Transcranial Sonography (TCS) of Brain Parenchyma in Movement Disorders: Quality Standards, Diagnostic Applications and Novel Technologies

Introduction

Transcranial B-mode sonography (TCS) of deep brain structures has been established as a tool for the diagnosis and monitoring of degenerative brain disorders in the past decade [1]. Several years ago, TCS could be recommended only with high-end ultrasound systems (US-S) [1, 2]. Meanwhile, technological advances have enabled standard applications (assessment of the substantia nigra [SN],...
measurement of ventricle widths) with sufficient quality even with a portable US-S [3]. With contemporary high-end US-S, excellent image resolution of deep brain structures is achieved which can be superior to that of magnetic resonance imaging (MRI) under clinical conditions [4]. Compared to MRI and computed tomography, the advances of TCS are its high mobility, short investigation times, non-invasiveness, and low cost. Involuntary head motion in movement disorder patients can be well compensated by the investigator. Most of all, TCS detects abnormalities that are not seen, or only seen with significant effort, with other neuroimaging modalities. The present article gives an overview of the current methodological standard and defines criteria of adequate image quality for diagnostically relevant deep brain structures. In addition, recent technological advances including MRI-TCS fusion imaging and semi-automated visualization techniques are reviewed.

Method

Equipment

For TCS an optimized US-S (recommended settings, **Table 1**) equipped with a 2.0- to 3.5-MHz phased-array transducer is used. With it the highest image resolution is achieved at an image depth (distance from the transducer face) of 5 – 9 cm which is the so-called focal zone of the transducer [4]. Due to the physical characteristics of ultrasound beams, the image resolution in the axial direction (i.e., along the axis of ultrasound propagation) is about two- to threefold higher than in the lateral direction, usually about 0.7 × 2 mm. This is the cause of some typical imaging artifacts (e.g. enlargement of small, highly echogenic structures in the lateral direction). Meanwhile, contemporary systems achieve a higher image resolution in the focal zone of up to 0.7 × 1.1 mm thanks to intelligent image post-processing technologies [4]. It should be stressed that system-specific image-processing techniques influence distinct measurements such as the assessment of echogenic areas of small brain structures. That is why normal ranges especially for SN echogenic areas need to be obtained separately for each different US-S. The application of tissue harmonic imaging (THI) rather than the conventional imaging mode increases the tissue contrast and can therefore enable an easier delineation of small echogenic structures, e.g. the SN. THI however largely depends on the quality of the bone window and is not recommended as a standard tool for measurements [2].

Investigation procedures

The patient is placed in a supine position on an examination chair layer with a variably adjustable lean part. The investigation room should be darkened. The investigator sits behind the patient’s head. For the usually performed transtemporal investigation, the TCS transducer is placed on the right temple near the ear and parallel to the orbitomeatal line in order to obtain a standardized axial view of intracranial structures. An important precondition for obtaining valid TCS findings is the identification and keeping of the optimum bone window for insonation. For this, the transducer is moved near the anterior helix of the ear conch to find the position with the best available visualization of brain structures and the contralateral skull bone. Once the optimum position has been found, it is kept by pressing the transducer as well as the small finger/ulnar edge of the hand firmly against the patient’s head throughout the whole examination. Even if applying optimum US-S settings (**Table 1**), assessment of intracranial structures may be not or only partially possible due to an insufficient transtemporal bone window which is found in 5–40% of patients depending on age, sex and geographic origin [3–6].

Quality criterion of good image quality: The contralateral skull bone is clearly visualized over its whole extension in the imaging sector.

In neurodegenerative diseases transtemporal TCS is usually carried out on standardized axial imaging planes (**Fig. 1**). For some diagnostic questions TCS is additionally performed on semi-coronal and coronal or transfrontal sagittal imaging planes, e.g. for the assessment of the corpus callosum or the localization of deep brain stimulation (DBS) electrodes [5–7]. TCS findings can be categorized into two types. The first is the semi-quantitative or quantitative assessment of the echogenicity of brainstem structures (SN, red nucleus, midbrain raphe) and basal ganglia (thalamus, lenticular nucleus, head of caudate nucleus), optionally also of the cerebellum and other deep brain structures (e.g. white matter, hippocampal region). The second is the measurement of widths (optionally the cross-sectional area) of the 4th ventricle, 3rd ventricle, frontal horns of lateral ventricles and if needed the cella media.

