DIR-visible grey matter lesions and atrophy in multiple sclerosis: partners in crime?

Steven H P van de Pavert,¹ Nils Muhlert,¹,² Varun Sethi,¹ Claudia A M Wheeler-Kingshott,¹ Gerard R Ridgway,³,⁴ Jeroen J G Geurts,⁵ Maria Ron,¹ Tarek A Yousry,⁶ Alan J Thompson,¹,⁷ David H Miller,¹,⁷ Declan T Chard,¹,⁷ Olga Ciccarelli¹,⁷

ABSTRACT

Background The extent and clinical relevance of grey matter (GM) pathology in multiple sclerosis (MS) are increasingly recognised. GM pathology may present as focal lesions, which can be visualised using double inversion recovery (DIR) MRI, or as diffuse pathology, which can manifest as atrophy. It is, however, unclear whether the diffuse atrophy centres on focal lesions. This study aimed to determine if GM lesions and GM atrophy colocalise, and to assess their independent relationship with motor and cognitive deficits in MS.

Methods Eighty people with MS and 30 healthy controls underwent brain volumetric T1-weighted and DIR MRI at 3 T, and had a comprehensive neurological and cognitive assessment. Probability mapping of GM lesions marked on the DIR scans and voxel-based morphometry (assessing GM atrophy) were carried out. The associations of GM lesion load and GM volume with clinical scores were tested.

Results DIR-visible GM lesions were most commonly found in the right cerebellum and most apparent in patients with primary progressive MS. Deep GM structures appeared largely free from lesions, but showed considerable atrophy, particularly in the thalamus, caudate, pallidum and putamen, and this was most apparent in secondary progressive patients with MS. Very little co-localisation of GM atrophy and lesions was seen, and this was generally confined to the cerebellum and postcentral gyrus. In both regions, GM lesions and volume independently correlated with physical disability and cognitive performance.

Conclusions DIR-detectable GM lesions and GM atrophy do not significantly overlap in the brain but, when they do, they independently contribute to clinical disability.

INTRODUCTION

Grey matter (GM) pathology has emerged as a significant and clinically relevant component of multiple sclerosis (MS). Advances in MRI technology have allowed the assessment of GM pathology in MS in vivo. Both GM volume loss (atrophy) and GM lesions occur in MS, and both correlate with neurological and cognitive deficits.¹ However, a key question is whether they share a common pathogenic mechanism, in particular whether lesions are the cause of atrophy or are caused by an independent process that contributes to clinical outcomes.

Histopathological studies have identified extensive cortical demyelination in people with MS and in those with progressive disease, GM lesion volume may exceed that of WM lesions.² However, it has proven difficult to detect in vivo GM lesions using conventional MRI techniques. Only a small percentage of GM lesions are identified on T2-weighted (<10%) and on fluid-attenuated inversion recovery (FLAIR) scans.³ The development of double inversion recovery (DIR) MRI has nearly doubled the detection of GM lesions.⁴ DIR studies demonstrate that GM lesions are spread throughout the cortex, appear early in the course of the disease and accumulate over time.⁵ ⁶

Deep and cortical GM atrophy is now well-recognised in MS and appears to accelerate as patients with MS enter a progressive phase of the disease.¹ GM atrophy is thought to mark irreversible tissue loss and it is likely to reflect a combination of neuronal morphological changes and loss, and glial abnormalities.¹ Previous in vivo work provides insight into the mechanisms of GM injury in MS. Two studies have assessed the relationship between GM atrophy and WM injury, and these showed that lesions in connecting WM tracts are associated with deep GM atrophy.⁷ ⁸ Lesions could directly cause localised atrophy, as suggested by pathological studies showing axonal transection and loss in cortical lesions.¹ There has been little histopathological work examining the co-localisation of cortical atrophy and demyelination, but in the only study we are aware of, local cortical thickness did not correlate with demyelination.⁹ However, fixation can affect cortical thickness (and fixation time may be correlated with it), and so it is possible that this may have obscured an association. As such, it is preferable to look for associations in fresh tissue samples or, better still, in vivo.

This study sought to clarify the spatial overlap between GM atrophy and GM lesions, as well as their independent relationship with cognitive and physical disability, in a large cohort of patients with MS and in different MS subtypes.

METHODS

We recruited 80 people who fulfil the following inclusion criteria: diagnosis of clinically definite MS;¹⁰ absence of a relapse or use of corticosteroids within the preceding 4 weeks; age <65 years; and no other neurological conditions which could have influenced the pattern of GM atrophy. Thirty
healthy volunteers with no known neurological disease were also studied. Patients were consecutively recruited from the National Hospital’s specialist MS clinics. Status of disease modifying therapy (DMT), antidepressant for either depression or neuropathic pain, and benzodiazepine for spasm or insomnia were recorded. All participants gave written informed consent.

