Steering technology for deep brain stimulation


Over the last two decades, deep brain stimulation has become widely accepted as a treatment for Parkinson’s disease, dystonia and tremor, and its use is increasing in disorders such as obsessive-compulsive disorder, depression and pain. The primary objective is always to achieve symptom suppression with few or no side effects; in other words, to attain as wide a therapeutic window as possible. In the past, efforts to achieve this were focused largely on ensuring accurate electrode placement, be it with the help of imaging and/or with microelectrode recordings. Excellent results can be obtained in this way, but unwanted side effects still occur in ~13% of patients (Deuschl et al., 2006). Today, a number of new technologies are under development to address this problem. In this issue of Brain, Pollo et al. present data from a randomized clinical trial in which one of these approaches—directional stimulation—produces a wider therapeutic window than traditional methods (Pollo et al., 2014).

To put this result into context, it is worth reviewing, albeit briefly, some of the other strategies that are under development with the aim of maximizing therapeutic benefit while minimizing side effects.

Demand pacemakers

Currently, most pacemakers deliver stimulation continuously at a fixed rate, in what is a rather simple but nevertheless effective therapy. However, constant stimulation can incur unwanted side effects by spreading to other fibre tracts or by disrupting normal brain signals embedded in pathological activity. Alteration of such ‘normal’ signals may affect emotion or cognition, for example. By targeting stimulation specifically to abnormal oscillations, it may be possible to apply stimulation intermittently and thus allow normal signals to re-emerge. Indeed, there is evidence that symptom suppression may be better with such intermittent stimulation than with continuous stimulation (Little et al., 2013). Other prospects include a pacemaker with telemetric capabilities, which could aid the identification of pathological markers in various disorders (Medtronic PC-S). Pacemakers that respond to posture could also reduce side effects, as in the case of spinal cord stimulation where lower levels of stimulation may be required in the supine position than in the upright position. Such pacemakers use directional accelerometers to determine movement and position.

Novel stimulator and electrode arrays

The Boston Scientific Vercise™ implant is capable of providing stimulation at up to two independent frequencies, assigned to any of its 16 contacts. Although stimulation is not directional, it is thought that the use of two frequencies may produce better therapeutic effects with fewer side effects. The implant is under evaluation for the treatment of Parkinson’s disease, and simultaneously delivered stimulation at 132 Hz in the thalamus and 10 Hz in the periventricular grey area has been used in a case of phantom limb pain (Sims-Williams et al., 2013).

Imaging

At present, structural MRI is usually used for targeting electrodes. Although not yet fully evaluated, the use of diffusion tensor imaging may improve results by allowing specific parts of a nucleus that are connected to another region or possibly part of a network to be targeted, rather than just the nucleus itself (van Hartevelt et al., 2014). As demonstrated in tumour surgery, diffusion tensor imaging can be used to identify fibre tracts that, if stimulated, would induce side effects, so that these can be avoided. It is also possible to somatotopically identify the best electrode position within homogeneous structures such as the thalamus (Hyam et al., 2012).

Interleaving or shaped stimulation

This technology was introduced by Medtronic and allows for two contacts to vary in amplitude and pulse width but have the same frequency. It does allow for some ‘shaping’ of the current field and is reported to help in stimulation of the subthalamic nucleus, globus pallidus and thalamus. However, it still produces an omnidirectional pattern of stimulation. The technology drains battery life, but with rechargeable pacemakers this is no longer such an issue. Although advantages of such stimulation have been reported in the literature, the technology has not yet been studied systematically.
Postoperative programming based on images of electrode locations

Traditionally, programming has been based on a physician or specialist nurse using a ‘trial and error’ method to determine the best parameters. Those with experience will often follow a particular set of principles such as always trying particular contacts first or basing stimulation on intraoperative findings, at least to begin with. However, technology is now emerging that can collate information on electrode positions with clinical effect and provide a visual representation of the electrical field related to the nucleus being stimulated. Such examples include the Boston Scientific Guide DBS™ system and the Medtronic Optivise™ system.

Directional stimulation

A good clinical response is sometimes limited by the proximity of the contacts to structures adjacent to the target. An electrode may be placed in the subthalamic nucleus, for example, but if it is too close to the capsule, stimulation will induce side effects within the therapeutic window. To overcome this problem, technology companies have produced alternative electrode configurations, such as splitting the ring contacts into two or three (an approach under development by various companies), or even arranging 32 contacts in an array resembling a fish-scale (Sapiens). Experimentally, the latter has been shown to offer directionality in the primate (Martens et al., 2011), as well as in a clinical case series (Schuurman et al., 2013) in which it was also possible to record local field potentials from multiple contacts for better localization.

Pollo et al. evaluated the simpler split-ring electrode configuration intraoperatively in a series of patients with Parkinson’s disease or essential tremor. Essentially, having confirmed the target with microelectrode recordings, they passed a split electrode array (directStim Aleva Neurotherapeutics) to the target and studied patients in which there was no microlesioning effect. Due to the smaller size of the electrodes, the current required to produce a therapeutic effect was significantly smaller than in a standard configuration. Pollo et al. have shown clearly that directionality is possible in an intraoperative setting, and that it has the potential to widen the therapeutic window. They should be congratulated for a number of reasons. Firstly, the world of neuromodulation has become swollen over the past decade with companies offering ever-increasing ‘advances’ in technology that are driven largely by engineers and are aggressively marketed as ‘superior’ to existing technology. Although these ‘advances’ are always good to see (and often very clever), there is frequently a lack of objective evidence to support their use, especially with the increased costs that they entail. Such examples include ‘burst’ technology in spinal cord stimulation, and high frequency stimulation. Pollo et al. have bucked the trend in that they have set out to evaluate the therapeutic effects of a new technology at the conceptual stage. This allows the technology to be abandoned if it does not work or for more refinements to be made to improve it before further development. Secondly, they should be congratulated for the quality of their study. Good quality randomized, blinded trials are difficult and seldom in neurosurgery and this one adds significantly to the literature.