Quality criterion of adequate standard of TCS report: The report includes the rating (normal vs. abnormal) and, if obtained, the quantitative measures of echogenicity of SN, red nucleus, midbrain raphe, lenticular nucleus, caudate nucleus (and of other brain structures if investigated) as well as the widths of the 3rd ventricle and frontal horns of lateral ventricles (and of other brain structures if investigated) as well as the final interpretation of TCS findings in response to the diagnostic question.

### Table 1  Recommended ultrasound system settings for TCS.

<table>
<thead>
<tr>
<th>parameter</th>
<th>settings</th>
</tr>
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<tbody>
<tr>
<td>ultrasound machine</td>
<td>start with 14 – 16 cm, adapt as needed</td>
</tr>
<tr>
<td>image depth</td>
<td>45 – 55 dB</td>
</tr>
<tr>
<td>dynamic range</td>
<td>moderate suppression of low echogenic signals</td>
</tr>
<tr>
<td>post-processing function</td>
<td>adapt manually as needed or, if available, apply automated image optimization (i.e., press the referring button on the keyboard, standard with contemporary high-end ultrasound systems)</td>
</tr>
<tr>
<td>time gain compensation</td>
<td>adapt manually as needed or, if available, apply automated image optimization (i.e., press the referring button on the keyboard, standard with contemporary high-end ultrasound systems)</td>
</tr>
<tr>
<td>image brightness</td>
<td>adapt manually as needed or, if available, apply automated image optimization (i.e., press the referring button on the keyboard, standard with contemporary high-end ultrasound systems)</td>
</tr>
<tr>
<td>Ultrasound transducer</td>
<td>density of crystals / channels as high as possible, ideally “matrix” probe</td>
</tr>
<tr>
<td></td>
<td>center frequency of insonation 2.0 – 3.5 MHz, usually 2.5 MHz</td>
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Midbrain structures

Visualization and assessment

For many diagnostic questions in movement disorders, the visualization of midbrain structures (SN, raphe) on an axial imaging plane is of importance.

Quality criterion of adequate midbrain visualization: The butterfly-shaped midbrain transection surrounded by the highly echogenic basal cisterns (cisterna ambiens, cisterna quadrigemina, cisterna suprasellaris) is completely displayed.
The SN echosignals may have a patchy, band-like or sometimes wide oval appearance (Fig. 2). Its appearance may slightly vary even in the same individual if using different transducer angulations or various US-S [8]. This variation is caused by the arched anatomic structure of the SN, the TCS image composition from an about 2-mm thick “slice” of the brain, the 1.5- to 3-fold higher axial than lateral TCS image resolution, and different imaging technologies of diverse US-S [6, 8]. The best-validated method to grade SN echogenicity is the planimetric measurement of the SN echogenic signals on an axial plane [1, 6, 8]. Semiquantitative visual grading is less reliable [6, 10]. Novel technologies, aiming to reduce investigator dependency, such as measuring the echointensity of the SN relative to the surrounding parenchyma, volumetry, semi-automated SN detection, or complex mathematical echo-signal analysis, have either failed or are not yet ready for clinical application [6, 11 – 13]. Because of potential interference with echosignals originating from structures of the basal cisterns, the echogenicity of the SN is assessed only ipsilaterally to insonation. Therefore, SN TCS needs to be performed from both sides. The axial midbrain transection showing the echosignals of the ipsilateral SN in its largest extension is located by slight tilting of the probe. The clearest, most compact view of the SN echogenic signals is located by very slight probe movements. If the SN is seen very clearly, the image is frozen immediately. After choosing the optimum frame using the cine mode if necessary, the midbrain is zoomed out two- to threefold. The SN echogenic signals are surrounded manually by the cursor using the trackball, resulting in automatic calculation of the echogenic area (for video guide see [8]).