Clinical status was assessed using the Expanded Disability Status Scale (EDSS)\textsuperscript{13,15} and the MS functional composite score (MSFC) which includes walking speed on the 25-foot Timed Walk Test (25TWT), 9-hole Peg Test (9HPT) and the Paced Auditory Serial Addition Test (PASAT). Z-scores of these tests were calculated using published means and SDs. Levels of anxiety and depression were also assessed using the Hospital Anxiety and Depression Scale.\textsuperscript{12}

All subjects underwent cognitive testing to assess executive function and memory. Executive function was assessed using the Hayling Sentence Completion Task\textsuperscript{13,14} and Stroop Task,\textsuperscript{14} from which averaged z-scores were calculated on the basis of healthy control performance, and the Symbol Digit Modalities Test (SDMT), from which the age-adjusted z-scores were calculated based on published normative values.\textsuperscript{15} Memory function was evaluated using a composite score of story recall (immediate and 30 min delay) and figure recall (immediate and 30 min delay) from the Adult Memory and Information Processing Battery,\textsuperscript{16} and word and face recognition from the Recognition Memory Test.\textsuperscript{17} z-scores based on the performance of the control sample were also calculated for these tests. When participants were not able to complete the task, their missing data would not be considered for the task’s analysis; these were executive function in one patient with primary progressive MS (PPMS), 25TWT in 3 PPMS, 1 relapsing–remitting MS (RRMS) and 9 patients with secondary progressive MS (SPMS), and 9HPT in 1 RRMS and 1 patient with SPMS.

MRI protocol
Brain MRI was performed on a Philips 3 T Achieva TX system (Philips Healthcare, Best, the Netherlands) using a 32-channel receive-only coil. T1-weighted (TR=6.9 ms, TE=3.1 ms, TI=824.5 ms, SENSE=2, voxel size =1×1×1 mm), turbo FLAIR (TR=8000 ms, TE=125 ms, TI=2400 ms, SENSE=1.3, voxel size=1×1×3 mm), and DIR (TR=16000 ms, TE=9.9 ms, TI=2400/325 ms, SENSE=4.16, 1×1×3 mm) sequences were acquired.

Image registration and lesion mapping
To limit the impact of WM lesions on tissues segmentations, T1-weighted (T1w) hypointense lesions were filled\textsuperscript{18} and the lesion-filled T1w images were then segmented using SPMS (http://www.fil.ion.ucl.ac.uk/spm/). Anatomical normalisation to Montreal Neurological Institute (MNI) space was achieved via a custom diffeomorphic anatomical registration through exponentiated Lie algebra (DARTEL) template,\textsuperscript{19} generated from all subjects’ (N=110) GM tissue segmentations. To make use of MNI atlases, the DARTEL GM template was affine-registered to the MNI standard space, and each subject’s T1-weighted GM was first non-linearly registered to the DARTEL template, and subsequently affine registered to MNI using the DARTEL to MNI transformation, moving it into MNI template space. This pipeline reduces the adverse effect of disease-associated brain atrophy on the registration accuracy. Spatially normalised T1-weighted images were averaged over subjects to form a study-specific T1-weighted MNI-space template. When spatially normalising the segmented GM images to MNI space (via the DARTEL and affine transformations), the images were modulated by the Jacobian determinants so that intensities represent the amount of deformation needed to normalise the images. All registrations were reviewed by SvdP to confirm their accuracy. Modulated, normalised, segmented GM images were smoothed with an 8 mm full-width at half-maximum Gaussian kernel.\textsuperscript{20}

GM lesions were marked on the DIR scans using JIM (V6.0, Xinapxe Systems, Northants, UK) by two independent raters (VS and SvdP) according to consensus guidelines.\textsuperscript{21} Marking of lesions was compared between raters and a consensus was reached on all lesions. Subsequently, one in five scans were analysed by DC, after which a final consensus was reached. Total GM lesion volume was then calculated.

Each participant’s DIR scan was affine registered to their T1-weighted scan; their DIR-to-T1 affine transformation, T1-to-DARTEL deformation field and DARTEL-to-MNI affine transformation were combined and used to move the binarised GM lesion mask into MNI space. All registrations were carried out in SPM8. After a nearest-neighbor interpolation, an 8 mm full-width at half-maximum Gaussian Kernel was then used to smooth the normalised lesion masks.

Two patients (one with SPMS, one with PPMS) were excluded from the subsequent imaging analysis due to inadequate registration.

