Academia de Științe Medicale din România

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THE SOCIETY FOR THE STUDY OF NEUROPROTECTION AND NEUROPLASTICITY

UMF UNIVERSITATEA DE MEDICINĂ ȘI FARMACIE IULIU HAȚIEGANU CLUJ-NAPOCA

TEL AVIV UNIVERSITY

2nd Romanian Medical Academy Brain Days

23 - 25 September, 2011 Intercontinental Hotel, Bucharest

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General Information

Congress Venue

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All materials and documentation will be available at the registration desk located at SSNN booth.
The staff will be pleased to help you with all enquiries regarding registration,
materials and program. Please do not hesitate to contact the staff members if there is anything they can do to make your stay more enjoyable.

Invited Speakers

(in alphabetical order)

Pierre Amarenco / France
Natan Bornstein / Israel
Michael Chopp / USA
Laszlo Csiba / Hungary
Ioan Ștefan Florian / Romania
Tudor Jovin / USA
Amos Korczyn / Israel
Didier Leys / France
Heinrich Mattle / Switzerland
Dafin F. Mureşanu / Romania
Bogdan O. Popescu / Romania
David Russell / Norway

Language

The official language is English. Simultaneous translation will not be provided.

Changes in program

The organizers cannot assume liability for any changes in the program due to external or unforeseen circumstances.

Name Badges

Participants are kindly requested to wear their name badge at all times. The badge constiutes admission to the scientific sessions and gala dinners.

Final Program & Abstract Book

The participants documents include the program and abstract book which will be handed out together with the congress bag at the registration counter.

Coffee Breaks

Coffee, tea and mineral water are served morning and afternoon coffee breaks free of charge to all registered participants.

Mobile Phones

Participants are kindly requested to keep their mobile phones turned off while attending the scientific sessions in the meeting rooms.

Currency

The official Romanian currency is RON.

Electricity

Electrical current is 220 volts, 50Hz. Two-prong plugs are standard.

Time

The time in Romania is Eastern European Time (GMT+2).

CONTACT:

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Ovidiu Selejan/e-mail/ovidius@ssnn.ro
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Dinners,
Lunches & Breaks

Friday, September 23rd, 2011

20:30 - Welcome reception / Fortuna Ballroom

Saturday, September 24th, 2011

10:40 – 11:00 - Coffee break / Foyer Ronda

12:40 – 14:00 - Lunch / Fortuna Ballroom

15:40 – 16:00 - Coffee break / Foyer Ronda

20:30 - Gala Dinner / Fortuna Ballroom

SCIENTIFIC PROGRAM

Friday, September 23rd, 2011

17:15 – 17:30	Opening Ceremony Dafin F. Mureşanu (Romania), Natan Bornstein (Israel) A. V. Ciurea (Romania)
Session 1 / Chairmen: Natan Bornstein, Israel; Laszlo Csiba, Hungary	
17:30 – 18:00	Neurobiology of brain recovery after stroke Michael Chopp, USA
18:00 – 18:30	Brain protection and recovery after stroke - clinical update Dafin F. Mureşanu, Romania
18:30 – 19:00	Acute stroke management – I.V. thrombolysis Laszlo Csiba, Hungary
19:00 – 19:10	Summary and general discussion
20:30	Welcome reception

Saturday, September 24th, 2011

Session 2 / Chairmen: Pierre Amarenco, France; David Russell, Norway	
09:00 – 09:30	Acute stroke management endovascular therapy Tudor Jovin, USA
09:30 – 10:00	Basilar artery occlusion clinical presentations and management Heinrich Mattle, Switzerland
10:00 – 10:30	Pathophysiology and management of malignant infarct Didier Leys, France
10:30 – 10:40	Summary and general discussion
10:40 – 11:00	Coffee break
Session 3 / Chairmen: Amos Korczyn, Israel; Didier Leys, France	
11:00 – 11:30	Should statins be prescribed for every stroke patient? Pierre Amarenco, France
11:30 – 12:00	Atrial fibrillation and stroke prevention David Russell, Norway
12:00 – 12:30	Patent Foramen Ovale (PFO) to close or not to close? Heinrich Mattle, Switzerland
12:30 – 12:40	Summary and general discussion
12:40 – 14:00	Lunch

Session 4 / Chairmen: Heinrich Mattle, Switzerland; **Ioan Ștefan Florian**, Romania	
14:00 – 14:30	Secondary stroke prevention Natan Bornstein, Israel
14:30 – 15:00	Management of symptomatic carotid stenosis Cea vs. Stent Natan Bornstein, Israel
15:00 – 15:30	Is vascular cognitive impairment a useful concept? Amos Korczyn, Israel
15:30 – 15:40	Summary and general discussion
15:40 – 16:00	Coffee break
Session 5 / Chairmen: Michael Chopp, USA; **Tudor Jovin**, USA	
16:00 – 16:30	Clipping aneurysms - some arguments in favor of surgery Ioan Ștefan Florian, Romania
16:30 – 17:00	Stem cell therapy in stroke –how far are we now? Bogdan O. Popescu, Romania
17:00 – 17:10	Summary and general discussion
17:10 – 17:30	Closing Remarks Dafin F. Mureşanu (Romania), Natan Bornstein (Israel)
20:30	Gala Dinner

ABSTRACTS

SECONDARY STROKE PREVENTION

NATAN M. BORNSTEIN

Professor of Neurology at the Tel-Aviv University Sackler Faculty of Medicine, Israel

Vice President of the World Stroke Organization (WSO)

Head of Stroke Unit at the Tel-Aviv Medical Center

Chairman of the Israeli Neurological Association

Patients with TIA or ischemic stroke carry a risk of recurrent stroke between 5 and 20% per year. In patients with TIA or ischemic stroke of noncardiac origin antiplatelet drugs are able to decrease the risk of stroke by 11-15% and the risk of stroke, MI and vascular death by 15-22%. Aspirin is the most widely used drug. It is affordable and effective. Low doses of 50-325 mg aspirin are as effective as high doses and cause less gastrointestinal side effects. Severe bleeding complications are dose-dependent. The combination of aspirin with slow release dipyridamole is superior to aspirin alone for stroke prevention (ESPS-2 and ESPRIT1). Both studies have shown approximately 20%-24% relative risk reduction (RRR) of stroke and death. Clopidgrel is superior to aspirin in patients at high risk of recurrence by about 8.7% RRR (CAPRIE2). The combination of aspirin plus clopidogrel is not more effective than clopidogrel alone but carries a higher bleeding risk (MATCH3 and CHARISMA4). None of the antiplatelet agents is able to significantly reduce mortality. The recent results of the PRoFESS trial 5,6 showed no difference between clopidogrel and aspirin with slow release dipyridamole in secondary stroke prevention.