▶ Quality criterion of the adequate visualization of the SN: The echosignals of the SN are displayed at a typical anatomic location in the crus mesencephali and are well separated from the echosignals of the red nucleus and basal cisterns. The inter-individual variation of SN echogenicity has been suggested to be caused by a variable degree of local iron accumula-

Fig. 1 Standard TCS axial imaging planes in movement disorders. Shown are corresponding TCS and MRI images displayed by an ultrasound system equipped with virtual navigation technology. a TCS image of axial transsection through the brain at midbrain level. b MRI image corresponding to the TCS images shown in a. c TCS image of axial transsection through the brain at thalamus level. d MRI image corresponding to the TCS images shown in c.

Quality criterion of adequate assessability of the midbrain raphe: Basal cisterns, SN and midline structures (raphe, aqueduct) are clearly displayed.

The red nucleus, located in the caudal midbrain between the raphe and SN, is typically visualized as two small stripe-like echoes at its medial and lateral border, respectively. Sometimes its lateral echosignal cannot be discriminated from the echoes of the SN but, if so, this usually does not relevantly interfere with measurements of the SN echogenic area. Occasionally a healthy subject exhibits marked echogenicity of the red nucleus in its full anatomical extension. This finding is rated as a hyperchogenicity even though the diagnostic meaning is unclear.

Diagnostic relevance

SN hyperechogenicity is characteristically found in more than 90% of Parkinson's disease (PD) patients, does not remarkably change in the disease course and is unrelated to PD severity [1]. Marked SN hyperechogenicity is also found in about 10% of healthy adults and has been associated with them having a (subclinical) malfunction of the nigrostriatal dopaminergic system [1, 16]. In a 5-year follow-up study performed in Southern Germany and Austria of 1800 subjects at ages between 50 and 70 years without PD at baseline, SN hyperechogenicity was associated with a 20-fold increased risk of developing PD [27]. However, the predictive value of this TCS finding alone is low since more than 80% of healthy subjects with SN hyperechogenicity will never develop PD during their lifetime [28]. Moreover, SN hyperechogenicity has been found with variable frequencies in a number of other neurodegenerative diseases [28]. Still, SN TCS is helpful for the discrimination of PD from essential tremor [21, 29]. For the differentiation of PD from atypical Parkinsonian syndromes, SN TCS should be combined with TCS of other brain structures (Table 3), or with distinct clinical findings [1, 30 – 33]. The combined presence of normal SN echogenicity and lenticular nucleus hyperechogenicity clearly discriminates atypical Parkinsonian syndromes from idiopathic PD [30, 31]. In turn, the triad of SN hyperechogenicity, motor asymmetry and hyposmia is highly predictive for PD already at very early disease stages [32]. The results of several studies underpin the idea that risk scores comprising the finding of SN hyperechogenicity and other risk markers may be valuable in the prediction of subsequent PD [27, 32, 33]. The recently issued recommendations of the European Federation of Neurological Societies and the European Section of the Movement Disorder Society for the diagnosis of PD state that TCS is recommended (Level A) for: (I) the differential diagnosis of PD from atypical Parkinsonian syndromes and secondary Parkinsonian syndromes, (II) the early diagnosis of PD and (III) the detection of subjects at risk for PD [33]. A reduced SN echogenicity (hypoechogenicity) has been demonstrated in patients with idiopathic restless legs syndrome [34, 35]. SN hypoechogenicity has been proposed to be present at a sum value ≤0.20 cm² of bilaterally measured SN echogenic areas [35]. Its diagnostic value, however, remains to be established.

The SN represents an important landmark structure for the sono graphic assessment of DBS electrode position in PD patients with DBS of the subthalamic nucleus. Optimum DBS electrode position in the subthalamic nucleus can be diagnosed on TCS if in the axial or slightly semi-axial sonogram of the midbrain the virtual tip of DBS electrode touches or dives within the echosignals of the SN which are usually hyperechogenic and therefore easily recognizable in PD patients (Fig. 3d) [7]. A reduced echogenicity of the midbrain raphe has been detected in about 10% of the normal population but in 50 – 70% of patients with depressive disorders, and is discussed to reflect an altera-
Cerebellum and 4th ventricle

Visualization and assessment

To approach the cerebellar imaging plane one should start at the axial midbrain plane. Then the transducer is twisted by about 45° in a semi-coronal position, with cranial movement of the anterior part of the transducer and caudal movement of the posterior part. Eventually a slight tilting of the transducer is necessary to find the optimum plane which is characterized by simultaneous display of the midbrain and thalamus (Fig. 4a). On this plane the 4th ventricle can be seen in dorsal vicinity to the midbrain. In children and young adults the 4th ventricle often cannot be recognized due to its tightness [39]. However, in elderly subjects and particularly in patients with cerebellar atrophy it is usually visible. Mild cerebellar atrophy corresponds to a comma-shaped appearance, and pronounced atrophy to an oval appearance of the 4th ventricle.