Co-localisation of GM atrophy and lesions
Voxel-based morphometry (VBM) and GM lesion probability mapping (LPM) analyses were carried out in SPM8. Two types of analyses were carried out: voxel-wise comparisons and region of interest (ROI) analyses. For voxel-wise VBM comparison, we used a significance level of 0.05 (family wise error (FWE) corrected). For voxel-wise LPM, we used a significance level of 0.001 (uncorrected). This threshold was used as no lesion clustering was found at 0.05 (FWE corrected).

In VBM and LPM comparisons, people with MS were compared to healthy controls to assess areas significantly more affected in people with MS.

To determine co-localisation of volume loss and DIR-visible GM lesions, permutation tests were run using Randomise\textsuperscript{22} implemented in FSL (FMRIB’s software library, http://www.fmrib.ox.ac.uk/fsl). For each of the MS groups, the following regression model was tested per voxel (ie, with LPM as a voxel-wise covariate; sometimes known as biological parametric mapping\textsuperscript{23}):

\[
\text{VBM} = \text{LPM} \times B_1 + \text{age} \times B_2 + \text{sex} \times B_3
\]
\[+ \text{total intracranial volume} \times B_4 + \text{intercept}\]

Total intracranial volume (ICV) was estimated by summing the thresholded GM, white matter (WM) and cerebrospinal fluid volumes using the ‘get_totals’ function in SPM8.

FSL Randomise uses a non-parametric permutation-testing procedure that derives an empirical null distribution without making assumptions about the normality of the data. The tests were performed in an inclusive GM mask (the average of the GM segments over subjects, thresholded at 0.5), using a cluster-forming threshold, and an uncorrected cluster-extent-based significance level of 0.01, with 5000 permutations.

The second analysis employed an ROI approach. ROIs involved in tasks assessing clinical and cognitive functioning in MS\textsuperscript{24,25} were chosen a priori. These regions were the bilateral cerebellum, medial temporal lobe, postcentral gyrus, precentral gyrus, insula, prefrontal cortex and thalamus (figure 1). Masks
for these regions were created by using Freesurfer to automatically segment the MNI-space cohort-specific T1-weighted template. For each GM ROI and in each patient, the total GM lesion volume and the GM volume were extracted from the VBM and LPM images, and co-localisation between atrophy and lesion load was assessed using linear regression analyses, correcting for age, sex, and ICV.

**Associations of disability with GM lesion load and GM atrophy**

To explore the associations of DIR-visible GM lesion load and GM atrophy with clinical measures (EDSS, PASAT, 9HPT, 25TWT, executive function and memory function), voxel-wise and ROI analyses were carried out. The first analysis, based on a voxel-wise factorial design, was conducted in SPM8, including age, sex and ICV, and using VBM or LPM values. In all voxel-wise comparisons, a cluster threshold of five voxels was applied. Linear regression models used EDSS, PASAT, 9HPT, 25TWT, executive function and memory function as the dependent variables; GM lesion load and GM volume extracted from the ROIs were used as the independent variables. Age, sex and ICV were also added to the model as additional covariates. SPSS (V21.0. Armonk, New York, USA: IBM Corp) was used to conduct this analysis. Differences between subtypes in scores, volume loss and lesion load were analysed using unpaired t tests (for VBM values) or non-parametric tests (for lesion-loads since they were non-normally distributed). When both GM lesion load and GM volume were compared between patients and controls (all p<0.001), with SPMS having a higher EDSS than patients with PPMS, who in turn had a higher EDSS than patients with RRMS (see table 1). All patient groups had significantly higher levels of depression than controls (all p<0.05), but no significant difference was found between subgroups. Anxiety levels were comparable between patients and controls. People with MS performed worse than healthy controls in all clinical domains. Patients had poorer executive functioning and memory function than healthy controls (all p<0.01). Memory functioning was best in patients with RRMS, followed by patients with PPMS, who in turn performed better than the SPMS subgroup (p<0.05 and p<0.01, respectively). When correcting for depression on clinical functioning, except for the subgroup comparison of patients with SPMS and PPMS on memory function, all group comparisons remained significant on all domains.

**GM atrophy**

People with MS showed significant GM atrophy compared to controls (figure 2A), predominantly in deep GM structures (thalamus, pallidum, putamen and caudate) in addition to a few small regions in the frontal (0.09 cm³), insular (0.06 cm³) and temporal lobes (0.12 cm³). Similarly, in the a priori defined ROIs (ie, cerebellum, medial temporal lobe, postcentral gyrus, precentral gyrus, insula, prefrontal cortex and thalamus, figure 1), mean GM volume was significantly smaller in patients than controls in the thalamus (p<0.001) and insula (p<0.05). Subgroup analyses, which showed that the most extensive atrophy in the deep GM regions and cortical areas was seen in SPMS, are reported in the online supplementary material.