References

1. Lancet 2006;367:1665-73
2. Lancet 1996;348:1392-1339
3. Lancet 2004;364:331-337
4. N Eng J Med 2006;354(16):1744-6
5. Cerebrovasc Dis 2007;23:368-380
6. N Engl J Med 2008;359:1238-51

MANAGEMENT OF SYMPTOMATIC CAROTID STENOSIS CEA VS. STENT

Symptomatic severe carotid stenosis (>70%) carries a high risk of subsequent stroke of about ~ 30% over 2 years.

Carotid endarterectomy (CEA) was proved to reduce the risk of stroke significantly, with Relative Risk Reduction (RRR) = 65% and Number Needed to Treat (NNT) = 6 if performed safely (perioperative

S&D =5.8%) and should be executed within 2 weeks of TIA or minor stroke (NASCET & ECST).

For carotid stenting to replace CEA we need to know the comparative safety, durability and efficacy of the procedure. Few randomized, controlled studies comparing CEA and stenting were conducted: CAVATAS, SAPPHIRE, EVA-3, SPACE, CREST (USA) and ICSS (Europe and Australia).

All the various studies have shown that CEA is safer then stenting and the peri-procedural stroke rate is higher in stenting compare to CEA. However, the interpretation of the results of CREST is still debatable.

Until more data will be available carotid stenting should be performed only in a selected group of patients with specific indications like: re-stenosis of the CEA, post neck radiation, inaccessible lesion for CEA and contra-indications for CEA.

NEUROBIOLOGY OF BRAIN RECOVERY AFTER STROKE

MICHAEL CHOPP

The Department
of Neurology
Henry Ford Hospital
Detroit, Michigan, USA

Traditionally, the treatment of stroke and neural injury has focused on neuroprotection, i.e. reducing the volume of cerebral infarction. We have, however, substantial opportunity to treat many more patients more effectively, if we focus our therapeutic efforts on stimulating brain plasticity and thereby enhancing neurological recovery. In this presentation, I will describe our studies using cell-based and pharmacological therapies that are designed to stimulate intrinsic central nervous system restorative processes, including neurogenesis, angiogenesis, oligodendrogenesis, neurite outgrowth, that act in concert to mediate neurological recovery. The interaction of these restorative events will be outlined. In addition, the molecular mechanisms underlying neurorestorative treatment of stroke and brain injury, including activation of the sonic-hedgehog (Shh) pathway, by cell-based and pharmacological therapies will be described.

ACUTE STROKE MANAGEMENT – I.V. THROMBOLYSIS

LÁSZLÓ CSIBA

Department of Neurology,
Debrecen University,
Hungary

The NINDS trial produced a breakthrough in fibrinolytic therapy. It proved the efficacy of rt-PA (alteplase) therapy in all subtypes of ischemic stroke, the benefit extends beyond 1 year after the treatment. The results of European cooperative acute stroke study (ECASS-III), a placebo-controlled trial, using IV rt-PA proved the safety of IV thrombolysis within the first 3–4.5 h following ischemic stroke with patient listed below excluded from the trial.: Younger than 18 or older than 80 years, severe neurological symptoms National Institute of Health Stroke Scale (NIHSS) >25, Taking anticoagulant (irrespectively of hemostatic parameters), History of diabetes mellitus and a previous stroke. In this study excellent clinical outcomes (0 or 1 point on the modified Rankin Scale) were more frequent in the rt-PA treated group than in the placebo group (52 vs. 45%, p = 0.04) 3 months after treatment. The mortality in the rt-PA treated group was not significantly different from that of placebo group (17% in the treated group a 21% in the placebo group). While, symptomatic intracranial bleedings were more frequent in the t-PA group (2.4 vs. 0.2%, p = 0.001).Before initiating IV thrombolysis, the cost-benefit ratio must be calculated. The inclusion and exclusion criteria must be followed strictly.When doing so, one has to bear in mind that 32 patients out of 100 thrombolysed will likely to show improvement and only three is likely to have harm. Follow-up studies also support the fact: the earlier the thrombolysis is performed the better clinical improvement can be achieved. Therefore medical systems must have a “fast lane” for patients arriving to the hospital for thrombolysis. The optimal time window for completing diagnostic workup and initiating IV treatment should not exceed 60 min.The recommended dose of rt-PA used IV is 0.9 mg/kg. A maximum total dose of 90 mg can be given. The patient cannot receive antiplatelet or anticoagulant drugs within the first 24 h if thrombolysis was applied. One day after thrombolysis a cranial CT must be performed to detect intracranial bleed.

CLIPPING ANEURYSMS - SOME ARGUMENTS IN FAVOR OF SURGERY

IOAN ȘTEFAN FLORIAN

2. Andrasoni Zorinela, 2. Tusnea D.

1. University of Medicine and Pharmacy "Iuliu Hatieganu" Cluj-Napoca, Department of Neurosurgery

2- Cluj County Emergency Hospital. Department of Neurosurgery

Objective

Our objective is to determine the value of the surgical treatment in experienced hands compared to the literature data regarding open-surgery, and the endovascular strategy in incidentally discovered intracranial aneurysm.

Material and methods

We designed a retrospective study based on our series of 49 cases with H&H 0 and 1 of intracranial aneurysm out of the total of 458 patients who underwent open-surgery for intracranial aneurysms.

Results

During a fourteen years' period, from the total of 458 cases treated by the authors for aneurismal pathology, 49 patients underwent open-surgery for non-ruptured intracranial aneurysms, in all cases definitive clipping being achieved. We reviewed the results using the Karnofsky Performance Status Score and Glasgow Outcome Scale, and we correlated these with the general and neurological status at admission, aneurismal localizations, associations, morphology and intra-operative particularities. From our series of 49 patients admitted with Hunt & Hess grade 0 and 1a, 83.7% were neurologically intact after surgery; only one patient was classified as GOS 3 immediately post surgery. In general, the outcome depended on the general status, age, the localization and the morphology of the aneurysm, associated aneurysms and co-morbidities.

Conclusions

Our results and comparisons show that open-surgery is in the most cases a very viable, if not the best option in the treatment of incidentally discovered intracranial aneurysms, conditioned by the fact that the surgical team must be an experienced one, and there must be an optimal collaboration between the surgeon, anesthesiologist and neurologist.

Keywords: cerebral aneurysm, open-surgery, surgical results.

