

DOPPLER TRANS CRANIEN

- EN TRAUMATOLOGIE
- MORT ENCÉPHALIQUE

TUSAR 2024-2025

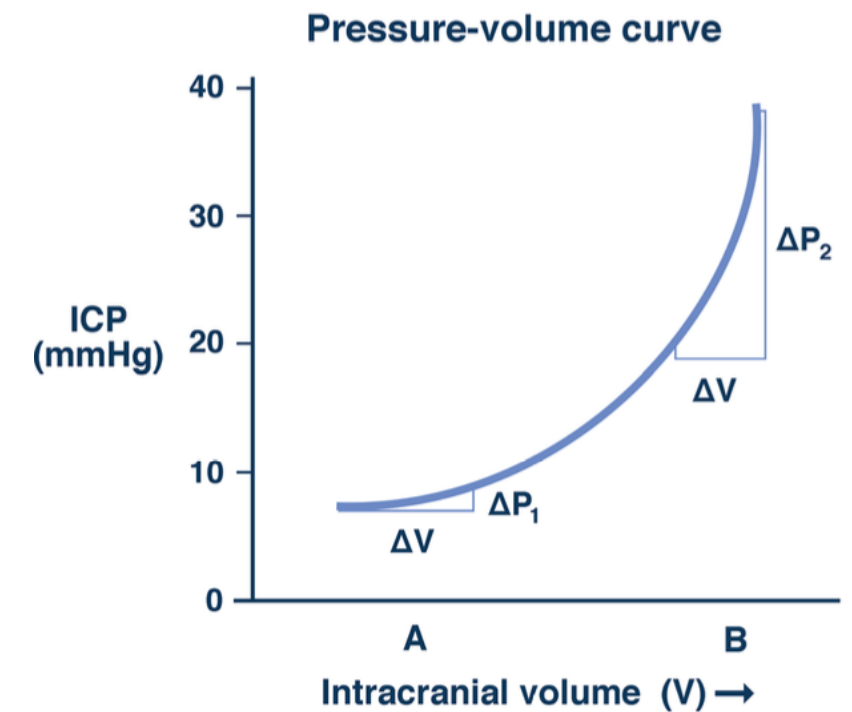
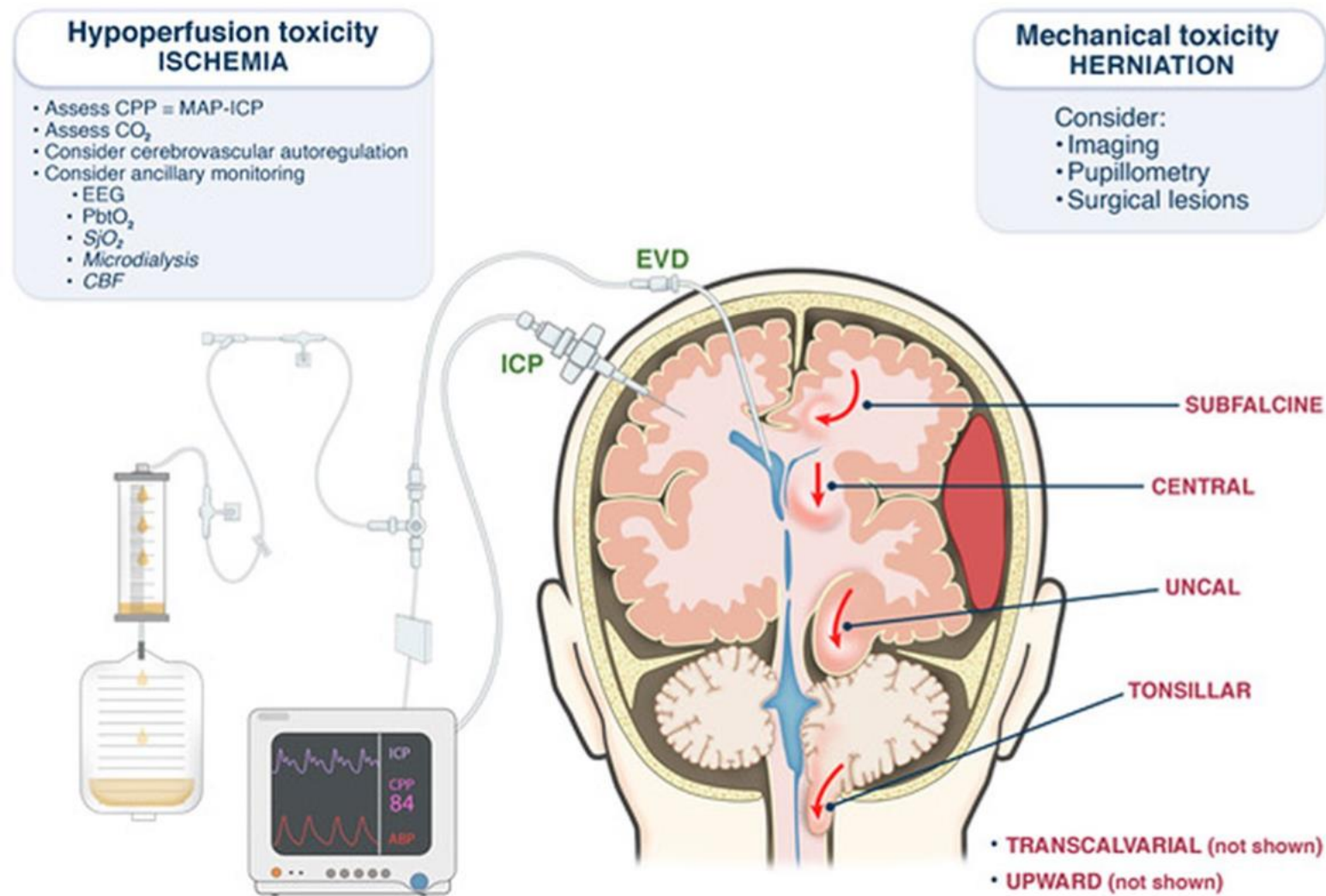
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DTC et traumatisé crânien

1. Rappels physiopathologiques traumatisme crânien
2. Facteurs confondants et limites
3. Apports du DTC dans la cas du traumatisé crânien
4. Conclusion

1. Rappels physiopathologiques - traumatisme crânien



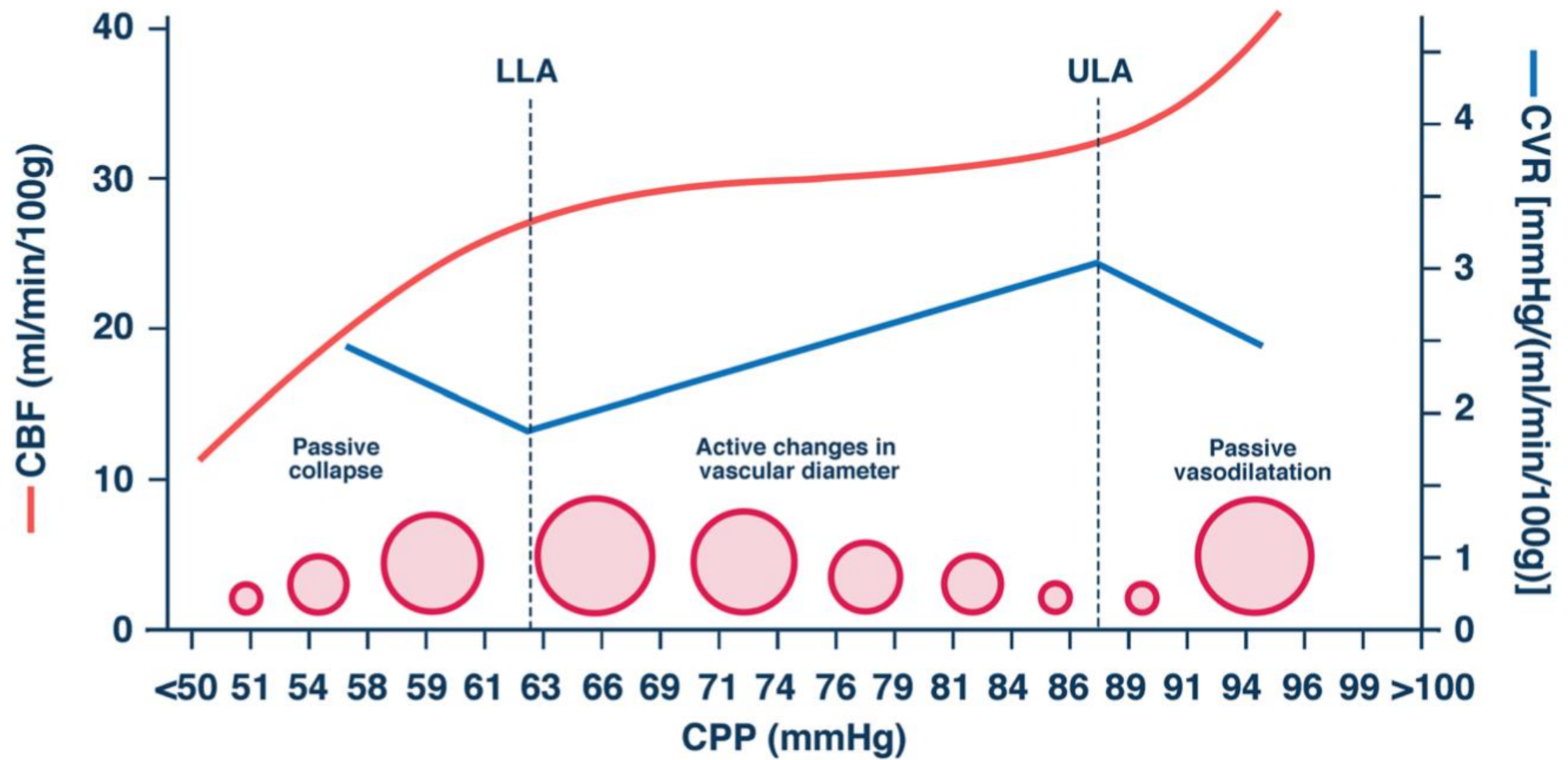
Sang (contenu dans les vx)
Parenchyme cérébral
LCR

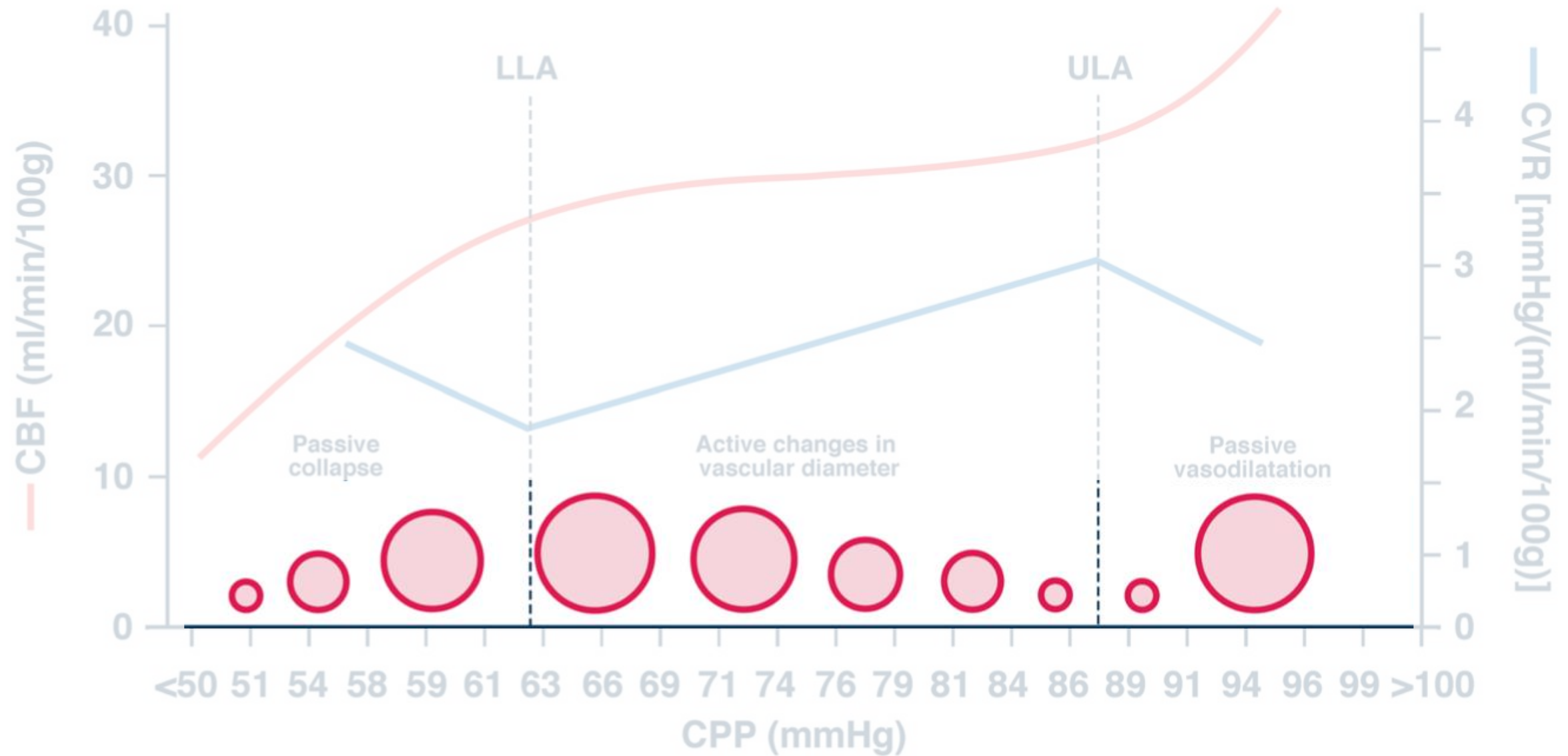
PIC = Pression intra-crânienne (Normale < 15 mmHg)

HTIC = Hyper Tension Intra-Cérébrale (PIC > 22 - 25 mmHg)