**GM lesions**

In patients, 1476 DIR visible lesions were found throughout the GM (neocortex: 1276, cerebellum: 154, deep GM: 46), with a mean total lesion volume of 1.20 cm³ (SD=0.92 cm³). Fourteen GM lesions were identified in healthy controls (in 4 participants).

At a threshold of p<0.001, patients had significantly higher GM lesion probability only in the right cerebellar hemisphere when compared with healthy controls (0.07 cm³; tmax=3.37; figure 2B). No deep GM structures showed a significantly increased lesion probability at this threshold or at a lower threshold (p<0.01, uncorrected). However, at this lower threshold, additional cortical areas showed increased lesion probability, notably the right precentral and postcentral gyrus, bilateral supplementary motor area, and bilateral temporal lobes (data not shown). People with MS had significantly more lesions in every ROI than healthy volunteers (all p<0.001). Subgroup analyses, which showed that PPMS and SPMS had regions of higher GM lesion probability than healthy controls, are detailed in the online supplementary material.

**Co-localisation of GM atrophy and lesions**

In the whole MS group, voxel-wise analyses showed that there was little co-localisation of GM atrophy and lesions. Overall the volume of co-localisation was much smaller (less than 1 cm³) when compared with total brain GM volumes (>500 cm³). Areas that showed a significant association between a higher probability of a voxel being lesional and smaller GM volume were scattered throughout the brain, particularly in the cerebellum (figure 2C). ROI analyses found that increased GM lesion load was significantly associated with reduced GM volume
within the cerebellum (B = −17.76, p < 0.001) and postcentral gyrus (B = −4.77, p = 0.037). The greatest extent of co-localisation was found in the PPMS cohort, while no co-localisation was seen in any group in the deep GM regions (see online supplementary material for more details on the subgroup analyses).

### Associations of GM atrophy and lesion load with clinical status

Voxel-wise models at p < 0.05 (FWE corrected) in people with MS subgroups differed significantly (all p < 0.05). All MS subgroups differed in their levels of depression from controls (all p < 0.05), but not between each other. *Patients with RRMS were significantly younger than patients with PPMS and SPMS (both p < 0.001). †Patients with SPMS had longer disease duration than patients with RRMS and SPMS (both p < 0.001). ‡All MS subgroups differed significantly (all p < 0.05). §All MS subgroups differed in their levels of depression from controls (all p < 0.05), but not between each other. ††Patients performed worse than healthy controls (p < 0.01). * *Controls performed better than patients (p < 0.01). Patients with RRMS performance was better than patients with PPMS, who in turn performed better than the SPMS subgroup (p < 0.05 and p < 0.01, respectively).

### DISCUSSION

The present study assessed the distributions of DIR-visible GM lesions and GM atrophy in patients with MS, aiming to determine if they co-localise and if they both contribute to clinical outcomes. Co-localisation was at best modest, with the majority of atrophy occurring in regions that showed few GM lesions. Of the GM regions found to be consistently atrophic or to contain lesions, only the cerebellum and postcentral gyrus showed associations between both types of pathology, and physical and cognitive function.

Deep GM volume was reduced in patients compared to controls. This is in line with previous findings. More limited cortical atrophy was also seen in regions consistent with past literature, including the right lateral prefrontal cortex, the left temporal and prefrontal cortex, and the bilateral superior and medial frontal gyrus and orbitofrontal regions. In addition, small areas of cortical atrophy were seen in the frontal, insular and temporal lobes, as reported previously. The most extensive atrophy was seen in SPMS and a feature common to all subtypes was thalamic atrophy, which was particularly extensive in the SPMS group; this is in line with previous findings.

GM lesions were found throughout the cerebral and cerebellar cortex, particularly in the right cerebellum, but rarely in the deep GM structures. Co-localisation between GM atrophy and GM lesions was observed only when lower statistical thresholds were used, and then too mainly in the cortical regions. It was