ACUTE STROKE MANAGEMENT ENDOVASCULAR THERAPY

TUDOR JOVIN

University of Pittsburgh School of Medicine, Department of Neurosurgery, Pittsburgh, PA, USA

Because of the high mortality and disability rates affecting its victims, ischemic stroke poses a substantial public health concern.Among all ischemic stroke subtypes, those presenting with occlusion of large intracranial vessels carry the worst prognosis. Reperfusion, most commonly achieved through recanalization, is the only intervention proven to improve outcomes in patient with acute stroke due to large vessel occlusion. Despite its proven efficacy intravenous t-PA has significant limitations primarily due to poor recanalization rates for occlusion of large vessels (intenal carotid artery, middle cerebral artery, basilar artery). This is because with increasing vessel diameter the thrombus burden becomes too high for intravenous t-PA to effectively exert its lytic proprties. Endovascular therapy has several theoretical advantages over intravenous rtPA, including site specificity, longer treatment windows and higher recanalization rates. Therefore it has become an increasingly used alternative for patients who are ineligible for or have failed intravenous thrombolysis. This presentation will focus on the pathophyisiological principles underlying endovascular therapy and on recanalization modalitites including lytic drugs and mechanical recanalization modalitites which are rapidly replacing lytic agents as first line endovascular treatment. Imaging tools available for appropriate patient selection, believed by many to represent the most critical aspect of endovascular acute stroke therapy, will be reviewed . An overview of the most important studies in the field of endovascular therapy will be provided along with a summary of the main challenges this field is confronted with.

IS VASCULAR COGNITIVE IMPAIRMENT A USEFUL CONCEPT?

AMOS D. KORCZYN

The Sieratzki Chair of Neurology, Sackler School of Medicine
Tel-Aviv University,
Ramat-Aviv,Israel

The epidemic proportions of dementia in old age are a cause of great concern for the medical profession and the society at large. It is customary to consider Alzheimer's disease (AD) as the most common cause of dementia, and vascular dementia (VaD) as being the second. This dichotomous view of a primary neurodegenerative disease as opposed to a disorder where extrinsic factors cause brain damage led to separate lines of research in these two entities.

New biomarkers, particularly the introduction of modern neuroimaging and cerebrospinal fluid changes, have, in recent years, helped to identify anatomical and chemical changes of VaD and of AD.

However, recently accumulated data suggest that the two disorders have additive effects and probably interact with each other, since older people most commonly harbour both neurodegenerative and vascular changes. It is still unknown to what degree the primary neurodegenerative processes and vascular changes occur independently or interact with each other. Furthermore, epidemiological studies have shown "vascular" risk factors to be associated with AD. Therefore, a clear distinction between AD and cognitive impairment due to vascular changes cannot be made in most demented people and is furthermore unhelpful. Moreover, in the absence of efficacious treatment for the primary degenerative process, special attention must be given to vascular component even in patients with presumed mixed pathology.

Symptomatic treatment of VaD is similar to that given to AD, although it is less effective than in AD. For prevention of dementia it is important to treat aggressively all relevant factors, in particular risk factors for stroke, even in stroke survivors who do not show evidence of cognitive decline or only mild changes.

PATHOPHYSIOLOGY AND MANAGEMENT OF MALIGNANT INFARCT

DIDIER LEYS

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Lille University Hospital,
Lille, France

Malignant infarcts in the territory of the middle cerebral artery (MCA) are usually the consequence of large infarcts involving more than two-thirds of the territory of the MCA and often also part of the anterior- or of the posterior artery territory. Most are the consequence of a T occlusion of the internal carotid artery and occur un cervical artery dissections or cardiopathies. They lead to a 80% mortality rate, usually between day 2 and day 5 in the absence of treatment. These malignant infarcts are more likely to occur in young patients, but they can also occur after the age of 60 years.

Pathophysiological studies with intracranial pressure (ICP) monitoring have shown that when the oedema occurs, the ICP remains within normal limits for a long period of time before it raises suddenly, these raise in ICP being associated with a rapid neurological worsening. For this reason, ICP monitoring cannot be considered as a reliable marker of malignant infarct, and other predictors of malignant infarcts are needed in clinical practice. Clinical studies have shown that malignant infarcts are more likely to occur in large infarcts, in the absence of collaterals, in case of T occlusion of the MCA, in delayed reperfusion, and in patients with high blood pressure, hyperthermia or hypervolemia. Patients with diffusion weighted imaging abnormalities of more than 145 cm3 at 24 hours or earlier have a very high rate of malignant infarcts and are the best candidates for surgery.

Three trials (DECIMAL, HAMMLET and DESTINY) have shown in their combine analysis that patients who undergo decompressive surgery using a large hémicraniectomie, before the neurological deficit is too severe, 50% absolute risk reduction to die or to have a modified Rankin scale (mRS) 5 or 6 one year after stroke, and that the probability to have a mRS <2 increases from 2% to 14%. The recommendations of the European Stroke Organisation are to perform decompressive surgery within 48 hours after symptom onset in patients below 60 years of age who have criteria for a high risk of malignant MCA infarct. Non randomised data suggest that the results are better when patients are operated earlier.

BASILAR ARTERY OCCLUSION
CLINICAL PRESENTATIONS AND MANAGEMENT

HEINRICH
P. MATTLE

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Switzerland

The basilar arterysuppliesblood tomost of the vessels in the posterior circulation. When the basilar artery (BA) is occluded devastating strokes can occur. BA occlusion (BAO) is rare. With an estimated annual incidence of 1 per 100'000 persons it accounts for about 1% of all the strokes. Usually elderly people are struck, but also young persons or even children may suffer BAO. The most important causesare atherosclerosis with local thrombosis and emboli from the aorta or heart or proximal large vessels to the BA. In younger patients emboli or propagation of a thrombosis from a dissected VA into the BA are increasingly recognized, and also other rare causes of stroke have to be considered in all the patients.

Clinical symptoms and signs depend on the anatomical regions that aredamagedbythe ischemia resulting from BAO. When the proximal and middle parts of the BA are occluded, large pontine infarcts result, when the distal part is affected bilateral thalamic and midbrain infarcts predominate.

More than half of the patients experience premonitory symptoms, patients with atherosclerotic thrombosis more often than patients with emboli to the BA. Vertigo and headaches are most common. Other premonitory symptoms and signs include loss of consciousness, yawning, double vision, visual field deficits, hemiparesis, hemisensory loss, dysequilibrium, dysarthria, dysphagia, facial paresis, tinnitus, hearing loss, drop attacks, convulsionsand jerking or shaking episodes. After premonitory symptoms or without strokes occur. Large pontine strokes show hemiplegia or mostly quadriplegia, often reduced consciousness, bilateral extensor plantar signs, dysarthria and dysphagia, horizontal gaze paresis and other cranial nerve palsies.They can result in a locked-in state, where patients are awake and alert but cannot move. Bilateral thalamic and midbrain strokes decrease consciousness and cause quadriparesis and nuclear or supranuclear oculomotor and pupillomotor dysfunctions. Patients with thalamic involvement, if not comatose, are often confused and amnestic, and those with posterior cerebral artery occlusions hemianopic or cortically blind.

BAO can be suspected on clinical grounds and is usually confirmed noninvasively with CT or MR imaging including CT- or MR angiography.