PPC = Pression de perfusion cérébrale

PPC = PAM - PIC



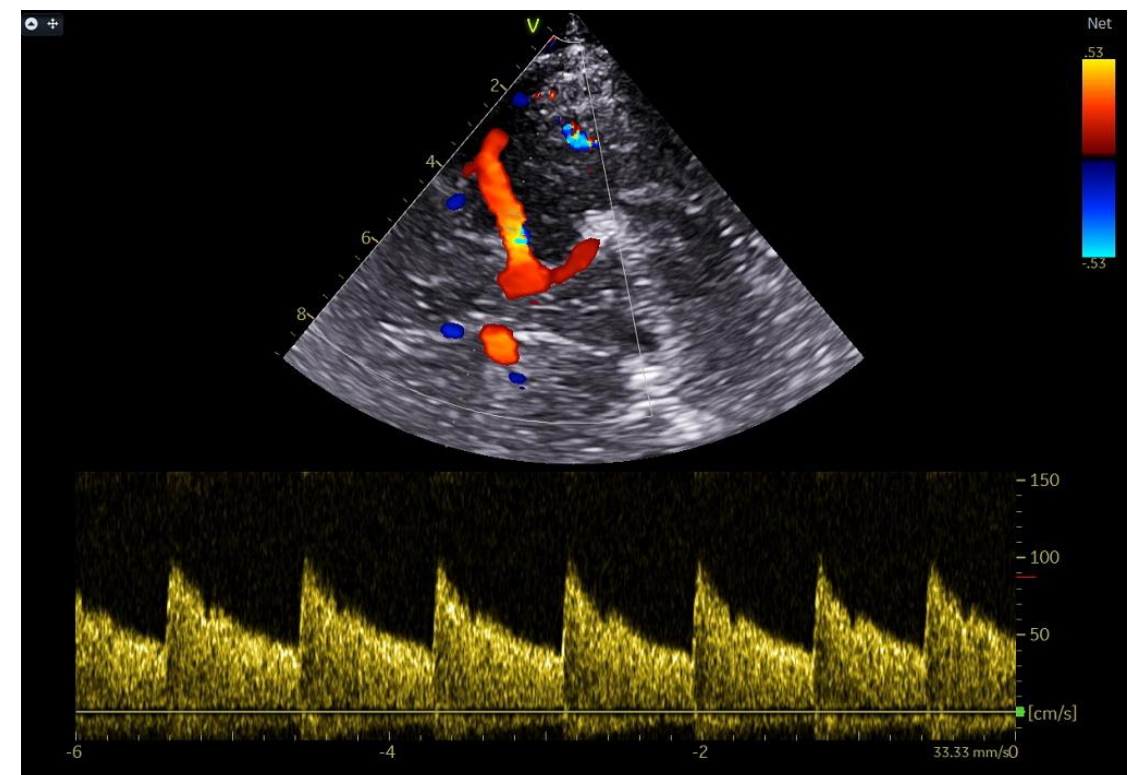


Variabilité du diamètre des artères cérébrales

DTC et Débit Sanguin Cerebral

En théorie

$$\text{DSC} = \text{FC} \times \text{ITV} \times \text{surface du vaisseau}$$



DTC et Débit Sanguin Cerebral

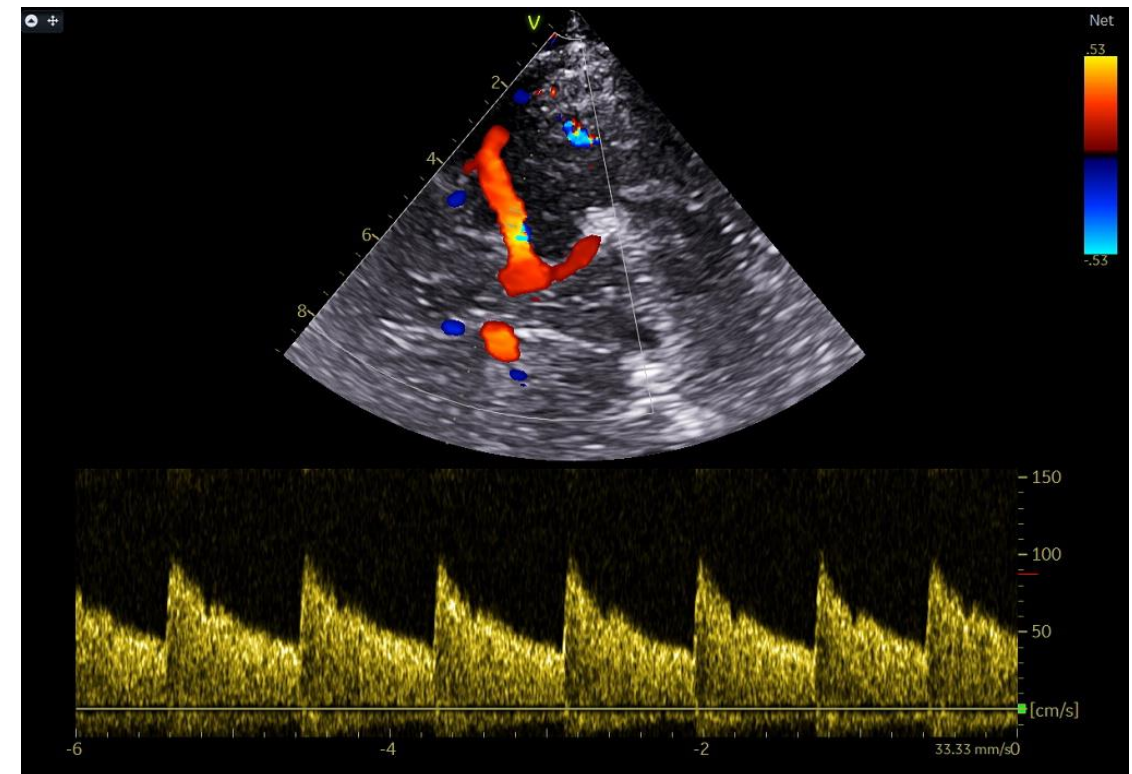
En théorie $DSC = F_c \times ITV \times \text{surface du vaisseau}$

Limite pratique :

Résolution spatiale et erreur de mesure

Variabilité du diamètre des vaisseaux

Variabilité augmente avec la distalité

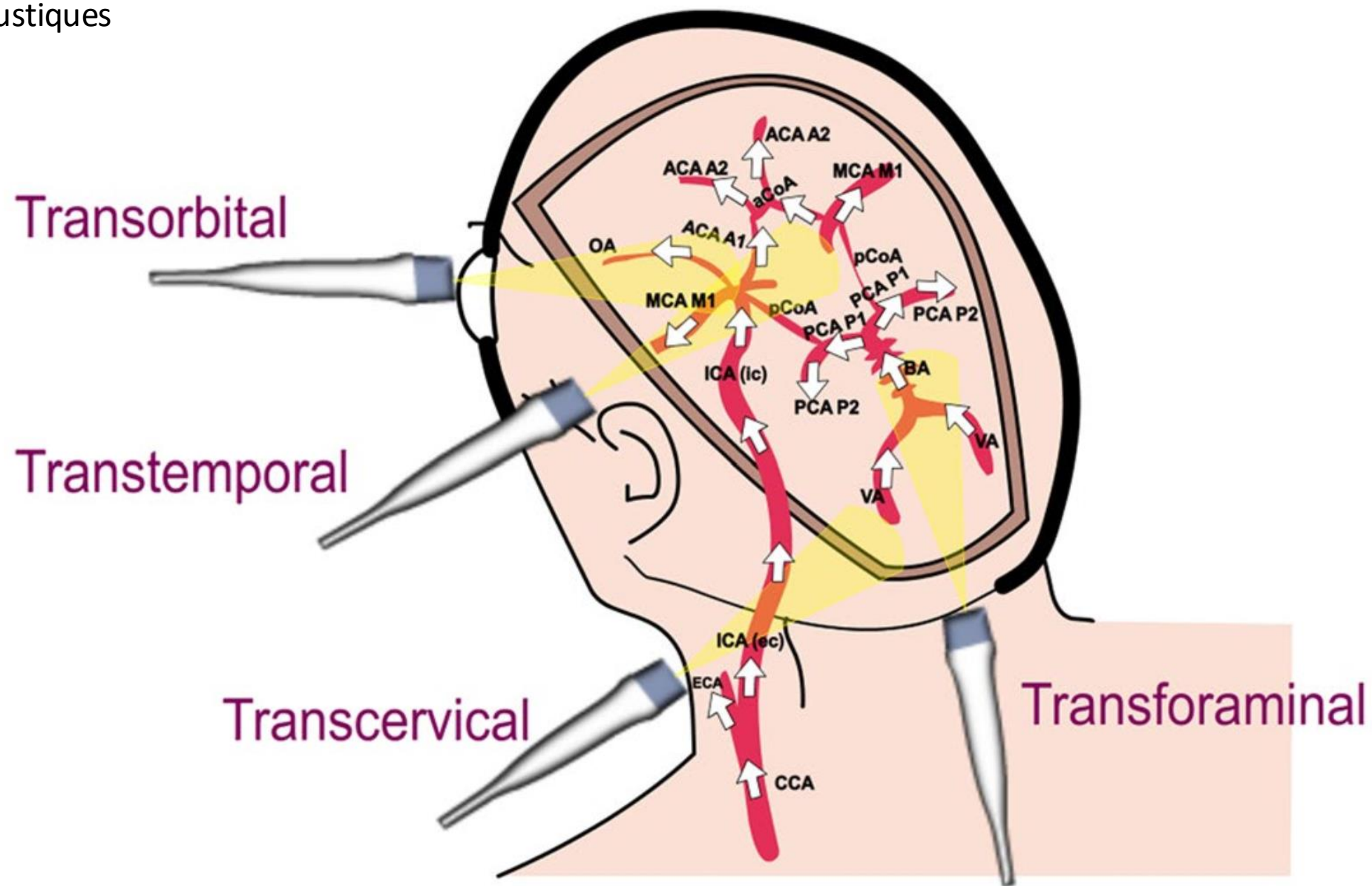


-> mesure précise impossible en pratique courante

-> mesure sur une artère ne reflétant pas l'hétérogénéité de la circulation cérébrale

DTC et Débit Sanguin Cérébral : exploration régionale

Fenêtres acoustiques



DTC et Débit Sanguin Cerebral : exploration régionale

Valeurs « Normales »

-> exploration REGIONALE

Artère	Voie	Sens du flux	Profondeur (mm)	Vm (cm.s ⁻¹)
Artère cérébrale moyenne	temporale	+	45 à 60	62 ± 12
Artère cérébrale antérieure	temporale	-	60 à 75	51 ± 12
Artère cérébrale postérieure	temporale	+	70 à 90	44 ± 11
Siphon carotidien	transorbitaire	+	50 à 75	42 ± 10
Tronc basilaire	sous-occipitale	-	70 à 110	40 ± 8

Utility of Transcranial Doppler in Moderate and Severe Traumatic Brain Injury: A Narrative Review of Cerebral Physiologic Metrics

Alwyn Gomez,^{1,2} Carleen Batson,² Logan Froese,³
Amanjot Singh Sainbhi,³ and Frederick Adam Zeiler¹⁻⁵

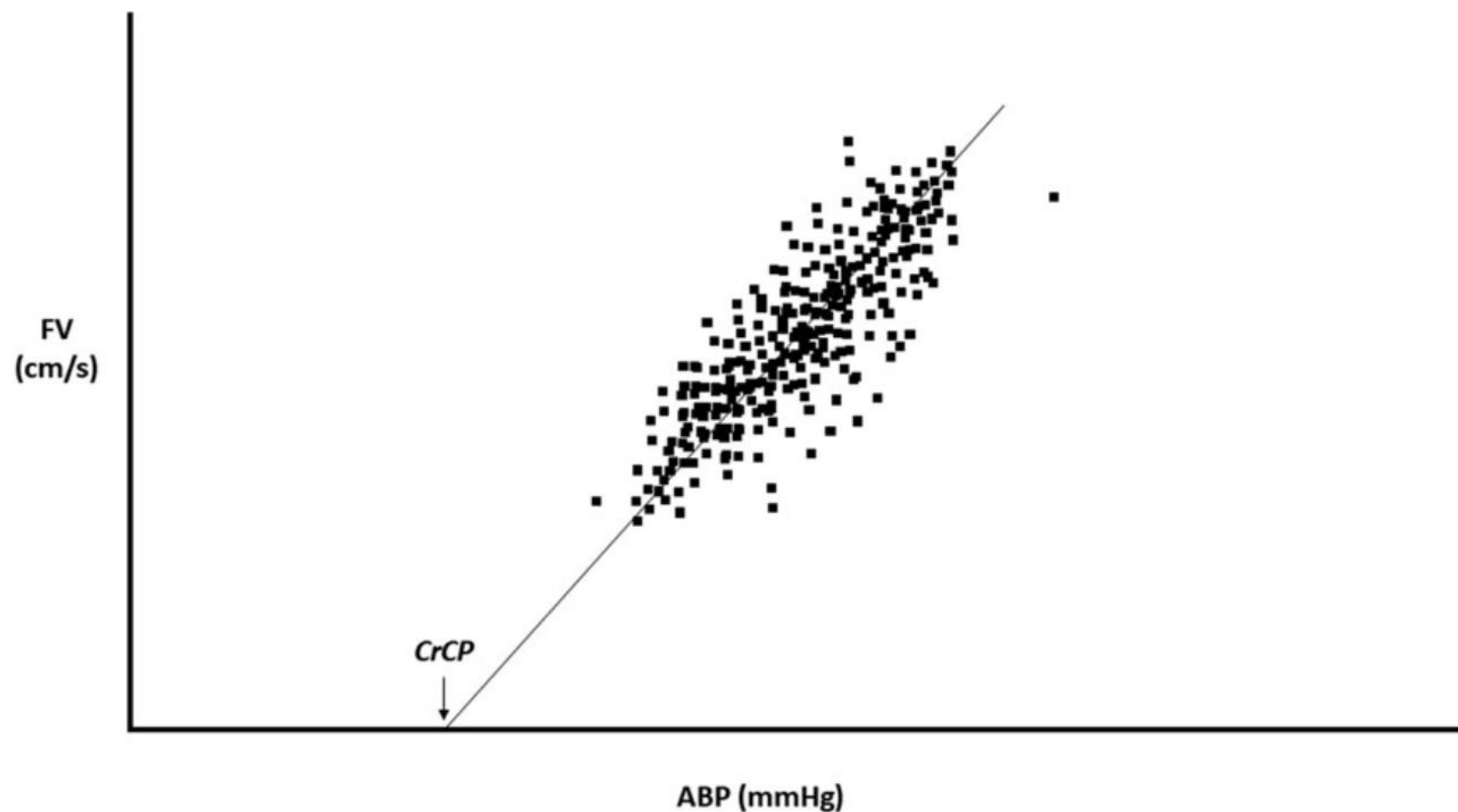


FIG. 3. A schematic representation of the derivation of critical closing pressure (CrCP). Flow velocity (FV) is plotted against arterial blood pressure (ABP) and the x intercept, which the ABP at which FV is zero, represents the CrCP.

Transcranial Doppler Measurements of the Middle Cerebral Artery

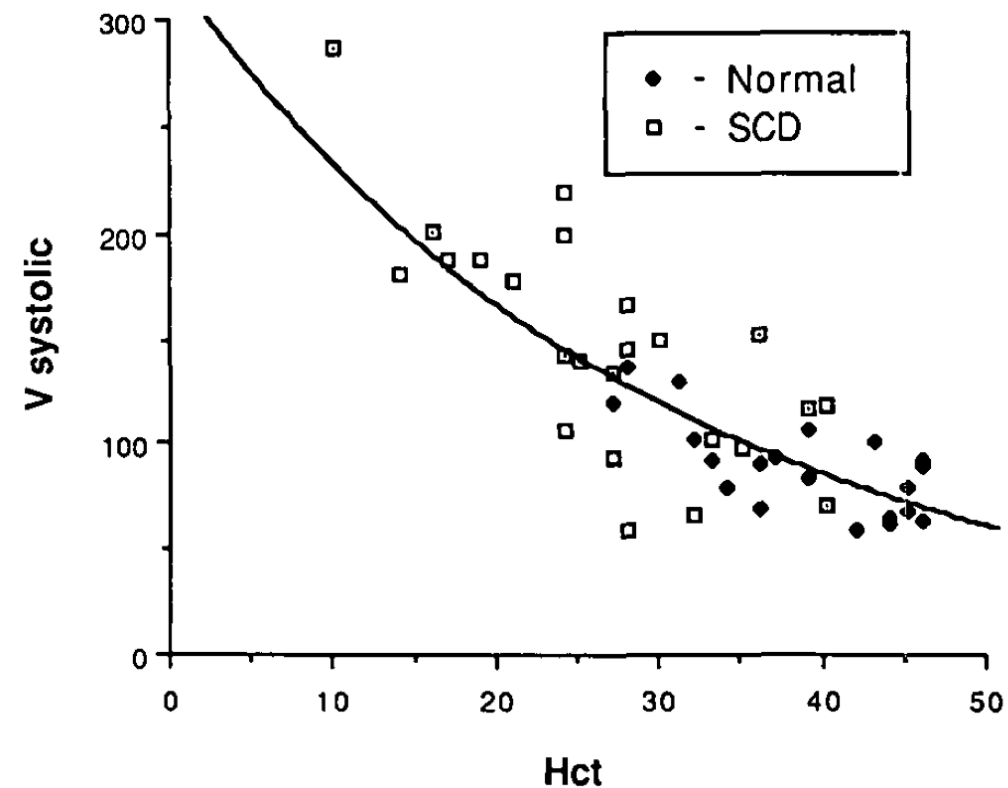
Effect of Hematocrit

L.M. Brass, MD, S.G. Pavlakis, MD, D. DeVivo, MD,
S. Piomelli, MD, and J.P. Mohr, MD

n = 45

Pas d'exploration de l'hémodynamique systémique
Patients stables d'hématologie

FIGURE 1. Relation between hematocrit as percent (Hct) and peak systolic blood velocity as centimeters per second (V_{systolic}) in normal patients and in those with sickle cell disease (SCD) examined with transcranial Doppler ultrasonography. Equation for regression curve is $V_{\text{systolic}} = 326 e^{-0.033 \times \text{Hct}}$, with correlation coefficient of 0.79 ($p < 0.001$).



