Correlation between Diastolic Function and Maximal Exercise Capacity on Exercise Test

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Abstract
Background: Increased pulmonary capillary pressure (PCP) is one of the mechanisms of exercise intolerance. Assessment of the diastolic function by echocardiography (ECHO) enables estimation of PCP.

Objective: To identify variables that determine the exercise capacity in patients undergoing routine exercise test (ET), conventional ECHO, and tissue Doppler imaging (TD).

Methods: A total of 640 patients undergoing ET, ECHO, and TD were retrospectively studied. Patients with ejection fraction < 55% were excluded. Mitral annulus velocities by conventional Doppler imaging were obtained in early diastole (E) and late diastole (A), and TD of the mitral annulus measured early diastole (e') and late diastole (a') velocities. E/e' > 10 was considered an estimate of increased PCP. Maximal exercise capacity was analyzed by the number of metabolic equivalents (MET). The patients were divided into two groups for analysis: MET<7 (n=48) and MET>7 (n=572). Morise score showed a population at low risk (60%) for coronary artery disease (CAD).

Results: The number of patients with E/e' > 10 was significantly higher in the MET < 7 group in relation to the MET > 7 group (41.7% vs 9.4%, p=0.001), and so was the presence of any degree of diastolic dysfunction (76.6% vs 34.1% p=0.001). Using logistic regression analysis, age, female gender and A velocity (late diastole) were the independent variables related to a low exercise capacity (MET < 7).

Conclusion: Diastolic dysfunction as determined by ECHO, female gender, and age are associated with a lower exercise capacity in a population at low risk for CAD. (Arq Bras Cardiol. 2010; [online].ahead print, PP.0-0)

Keywords: Ventricular dysfunction; exercise test; exercise; diastole.

Introduction
Exercise capacity is influenced by innumerable factors, such as advanced age, comorbidities (metabolic syndrome and hypertension), obesity and previous cardiorespiratory fitness. Identification of other factors that modify the exercise capacity is highly relevant, because its reversal can improve the quality of life of the patients and have an effect on survival, since exercise capacity is associated with prognosis both in healthy individuals and in patients with heart diseases.

In an attempt to explain the cardiac mechanisms that decrease exercise capacity, ejection fraction did not show a significant correlation, perhaps for being dependent on the preload. However, maximal exercise capacity, as well as the symptoms triggered by exercise, are directly related to increased pulmonary capillary pressure and, therefore, to increased left ventricular filling pressures. Filling pressures, in turn, are directly related to the left ventricular diastolic function.

Recent clinical studies observed a significant correlation between exercise capacity and diastolic function parameters, especially in patients with cardiovascular disease.

Recent advances in tissue Doppler imaging improved the accuracy of echocardiography in the identification of abnormalities of left ventricular early-diastole, including the estimation of filling pressures. Consequently, the use of tissue Doppler imaging and of the analysis of diastolic function may be useful to explain the correlation between the presence of diastolic dysfunction and maximal exercise capacity on exercise test.

The objective of the present study was to analyze the exercise capacity and its correlation with diastolic function, as well as with the different clinical parameters in a population predominantly consisting of individuals at a low risk for coronary artery disease.

Methods
This is a retrospective cross-sectional study conducted from July 2007 to January 2008, which evaluated 640 individuals with a mean age of 49±13 years. The study was approved by the Research Ethics Committee of Instituto de Cardiologia do Distrito Federal.
All individuals underwent exercise test and transthoracic echocardiography within an interval of up to 30 days. Patients with ejection fraction < 55% were not included in the analysis.

Functional capacity was assessed by the peak metabolic equivalent (MET peak), indirectly obtained by formulas, according to the maximum slope and speed achieved in an incremental exercise treadmill test, with the ramp protocol adjusted to the individual.

Echocardiographic study was performed with two-dimensional images of the M mode and with pulsed Doppler using a echocardiographic equipment (Philips HDI 5000) with a 2 to 4 mHz multifequency transducer. Mitral inflow velocities were recorded using pulsed Doppler in the apical 4-chamber view, with a sample volume of 5 mm at the tip of the mitral leaflets. Early diastolic velocity (E), late diastolic velocity (A) and deceleration time were measured; the E/A ratio was also calculated. Using the apical 4-chamber view, a 2-mm sample volume was placed in the junction of the LV wall with the septal mitral annulus in order to record tissue Doppler, deriving the velocities during systole (S), early diastole (e'), and late diastole (a'). The E/e' ratio was calculated to estimate LV filling pressures, and values greater than ten (10) were considered increased filling pressures. The cut-off point for the E/e' ratio was set at 10. All individuals underwent exercise test and transthoracic echocardiography within an interval of up to 30 days. Patients with ejection fraction < 55% were not included in the analysis.