The outcome depends mainly on the severity of the clinical signs. There is a high rate of fatality and permanent morbidity, even with treatment. The most effective therapy is thrombolysis with intravenous rt-PA or endovascular

rt-PA or urokinase with or without combined mechanical recanalisation techniques. Endovascular techniques lead to higher recanalisation rates but unequivocally better clinical outcomes compared to intravenous rt-PA are not proved. Patients with residual symptoms after acute treatment should receive intensive rehabilitation.

PATENT FORAMEN OVALE (PFO) TO CLOSE OR NOT TO CLOSE?

In approximately a quarter of adults the foramen ovale remains functionally patent, a situation called PFO, and blood is shunted from the right to the left atrium. PFO is frequently associated with abnormal interatrialseptal mobility, which is called atrial septal aneurysm (ASA).
Several case control studies found a significant association of PFO, ASA and cryptogenic stroke. Two population-based studies point in the same direction but do not show a signifcant association. The mechanisms proved or believed to cause stroke with septal abnormalities are paradoxical emboli from the venous to the arterial circulation through the PFO, intracardiac formation of thrombi, or cardiac arrhythmias attributable to the septal abnormality. All these presumed mechanisms and risks may be enhanced by the presence of thromboembolic factors such as coagulation disorders with hypercoagulability, venous thrombosis, right atrial pressure overload, or anatomical features such as ASA, an Eustachian valve, a Chiari network, and increasing PFO size. Furthermore, patients with PFO and multiple cerebrovascular events are at increased risk for stroke recurrence.
The course after cryptogenic stroke associated with septal abnormalities is highly variable and largely unknown. The presence of PFO alone does not seem to increase the risk of stroke recurrence when antithrombotic and other medical preventive treatments are used. However, the risk is elevated when PFO is combined with ASA. Medical prevention with aspirin is equally effective as anticoagulation.
In recent years several devices have been available for transcatheter closure of PFO, and surgical closure has largely been abandoned. The device with probably the lowest complication and highest success rates is the Amplatzer PFO occluder.
The ease of transcatheter closure and the low complication rate associated with it are tempting to close all the PFOs. Retrospective comparisons favourtranscatheter closurein addition to medical therapy. However, the question whether the low risk of recurrence justifies this intervention can only be answered with prospective randomized trials. Several such trials are under way (e.g. PC-Trial, RESPECT, CARDIA) or finished (CLOSURE). CLOSURE did not show an advantage of PFO closure. Considering the current event rate, all studies are underpowered and only pooling of all the results will likely give an answer.

At present, every patient with PFO ans stroke or TIA should receive optimal

management of vascular risk factors including medical therapy. The reality is that in many places transcatheter closure is offered to all patients and in some places it is not available. When PFOs in cryptogenic stroke patients are associated with additonal risks such as an ASAor if patients have suffered more than one ischemic event, closure is probably indicated. However, with every recurrent event etiologic workup should be repeated in order not to miss other stroke causes than PFO.Whether „only a closed PFO is a good one" is true, can be said only when we have more evidence from randomized trials.

BRAIN PROTECTION AND RECOVERY AFTER STROKE - CLINICAL UPDATE

DAFIN F. MUREŞANU

Department of Neurology, University of Medicine and Pharmacy "Iuliu Haţieganu" , Cluj-Napoca, Romania

Endogenous neurobiological processes, such as neurotrophicity, neuroprotection, neuroplasticity and neurogenesis, are central to protection and recovery and represent the background of endogenous defens activity (EDA).

Whenever we pharmacologically interfere with one pathophysiological mechanism using a classical chemical drug, with a single mechanism of action, the outcome is an imbalance in EDA.

The biological reality of the nervous system is far more complex. In fact, there is a holistic process of neuroprotection and neurorecovery that should be approached therapeutically in different way (1).

The current tendency to exclusively frame drug activity in terms of single mechanisms and single focus effect might distract from other paradigms with greater explanatory power and hind

STEM CELL THERAPY IN STROKE – HOW FAR ARE WE NOW?

BOGDAN O. POPESCU

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Laboratory of Molecular Medicine, "Victor Babes" National Institute of Pathology, Bucharest, Romania

Ischemic stroke remains one of the most devastating brain diseases, at least in part due to the limited percentage of patients able to benefit from active thrombolytic therapy with rt-PA. Moreover, a short time window for intervention and bleeding risks are associated with rt-PA treatment. In contrast to thrombolysis, the use of stem cells for neurorestoration looks promising from experimental studies done so far. Stem cells derived from different tissues have the capability to stimulate neurogenesis, angiogenesis, remyelination and synaptic plasticity. Interestingly, it seems that their mechanism of action is not mainly based on cell replacement but on inhibition of inflammation and other deleterious stroke-related pathogenic pathways. Brain regeneration after stroke takes a long period of time and therefore the use of stem cells might have the advantage of a large therapeutic window which would increase the access to treatment beyond the first hours after the onset. However, the cell-based therapies in stroke need more exploration of proliferation, cell signaling, integration and migration both from bench work and early clinical trials.

Acknowledgement
This paper is supported by the Sectorial Operational Programme Human Resources Development (SOP HRD), financed from the European Social Fund and by the Romanian Government under the contract number POSDRU/89/1.5/S/64109.

ATRIAL FIBRILLATION AND STROKE PREVENTION

DAVID RUSSELL

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Atrial fibrillation (AF) is the most common sustained cardiac arrhythmia, affecting approximately 1% of the adult population. It causes 15–20% of ischemic strokes and the overall risk of stroke in patients with nonvalvular atrial fibrillation is about 5% per year. The prevalence of AF increases dramatically with age, occurring in 9% of those aged 80 years and older. In Europe alone, the prevalence of AF is projected to double by 2030. Long-term studies have consistently shown that patients with AF have a 5-fold increased risk of stroke compared with individuals without AF.

Stroke in patients with AF is nearly twice as likely to be fatal compared with non-AF stroke. This is due to the development of larger thrombi in the left atrial appendage and large emboli which occlude the major arteries of the brain, resulting in larger infarct volumes and more severe strokes.

The magnitude of stroke reduction from aspirin vs. placebo (19%) is broadly similar to that seen when aspirin is given to vascular disease subjects. The efficacy of warfarin in reducing the risk of stroke in patients with AF has been confirmed by randomized, placebo-controlled clinical trials. A meta-analysis of 6 major studies showed a 64% reduction in the risk of stroke in patients with nonrheumatic AF treated with warfarin compared with placebo. However, 14–44% of patients with atrial fibrillation who are at risk of stroke are ineligible for anticoagulation therapy, primarily due to the risk of major bleeding. In patients who are eligible, the risk of bleeding, the need for frequent INR monitoring and dose adjustments, drug interactions, and restrictions on diet may explain why warfarin discontinuation rates are as high as 38% per year.