### Table 1 Demographics and clinical performance

<table>
<thead>
<tr>
<th></th>
<th>PPMS</th>
<th>RRMS</th>
<th>SPMS</th>
<th>All patients</th>
<th>Healthy controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Females/males</td>
<td>14/11</td>
<td>20/10</td>
<td>14/11</td>
<td>48/32</td>
<td>18/12</td>
</tr>
<tr>
<td>Age (years)†</td>
<td>52.5 (9.8)</td>
<td>42.5 (9.6)</td>
<td>52.8 (7.6)</td>
<td>48.8 (10.2)</td>
<td>37.8 (11.8)</td>
</tr>
<tr>
<td>Disease duration (years)†</td>
<td>12.0 (7.4)</td>
<td>11.5 (10.5)</td>
<td>24.0 (8.2)</td>
<td>15.6 (10.5)</td>
<td>–</td>
</tr>
<tr>
<td>DMT (number of patients)</td>
<td>1</td>
<td>20</td>
<td>7</td>
<td>28</td>
<td>–</td>
</tr>
<tr>
<td>Psychotopic drugs (number of patients)</td>
<td>6</td>
<td>8</td>
<td>9</td>
<td>24</td>
<td>–</td>
</tr>
<tr>
<td>Benzodiazepines (number of patients)</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>–</td>
</tr>
<tr>
<td>Median EDSS (range)‡</td>
<td>6.0 (0.0–6.5)</td>
<td>1.75 (1.0–6.5)</td>
<td>6.5 (4.5–8.5)</td>
<td>5.75 (0.0–8.5)</td>
<td>–</td>
</tr>
<tr>
<td>HADS depression§</td>
<td>6.40 (3.59)</td>
<td>5.83 (3.56)</td>
<td>7.12 (3.69)</td>
<td>6.41 (0.40)</td>
<td>2.87 (3.50)</td>
</tr>
<tr>
<td>HADS anxiety</td>
<td>6.08 (4.33)</td>
<td>6.93 (3.31)</td>
<td>7.16 (4.18)</td>
<td>6.74 (0.44)</td>
<td>5.77 (4.41)</td>
</tr>
<tr>
<td>z PASAT</td>
<td>–0.70 (1.38)</td>
<td>–0.69 (1.32)</td>
<td>–0.94 (1.12)</td>
<td>–0.77 (1.27)</td>
<td>0.12 (1.05)</td>
</tr>
<tr>
<td>z SHPT</td>
<td>–1.00 (1.13)</td>
<td>–0.66 (0.65)</td>
<td>–1.16 (0.90)</td>
<td>–0.93 (0.92)</td>
<td>0.63 (0.61)</td>
</tr>
<tr>
<td>z 25TWT</td>
<td>0.32 (0.97)</td>
<td>0.00 (1.03)</td>
<td>0.56 (1.01)</td>
<td>0.24 (1.02)</td>
<td>–0.44 (0.08)</td>
</tr>
<tr>
<td>Composite z MSFC</td>
<td>–0.62 (0.81)</td>
<td>–0.41 (0.76)</td>
<td>–0.77 (0.66)</td>
<td>–0.56 (0.76)</td>
<td>–</td>
</tr>
<tr>
<td>Hayling</td>
<td>4.80 (2.02)</td>
<td>5.17 (2.09)</td>
<td>4.64 (2.43)</td>
<td>4.89 (2.16)</td>
<td>6.17 (1.76)</td>
</tr>
<tr>
<td>Stroop</td>
<td>174.4 (76.7)</td>
<td>135.83 (36.9)</td>
<td>174.58 (80.9)</td>
<td>158.59 (66.7)</td>
<td>109.80 (20.0)</td>
</tr>
<tr>
<td>SDMT</td>
<td>43.44 (11.91)</td>
<td>52.33 (9.88)</td>
<td>41.09 (10.45)</td>
<td>46.23 (11.71)</td>
<td>63.10 (9.91)</td>
</tr>
<tr>
<td>Composite z executive†</td>
<td>–1.58 (1.69)</td>
<td>–0.71 (1.09)</td>
<td>–1.51 (1.55)</td>
<td>–1.23 (1.48)</td>
<td>0.23 (0.69)</td>
</tr>
<tr>
<td>Story recall immediate</td>
<td>30.04 (10.96)</td>
<td>33.97 (11.35)</td>
<td>27.76 (11.44)</td>
<td>30.80 (11.42)</td>
<td>37.13 (10.35)</td>
</tr>
<tr>
<td>Story recall delay</td>
<td>27.20 (12.29)</td>
<td>31.57 (10.93)</td>
<td>24.80 (12.22)</td>
<td>28.09 (11.97)</td>
<td>34.90 (10.31)</td>
</tr>
<tr>
<td>Figure recall immediate</td>
<td>51.09 (15.41)</td>
<td>62.20 (11.14)</td>
<td>51.57 (16.17)</td>
<td>55.80 (14.86)</td>
<td>67.67 (11.94)</td>
</tr>
<tr>
<td>Figure recall delay</td>
<td>48.73 (15.84)</td>
<td>60.07 (11.22)</td>
<td>48.67 (14.83)</td>
<td>53.37 (14.72)</td>
<td>66.30 (12.06)</td>
</tr>
<tr>
<td>RMT Words</td>
<td>46.17 (3.63)</td>
<td>47.60 (2.43)</td>
<td>45.61 (3.69)</td>
<td>46.56 (3.31)</td>
<td>49.00 (1.26)</td>
</tr>
<tr>
<td>RMT Faces</td>
<td>40.21 (5.27)</td>
<td>42.33 (4.23)</td>
<td>37.43 (5.53)</td>
<td>40.21 (5.31)</td>
<td>44.27 (3.20)</td>
</tr>
<tr>
<td>Composite z memory**</td>
<td>–1.13 (1.15)</td>
<td>–0.55 (0.89)</td>
<td>–1.63 (1.27)</td>
<td>–1.13 (1.18)</td>
<td>0.00 (0.58)</td>
</tr>
</tbody>
</table>