Future directions

In the future it would seem that a combination of all the technologies described above will lead to better outcomes with deep brain stimulation. However, with ever increasing numbers of contacts and electrode combinations, manual programming will become impossible. It may well be that a visual representation incorporating imaging and virtual rendering of tissue activation will be the way forward. Surgical techniques may have to be modified to take into consideration the fact that careful intraoperative alignment of best contacts must be maintained after fixation, as rotation of the electrode could abolish these.

Deep brain stimulation in its current form is beyond the economic resources of most of the world’s population. This situation will not be helped by the increased production costs of cutting edge technology, which means that a large proportion of the world’s population will probably not benefit from these new advances, at least in the medium term. For financial reasons, therefore, conventional deep brain stimulation will remain the therapy of choice for many patients.

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Sims-Williams HP, Selbi WR, Javed S, Pickering AE, Patel NK. Two birds, one stone: single electrode dual target stimulation for the
Human memory: insights into hippocampal networks in epilepsy

This scientific commentary refers to ‘Differential influence of hippocampal subfields to memory formation: insights from patients with temporal lobe epilepsy’, by Coras et al., (doi.10.1093/brain/awu100).

Memory is one of the core cognitive abilities that shapes our sense of self-identity and we strive to maintain and improve our memory function throughout our lives. Memory impairments are a key component of a number of neurological and psychiatric diseases, and represent a large part of the disease burden in many patients. The hippocampus has been central to the study of human memory, having been implicated in episodic and long-term memory, novelty detection, sleep-dependent memory consolidation, the ability to imagine the future, as well as spatial navigation and the binding of temporally and spatially distributed representations (Bartsch, 2012). What’s more, the hippocampus is also involved in neurobiological mechanisms beyond memory formation such as the regulation of emotion, fear, anxiety, and stress. Notably, the hippocampus displays a particular vulnerability to hypoxic, ischaemic, or neurotoxic insults, and is thought to be involved in the pathophysiology of various neurological and psychiatric diseases including epilepsy and neurodegeneration, as well as ageing. In this issue of Brain, Coras et al. use the memory performance of patients undergoing surgery for the treatment of temporal lobe epilepsy to obtain new insights into the anatomical basis of memory formation (Coras et al., 2014).

The hippocampus has an intriguing anatomy, although how this relates to the formation of episodic memory is still incompletely understood. The trisynaptic pathway from the perforant path to the dentate gyrus, to CA3 via mossy fibres and onwards to CA1 via Schaffer collaterals, is the principal sequential feedforward neural circuit involved in the processing of information by the hippocampus. CA1 pyramidal cells project via the subiculum to deep layers of the entorhinal cortex and to various subcortical and cortical areas. Within the hippocampus, axon collaterals of CA3 pyramidal neurons synapse onto other CA3 neurons, forming recurrent autoassociative networks. Animal experiments show that these networks perform differential computations in different cognitive tasks. Through the use of animal models and, more recently, functional imaging in patients, researchers have sought to correlate components of the hippocampal subnetworks with distinct cognitive or mnemonic operations. For example, it has been argued that the dentate gyrus is involved in pattern separation—a function that is impaired in ageing and mild cognitive impairment—whereas the CA3 network is involved in pattern completion, and the CA1 network is engaged in input integration, novelty and mismatch detection (Bakker et al., 2008; Duncan et al., 2012). The CA1 region is also involved in autobiographical memory retrieval (Bartsch et al., 2011). High-resolution imaging in humans shows an involvement of CA3 and the dentate gyrus in memory encoding and early retrieval, and an involvement of CA1 in late retrieval, consolidation and recognition (Mueller et al., 2011). In accordance with the cognitive-map theory, which suggests that allocentric spatial representations of locations are processed in the hippocampus, the CA1 subregion is involved in our ability to learn a map-like representation of an environment (Bartsch et al., 2010).

Recently, it has been suggested that distinct clinical disorders affect hippocampal subregions in different ways, which could account for the variety of cognitive deficits observed in amnesic disorders. Deficits in memory encoding correlated specifically with CA1 subfield atrophy in mild cognitive impairment and in Alzheimer’s disease (Mueller et al., 2010). Apolipoprotein E4 status has an effect on the volume of CA3/dentate gyrus in healthy controls and in patients with Alzheimer’s disease (Mueller and Weiner, 2009).

In this issue of Brain, the Erlangen epilepsy group addresses the question of subfield-associated mnemonic processes from a different perspective (Coras et al., 2014). They studied the functional subfield anatomy of the hippocampus in patients with temporal lobe epilepsy and hippocampal sclerosis, and correlated subfield lesion patterns with the verbal memory deficits revealed by presurgery intracarotid amobarbital testing. One hundred patients were tested before...