-term plastic changes that could restore a normal function of the brain circuitry. Indeed, short bursts of VNS increase neuronal firing in the LC, leading to elevations in NE concentrations. [Berger et al., 2021]

Studies have demonstrated indirect projection of the LC to the DRN, which sends widespread projections to upper cortical regions. DRN appears to have a more delayed response to VNS [Hachem et al., 2018].

Vagal afferents project to the PBN by way of both the NTS and LC. Cell bodies within the PBN send diffuse outputs to forebrain structures including the thalamus, insular cortex, amygdala, and hypothalamus. Moreover, PBN likely plays an important role in regulating thalamocortical circuitry that may be implicated in seizure generation. Specifically, PBN activates the intralaminar nuclei of the thalamus, which in turn relays sensory signals to widespread cortical areas. [Hachem et al., 2018]

The Vagus Afferent Network

Structural and Functional connectivity

Structural connectivity and functional connectivity are two concepts that describe different aspects of brain organization. Structural connectivity refers to the anatomical organization of the brain by means of fiber tracts that connect different brain regions. Functional connectivity refers to the statistical dependence or correlation of neural activity patterns between different brain regions. Structural connectivity is often measured by diffusion magnetic resonance imaging (dMRI). Functional connectivity is often measured by electro-encephalography (EEG) or functional magnetic resonance

imaging (fMRI)¹.

The main difference between structural connectivity and functional connectivity is that structural connectivity reflects the physical architecture of the brain, while functional connectivity reflects the dynamic interactions of neural activity. Functional connectivity can emerge from direct or indirect structural connections, as well as from external inputs or intrinsic dynamics.

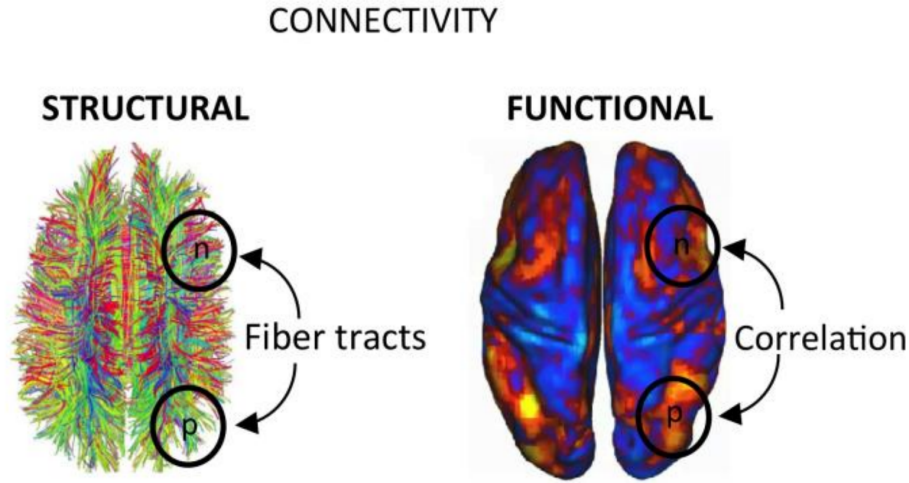


Figure 2.6: Differences between structural and functional connectivity [Cabral et al., 2017].

Thalamocortical Connections

Thalamocortical connections are believed to be an important substrate of VNS responsiveness because they modulate cortical excitability, rendering the brain less susceptible to seizures. The thalamus receives direct inputs from the NTS and PBN [Beckstead et al., 1980]. More recently, thalamic activation measured by BOLD fMRI was associated with improved VNS treatment response in patients with seizures [Narayanan et al., 2002]. The importance of thalamocortical connections in mediating the VNS antiseizure effect is further borne out by a study that utilized resting-state functional MRI (rs-fMRI) data pre-VNS implantation and found an association of greater VNS efficacy with larger connectivity between the thalami to the anterior cingulate cortex (ACC) and left insular cortex [Ibrahim et al., 2017]. Significantly greater FA was observed in VNS (lateralized to the left) responders particularly within anterior and retrolenticular limbs of the internal capsule, anterior, superior and posterior corona radiata, and posterior thalamic radiation. Functional connectivity in MEG also supports the role of intrinsic thalamocortical connectivity in VNS responders, was found that a functional network is significantly more active in VNS responders. [Mithani et al., 2019]

¹fMRI is a non invasive neuroimaging technique that detects the changes in blood oxygenation and flow that occur in response to neural activity

Limbic Circuitry

The limbic system is a collection of neuronal structures involved in controlling emotion, memory, behavior, and motivation. The fornix is the main efferent tract of the hippocampus projecting to the mammillary bodies, nucleus accumbens, septal nuclei, anterior thalamic nuclei and cingulate cortex. While the stria terminalis forms the major input tract from the amygdala to the hypothalamus.