A very significant advance in the treatment of AF is the development of novel anticoagulants that selectively block specific pathways of the coagulation cascade (primarily thrombin and factor Xa inhibitors).These drugs have a fast onset, a better risk-benefit profile and anticoagulation does not need intensive monitoring. These novel agents provide new treatment possibilities for the prevention of stroke in patients with AF and they hopefully will lead to the treatment of the large number AF patients who are at present are not receiving anticoagulation treatment.

CURRICULUM VITAE

PIERRE AMARENCO

FRANCE

Current Position :

Professor of Neurology at Paris-Diderot University and
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Education :
1980 Graduated from University of Paris Medical School
1986 Fellow in Neurology, Saint-Antoine University hospital, Paris
1995 Professor of neurology, Pierre and Marie Curie University, Paris
2001 Professor and Chairman, Paris-Diderot University

Clinical training :
Neurology
Vascular Neurology

Other Activities (eg membership of societies) :
FAHA 5Fellow of the American Heart Association)
FAAN (Fellow of the American Academy of Neurology)
ESO (European Stroke Organization) member (Board of Director)
SFNV (French Neurovascular Society) member (excutive committee)
Editor-in-Chief: neurologie.com (www.webneurologie.com)
European Associate Editor of Stroke journal (starting July 1st, 2010)
Steering Committee member: SPARCL trial
Executive Committee member: PERFORM trial
Chair of Steering Committee (PI): OPTIC registry, TIAregistry.org, TST (Treat Stroke to Target) trial, ARCH trial, RECANALISE trial, GENIC study, MASS study, Lacunar-B.I.C.HA.T. (Brain Infarction Cerebral Hyperreactivity and Atorvastatin Trial) registry and trial, AMISTAD study, HITS study

NATAN M. BORNSTEIN

ISRAEL

Professor of Neurology at the Tel-Aviv University, Sackler Faculty of Medicine.

Head of Stroke Unit at the Tel-Aviv Medical Center
Chairman of the Israeli Neurological Association (since 2009)
Vice President of the World Stroke Organization (WSO) (since 2008).
Chairman of Neurology Department, Tel-Aviv Medical Center (2002-2007)
Consulting Editor of Stroke
Editorial Board of CVD, EjoN, Acta Neurologica Scandinavica, International Journal of Stroke, Neurosonology, Frontiers in Stroke, Journal of Annals of Medical Science.
Fellowship program in vascular neurology (stroke) in Toronto, Canada with Prof. John Norris(1984-87)
Main research interests are: Epidemiology of stroke, Stroke prevention, Vascular dementia, Inflammation and stroke, Neurosonology.

MICHAEL CHOPP

USA

Positions and Honors
Positions and Employment
1983—Present Senior Staff Investigator, Director of Neurophysics, Neurology Department, Henry Ford Hospital, Detroit, MI
1976—2004 Professor of Physics and Health Sciences, Oakland University, Rochester, MI
1991—Present Vice Chairman, Department of Neurology, Henry Ford Hospital, Detroit, Michigan
1999—Present Scientific Director, Neurosciences Institute, Henry Ford Hospital, Detroit, MI
2004—Present Distinguished Professor, Department of Physics, Oakland University, Rochester, MI
2004—Present Zolton J. Kovacs Chair in Neuroscience Research, Henry Ford Health System, Detroit, MI

Other Experience and Professional Memberships
1989 NINDS Study Section A, IRG
1991—1995 NINDS Neurology A PPG Study Section
1995—1998 NINDS—NSDA
1998—2001 Chair, NSDA
1999—Present Fellow-American Heart association
1996—Present Editorial Board, Journal Cerebral Blood Flow and Metabolism
2001—Present NINDS Ad-hoc
2004—2010 Editorial Board, STROKE
2006 Co-Chair, "Biology of Repair" (formerly Healing Process of Stroke), NIH/NINDS Stroke Progress Review Group II Meeting, Washington, DC
2008 Member, International and Scientific Board, Brain Ischemia and Stroke (BIS), Rome, Italy
2009 Editorial Board, Cell Transplantation
2009 Editorial Board, Translational Stroke Research
2010—2013 Advisory Board, Brain Rehabilitation Research Center (BRRC), Rehabilitation Neuroscience Translational Research Initiative Strategic Plan, Department of Veterans Affairs
2010—2014 National Institutes of Health: Acute Neural Injury and Epilepsy (ANIE) Study Section
2011 Co-Chair, NINDS Stroke Progress Review Group (SPRG)
2011—2014 Editorial Board, Experimental Neurology

Honors
Distinguished Scientist Award, Henry Ford Medical Group—Board of Governors, 2005
American Heart Association—Top Ten Research Advances of 2001 . . .
Treatment of Stroke with Bone Marrow Stromal Cells
337 Plenary Lectures/Invited Presentations

LÁSZLÓ CSIBA

HUNGARY

László Csiba was born in 1952, Sajószentpéter, Hungary. Now he is the Chairman of Department of Neurology of University Debrecen and Chair of Board of Director's (European Stroke Organisation), President of European Society of Neurosonology and Cerebral Hemodynamics. He is the chair of European Cooperation Committee of EFNS.

His research interests are stroke and stroke-prone diseases, ultrasonic studies in cerebrovascular diseases and clinicopathological studies on cerebrovascular diseases. He published numerous papers on stroke and stroke-related diseases, associated editor of Frontiers on Stroke and member of editorial committee (Intern. J Stroke)

IOAN ȘTEFAN FLORIAN

ROMANIA

Education & Positions Held
• June-2001: Ph.D. degree of the Faculty of Medicine, University of Medicine and Pharmacy "Iuliu Hatieganu" Cluj-Napoca, : "The neurosurgical treatment of the pituitary adenomas"
• 2002 -present: Head of the Department of Neurosurgery, Cluj County Emergency Hospital
• 2001 – 2005: Director of the Cluj County Public Health Institute
• 2003 – 2010: Vice-president of the Romanian Society of Neurosurgery
• 2006- present: Vice-dean of the Faculty of Medicine
• 2007-present: Full professor of the Faculty of Medicine, University of Medicine and Pharmacy "Iuliu Hatieganu" Cluj-Napoca,
• October 2010: President of the Romanian Society of Neurosurgery

Scientific & research activity
Scientific activity: 38 article published in extenso in the country, 70 papers as abstracts, 12 articles published abroad and 28 papers published as abstracts; furthermore 53 posters presented in the country and abroad at different scientific events (course, conferences, and congresses). Author and co-author of 13 books and treaties dealing with neurosurgery topics (treatment options in pituitary adenomas, in intracerebral hemorrhage)

Research line in neurosurgery-oncology (the evaluation of the therapeutical effect of Temozolomide and antiangiogenetic factors in glioblastoma multiforme; the evaluation of the therapeutical effect of the Calpaine inhibitors and angiogenetic factors in spine cord injuries) can be enumerated.