▶ Quality criterion of adequate assessability of the 4th ventricle and dentate nucleus: Bilateral thalamus, midbrain (= reference structure), the lateral borders of the 4th ventricle and central parts of the cerebellum are clearly displayed.

There is currently no standard for the assessment of the cerebellum. Reported abnormal findings are 4th ventricle dilatation, a coarse appearance of the cerebellar sulci, and increased echogenicity of the dentate nuclei [39, 40]. Fourth-ventricle measures are the width and cross-sectional area on a semi-coronal plane. A cross-sectional area > 0.6 cm² can be regarded as abnormal.

Diagnostic relevance

Abnormal TCS findings of the 4th ventricle and cerebellum have been demonstrated in patients with various forms of hereditary spinocerebellar ataxia (Friedreich's ataxia, SCA-3, SCA-17) [39, 40]. So far there are no reports showing a diagnostic specificity of abnormal cerebellum TCS findings, neither alone nor in combination with other TCS findings.

Basal ganglia and ventricles

Visualization and assessment

The second standard imaging plane in the assessment of movement disorders is the axial basal ganglia plane (thalamus plane). This plane is approached, if starting from the axial midbrain plane, by tilting the transducer about 20° upwards (Fig. 1). In the case of a narrow transtemporal bone window, the transducer should be slightly shifted caudally – simultaneously with the upward tilting maneuver – in order to keep the bone window. Even if the bone window is poor, the pineal gland is mostly visible due to its tightness [39]. However, in elderly subjects and particularly in patients with cerebellar atrophy it is usually visible.

Table 2  Reported cut-off values for the discrimination between normal echogenicity and hyperechogenicity of substantia nigra with different contemporary ultrasound systems.

<table>
<thead>
<tr>
<th>manufacturer/ ultrasound system</th>
<th>probe/ frequency [MHz]</th>
<th>cut-off value [cm²]</th>
<th>references</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aloka/Prosound Alpha 10</td>
<td>UST-52 105/2.5</td>
<td>≥ 0.19</td>
<td>≥ 0.25</td>
</tr>
<tr>
<td>Esato/MyLab25 Gold</td>
<td>PA240/2.5</td>
<td>≥ 0.20</td>
<td>≥ 0.25</td>
</tr>
<tr>
<td>Esato/MyLab Twice</td>
<td>PA240/2.5</td>
<td>≥ 0.24</td>
<td>≥ 0.30</td>
</tr>
<tr>
<td>General Electric/Logiq 7</td>
<td>35/2.5</td>
<td>≥ 0.24</td>
<td></td>
</tr>
<tr>
<td>General Electric/Logiq 9</td>
<td>35/2.5</td>
<td>≥ 0.20</td>
<td></td>
</tr>
<tr>
<td>Philips/HDI 5000 SonicT</td>
<td>P2 – 4/2.5</td>
<td>≥ 0.20</td>
<td></td>
</tr>
<tr>
<td>Philips/HP Sonos 5500</td>
<td>S4/2.0 – 2.5</td>
<td>≥ 0.20</td>
<td>≥ 0.27</td>
</tr>
<tr>
<td>Siemens/Acuszon Antares</td>
<td>PX4 – 1/2.5</td>
<td>≥ 0.24</td>
<td>≥ 0.30</td>
</tr>
<tr>
<td>Siemens/Sonoline Elegra</td>
<td>2.5PL20/2.6</td>
<td>≥ 0.20</td>
<td>≥ 0.25</td>
</tr>
<tr>
<td>Toshiba Apio XG</td>
<td>PST-20CT/2.5</td>
<td>≥ 0.16</td>
<td>≥ 0.22</td>
</tr>
</tbody>
</table>

SN-h = substantia nigra hyperechogenicity

1 The cut-off values for the ultrasound systems Siemens Sonoline Elegra, GE Logiq 7, Philips HP Sonos 5500 and Toshiba Apio XG were obtained by studying large normal populations. With most other TCS systems, the cut-off values were derived from receiver operating characteristic curve analysis of diagnostic discrimination between Parkinson’s disease patients and healthy subjects, and/or by direct comparison of two different ultrasound systems in the same study cohort.