L M Brass, S G Pavlakis, D DeVivo, S Piomelli, and J P Mohr

Originally published 1 Dec 1988 | <https://doi.org/10.1161/01.STR.19.12.1466> |
Stroke. 1988;19:1466–1469 |

Effect of hyperventilation on cerebral blood flow in traumatic head injury: Clinical relevance and monitoring correlates*

Jonathan P. Coles, FRCA; Pawan S. Minhas, FRCS; Tim D. Fryer, PhD; Peter Smielewski, PhD; Franklin Aigbirihio, PhD; Tim Donovan, BSc; Stephen P. M. J. Downey, MSc; Guy Williams, PhD; Dot Chatfield, BSc; Julian C. Matthews, PhD; Arun K. Gupta, FRCA; T. Adrian Carpenter, PhD; John C. Clark, DSc; John D. Pickard, FRCS; David K. Menon, PhD

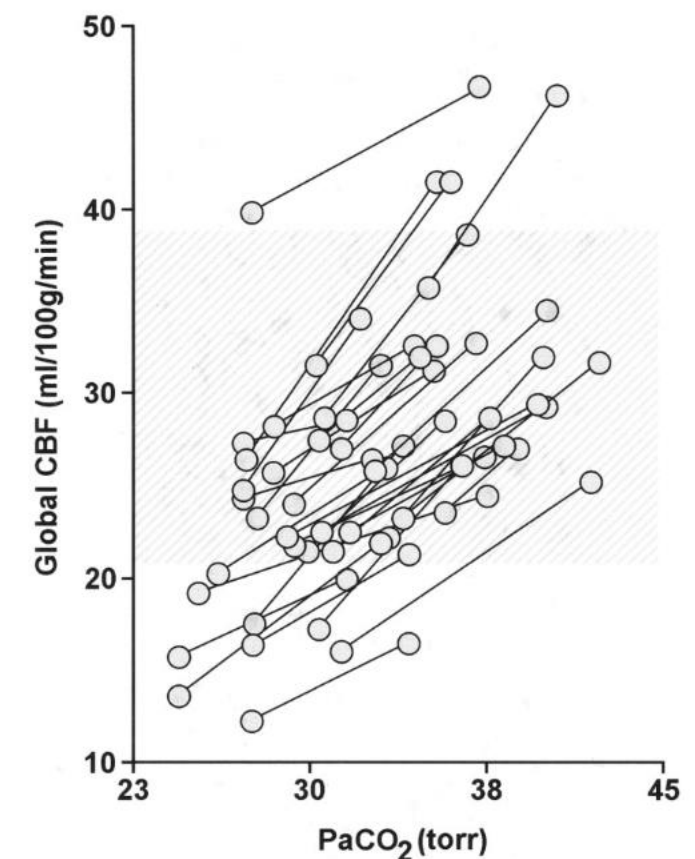
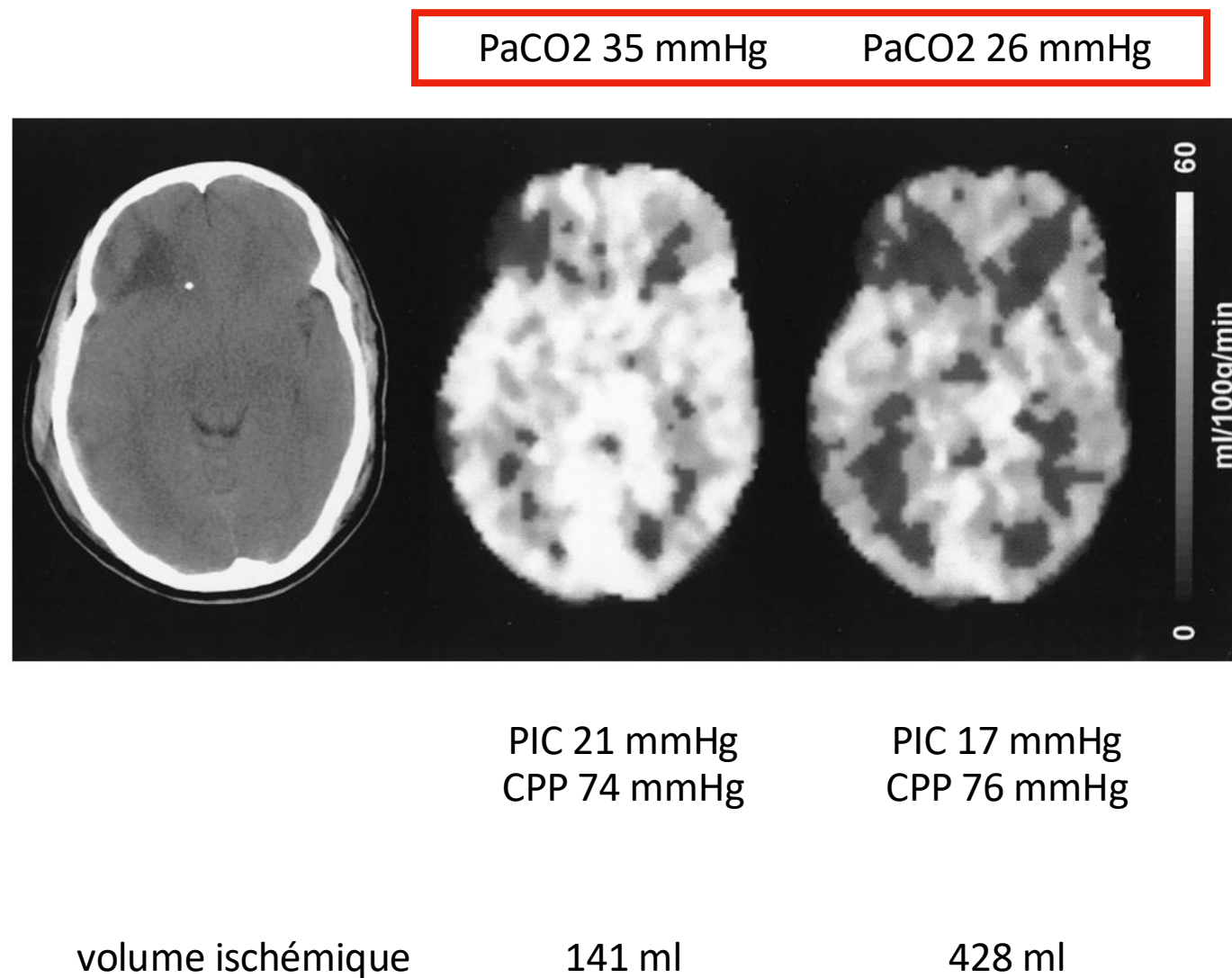


Figure 5. Relationship of positron emission tomographic-derived global cerebral blood flow (CBF) to PaCO₂ in patients imaged at baseline and following hyperventilation. The 95% confidence interval for global CBF in healthy volunteers is shown in *hatched gray*.

Intracranial blood flow velocity after head injury: relationship to severity of injury, time, neurological status and outcome

Kwan-Hon Chan, J Douglas Miller, N Mark Dearden

N = 121 TC (sévère 50, modéré 16, léger 55)

Comparaison des Vs en fonction des groupes

- Association entre Vs basse et sévérité
- Persistance de la Vs basse jusqu'à la sortie
- Association Vs basse et évolution neurologique défavorable à 6 mois

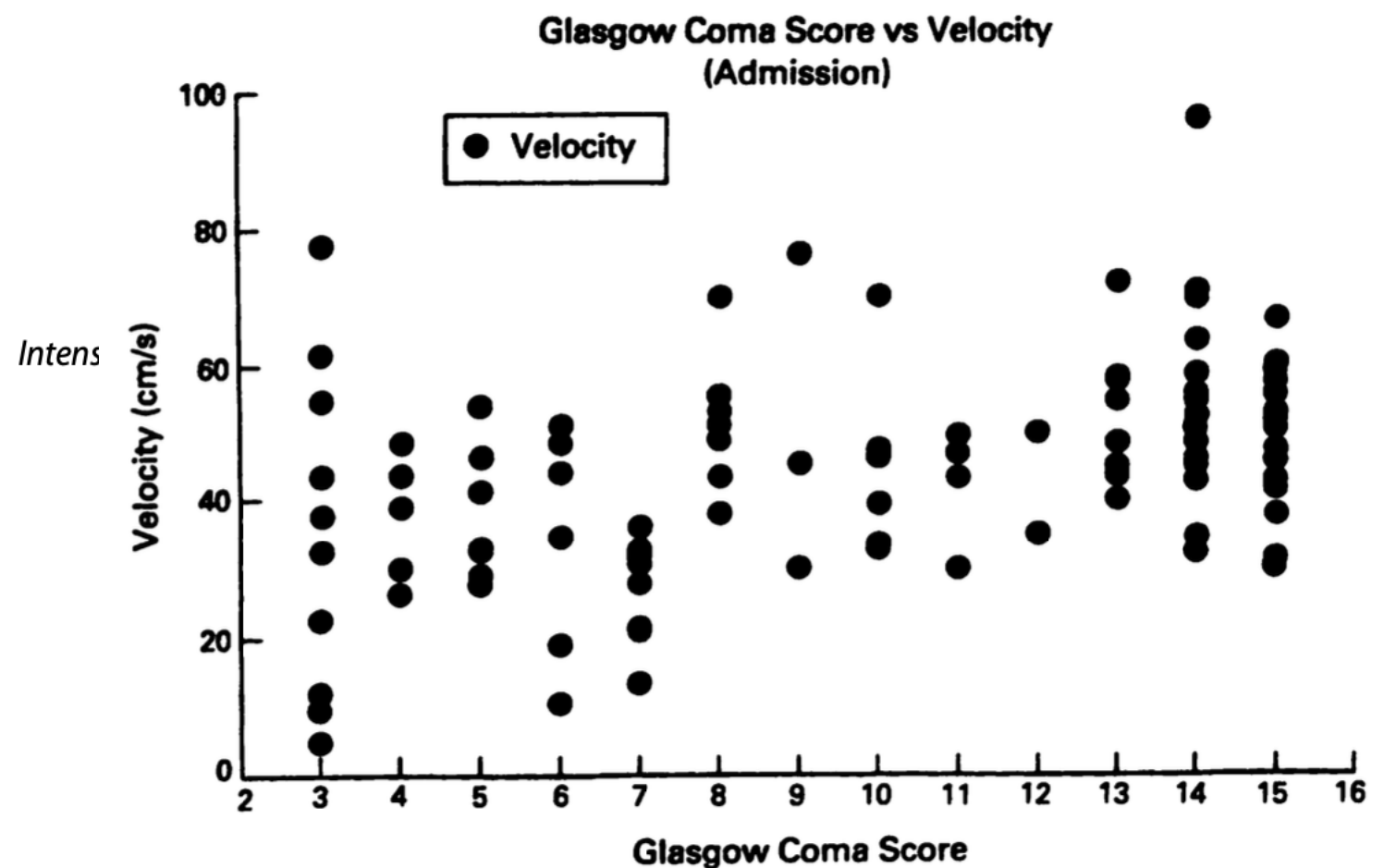


Figure 2 Plot of velocity against Glasgow Coma Score on admission in 121 patients studied.

Dispersion

Comparative Analysis of Simultaneous Transcranial Doppler and Perfusion Computed Tomography for Cerebral Perfusion Evaluation in Patients with Traumatic Brain Injury

Alex Trofimov,

Department of Neurosurgery, Privolzhsky Research Medical University, Nizhny Novgorod, Russia

n=170 patients

Groupe 1 TCG diffus (n=75)

Groupe 2 TCG hématome intracrânien (n=95)

Réalisation de TDM perfusion et DTC

Entre J2 et J15 post traumatisme



Fig. 1.

The Neuromonitoring System: white arrow, CT; blue arrow, TCD; red arrow, ECG-ABP monitor; black arrow, syringe injector; and green arrow, cerebral oximeter

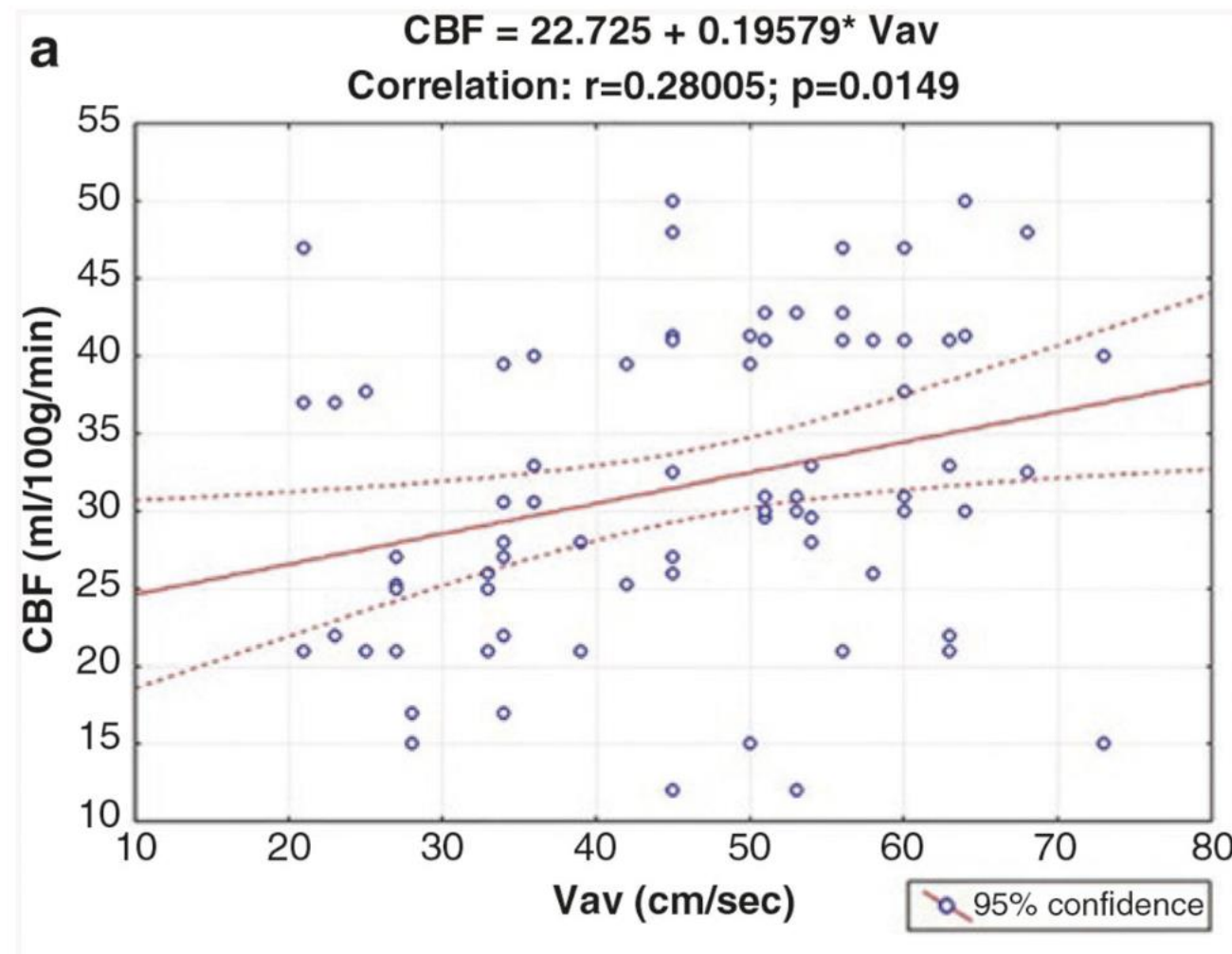


Fig. 2.