Rich organizing activity aiming the continous medical education of neurosurgerons, from which the annual CME Course for resident doctors since 2003, two neuro-oncology conferences (National Conference of Neurooncology with International Participation in 2007, 2008), the annual German Romanian Neurosurgery Courses (2009,2010, the forthcoming course in May 2011), promoter and organizer of the 1st Regional Congress of the Danube-Carpathian Region in the period of 24th -27th May 2011, at Cluj-Napoca, Romania.

TUDOR JOVIN

USA

EDUCATION AND TRAINING

1985 - 1989 Carol Davila University, Medical School, Bucharest, Romania Transferred to Heinrich Heine University
1990 - 1994 Heinrich Heine University, Medical School, Düsseldorf, Germany M.D. 1994,
1996 - 1997 Intern, Pennsylvania Hospital Philadelphia, PA Internal Medicine Charles Wolf, MD
1997 - 2000 Resident , University of Pennsylvania , Pennsylvania Hospital, Philadelphia , PA Neurology Residency Howard Hurtig , MD
2000 - 2002 Presbyterian University Hospital, Stroke Institute, Pittsburgh PA Cerebrovascular Fellow Lawrence Wechsler, MD
7/2002-6/2004 Presbyterian University Hospital, Pittsburgh PA Fellow Interventional Vascular Neurology , Michael Horowitz, MD, Charles Jungreis, MD

APPOINTMENTS AND POSITIONS:

3/2010-present University of Pittsburgh School of Medicine, Department of Neurosurgery, Pittsburgh, PA Associate Professor of Neurology and Neurosurgery

3/2010-present UPMC Presbyterian Stroke Institute Director, UPMC Stroke Institute
3/20/04-present University of Pittsburgh School of Medicine, Department of Neurosurgery, Pittsburgh, PA Co-Director, UPMC Center for Neuroendovascular Therapy

SELECTED PUBLICATIONS:

1 Jovin TG, Yonas H, Gebel JM, Kanal E, Chang YF, Grahovac SZ, Goldstein S, Wechsler LR. The cortical ischemic core and not the consistently present penumbra is a determinant of clinical outcome in acute middle cerebral artery occlusion. Stroke 2003 Oct;34(10):2426-33. Epub 2003 Sep 18.
2 Chimowitz MI, Lynn MJ, Howlett-Smith H, Stern BJ, Hertzberg VS, Frankel MR, Levine SR, Chaturvedi S, Kasner SE, Benesch CG, Sila CA, Jovin TG, Romano JG; Warfarin-Aspirin Symptomatic Intracranial Disease Trial Investigators. Comparison of warfarin and aspirin for symptomatic intracranial arterial stenosis. N Engl J Med 2005 Mar 31;352(13):1305-16.
3 Jovin, TG, Gupta R, Uchino K, Jungreis CA, Wechsler, LR, Hammer MD, Tayal A, Horowitz MB. Emergent stenting of extracranial internal carotid artery occlusion in acute stroke has a high revascularization rate. Stroke 2005 Nov;36 (11):2426-30. Epub 2005 Oct 13.
4 Kasner SE, Chimowitz MI, Lynn MJ, Howlett-Smith H, Stern BJ, Hertzberg VS, Frankel MR, Levine SR, Chaturvedi S, Benesch CG, Sila CA, Jovin TG, Romano JG, Cloft HJ; Warfarin Aspirin Symptomatic Intracranial Disease Trial Investigators. Predictors of ischemic stroke in the territory of a symptomatic intracranial arterial stenosis. Circulation 2006 Jan 31;113(4):555-63. Epub 2006 Jan 23.

5 Gupta R, Vora NA, Horowitz MB, Tayal AH, Hammer MD, Uchino K, Levy EI, Wechsler LR, Jovin TG. Multimodal reperfusion therapy for acute ischemic stroke: factors predicting vessel recanalization. Stroke 2006 Apr;37(4):986-90. Epub 2006 Mar 9.
6 Gupta R, Al-Ali F, Thomas AJ, Horowitz MB, Barrow T, Vora NA, Uchino K, Hammer MD, Wechsler LR, Jovin TG. Safety, feasibility, and short-term follow-up of drug-eluting stent placement in the intracranial and extracranial circulation. Stroke 2006 Oct;37(10):2562-6. Epub 2006 Sep 7.
7 Thomas AJ, Gupta R, Tayal AH, Kassam AB, Horowitz MB, Jovin TG. Stenting and angioplasty of the symptomatic chronically occluded carotid artery. AJNR Am J Neuroradiol 2007 Jan 28(1):168-71.
8 Jovin TG, Gupta R, Horowitz MB, Grahovac SZ, Jungreis CA, Wechsler L, Gebel JM, Yonas H. Pretreatment ipsilateral regional cortical blood flow influences vessel recanalization in intra-arterial thrombolysis for MCA occlusion. AJNR Am J Neuroradiol 2007 Jan;28(1):164-7.
9 Jovin TG, Demchuk A., Gupta R. Pathophysiology of acute ischemic stroke. Continuum 2008 14(6) Acute Ischemic Stroke:28-45.
10 Jovin TG, Gupta R, Horowitz MB. Management of symptomatic intracranial atherosclerotic disease. Curr Cardiol Rep 2007 Mar;9(1):32-40.
11 Lin R, Aleu A, Jankowitz B, Kostov D, Kanaan H, Horowitz M, Jovin TG. Endovascular Revascularization of Chronic Symptomatic Vertebrobasilar Occlusion. J Neuroimaging. 2010 Dec 1
12 Jumaa MA, Zhang F, Ruiz-Ares G, Gelzinis T, Malik AM, Aleu A, Oakley JI, Jankowitz B, Lin R, Reddy V, Zaidi SF, Hammer, MD Wechsler LR, Horowitz M, Jovin TG. Comparison of safety and clinical and radiographic outcomes in endovascular acute stroke therapy for proximal middle cerebral artery occlusion with intubation and general anesthesia versus the nonintubated state. Stroke. 2010 Jun;41(6):1180-4. Epub 2010 Apr 29.
13 Malik, A.M., Vora, N.A, Lin, R., Zaidi, S.F., Aleu, A., Jankowitz, B.T., Jumaa, M.A., Reddy, V.K., Hammer, M.D., Wechsler, L.R., Horowitz, M.B, Jovin, T.G. Endovascular Treatment of Tandem Extracranial/ Intracranial Anterior Circulation Occlusions: Preliminary Single Center Experience. Stroke. 2011 Jun;42(6):1653-7.
14 Jovin, T.G., Liebeskind, D.S., Gupta, R., Rymer, M., Rai, A., Zaidat, O.O., Abou-Chebl, A., Baxter, B., Levy E.I., Barreto, A., Nogueira, R.G. Imaging- Based Endovascular Therapy for Acute Ischemic Stroke due to Proximal Intracranial Anterior Circulation Occlusion Treated Beyond 8 Hours From Time Last Seen Well: Retrospective Multicenter Analysis of 237 Consecutive Patients. Stroke. 2011 Aug; 42(8):2206-11. Epub 2011 Jul 21.