In fornix and stria terminalis, exclusively lateralized to the left, was observed a greater FA in VNS responders. A functional analysis performed by MEG² revealed a functional network with significantly greater connectivity in VN responders. These change in the structure and function connectivity imply that the limbic system is involve in an antiseizure action. [Mithani et al., 2019, Mithani et al., 2020]

2.3 Review of DW-MRI in VNS

DTI

In a study of 56 children done by Mithani et al significantly greater FA (within the left size) was observed in VNS responders in the left internal capsule, external capsule, corona radiata, posterior thalamic radiation, fornix and stria terminalis, superior longitudinal fasciculus, inferior longitudinal fasciculus, and inferior front-occipital fasciculus. The mean FA value in these tracts was 0.352 (standard deviation SD = 0.048) in responders and 0.309 (SD = 0.064) in non responders. No significant voxels were observed in the right hemisphere. Furthermore, no statistically significant differences were observed in any other DTI parameters, including MD, radial diffusivity, and axial diffusivity. Healthy controls showed that the profile of responders was more closely related to healthy children than non responders. The mean FA value in significant tracts for matched controls was 0.377 (SD = 0.0274) in healthy controls. [Mithani et al., 2019].

A study conducted on a 4-year-old boy with intractable epilepsy at 10 months after implantation of VNS showed increased FA in the right fimbria-fornix at the level of both cerebral peduncles. [Fan et al., 2014]

²Magnetoencephalography: is a functional neuroimaging technique that maps brain activity by recording magnetic fields produced by electrical currents occurring naturally in the brain, using very sensitive magnetometers.

Chapter 3

Methods

3.1 Data

3.1.1 Subjects

3.1.2 Data acquisition

The MRI acquisitions were realized following the *LivaNova guidelines*, requiring the neurostimulators to be turned off during the acquisitions. A trained neurologist used the programming system to set the output current of the device to 0 mA and turn off the sensing before that the patients entered the MRI acquisition room.

Imaging data were acquired using the *SIGNA™ Premier 3T MRI* system (GE Healthcare, Milwaukee, WI, USA), with a transmit-receive 48-channel head coil. T1-anatomical images were acquired using a *Magnetization Prepared - RApid Gradient Echo* (MPRAGE) sequence with the following parameters: $TR = 2186ms$, $TE = 2.95ms$, $FA = 8^\circ$, $TI = 900ms$, bandwidth = $244.14Hz$, matrix size = 256×256 , 156 axial slices, imaging frequency = $127.77Hz$, voxel size = $1 \times 1 \times 1 mm^3$, acquisition time = 5:26 min.

Diffusion MRI data were acquired with a *Pulsed Gradient Spin Echo* (PGSE) sequence with the following parameters : $TR = 4837ms$, $TE = 80.5ms$ and flip angle = 90° . A multi-shell diffusion scheme was used and was composed of 64 gradients at $b = 1000$, and 32 gradients at $b = 2000, 3000$ and $5000 [s \cdot mm^{-2}]$, interleaved with 7 b_0 images. The in-plane FOV was $220 \times 220 mm^2$ and the data contained 68 axial slices with a $2mm$ thickness (no inter-slice gap, $2mm$ isotropic voxels). A multi-slice excitation scheme was used during the acquisition with a hyperband slice factor of 3 to reduce the acquisition time. The total acquisition time was 13:33 min.

Anatomical files are composed of a NIfTI file (`.nii.gz`) 3.2 containing the measured signal and a JSON file (`.json`) regrouping the acquisition sequence parameters.

Figure 3.1: Anatomical volume slices of a T1 in the sagittal, frontal and axial views

Figure 3.2: Anatomical volume slices of a T2 in the sagittal, frontal and axial views

Diffusion files are composed of a NIfTI file and a JSON file plus two text files (`.bval`) and (`.bvec`) containing the b-values and the b-vectors.

Figure 3.3: Raw diffusion volume slices of a patient for different b-values

3.2 Data preprocessing

3.3 Tractography

3.4 Microstructural analysis

3.5 Statistical analysis

Chapter 4

Results

Chapter 5

Discussion

5.1 Limitations

5.2 Applications

Conclusion and perspectives

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UNIVERSITÉ CATHOLIQUE DE LOUVAIN
École polytechnique de Louvain

Rue Archimède, 1 bte L6.11.01, 1348 Louvain-la-Neuve, Belgique | www.uclouvain.be/epl