Volumetric CBF plotted against Vav (CBFV) on the left side (**a**) and right side (**b**) in Group 1 with diffuse TBI. Dashed red lines represent 95% confidence intervals for the regression (solid red line)

Evaluating the outcome of severe head injury with transcranial Doppler ultrasonography

JOSÉ A. MORENO, M.D., EDUARD MESALLES, M.D., JUAN GENER, M.D.,
ANTONIO TOMASA, M.D., ADOLFO LEY, M.D., JOSEP ROCA, M.D.,
AND JAIME FERNÁNDEZ-LLAMAZARES, M.D.

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Hospital Universitario "Germans Trias i Pujol," Badalona;
and Universidad Autónoma de Barcelona, Barcelona, Spain*

n=125 patients avec TC
Monitorage PIC et DTC

Evaluation neurologique à 6 mois (GOS)

TABLE 1

GENERAL DESCRIPTION OF STUDY VARIABLES
OBTAINED IN 125 SEVERELY HEAD INJURED PATIENTS*

Characteristic	No. of Cases (%)
sex	
male	96 (77)
female	29 (23)
associated lesion	92 (74)
pupillary anomalies	36 (29)
focal injury	17 (14)
convulsion	7 (6)
otorrhagia	37 (30)
cranial fracture	52 (41)
shock	35 (28)
CT classification	
Type II lesion	82 (66)
Type III lesion	18 (14)
SAH	65 (52)
exitus	46 (37)

* Classification based on that reported in TCDB.

TABLE 2

MEAN VALUES OBTAINED OF THE QUANTITATIVE VARIABLES STUDIED

Variable	Mean Value	Standard Deviation
age (yrs)	34.14	19.16
pH	7.37	0.08
PaCO ₂ (mm Hg)	35.9	9.75
PaO ₂ (mm Hg)	173	113.5
hemoglobin (g/l)	11.49	2.48
glucose level (mg/dl)	161.76	62.52
MAP* (mm Hg)	85.86	11.45
GCS score	6.02	1.81
APACHE II	13.68	4.34
ICP (mm Hg)	22.07	17.29
CPP (mm Hg)	63	19.70
blood flow velocity (cm/s)	40.75	17.86
PI	1.26	0.73

* MAP = mean arterial blood pressure.

Rappel :
Index de pulsatilité (IP) = (Vs-Vd)/Vm

Evaluating the outcome of severe head injury with transcranial Doppler ultrasonography

Association IP et pronostic

TABLE 5
RESULTS OF MULTIVARIATE ANALYSIS OF DATA OBTAINED
AT 6 MONTHS*

Variable	Odds Ratio	95% Confidence Interval	p Value
GCS score	0.24	0.11–0.42	0.0001
pupillary anomalies	3.86	0.59–27	0.04
presence of shock	0.13	0.02–0.63	0.013
PI	21.42	3.81–183.08	0.001

* Hosmer–Lemeshow best-of-fit test of reliability of statistical adjustment, $p = 0.9952$. Area below ROC curve 95%.

Bon pronostic

IP = 1 (moy)

Mauvais pronostic

IP = 1,56 (moy)

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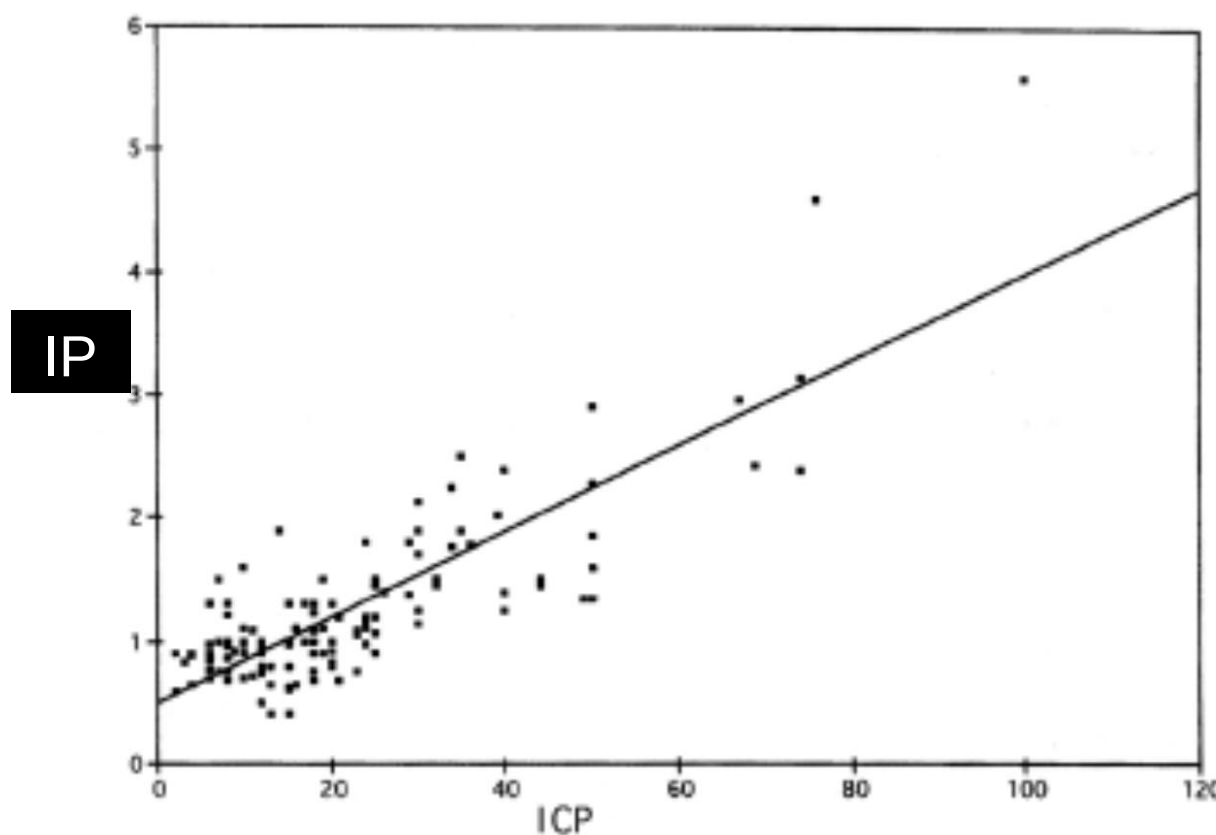


Fig. 1. Graph illustrating the correlation between ICP and PI.

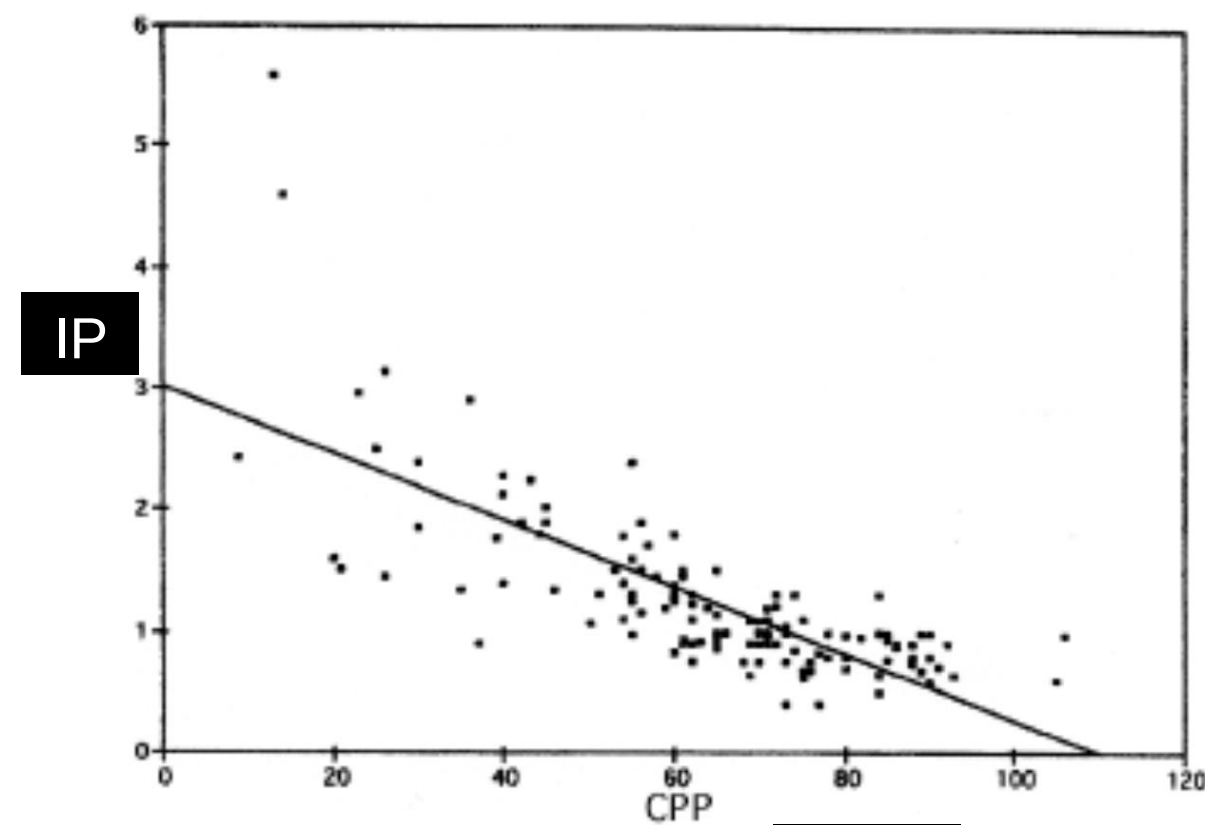


Fig. 2. Graph illustrating the correlation between CPP and PI.

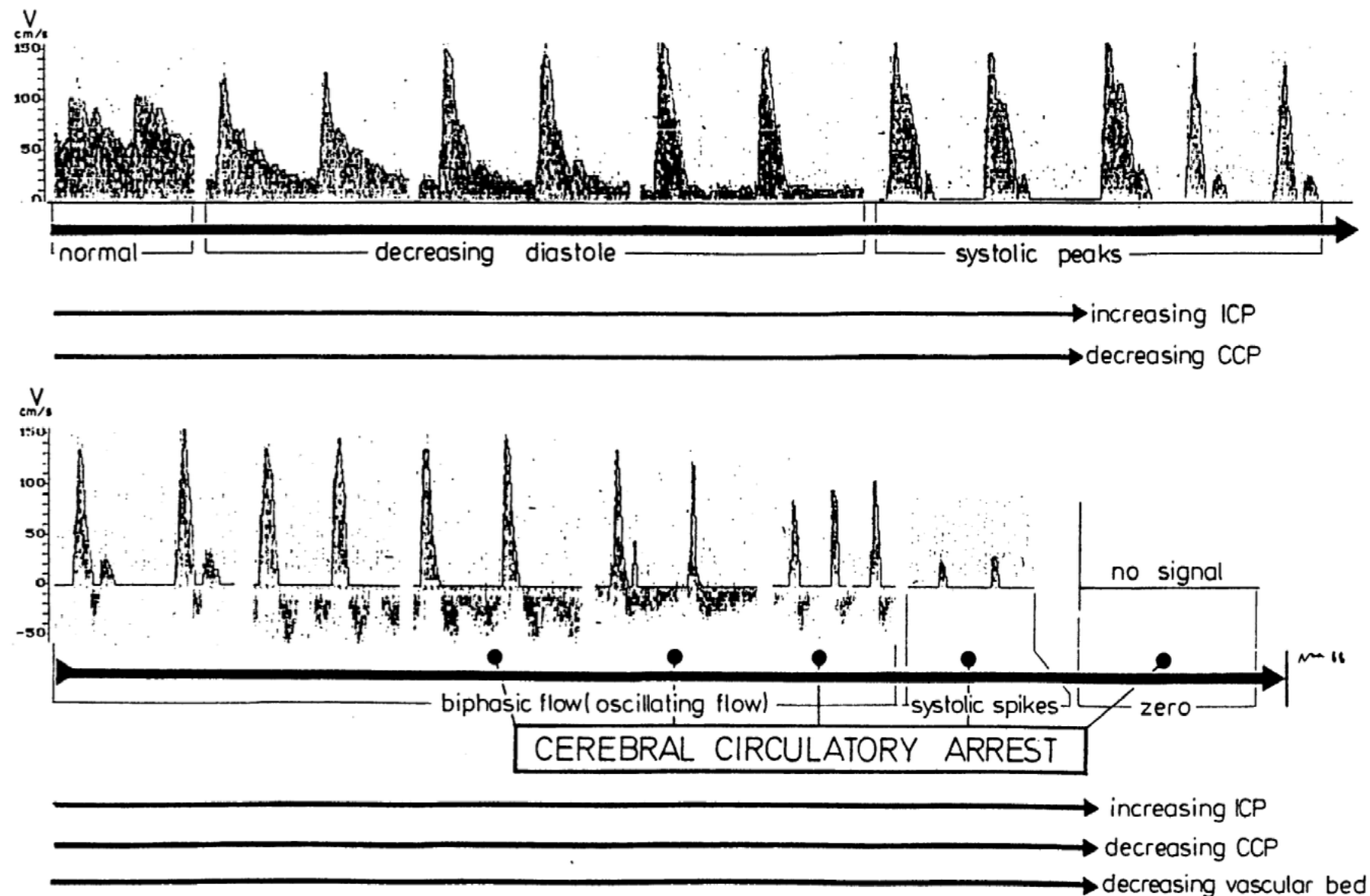
PIC

PPC

Consensus opinion on diagnosis of cerebral circulatory arrest using Doppler-sonography

Task Force Group on cerebral death of the Neurosonology Research Group of the World Federation of Neurology

TIME-COURSE OF FLOW VELOCITIES IN MCA FROM NORMAL CONDITION UP TO
CEREBRAL CIRCULATORY ARREST



Review: pathophysiology of intracranial hypertension and noninvasive intracranial pressure monitoring

Nicolas Canac ^{*}, Kian Jalaeddini, Samuel G. Thorpe, Corey M. Thibeault and Robert B. Hamilton

Estimation PIC par DTC -> cela ne fonctionne pas, même modèles intégrant PaCO₂, PAM, Hte

Table 4 Studies exploring PI-based TCD method

References	Population	Classification use score	Estimation use score
Gao [124]	TBI, 43; hemorrhagic stroke, 7	2	1
Prunet [126]	TBI/stroke/SAH, 20 Control, 20	4	–
Robba [127]	TBI/polytrauma/SAH, 22	1	–
Robba [128]	TBI/SAH/intracranial hemorrhage, 64	1	–
Voulgaris [129]	TBI, 37	3	–
Wakerley [130]	Varied, 78	3	–
Wang [131]	TBI, 75; hypertensive brain injury, 15; intracranial lesions, 3	4	–
Zweifel [132]	TBI, 290	2	1
Bellner [133]	TBI/SAH/other, 81	4	3
Moreno [134]	TBI, 125	4	–
Brandi [135]	TBI, 45	–	2
Behrens [136]	INPH, 10	–	1
Rainov [137]	Hydrocephalus, 29	2	1
Rajajee [138]	ALF, 21	1	–
Park [125]	TBI, 11	2	3

Refer to Table 3 for interpretation of scores. If a method was not evaluated in the context of either classification or evaluation, then no score is provided for that use case