AMOS D. KORCZYN

ISRAEL

Professor Amos D. Korczyn is the Sieratzki Professor of Neurology at Tel-Aviv University. Professor Korczyn graduated from the Hebrew University – Hadassah Medical School in Jerusalem in 1966 (MD), where he also received an MSc degree in pharmacology (cum laude) in 1966. He trained in neurology at Beilinson Hospital and at the National Hospital for Nervous Diseases, Queen Square, London. He was the Chairman of the Department of Neurology at the Tel-Aviv Medical Center since 1981 until 2002. Professor Korczyn has a particular interest in dementia. He has authored or co-authored over 600 articles in peer-reviewed journals, as well as chapters in books, etc. Professor Korczyn is or has been an Editorial Board member of 15 international journals, and organized several neurological conferences, mainly in the field of dementia, Parkinson's disease and other degenerative brain disorders, as well as CONy – the International Congress on Controversies in Neurology.

DIDIER LEYS

FRANCE

Didier Leys was appointed as Professor of Neurology and Head of the Neurological Department at the Lille University Hospital in 1990.

He was chairman of the French Stroke Society from 1998–2000. He was member of the Executive Committee of several national and international societies, including the International Stroke Society and the European Stroke Initiative. He is currently president of the European Stroke Organisation. He is member of the Belgian Society of Neurology and honorary member of the Belgian Stroke Council.

Professor Leys has authored or co-authored more than 250 scientific papers (H score = 45), book chapters, and books on stroke, and on the relationship between vascular factors and dementia. His main topic of interest over the last 10 years was on stroke and especially acute stroke, determinants of post stroke dementia, and genetical predisposition to cervical artery dissections.

He is member of the editorial board of several scientific journals including stroke and Cerebrovascular Diseases, and has been one of the editors of the Journal of Neurology, Neurosurgery and Psychiatry.

List 5 selected publications :

Cordonnier C, Leys D, Dumont F, et al. What are the causes of pre-existing dementia in patients with intracerebral haemorrhages? Brain 2010;133:3281-3289.

Debette S, Leys D. Cervical-artery dissections: predisposing factors, diagnosis, and outcome. Lancet Neurol 2009;8:668-678.

Leys D, Cordonnier C. Profiling of patients and risk after carotid stenting. Lancet Neurol 2008;7:193-194.

Mas JL, Trinquart L, Leys D, et al. Endarterectomy Versus Angioplasty in Patients with Symptomatic Severe Carotid Stenosis (EVA-3S) trial: results up to 4 years from a randomised, multicentre trial. Lancet Neurol 2008;7:885-892.

Leys D, Ringelstein EB, Kaste M, Hacke W. Facilities available in European hospitals treating stroke patients. Stroke 2007;38:2985-2991.

HEINRICH P. MATTLE

SWITZERLAND

Professor Heinrich P. Mattle studied medicine in Bern and Zurich, graduated in 1976, trained in internal medicine, neurosurgery and neurology in several academic and non-academic Swiss hospitals and was a clinical and research fellow in neuro-MRI at Beth Israel Hospital and Harvard Medical School in Boston. He has been on staff in the University Department of Neurology at the Inselspital Bern in Switzerland since 1983 and is deputy chairman since 1990. His research interest is mainly stroke, and he has written or coauthored more than 300 articles, more than 230 quoted in Medline. Most studies are on diagnostic techniques, clinical manifestations, treatment and prevention of stroke or general neurologic problems. Together with his former chairman Marco Mumenthaler he is author of "Neurology", a textbook of neurology, and "Fundamentals of Neurology" for students, books that are widely used in German speaking countries. Professor Mattle is involved in several multicenter trials, e.g. principal neurology investigator of the PC-Trial to compare percutaneous closure and medical management of patients after cryptogenic stroke associated with PFO. He has been a founding member of the Swiss Stroke Society, is a member of of the Swiss Academy of Medical Sciences and is vice-president of the European Stroke Organisation.

DAFIN F. MUREŞANU

ROMANIA

CURRENT POSITIONS

Chairman and Professor of Neurology, Department of Neurology, University CFR Hospital, Cluj Napoca, Romania

Vice Dean of the Faculty of Medicine, "Iuliu Hatieganu" University of Medicine and Pharmacy, Cluj-Napoca, Romania

President of the Society for the Study of Neuroprotection and Neuroplasticity

Member of the Romanian Academy of Medical Sciences, Romania

OTHER ACADEMIC DEGREES

2002-2004 MBA, School of Health Care Systems Management, The Danube University, Krems, Austria

1998 Specialization in Leadership, The Arthur Anderson Institute, Illinois, USA

PAPERS PUBLISHED IN INTERNATIONAL JOURNALS (INDEXED IN ISI AND PUBMED)

30 articles

PAPERS PUBLISHED IN OTHER JOURNALS, (INDEXED IN OTHER DATABASES)

44 articles

PAPERS PUBLISHED IN ROMANIAN JOURNALS

46 articles

MONOGRAPHS

7 monographs

CHAPTERS IN PUBLISHED BOOKS

5 chapters

Fluent in: English, Italian

ACADEMIC MEMBERSHIPS

INTERNATIONAL SCIENTIFIC SOCIETIES

World Academy for Multidisciplinary Neurotraumatology (WAMN); Chairman of the Scientific Committee (2008-2010); Secretary (2010-present)

Danube Neurological Society; Executive Management Committee

European Society of Clinical Neuropharmacology; Secretary General

European Federation of Neurological Societies (EFNS); Member of the Neurotrauma Panel
Global College for Neuroprotection and Neuroregeneration (GCNN); Vice-President, Chairman of the Clinical Committee

The Society for the Study of Neuroprotection and Neuroplasticity (SSNN); Founder and President

European Neurological Society (ENS)

Society for Neuroscience

European Stroke Organization

New York Academy of Science

EDITORIAL BOARD

Frontiers in Neuroscience; Associate Editor

International Journal of Neuroprotection and Neuroregeneration

The Romanian Journal of Neurology

Romanian Journal of Clinical Anatomy and Embryology

Acta Neurologica Transilvaniae

American Journal of Neuroprotection and Neuroregeneration; Guest editor

Journal of Cellular and Molecular Medicine; Guest editor

Journal of Medicine and Life

AWARDS

2010 University of Medicine and Pharmacy Cluj-Napoca, Faculty of Medicine

"Octavian Fodor" Award for the best scientific activity of the year

2009 Romanian Academy "Gheorghe Marinescu Award" for contribution to neuroprotection and neuroplasticity

2009 Excellence Award; "Viata Medicala Romaneasca" Medical Journal
2007 Award for the best Medical TV Series Program; Romanian Television Channel 2.