MAA-P = multiple system atrophy, parkinsonian type; PSP-RS = progressive supranuclear palsy, Richardson syndrome. If a brain structure is assessed bilaterally, the most abnormal finding is used for classification of a patient. The symbols indicate the frequency of abnormal TCS findings in the patients investigated in our labs: – = found in no case; (+) = rarely found (< 10 %); ++ = occasionally found (10 – 20 %); +++ = frequently found (30 – 50 %); +++ = very frequently found (> 80 %).

1 Hyperechogenicity also of the caudate nucleus is very frequently found in HD patients.
to its calcification which therefore represents an important landmark structure of this plane. The reference structures of the axial basal ganglia plane are the bilateral, weakly echogenic thalami and the 3rd ventricle which appears as a highly echogenic double line between the thalami (● Fig. 4b). Near to the midline in a more frontal position, the frontal horns of lateral ventricles are displayed. Sometimes it is necessary to tilt the transducer slightly in a frontal direction for visualization.

▶ Quality criterion of the adequate display of the axial basal ganglia plane: Pineal gland (usually highly echogenic due to calcification), bilateral thalami (= reference structure), 3rd ventricle and contralateral frontal horn are clearly visible. On this imaging plane the widths of the 3rd ventricle and contralateral frontal horn are measured. So far there is no consensus guideline on the location at which these measures should be obtained. While in early reports the maximum width of the 3rd ventricle was measured, most groups meanwhile prefer measuring the minimum width [2]. The width of the contralateral frontal horn is measured, as a standard in our labs, at the most frontal position at which the bilateral frontal horns are in junction (● Fig. 4b). The measurement points are placed in a way that their conjunction line is parallel to the mid-axis of the imaging sector. Normal ranges of ventricle widths are age-dependent. In subjects under/over the age of 60, widths of >7/>10 mm (3rd ventricle) and >17/>20 mm (frontal horn) are regarded as abnormal [2].

If the contralateral thalamus and the contralateral frontal horn are clearly visible, the location of the (contralateral) lenticular nucleus and caudate nucleus can be inferred from their expected anatomical position, as these basal ganglia usually are not discernible from the surrounding white matter. Increased echogenicity, on visual assessment, of basal ganglia compared to the surrounding white matter is regarded as abnormal (“hyperechogenicity”) (● Fig. 5). Hyperechogenicity of the lenticular or caudate nucleus usually appears in a circumscribed area rather than as a diffuse change of the referring nucleus. It is important to distinguish other structures that can cause misdiagnosis of basal-ganglia hyperechogenicity due to lateral imaging artifacts. These are mainly the highly echogenic borders of the lateral ventricles, and more caudally the basal cisterns. Moreover, especially..
in patients with very good bone windows, reverberation artifacts originating from the highly echogenic ventricular structures (borders, choroid plexus) may mimic basal-ganglia hyperechogenicity. To avoid such misdiagnosis, it is indispensable to gain certainty about the anatomical relationship between the basal ganglia and neighboring structures potentially causing apparent hyperechogenicity by slightly tilting and twisting the transducer. Most groups assess the basal ganglia contralateral to the side of insonation (unlike SN) since the contralateral structures are displayed in a larger area in the sector-shape sonogram [2]. On the other hand, some authors prefer ipsilateral assessment of basal ganglia since they are ipsilaterally more in the focal zone of the transducer and are therefore displayed with higher image resolution. In our experience assessment of contralateral basal ganglia can be reliably performed with most US-S. However, because of higher image resolution in the focal zone, we prefer assessment of the DBS electrode position in the basal ganglia (globus pallidus internus, thalamus) ipsilaterally to the side of insonation [7]. The diagnosis of basal-ganglia hyperechogenicity is usually made visually [2]. In addition, hyperechogenic areas may be measured planimetrically, similar to measurements of SN hyperechogenicity [2, 41]. Recently, the echo-intensity of basal ganglia was reliably quantified using digitized image analysis [12, 42].