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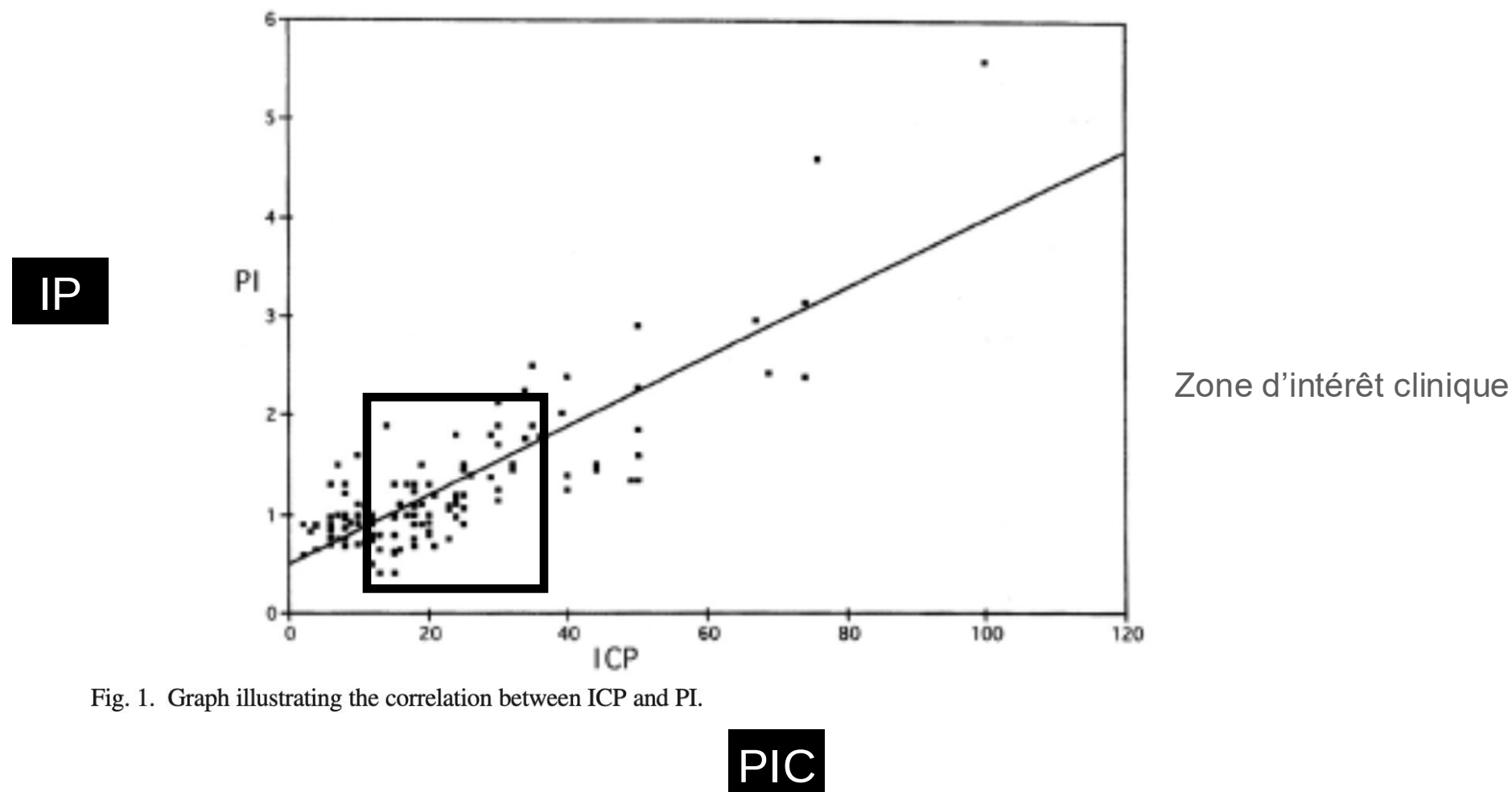


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Transcranial Doppler as a screening test to exclude intracranial hypertension in brain-injured patients: the IMPRESSIT-2 prospective multicenter international study

N = 266 patients (interruption COVID)

Patients cerebro-lésés avec indication monitoring invasive PIC

Calcul de la PIC par estimation PPC par le doppler trans-crânien

$$PPCe = PAM \times Vd/Vm + 14$$

$$PIC = PAM - PPC$$

Comparaison de 3 couples de mesures PIC invasive vs PICdtc

Evaluation performance diagnostique pour 3 seuils de PIC 20, 22 et 25 mmHg

	PIC> 20	PIC>22	PIC>25
VPP	32,6 %	23 %	23,1 %
VPN	91,3 %	95,6 %	98,6 %

Nombreuses approches pour évaluer la PPC de manière non-invasive

Czosnyka M, Matta BF, Smielewski P, Kirkpatrick PJ, Pickard JD. Cerebral perfusion pressure in head-injured patients: a noninvasive assessment using transcranial Doppler ultrasonography. *J Neurosurg* 1998;88(5):802–8.

$$PPCe = (PAM \times Vd) / Vm + 14$$

Bellner J, Romner B, Reinstrup P, Kristiansson KA, Ryding E, Brandt L. Transcranial Doppler sonography pulsatility index (PI) reflects intracranial pressure (ICP). *Surg Neurol* 2004;62(1):45–51 [discussion].

$$PPCe = 89,646 - 8,258 \times IP$$

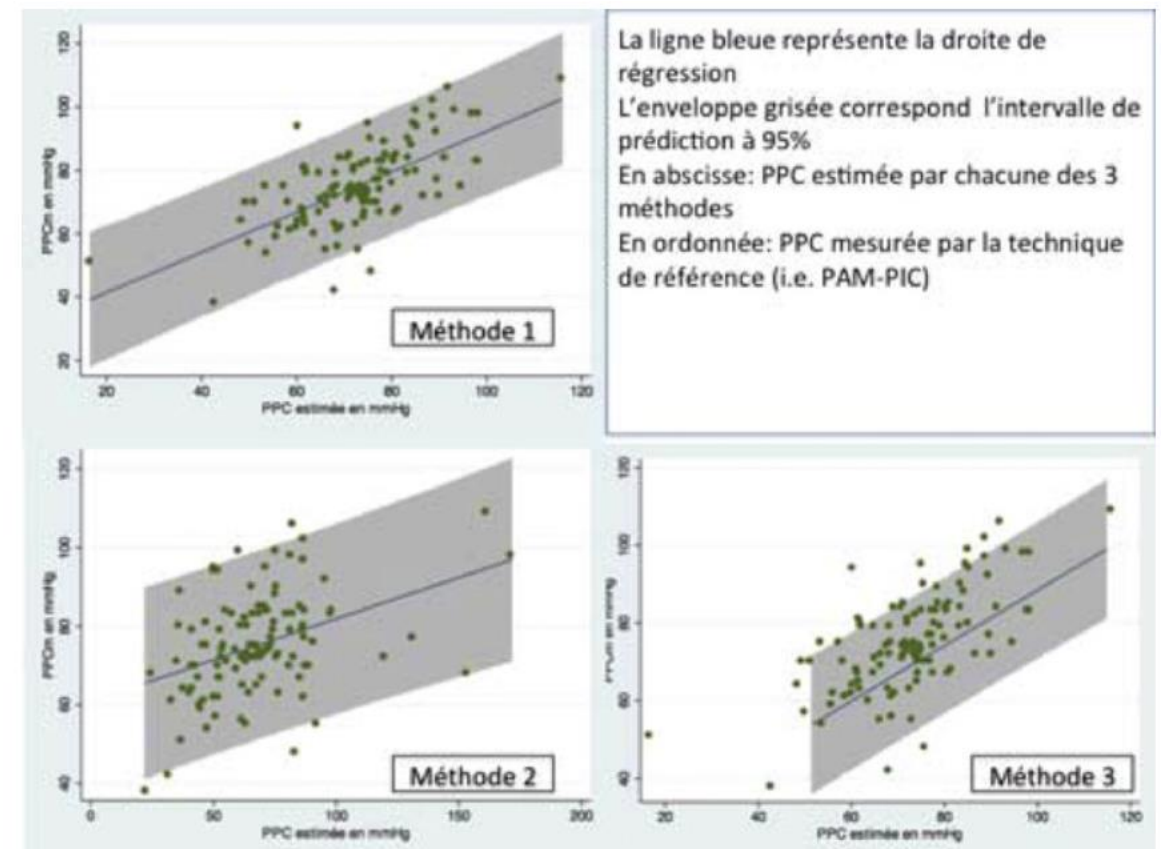
Édouard AR, Vanhille E, Le Moigno S, Benhamou D, Mazoit JX. Non-invasive assessment of cerebral perfusion pressure in brain injured patients with moderate intracranial hypertension. *Br J Anaesth* 2005;94(2):216–21.

$$PPCe = (Vm / (Vm - Vd)) \times PAM - PAD$$

R043

Estimation de la pression de perfusion cérébrale par le Doppler transcrânien : quelle est la meilleure méthode ?

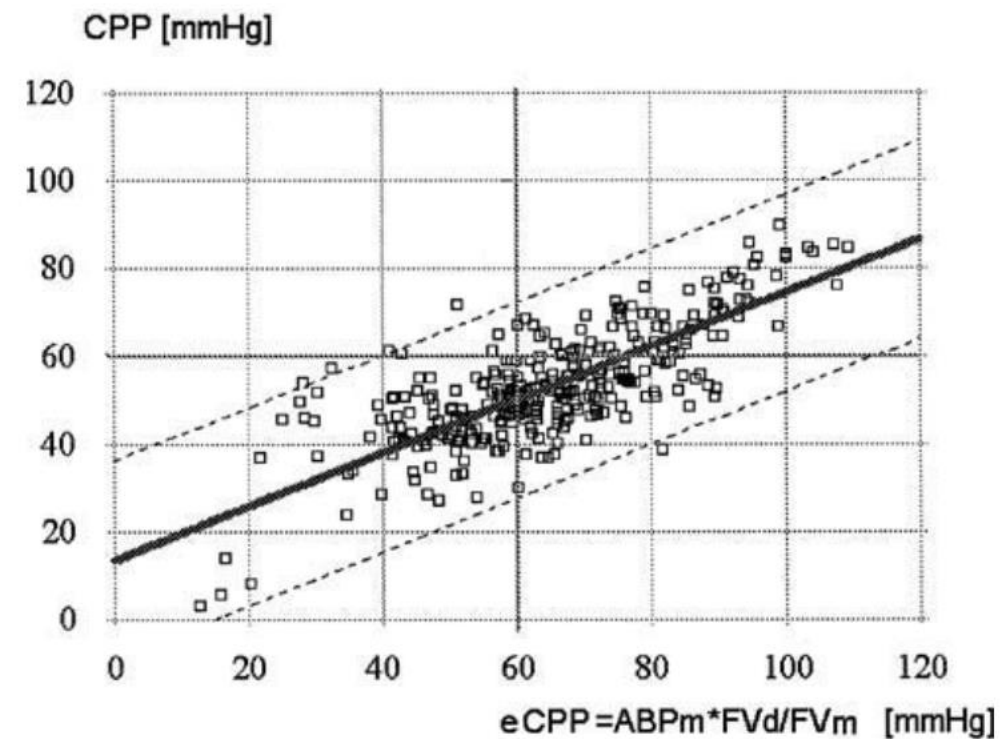
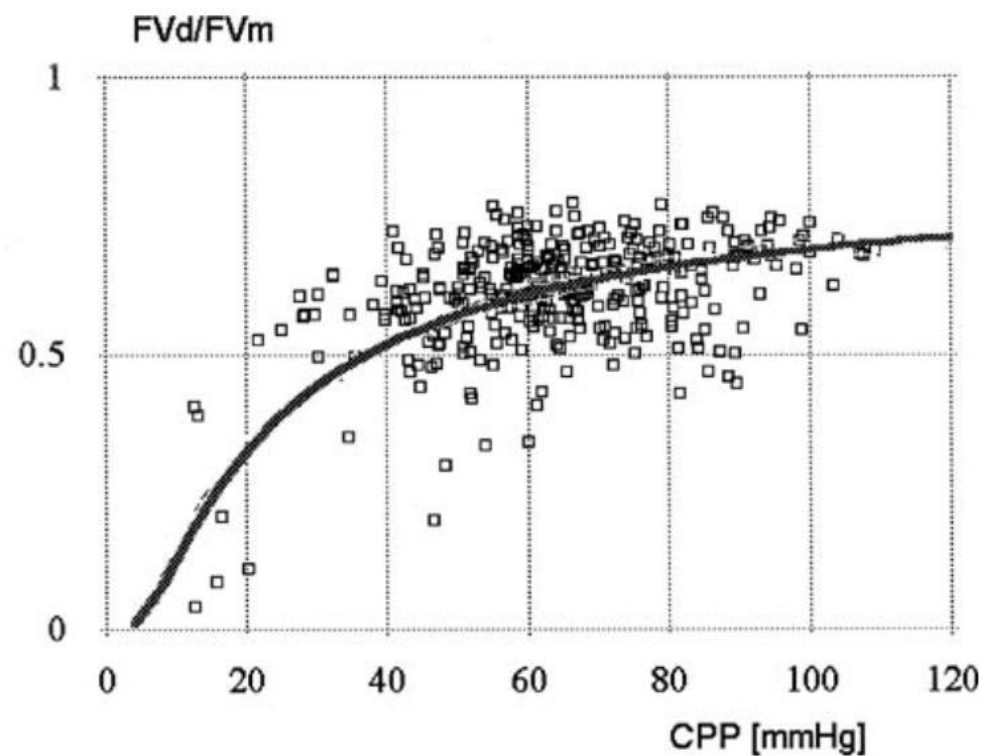
C. Leviland*, N. Mayeur, M. Srairi, S. Mrozek, H. Gonzalez, O. Fourcade, T. Geeraerts



Cerebral perfusion pressure in head-injured patients: a noninvasive assessment using transcranial Doppler ultrasonography

MAREK CZOSNYKA, PH.D., BASIL F. MATTA, M.B., F.R.C.A., PIOTR SMIELEWSKI, PH.D., PETER J. KIRKPATRICK, M.D., F.R.C.S., AND JOHN D. PICKARD, M.CHIR., F.R.C.S.