Mean values are presented and values in parentheses are SDs, unless specified otherwise. Clinical scores presented in bold are used in image analyses to study different domains of clinical function.

**Multiple sclerosis


**Controls performed better than patients with RRMS, who in turn performed better than the SPMS subgroup (p < 0.05 and p < 0.01, respectively).

§All MS subgroups differed in their levels of depression from controls (all p < 0.05), but not between each other.

††Patients performed worse than healthy controls (p < 0.01).
Coordinates of sections are x = 29, y = -14, z = -22, z = 3. (B) Areas showing clusters of increased GM lesion probability in patients compared to controls at p < 0.001, uncorrected. The RRMS group did not show clusters of increased GM lesion probability at this threshold, while SPMS showed increased cerebellar lesion load and PPMS had clusters of increased lesion probability throughout the cerebral and especially the cerebellar cortex. Coordinates of sections are x = -5, y = -13, z = -39. (C) Areas showing a significant correlation of atrophy and increased probability of a GM voxel being lesional (at p < 0.01, uncorrected) in all patient groups together. Coordinates of sections are x = 29, y = -66, z = -28.

rarely seen in the deep structures, which showed atrophy. Work by Wegner et al.7 has shown pathological changes within cortical lesions and to a lesser degree, in non-lesional cortex, but did not find an association between demyelination and cortical thickness, suggesting that demyelination per se is not directly responsible for cortical atrophy. Our findings are in agreement with this and we, therefore, suggest with caveats (see the discussion of the limitations of this work below) that GM atrophy and DIR-visible GM lesion are often not directly linked. This view is supported by recent findings that cortical MTR abnormalities, which is heavily influenced by demyelination, rarely co-localises with atrophy in MS,20 further suggesting differences in pathogenic mechanisms.

Previous papers have demonstrated that the topographic distribution of GM lesions is rather similar between patient subtypes, and that PPMS and RRMS share more similarities than differences in terms of GM lesion number, volume and topographic distribution.5 Additionally, there are differences in GM atrophy between subtypes of MS which involve not only a selective involvement of brain regions but also an increased extent of atrophy in common regions, such as the thalamus, in the progressive phase of MS.34 We confirmed these findings in this paper and therefore, combined all the phenotypes to investigate the overlap between lesions and atrophy. Based on our observed differences between the subgroups, we performed a sample size calculation to estimate the number of subjects a future study might require to detect (with 80% power at 5% significance) a difference between subgroups in the volume of the prefrontal cortex (which was the ROI with the least power to detect differences) of 8 cm³ (as observed in our study), as well as in the proportion of lesional voxels of 0.22, using the means and SDs of concentrations provided by our data and standard methods for comparisons of means.15 We found that the sample size required to detect significant GM volume differences between subtypes of MS was 75 per group for GM volume and 39 per group for GM lesion probability. This

### Table 2

Regions with increased lesion probability associated with poorer performance in clinical domains (thresholded at p < 0.001 uncorrected)