Fig. 4 Further standard imaging planes on TCS. a Cerebellar imaging plane with measurement of the 4th ventricle (rectangle). Cer = cerebellum, D = dentate nucleus, M = midbrain, T = thalamus, * = frontal horn of lateral ventricle. b Basal-ganglia imaging plane with measurement of the 3rd ventricle (short bar) and the contralateral frontal horn (long bar). Lenticular and caudate nuclei normally are isoechogenic to surrounding brain parenchyma. C = caudate nucleus, L = lenticular nucleus, P = pineal gland, Pl = choroid plexus in the dorsal horn of lateral ventricle, T = thalamus, * = frontal horn of lateral ventricle.


Fig. 5 TCS findings of basal ganglia. C = caudate nucleus, L = lenticular nucleus, T = thalamus, * = frontal horn of lateral ventricle. The triangle indicates pineal gland (highly echogenic on TCS). a The MR image corresponds to the sonograms in b–d. b Normal echogenicity of basal ganglia, including the lenticular nucleus. c Hyperechogenicity of the lenticular nucleus (arrow). d Hyperechogenicity of the caudate nucleus (arrow).


Diagnostic relevance

Increasing width of the 3rd ventricle and frontal horns correlates with the degree of cognitive impairment in the normal population [43]. A pronounced dilatation of all ventricles is an instant diagnosis on TCS and indicates the presence of hydrocephalus or advanced brain atrophy [1]. Third-ventricle dilatation typically found already at early stages of progressive supranuclear palsy (Richardson syndrome) supports its discrimination from PD [31]. Hyperechogenicity of the lenticular nucleus is a characteristic finding in patients with generalized, segmental, focal and task-related forms of idiopathic dystonia [41, 42]. However, the specificity of this TCS finding has been challenged by one study [44], and further studies are needed to assess its diagnostic value, e.g.
for the discrimination of idiopathic dystonia from psychogenic movement disorders. Lenticular nucleus hyperechogenicity is frequently detected in brain disorders with an accumulation of iron, manganese, or copper, e.g. in Wilson’s disease [14]. This finding is also present in 70–90% of patients with atypical Parkinsonian syndromes and supports, especially if combined with other TCS findings (Table 3), their discrimination from PD [1, 30, 31]. Caudate nucleus hyperechogenicity is often found in patients with Huntington's disease [38] and may support discrimination from other chorea disorders [unpublished data]. A pronounced hyperechogenicity of basal ganglia, with brightness similar to that of the pineal gland and calcified structures of the choroid plexus in the dorsal horn of the lateral ventricle, indicate calcification of the basal ganglia and may be seen as a dot-like lesion in elderly subjects but is more extended in Fahr’s disease [1, 45].