Wolfson Brain Imaging Centre, Medical Research Council/Cambridge Centre for Brain Repair and Academic Neurosurgical Unit, Department of Anaesthesia, and The Neurosciences Critical Care Unit, Addenbrooke's Hospital, Cambridge, United Kingdom



Transcranial Doppler as a screening test to exclude intracranial hypertension in brain-injured patients: the IMPRESSIT-2 prospective multicenter international study

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Transcranial Doppler as a screening test to exclude intracranial hypertension in brain-injured patients: the IMPRESSIT-2 prospective multicenter international study

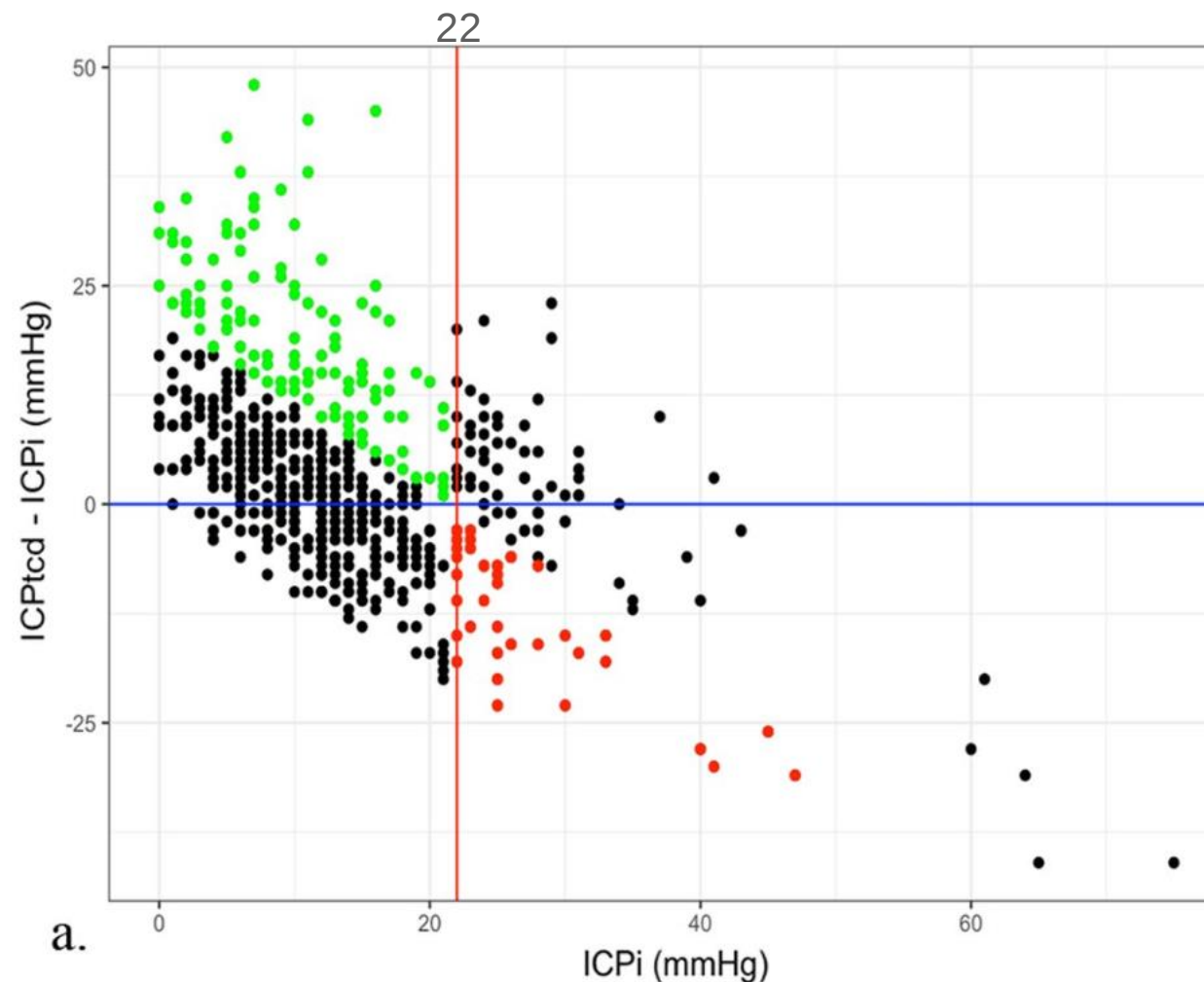


Fig. 4 a Distribution of differences between paired ICPTcd and ICPI measurements as a function of ICPI. Black points represent concordant measurements (either true positive and true negative cases); green points indicate $\text{ICPI} < 22$ and $\text{ICPTcd} \geq 22$ (false positive measurements); red points indicate $\text{ICPI} \geq 22$ and $\text{ICPTcd} < 22$ (false negative cases). **b** Bland–Altman analysis yielded a mean bias ($\text{ICPTcd} - \text{ICPI}$) of -3.3 mmHg with an agreement range comprised between -26.1 and $+19.5$

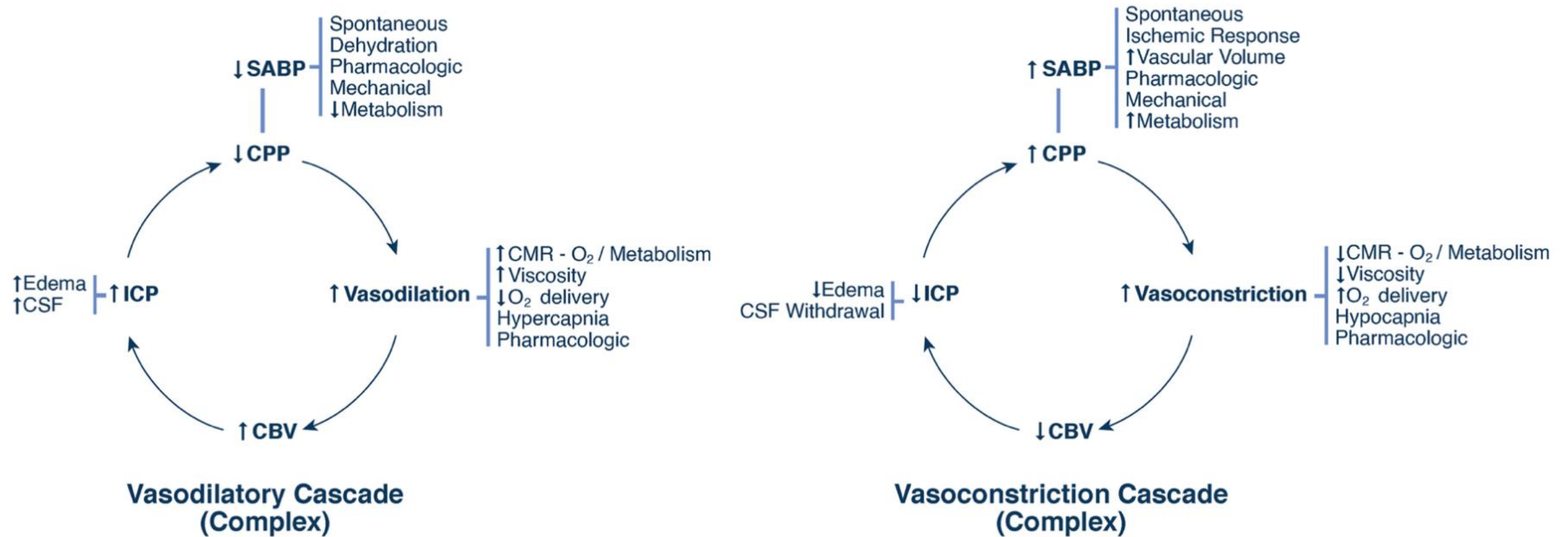
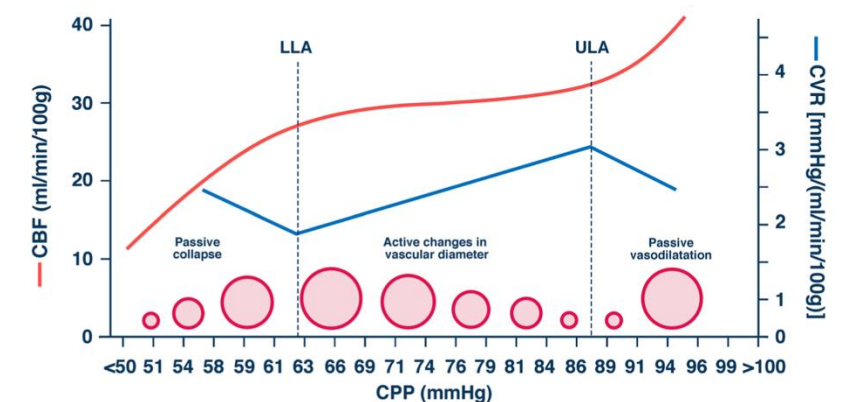


Fig. 4 Rosner's vasodilatory and vasoconstriction cascades. The vasodilatory and vasoconstriction cascades reflect broad autoregulatory processes which can influence the diameter of the cerebral vasculature and thus the cerebral blood volume and intracranial pressure despite injury to the brain. These cascades were described by Rosner based on clinical observations. These cascades are clinically relevant as they demonstrate a means by which ICP can be reduced by increasing nutrient delivery to the brain. Adapted from Rosner et al., 1995 [54]

Bénéfice patient
-> optimisation du débit sanguin cérébrale



Transcranial Doppler to Predict Neurologic Outcome after Mild to Moderate Traumatic Brain Injury

Pierre Bouzat, M.D., Ph.D., Luc Almeras, M.D., Pauline Manhes, Ph.D., Laurence Sanders, M.D., Albrice Levrat, M.D., Jean-Stephane David, M.D., Ph.D., Raphael Cinotti, M.D., Russel Chabanne, M.D., Aurélie Gloaguen, M.D., Xavier Bobbia, M.D., Sophie Thoret, M.Sc., Lydia Oujamaa, M.D., Jean-Luc Bosson, M.D., Ph.D., Jean-François Payen, M.D., Ph.D., for the TBI-TCD Study Investigators*

Modèle de triage à la phase initiale
en complement du TDM

N = 356 TC légers à modérés
-> Glasgow 9 à 15

TDM avec lésions
-> Traumatic data bank : II

DTC : Définition olighémie
Vd < 25 cm/sec
IP > 1,25

Modèle prédictif incluant :
Age, Glasgow, DTC

Table 1. Demographic Data Collected on Admission of the Study Population (n = 356 Patients)

Variable	Value
Age (yr)	42 (29–61)
Male/female, n	277/79
ISS	16 (14–22)
Circumstances, n (%)	
Road traffic accident	139 (39)
Falls	59 (17)
Sport	76 (21)
Admission, n (%)	
Emergency room	173 (49)
Emergency service	151 (42)
ICU	32 (9)
Pre-hospital medical care, n (%)	225 (63)
GCS on admission	14 (14–15)
Alcohol intoxication, n (%)	61 (17)
Aspirin, n (%)	22 (6)
Mean arterial pressure (mmHg)	93 (84–105)
Heart rate (beats/min)	80 (70–90)
Respiratory rate (breaths/min)	16 (15–20)
Arterial oxygen saturation (%)	98 (97–100)
Temperature (°C)	36.9 (36.4–37)
VAS (n)	2 (1–4)

Continuous values are medians (25th to 75th interquartiles).

GCS = Glasgow coma scale; ICU = intensive care unit; ISS = injury severity score; VAS = visual analog pain scale.

Transcranial Doppler to Predict Neurologic Outcome after Mild to Moderate Traumatic Brain Injury

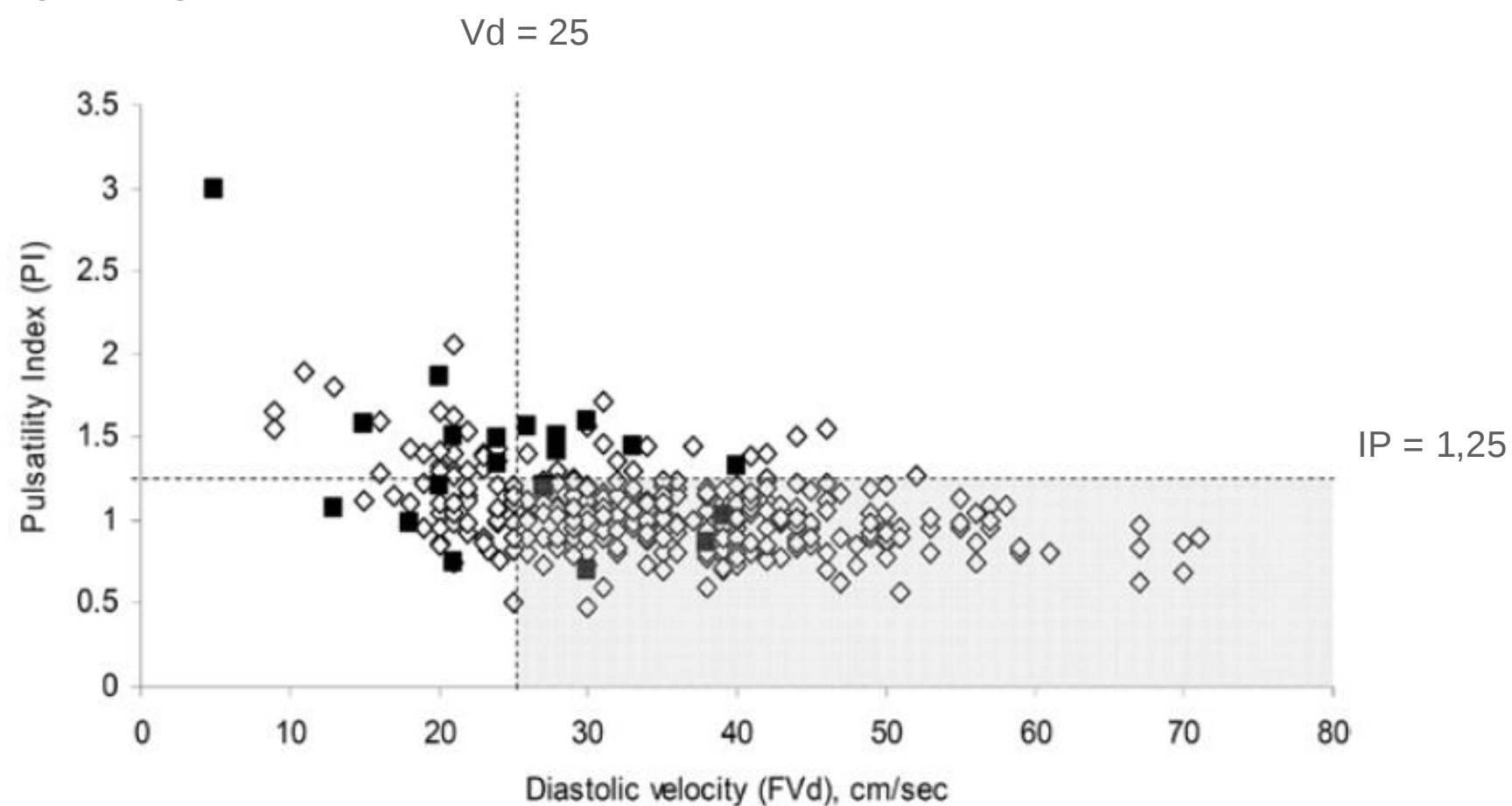
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N = 356 TC légers à modérés

Vd < 25 cm/sec

IP > 1,25

Modèle prédictif incluant :Age, Glasgow, DTC



Carré noirs = évolution défavorable

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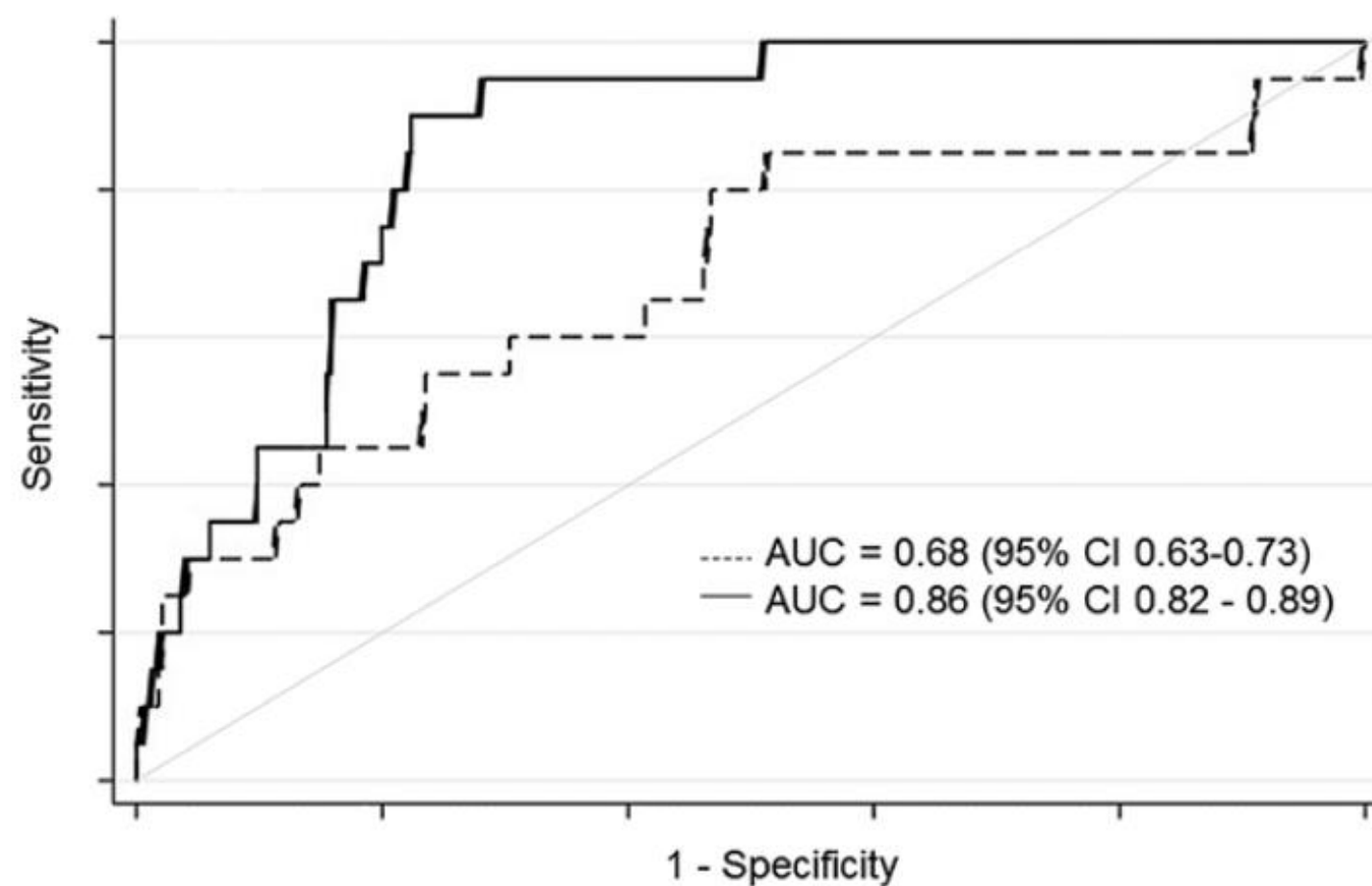
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N = 356 TC légers à modérés