<table>
<thead>
<tr>
<th>Domain</th>
<th>Region</th>
<th>Side</th>
<th>Peak T value</th>
<th>MNI coordinates of local maxima</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive function</td>
<td>Precentral gyrus</td>
<td>R</td>
<td>0.08 3.75</td>
<td>48 8 29</td>
</tr>
<tr>
<td></td>
<td>Superior frontal operculum</td>
<td>R</td>
<td>0.24 3.84</td>
<td>49 9 28</td>
</tr>
<tr>
<td></td>
<td>Anterior cingulum</td>
<td>L</td>
<td>0.07 3.48</td>
<td>-2 43 14</td>
</tr>
<tr>
<td></td>
<td>Cerebellum crus1</td>
<td>R</td>
<td>0.18 3.51</td>
<td>40 -65 -37</td>
</tr>
<tr>
<td></td>
<td>Cerebellum crus2</td>
<td>R</td>
<td>0.04 3.48</td>
<td>40 -65 -38</td>
</tr>
<tr>
<td></td>
<td>Cerebellum B</td>
<td>R</td>
<td>0.01 3.32</td>
<td>38 -57 -47</td>
</tr>
<tr>
<td>Memory function</td>
<td>Superior frontal lobe</td>
<td>R</td>
<td>0.01 3.29</td>
<td>17 3 72</td>
</tr>
<tr>
<td></td>
<td>Cerebellum crus2</td>
<td>L</td>
<td>0.02 3.31</td>
<td>-30 -77 -36</td>
</tr>
<tr>
<td></td>
<td>Supramarginal gyrus</td>
<td>R</td>
<td>0.01 3.28</td>
<td>58 -39 33</td>
</tr>
<tr>
<td></td>
<td>Cerebellum crus1</td>
<td>L</td>
<td>0.01 3.34</td>
<td>-29 -60 -38</td>
</tr>
<tr>
<td></td>
<td>Cerebellum B</td>
<td>L</td>
<td>0.03 3.59</td>
<td>-27 -58 -35</td>
</tr>
<tr>
<td></td>
<td>Precentral gyrus</td>
<td>R</td>
<td>0.04 3.36</td>
<td>11 -24 75</td>
</tr>
</tbody>
</table>

Lesion load in the cerebellum in particular is related to poorer executive, TWT speed, and PASAT performance. 9HPT, 9-hole Peg Test; zPASAT, Paced Auditory Serial Addition Test; 25TWT, 25-foot Timed Walk Test.

sample size calculation can be used by future studies that will aim to investigate the differences between groups in lesion probability and GM volume.

With regard to the association between GM lesions and atrophy with clinical disability, one interesting observation from the ROI analysis was that both GM lesion volume and atrophy in the postcentral gyrus (the primary somatosensory cortex) were linked to clinical measures of physical disability and to worse performance in almost all cognitive domains. Additionally, a significant and independent association was found between cerebellar lesion load and atrophy with lower physical and cognitive performance. This fits with the known involvement of the cerebellum in sensorimotor and cognitive function. In addition, the postcentral gyrus and cerebellum, which are both functionally and structurally connected, were the only regions in which lesion burden and volume loss were linked. Further work focusing on these two regions may shed light on the mechanisms of disability in MS. Using the voxel-wise analysis, we found that deep GM atrophy was generally not linked to functional outcomes, except for an effect of SSRIs and benzodiazepines on the PASAT, stroop, verbal memory or executive function test performance. These did, however, show an effect on a reaction time test. While use of psychotropic drugs may have subtly influenced our findings, the concomitant alleviation of depression, which is itself linked to cognitive impairment, is likely to have balanced out these effects. Not all patients were able to finish all clinical tasks due to disability, which led to the exclusion of their missing data from this task’s analysis. It is, therefore, likely that the effects found were an underestimation of the real effects of MS as the excluded disabled patients were likely to also have the poorest cognitive function.

The present study assessed the distributions of DIR-visible GM lesions and GM atrophy in patients with different subtypes of MS and their relationship with clinical outcomes. We found that GM lesions (as seen using DIR) and GM atrophy do not usually co-localise, indicating that they are not directly spatially coupled. We also found that both GM lesions and atrophy separately contributed to disability, suggesting that the substrates of disability in MS are both pathologically and spatially heterogeneous.

### Author affiliations

1. NMR Research Unit, Queen Square Multiple Sclerosis Centre, UCL Institute of Neurology, London, UK
2. School of Psychology and Cardiff University Brain Research Imaging Centre, Cardiff University, Cardiff, Glamorgan, UK
3. Wellcome Trust Centre for Neuroimaging, UCL Institute of Neurology, London, UK
5. Department Anatomy & Neurosciences, Section of Clinical Neuroscience, VU University Medical Centre, Amsterdam, The Netherlands
6. Sara Koe PSP Research Centre, UCL Institute of Neurology, London, UK
7. NIHR UCL/UCLH Biomedical Research Centre, London, UK