Novel technologies

The reliability of TCS assessment of small deep brain structures such as the SN mainly depends on two factors: (1) the investigator’s experience and skill, which is associated with a potential subjective bias, and (2) the quality of the bone window [1 – 6, 8 – 10]. The influence of the latter may be reduced only slightly by lowering the insonation frequency, usually to 1.8 – 2.0 MHz, in the case of poor bone windows. However, the influence of the investigator dependency could potentially be overcome by applying optimized techniques for automated structure detection and digitized image analysis. Several approaches for automated SN detection and the quantification of its echogenicity have been published recently, including principal component analysis-based artificial neural networks [46], active contour segmentation algorithms [47], invariant scale blob detection [13], and 3-dimensional SN detection (volumetry) based on random forests [48]. Still, the performance of these off-line image analysis technologies is largely influenced by the quality of the TCS image primarily obtained by the investigator. So it was important to integrate a test for sufficient image quality into such software as a prerequisite for diagnostic application in the clinical routine [12]. In first clinical studies employing such a digitized image analysis tool for 2-dimensional TCS images [12], the elliptical marker highlighting the region of interest (ROI) was manually placed in the target area (SN, lenticular nucleus) [42, 49]. After the placement of the ROI in the target area within the TCS image, the algorithm computes the area for each grayscale intensity I (from 0 to 255) inside the ROI area (here, size of ROI area A = 50 mm²) (Fig. 6). In a pilot study using this novel software [12], the automatically measured SN echogenic areas in the normal population were similar across different US-S (e.g., Esaote MyLabTwice and GE Vivid 7 Pro; r = 0.996) [49]. Moreover, manual measures of SN echogenic area obtained by highly experienced investigators correlated well with measures of digitized analysis (correlation coefficients ranging from 0.79 to 0.81) [49], as did lenticular nucleus measures (r = 0.74) [42]. The sensitivity and specificity for the diagnosis of PD based on the detection of SN hyperechogenicity by digitized image analysis were 87% and 92%, respectively [49]. In another study applying 3-dimensional quantification of SN echogenicity (volumetry), a sensitivity and specificity for the diagnosis of PD of up to 91% and 73% were reported [11]. Nevertheless, the accuracy of digitized image analysis-based TCS diagnostics still depends on the investigators ability to identify and focus on the best available TCS image for visualization of a specific brain structure. Novel technologies enabling the real-time image fusion of TCS with MRI, CT or PET images, previously obtained and imported into the US-S, promise a further reduction of investigator dependency of TCS. Meanwhile, several manufacturers are marketing virtual navigation and fusion imaging applications embedded in their high-end US-S. To enable the virtual navigation on TCS-MRI fusion images, the position and orientation of the ultrasound transducer are continuously tracked.
by an electromagnetic system, composed of a transmitter and a small receiver, mounted on the transducer [50]. Pilot studies demonstrated a very high accuracy of fusion images, with an average cranio-caudal error of 0.5 (range, 0 – 0.7) cm and an average lateral shift of 0.1 (0 – 0.5) cm [50]. The mean time for the complete TCS examination including the fusion imaging procedure did not exceed 40 minutes. An interesting clinical application in movement disorder patients with DBS is the control of intracranial lead tip position which can be documented by the fusion of post-implantation TCS images with preoperative MRI (Fig. 3).

All these new technologies, i.e., automated structure detection, digitized image analysis, and fusion imaging, promise a more reliable detection of brain pathologies on TCS in the future, even of brain structures that are hardly assessable visually due to their isoecho-genicity to the surrounding parenchyma. This might even enable the detection of subtle changes of echogenicity over time in distinct brain structures as a correlate of disease progression.

Concluding remarks

TCS can currently be recommended in clinical practice for the assessment of ventricle widths (especially the 3rd ventricle), the early and differential diagnosis of PD, and the post-operative position control of DBS electrodes. High intra- and interrater reliability and diagnostic accuracy of planimetric SN echogenicity measurements have been demonstrated by numerous groups (for review, see [8]) which is a clear progress compared to the previous review published here in 2006 [51]. The following factors impair the reliability of SN TCS and need to be excluded before diagnostic application [8]:

1. the inadequate qualification of the investigator,
2. the missing instruction and supervision of the investigator by another expert experienced in TCS in movement disorders,
3. the use of a US-S not specifically engineered and adapted for TCS,
4. inappropriate, or changing US-S settings,
5. the missing establishment of normal ranges of SN echogenicity in the referring ultrasound lab by investigation of at least 50 healthy subjects,
6. the variable, erroneous inclusion of highly echogenic signals of structures neighboring the SN such as the red nucleus and structures of the basal cisterns.

After excluding these sources of error, SN TCS can be learned by a physician within 2 – 8 weeks depending on her/his previous ultrasound experience, and is reliably performed even by adequately trained doctoral students and medical technicians [1, 8]. However, the ability of reliably assessing the midbrain raphe, basal ganglia and other structures still requires more experience and supervision, at least for several months. Still, for scientific publications only TCS data should be used that were obtained by investigators who had performed and analyzed images of at least 200 patients under qualified supervision [8]. The upcoming digitized analysis and fusion imaging technologies promise a more investigator-independent assessment of deep brain structures in the near future.

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