Vd < 25 cm/sec

IP > 1,25

Modèle prédictif incluant :Age, Glasgow, DTC



Pour le sous-groupe Glasgow 14-15
VPN = 98%

Attention faux négatif possible si lésion en fosse postérieure
-> limite de l'exploration régionale par DTC

Transcranial Doppler ultrasound goal-directed therapy for the early management of severe traumatic brain injury

Catherine Ract
Sophie Le Moigno
Nicolas Bruder
Bernard Vigué

N = 24 TCG

Prospectif observationnel

DTC à l'admission -> groupe Normal vs Anormal

Anormal si :

Vm < 30 cm/sec

Vd < 20cm/sec

IP>1,4

Intervention si anormal : mannitol ou noradrénaline

Table 1 Demographic data

	Abnormal admission TCD (<i>n</i> = 11)	Normal admission TCD (<i>n</i> = 13)
Age (years)	33 ± 12	35 ± 12
Glasgow Coma Scale*	5 [3–7]	7 [3–8]
Injury Severity Score	25 [16–34]	20 [16–57]
Multiple injuries (<i>n</i>)	2	7
Time from trauma to admission (min)	202 ± 139	142 ± 64
Glasgow Outcome Score*	3 [1–5]	1 [1–4]

Data are given as median [range] or mean ± SD

Glasgow Outcome Score 1 good recovery, 2 moderate disability, 3 severe disability, 4 vegetative state, 5 dead.

* *p* < 0.05 between groups

Transcranial Doppler ultrasound goal-directed therapy for the early management of severe traumatic brain injury

	Abnormal admission TCD (<i>n</i> = 11)		Normal admission TCD (<i>n</i> = 13)	
	T0	T1	T0	T1
1				
Delay from admission (min)	16 ± 8	219 ± 96	20 ± 12	262 ± 123
Abnormal TCD (<i>n</i>)	11	2	0	0
Mean velocity (cm/s)	30 ± 6	43 ± 10*	49 ± 13**	51 ± 11
Diastolic velocity (cm/s)	13 ± 5	25 ± 8*	34 ± 11**	36 ± 11**
Pulsatility index	2.1 ± 0.5	1.4 ± 0.3*	1.2 ± 0.6**	0.9 ± 0.3**
MAP (mmHg)	89 ± 15	105 ± 17*	89 ± 11	93 ± 19
ICP (mmHg)		32 ± 13		22 ± 10**
CPP (mmHg)		73 ± 15		71 ± 14
SjvO ₂ (%)		67 ± 2		72 ± 9
pH	7.39 ± 0.04	7.39 ± 0.02	7.32 ± 0.06**	7.36 ± 0.07*
PaCO ₂ (mmHg)	40 ± 5	42 ± 5	45 ± 6**	41 ± 6*
Haemoglobin (g/dl)	12 ± 1	11 ± 1	12 ± 2	11 ± 2
Norepinephrine (<i>n</i>)	1	9	2	4
Mannitol (<i>n</i>)	0	5	1	0
Neurosurgery (<i>n</i>)	-	3	-	0

* $p < 0.05$ between T0 and T1

** $p < 0.05$ between groups

Transcranial Doppler ultrasound goal-directed therapy for the early management of severe traumatic brain injury

Catherine Ract
Sophie Le Moigno
Nicolas Bruder
Bernard Vigué

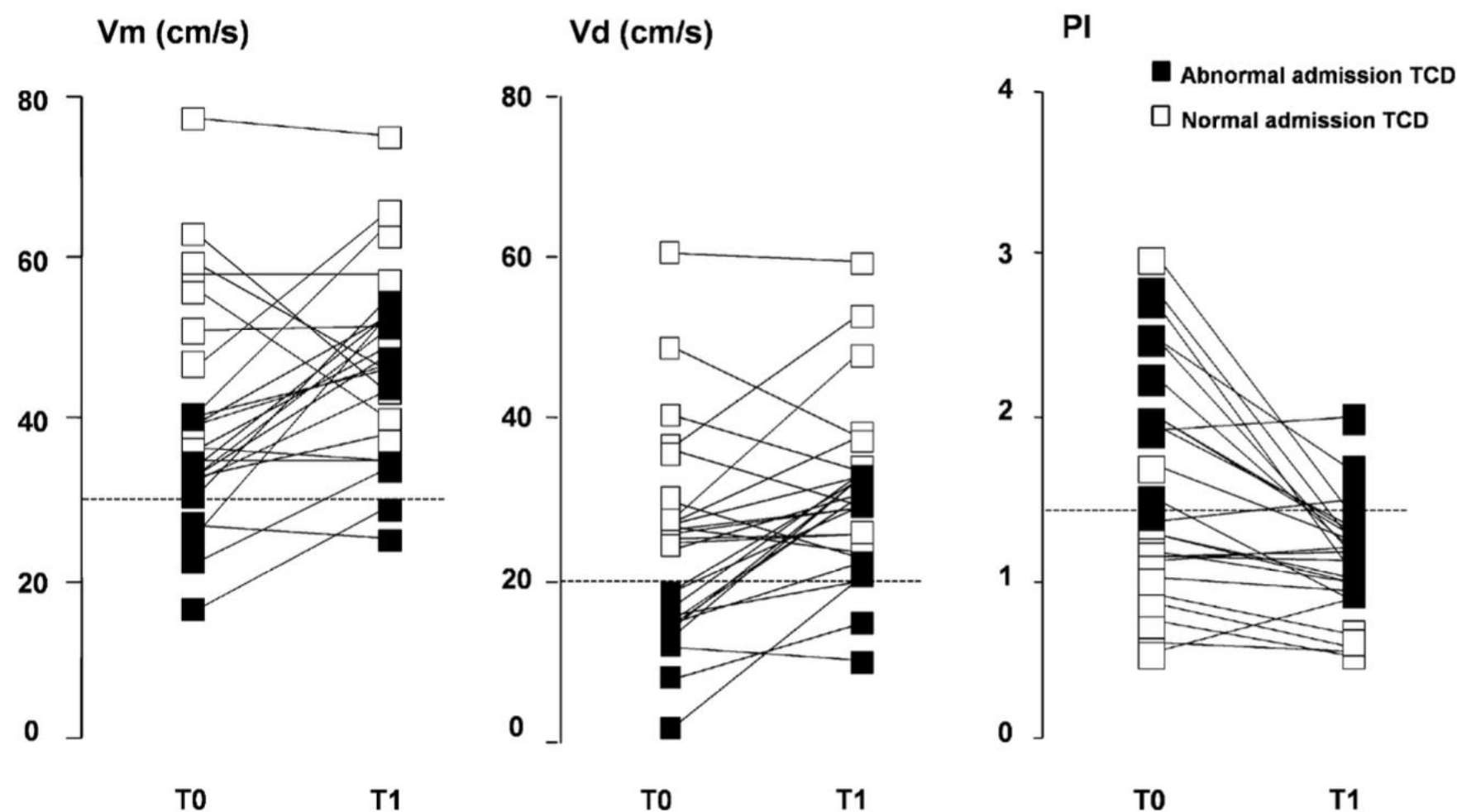


Table 1 Summary of the main characteristics of invasive and non-invasive methods for intracranial pressure (ICP) estimation

	Availability	Accuracy	Risks of infection/ hemorrhage	Operator dependency	Cost
External ventricular drain	Moderate/high	High	Moderate	Low (Level of external trans- ducer)	Moderate (antibiotic impregnation approx- imately doubles cost)
ICP microtransducer	Moderate/high	High	Low	None	High (higher than both conventional and antibiotic impreg- nated EVDs)
Radiological findings (MRI/CT)	High	Low	None	Low	Low/moderate
ONSD	High	Low	None	High	Low
Transcranial Doppler	High	Low	None	High	Low
Automated pupillometry	High	Low	None	Low	Low

MRI, magnetic resonance imaging; CT, computed tomography; ONSD, optic nerve sheath diameter

DTC ET TRAUMATISME CRÂNIEN

Utilisation clinique

- Evaluation initiale
 - Triage Traitement en urgence
- Suivi thérapeutique
 - Dépister olighémie - monitoring cérébral
 - Dépister le vasospasme Intégration dans réflexions clinique globale
- Intégration dans un monitoring multimodale (DTC, PIC, PtiO₂, TDM...)

Limites

- Examen ponctuel
- NE MESURE PAS LA PIC NI LE DSC
- Les résultats donnés par le DTC sont le reflet des conditions hémodynamique intra cérébrales ET systémiques

Attention lésions en fosse postérieure

DTC ET MORT ENCEPHALIQUE

Transcranial Doppler study of intracranial circulatory arrest

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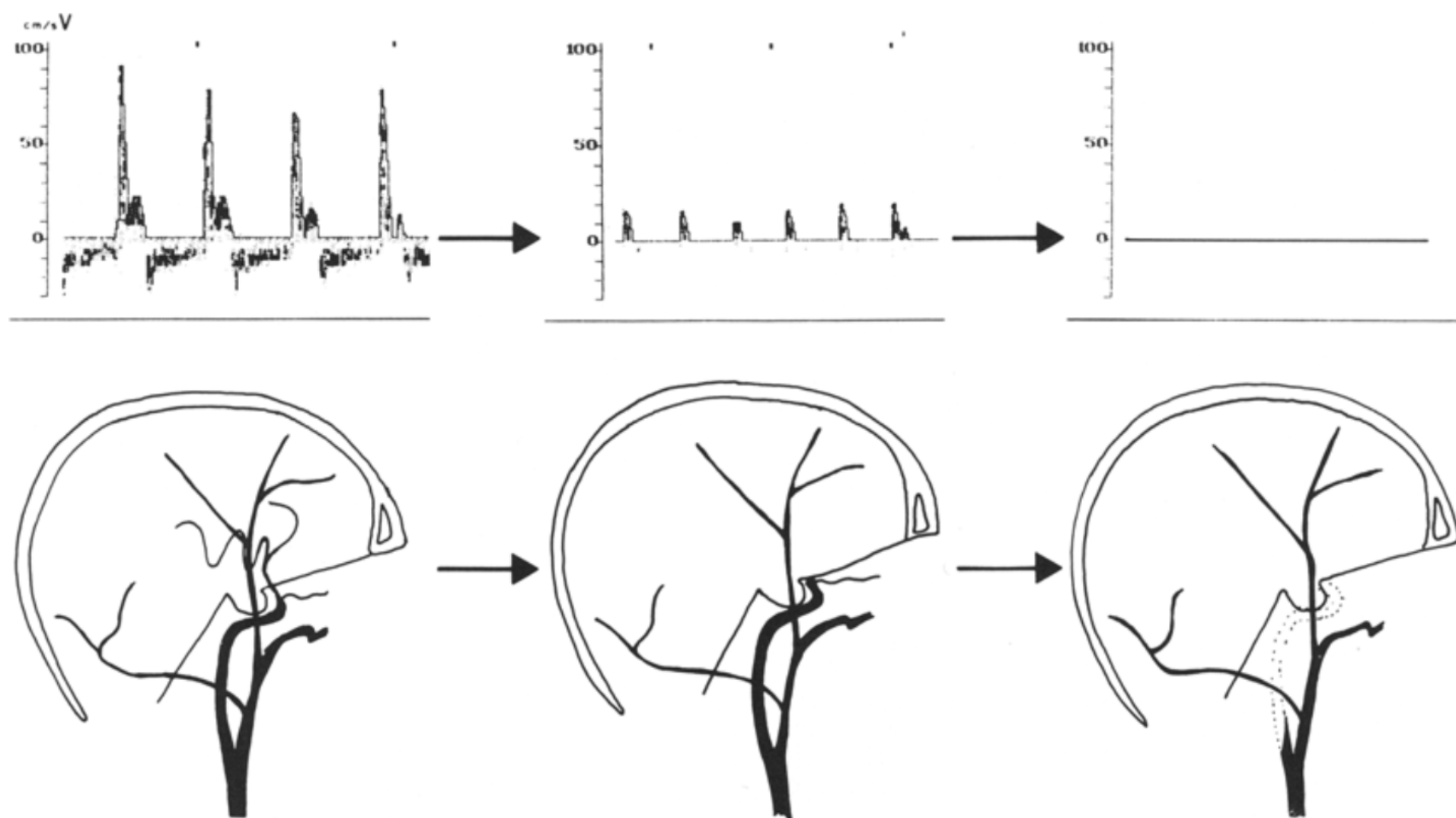
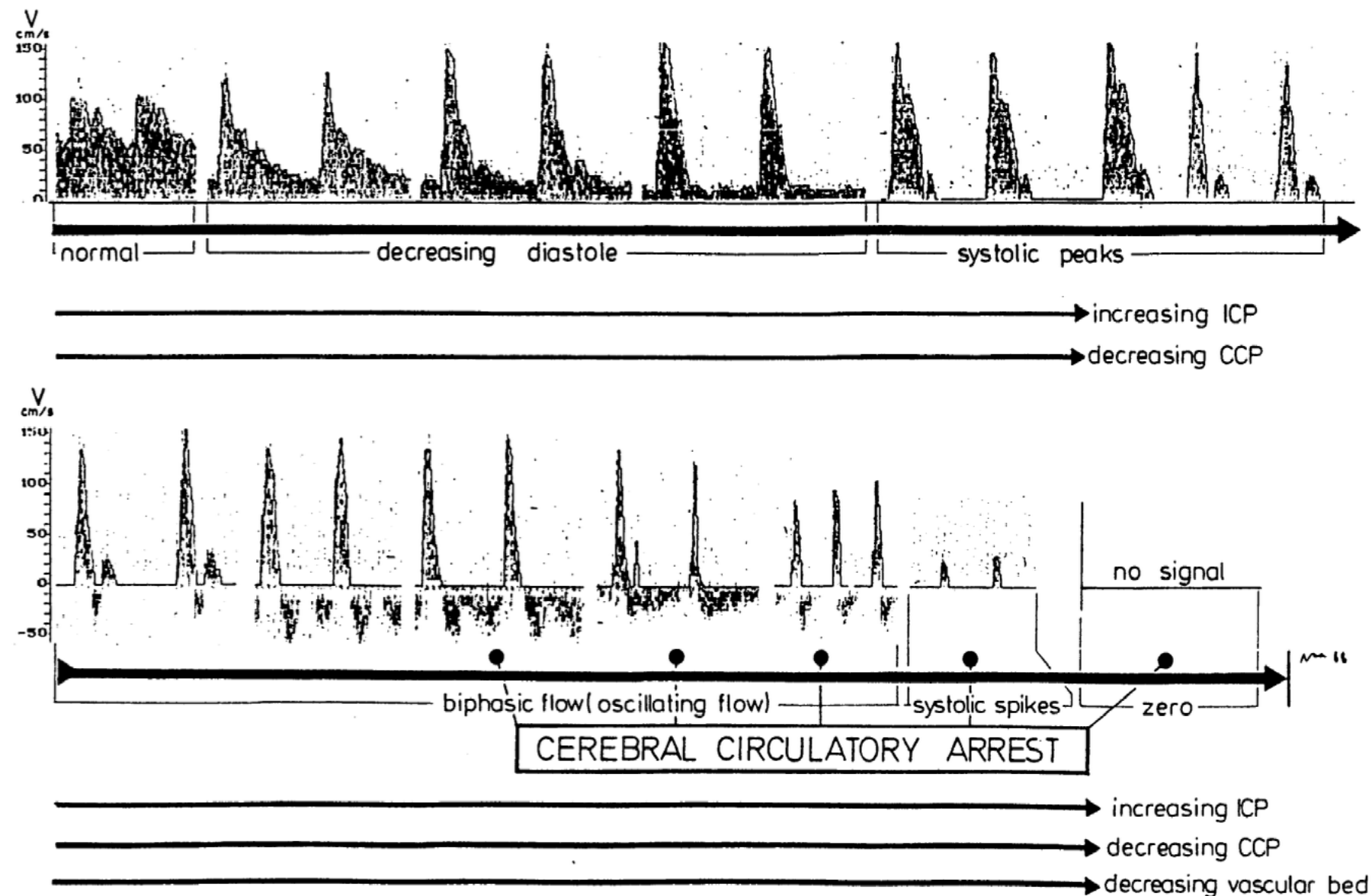


FIG. 6. Intracranial hemodynamics in early (*left*), intermediate (*center*), and late (*right*) intracranial circulatory arrest. The typical progress of the transcranial Doppler ultrasonography patterns (*upper*) correlates with a descent of the angiographic cessation of flow from subarachnoid to cervical levels (*lower*). V = velocity.