---

### Table 3 MRI abnormality (volume loss and/or lesions) in ROIs significantly associated with poorer clinical function

<table>
<thead>
<tr>
<th>Domain</th>
<th>ROI</th>
<th>Total GM volume</th>
<th></th>
<th>GM lesion volume</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>B</td>
<td>SE</td>
<td>p Value</td>
<td>Adj R²</td>
</tr>
<tr>
<td>EDSS</td>
<td>Cerebellum</td>
<td>−0.053</td>
<td>0.022</td>
<td>0.018</td>
<td>0.203</td>
</tr>
<tr>
<td></td>
<td>Postcentral gyrus</td>
<td>−0.294</td>
<td>0.093</td>
<td>0.002</td>
<td>0.242</td>
</tr>
<tr>
<td>Executive function</td>
<td>Cerebellum</td>
<td>0.042</td>
<td>0.015</td>
<td>0.006</td>
<td>0.067</td>
</tr>
<tr>
<td></td>
<td>Postcentral gyrus</td>
<td>0.026</td>
<td>0.011</td>
<td>0.020</td>
<td>0.066</td>
</tr>
<tr>
<td></td>
<td>Prefrontal lobe</td>
<td>0.011</td>
<td>0.004</td>
<td>0.014</td>
<td>0.156</td>
</tr>
<tr>
<td></td>
<td>Prefrontal lobe</td>
<td>0.072</td>
<td>0.023</td>
<td>0.001</td>
<td>0.150</td>
</tr>
<tr>
<td></td>
<td>Prefrontal lobe</td>
<td>0.034</td>
<td>0.015</td>
<td>0.001</td>
<td>0.122</td>
</tr>
<tr>
<td>Prefrontal lobe</td>
<td>Prefrontal lobe</td>
<td>0.026</td>
<td>0.011</td>
<td>0.025</td>
<td>0.052</td>
</tr>
</tbody>
</table>

*If both volume loss and increased lesion burden is associated, the strongest contributor is presented in bold.

EDSS, Expanded Disability Status Scale; GM, grey matter; z9HPT, 9-hole Peg Test; z25WT, 25-foot Timed Walk Test; zPASAT, Paced Auditory Serial Addition Test; ROI, region of interest.
Acknowledgements The authors would like to thank all the participants in this study, as well as Daniel Attman (London School of Hygiene and Tropical Medicine) and Carmen Tur (UCL Institute of Neurology) for help with some of the statistical analyses.

Contributors NM, DTC, DHM, AIT and OC were involved in the conception and design of the study. NM and VS recruited and obtained consent from participants. SHPvdP, NM, VS and GRR conducted the MRI processing and statistical analyses. All authors contributed to preparation of the manuscript.

Funding This work was supported by the MS Society of Great Britain and Northern Ireland (grant numbers 892/08 and 917/09). This work was undertaken at University College London Hospitals/ University College London who received a proportion of funding from the Department of Health’s National Institute for Health Research Biomedical Research Centre’s funding scheme. SHPvdP received research support from Stichting MS Research and Prinses Beatrix Fonds. NM is supported by a Wellcome Trust ISSF fellowship and a Welsh Government NISCHR Health Fellowship. GR is supported by the Medical Research Council (grant number MR J014257/1). The Wellcome Trust Centre for Neuroimaging is supported by core funding from the Wellcome Trust (grant number 091593/Z/10/Z).

Competing interests None declared.

Patient consent Obtained.

Ethics approval UCL research ethics committee.

Provenance and peer review Not commissioned; externally peer reviewed.

Open Access This is an Open Access article distributed in accordance with the terms of the Creative Commons Attribution (CC BY 4.0) license, which permits others to distribute, remix, adapt and build upon this work, for commercial use, provided the original work is properly cited. See: http://creativecommons.org/licenses/by/4.0/.

REFERENCES
16 Coughlan A, Hollows S. The adult memory and information processing battery (AMIB). Leeds, UK: St James University Hospital, 1985.

Multiple sclerosis


467
DIR-visible grey matter lesions and atrophy in multiple sclerosis: partners in crime?

Steven H P van de Pavert, Nils Muhlert, Varun Sethi, Claudia A M Wheeler-Kingshott, Gerard R Ridgway, Jeroen J G Geurts, Maria Ron, Tarek A Youry, Alan J Thompson, David H Miller, Declan T Chard and Olga Ciccarelli

J Neurol Neurosurg Psychiatry 2016 87: 461-467 originally published online April 29, 2015
doi: 10.1136/jnnp-2014-310142

Updated information and services can be found at:
http://jnnp.bmj.com/content/87/5/461

These include:

Supplementary Material
Supplementary material can be found at:
http://jnnp.bmj.com/content/suppl/2015/05/05/jnnp-2014-310142.DC1.html

References
This article cites 35 articles, 8 of which you can access for free at:
http://jnnp.bmj.com/content/87/5/461#BIBL

Open Access
This is an Open Access article distributed in accordance with the terms of the Creative Commons Attribution (CC BY 4.0) license, which permits others to distribute, remix, adapt and build upon this work, for commercial use, provided the original work is properly cited. See:
http://creativecommons.org/licenses/by/4.0/

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Topic Collections
Articles on similar topics can be found in the following collections

Open access (221)
Immunology (including allergy) (1943)
Multiple sclerosis (934)
Brain stem / cerebellum (670)
Disability (194)

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/