BOGDAN O. POPESCU

ROMANIA

Born March 8th, 1971 in Bucharest, Romania.

Academic Education and Appointments

1996	MD, 'Carol Davila' University School of Medicine, Bucharest, Romania
1997- 2002	Resident in Neurology, University Hospital Bucharest
2000 -	Assistant Professor, 'Carol Davila' University School of Medicine
2001	PhD, 'Carol Davila' University School of Medicine - suma cum laudae
2002 -	Neurologist, University Hospital Bucharest
2004	PhD, Karolinska Institute, Stockholm, Sweden
2005 -	Head of Laboratory of Molecular Medicine, 'Victor Babeş' National Institute of Pathology, Bucharest, Romania
2008-	Senior Neurologist, University Hospital Bucharest
2009 -	Lecturer, 'Carol Davila' University School of Medicine
2009 -	Senior Researcher, 'Victor Babeş' National Institute of Pathology, Bucharest, Romania

Awards

1999	Beaufour-Ipsen prize for the best research study in neurology
2000	Young histochemist award - International Society of Histochemistry and Cytochemistry
2004	Diploma of scientific merit – 'Victor Babeş' National Institute of Pathology
2007	Romanian Academy award for medical research
2010	Science and Art National Foundation (Romanian Acadamy) Award of Excellence for research in the field of Neuroscience and Neuropathology

Other current activities

Guest editor for Alzheimer's review series at Journal of Cellular and Molecular Medicine
Executive editor of Romanian Journal of Neurology
Secretary General of the Romanian Society of Neurology
Research director of the Society for the Study of Neuroprotection and Neuroplasticity
Director, Victor Babeş' National Institute of Pathology, Bucharest, Romania
Spokesman for University Hospital Bucharest

Selected publications

1. Enciu AM, Popescu BO, Gheorghisan-Galateanu A. MicroRNAs in brain development and degeneration. Mol Biol Rep. 2011 Jun 5. [Epub ahead of print] PMID: 21643950.
2. Popescu BO, Toescu EC, Popescu LM, Bajenaru O, Muresanu DF, Schultzberg M, Bogdanovic

N. Blood-brain barrier alterations in ageing and dementia. J Neurol Sci, 283:99-106, 2009.
3. Romanitan MO, Popescu BO, Winblad B, Bajenaru OA, Bogdanovic N. Occludin is overexpressed in Alzheimer's disease and vascular dementia. J Cell Mol Med. 2007;11(3):569-79.
4. Cowburn RF, Popescu BO, Ankarcrona M, Dehvari N, Cedazo-Minguez A. Presenilin-mediated signal transduction. Physiol Behav. 2007;92:93-7.
5. Hansson CA, Popescu BO, Laudon H, Cedazo-Minguez A, Popescu LM, Winblad B, Ankarcrona M. Caspase cleaved presenilin-1 is part of active gamma-secretase complexes. J Neurochem. 2006;97:356-64.
6. Popescu BO, Ankarcrona M. Mechanisms of cell death in Alzheimer's disease: role of presenilins. J Alzheimers Dis. 2004;6:123-8.
7. Popescu BO, Cedazo-Minguez A, Benedikz E, Nishimura T, Winblad B, Ankarcrona M, Cowburn RF. Gamma-secretase activity of presenilin 1 regulates acetylcholine muscarinic receptor-mediated signal transduction. J Biol Chem. 2004;279:6455-64.
8. Cedazo-Mínguez A, Popescu BO, Blanco-Millán JM, Akterin S, Pei JJ, Winblad B, Cowburn RF. Apolipoprotein E and beta-amyloid (1-42) regulation of glycogen synthase kinase-3beta. J Neurochem. 2003;87:1152-64.
9. Popescu BO, Oprica M, Sajin M, Stanciu CL, Bajenaru O, Predescu A, Vidulescu C, Popescu LM. Dantrolene protects neurons against kainic acid induced apoptosis in vitro and in vivo. J Cell Mol Med. 2002;6:555-69.
10. Popescu BO, Cedazo-Minguez A, Popescu LM, Winblad B, Cowburn RF, Ankarcrona M. Caspase cleavage of exon 9 deleted presenilin-1 is an early event in apoptosis induced by calcium ionophore A 23187 in SH-SY5Y neuroblastoma cells. J Neurosci Res. 2001;66:122-34.

DAVID RUSSELL

NORWAY

DEGREES & EXPERIENCE

1972 Bachelor of Medicine, Queens University Belfast, Northern Ireland
1981 Specialist in Neurology, University of Oslo
1983 Senior Lecturer in Neurology, University of Oslo
1985 Doctor of philosophy, University of Oslo
1989 Professor of Neurology, University of Oslo
2001 Guest Professor, University of Applied Sciences, Ulm, Germany
2008 Guest Professor, University of Debrecen, Hungary
2009 Guest Professor, University of Belgrade

MEDICAL PRIZES & AWARDS

1981 Professor Haakon Saethres Memorial Award
1983 The International Enrico Greppi Award
1993 Ragnhild and August Gillums Award

MEMBER OF MEDICAL BOARDS, SOCIETIES AND COMMITTEES

Founding President of the European Society of Neurosonology and Cerebral Hemodynamics
Chair European Stroke Organisation`s Council of Fellows
Past president of The Nordic Stroke Society
Chairman of the Norwegian Stroke Association
Founding Member of the European Stroke Council
Fellow of The Royal College of Physicians
Fellow of the Royal Academy of Medicine in Ireland
Founding Member of the International Society of Behavioural and Cognitive Vascular Disorders
Honorary Member of The Hungarian Stroke Society
Founding Member of the International Intracranial Hemodynamics Society
Representative of The Nordic Stroke Society on the European Stroke Council
Founding Chairman of the Norwegian Society of Neurosonology
Member of the Neurosonology Research Group of the World Federation of Neurology
Member of the World Federation of Neurology's Research Group on Cerebrovascular Diseases
Founding Associate Editor of Cephalalgia, The official Journal of the International Headache Society
Member of The Norwegian Neurological Association
Member of The American Heart Association
Member of The British Neurological Association
Member of the International Society for Cerebral Blood Flow and Metabolism

PUBLICATIONS

Over 300 scientific publications concerning cerebrovascular disease, cerebrovascular ultrasound and cerebral hemodynamics.

THE SOCIETY FOR THE STUDY OF NEUROPROTECTION AND NEUROPLASTICITY

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