Consensus opinion on diagnosis of cerebral circulatory arrest using Doppler-sonography

Task Force Group on cerebral death of the Neurosonology Research Group of the World Federation of Neurology

TIME-COURSE OF FLOW VELOCITIES IN MCA FROM NORMAL CONDITION UP TO
CEREBRAL CIRCULATORY ARREST



Consensus opinion on diagnosis of cerebral circulatory arrest using Doppler-sonography

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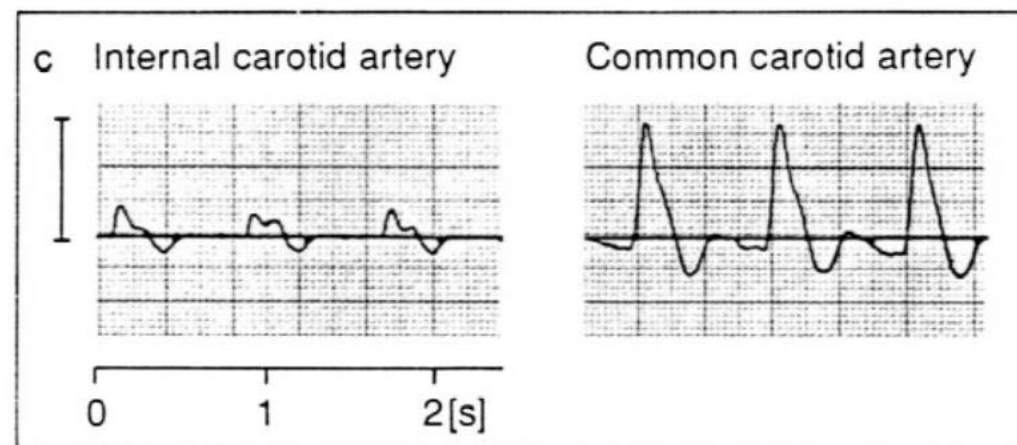


Fig. 2. Recording of the extracranial internal carotid artery and the common carotid artery with conventional zero crossing technique (a) and of the middle cerebral artery by transtemporal recording with spectrum analysis (b) in the same patient with established cerebral circulatory arrest. The examination of the middle cerebral artery shows the typical systolic spikes. For further explanation see text. (Reprinted from [37].)

Consensus opinion on diagnosis of cerebral circulatory arrest using Doppler-sonography

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- L'utilisation du DTC est toujours soumise aux pré-requis fondamentaux

Démarche diagnostic de l'état de mort encéphalique

Connaissance du diagnostic

Absence de facteurs confondant

Examen clinique de mort encéphalique

- PAM > 60 mmHg

PAS EN FRANCE

- Examen bilatéral

Artères intra et extra crâniennes

2 examens enregistrés à au moins 30 minutes d'intervalle

Flux oscillant (aire sous la courbe positives et négatives égales)

OU

Pic systolique < 200 ms et < 50 cm/sec

Possible en Allemagne

Absence de signal n'est pas une preuve

La disparition du signal est acceptée

Diagnostic Accuracy of Transcranial Doppler for Brain Death Confirmation: Systematic Review and Meta-Analysis

J.J. Chang, G. Tsivgoulis, A.H. Katsanos, M.D. Malkoff, and A.V. Alexandrov

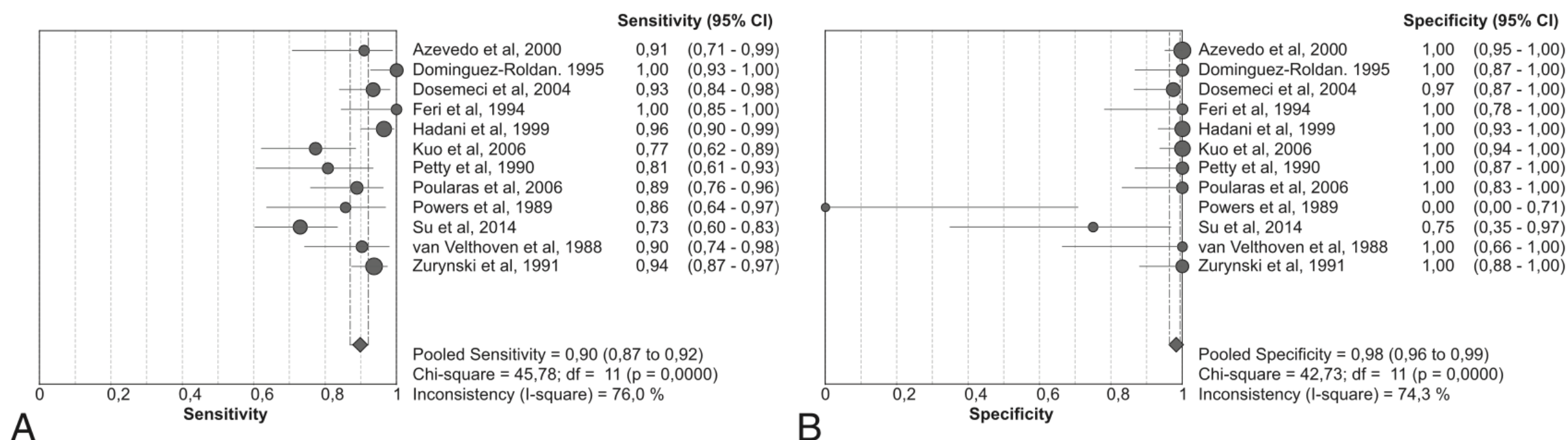


FIG 3. Pooled sensitivity (A) and specificity (B) of eligible studies reporting both diagnostic accuracy testing parameters.

Limites

- Le DTC à une sensibilité inférieure à l'examen clinique
- Sensibilité de l'examen influencée par le mécanisme lésionnel
- Pas de sensibilité 100% (arrêt circulatoire survient après EME)
- Faux positifs
- Patients sans fenêtre echo

Transcranial Doppler Shortens the Time Between Clinical Brain Death and Angiographic Confirmation: A Randomized Trial

Jean-Christophe Orban,^{1,2,4} Ali El-Mahjoub,¹ Laurent Rami,¹ Patrick Jambou,² and Carole Ichai^{1,3}

N = 44

22 standard TDM H+6 examen clinique

22 TDM si DTC signant un arrêt circulatoire (pic systolique / oscillant / disparition). Répété toutes les 2 heures.

Critère de jugement temps diagnostic clinique -> TDM

TABLE 2. Number of flow patterns of the extra and intracranial arteries

	Normal Flow	Systolic Forward Flow and Diastolic to and fro Flow	Oscillating Flow	Systolic Spikes	Absence of Flow
ICA, n (%)	10 (23)	19 (43)	11 (25)	2 (4.5)	2 (4.5)
MCA, n (%)	0	0	9 (20)	13 (30)	22 (50)
VA, n (%)	0	0	4 (9)	5 (11)	35 (80)
BA, n (%)	0	0	3 (14)	1 (4)	18 (82)

BA, basilar arteries; ICA, internal carotid arteries; MCA, middle cerebral arteries; VA, vertebral arteries.

Transcranial Doppler Shortens the Time Between Clinical Brain Death and Angiographic Confirmation: A Randomized Trial

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N = 44

22 standard TDM H+6 examen clinique

22 TDM si DTC signant un arrêt circulatoire (pic systolique / oscillant / disparition). Répété toutes les 2 heures.

Critère de jugement temps diagnostic clinique -> TDM

Nb : 1 patient groupe DTC ayant nécessité 2 TDM

Bénéfice d'un raccourcissement du diagnostic de ME non établi
Intérêt logistique

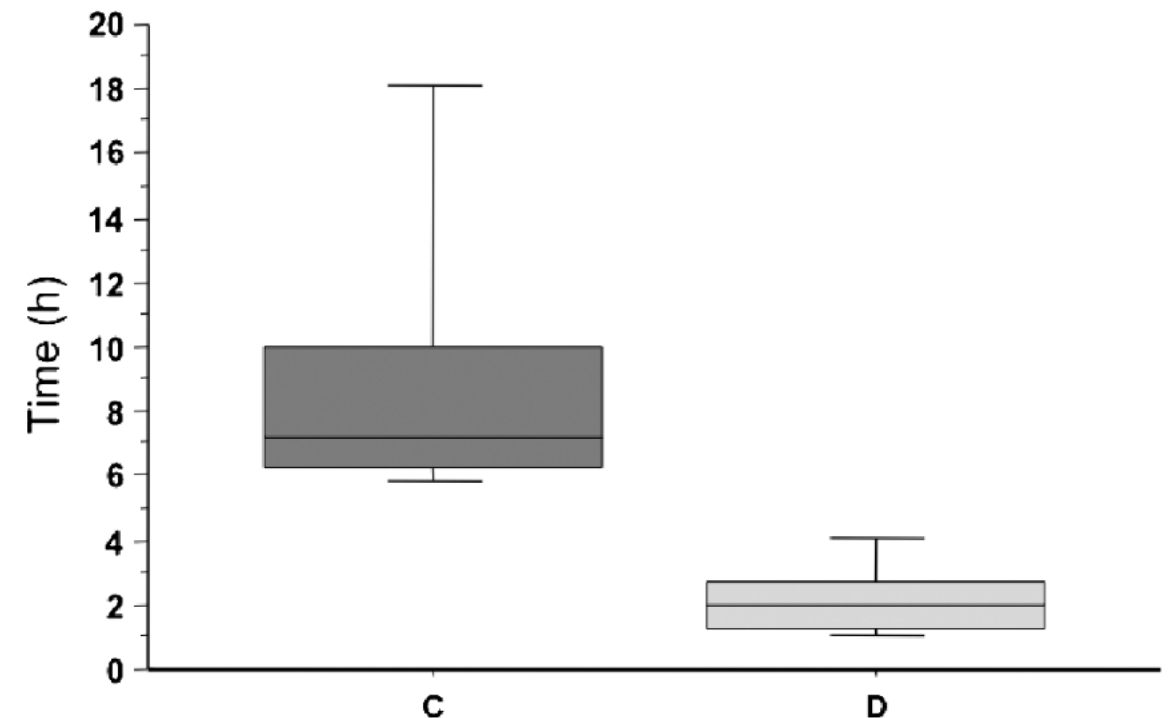


FIGURE 2. Time between clinical diagnosis of brain death and computed tomography angiography confirmation in the conventional (C) and Doppler (D) groups. Data are expressed as median and interquartile range.

DTC ET MORT ENCEPHALIQUE

- EN FRANCE outil non validé pour le diagnostic
- Intérêt?
 - Observationnel - physiopathologique
 - Augmenter la rentabilité du transport TDM
 - > ne pas « descendre au scanner » pour rien
- Législation à suivre

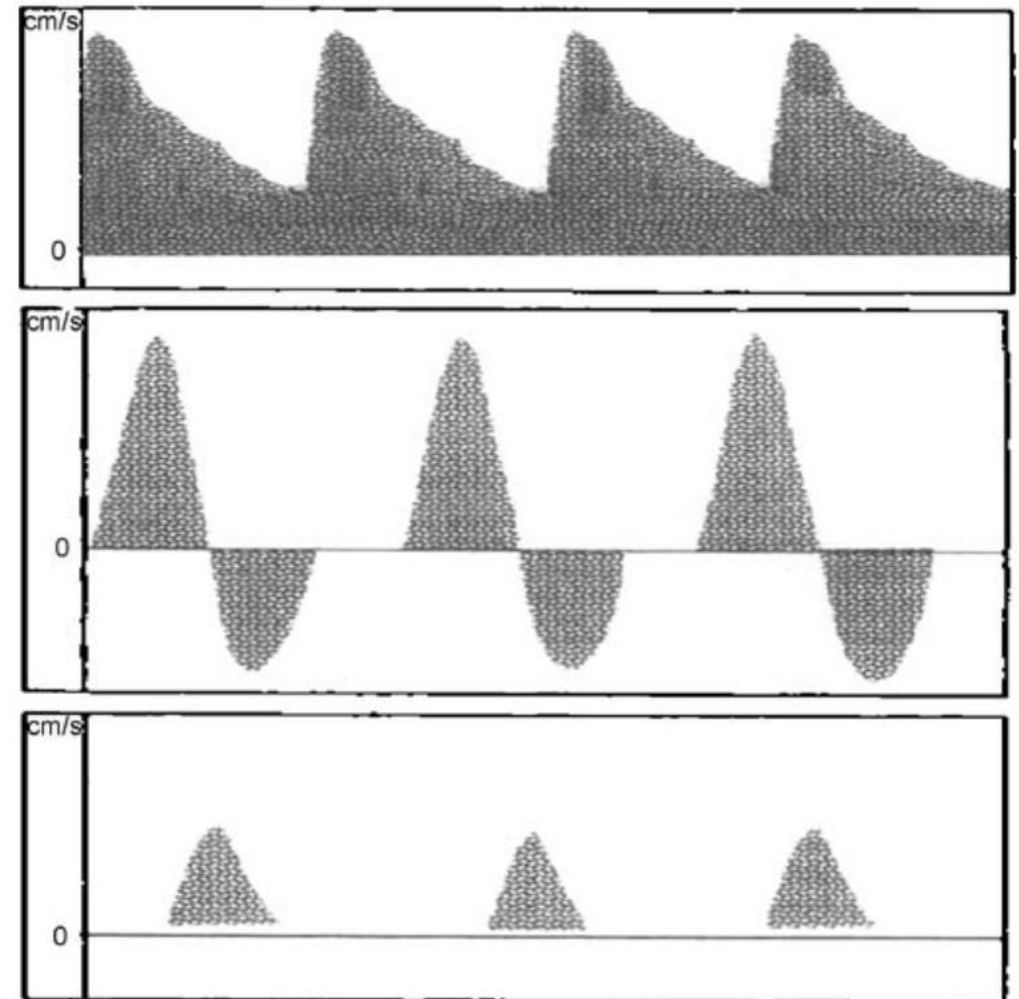


Fig.1 Transcranial Doppler flow patterns. Transcranial Doppler flow patterns demonstrate normal flow with systolic and diastolic forward flow (*top*), oscillating flow with systolic forward flow and reversed diastolic flow (*middle*), and brief systolic forward flow (*bottom*)

Merci pour votre attention