The chi square test and Fisher test were used to analyze the statistical significant difference between the groups. The Wilcoxon test was used for comparison of the means of the groups for functional capacity and exercise capacity (MET > 7).

Results

The baseline clinical characteristics and main echocardiographic measurements are described in Tables 1 and 2, respectively.

Analysis of the diastolic function

Normal diastolic function was observed in 62% of the individuals; 30.4% showed diastolic dysfunction with relaxation abnormality; 6.1% showed pseudonormal diastolic dysfunction; 0.32% restrictive diastolic dysfunction; and 1.1% undetermined degree of diastolic dysfunction. Only 12.7% had increased filling pressures (as assumed by an E/e' ratio > 10). Of these 12.7%, 17 patients (2.6%) had normal diastolic dysfunction and normal exercise capacity (MET > 7).

Risk of CAD in the population

The probability of CAD was calculated based on the Morise score. We found 60% of individuals with low probability, 39% with moderate, and 1% with high probability of CAD. Therefore, most of the patients had low probability of CAD.
Determinants of functional exercise capacity on exercise test

Univariate analysis of the exercise capacity in MET was carried out in relation to clinical and echocardiographic parameters. We observed that the clinical parameters that correlated with a low functional capacity (MET < 7) were female gender, age, presence of DM, presence of hypertension, and obesity (Table 3). In relation to the echocardiographic parameters, we observed that the LV mass index, A wave velocity of the mitral flow velocity, E/A ratio of the mitral flow, e′ wave velocity of tissue Doppler of the mitral annulus, S wave velocity of tissue Doppler of the mitral annulus, and the E/e′ ratio were associated with MET < 7 (Table 4).

The clinical and echocardiographic parameters which were independently associated with a low exercise capacity in the adjusted logistic regression model were age, female gender, and A wave velocity of the mitral flow (Table 5).

The comparative analysis of the MET < 7 and MET > 7 groups in relation to the presence of increased filling pressures (Graph 1) showed that 41.6% of the individuals with low functional capacity had an E/e′ ratio > 10, whereas only 9.4% of the individuals had a good functional capacity. The same was observed in relation to the presence of diastolic dysfunction: 76.6% of the patients with low functional capacity had some degree of diastolic dysfunction in comparison to 34.1% of the patients with a better functional capacity (Graph 2).

Discussion

The novel and important finding of the present study is that even in patients at low risk of CAD there is a significant correlation between diastolic function and exercise capacity. Another significant finding corroborating other studies\(^1,10,21\) is that clinical parameters such as advanced age and female gender are independent predictors of a low functional capacity.

Undoubtedly, the presence of diastolic dysfunction has a physiological ground on the decreased exercise capacity since, during exercise, the maximal cardiac output is dependent

| Table 3 - Clinical parameters in the univariate analysis |
|-----------------|-----------------|-----------------|
| **Clinical parameters** | **MET < 7 (n=48)** | **MET ≥ 7 (n=572)** | **p** |
| Age (years) | 62.1 ± 10.6 | 48.3 ± 12.4 | 0.001 |
| Gender | | | |
| Female | 15.2% (39) | 84.8% (217) | 0.001 |
| Male | 2.3% (9) | 97.7% (375) | |
| Diabetes mellitus | | | |
| No | 6.1% (36) | 93.9% (554) | 0.001 |
| Yes | 24% (12) | 76% (38) | |
| Hypertension | | | |
| No | 4.0% (16) | 96% (383) | 0.001 |
| Yes | 13.3% (32) | 86.7% (209) | |
| Cigarette smoking | | | |
| No | 7.6% (43) | 92.4% (523) | 0.796 |
| Yes | 6.8% (5) | 93.2% (69) | |
| Dyslipidemia | | | |
| No | 5.3% (24) | 94.7% (450) | 0.001 |
| Yes | 12.6% (24) | 87.3% (190) | |
| CAD | | | |
| No | 6.8% (31) | 93.2% (453) | 0.326 |
| Yes | 9.1% (17) | 90.9% (167) | |
| Obesity | | | |
| No | 5.5% (27) | 94.5% (489) | 0.001 |
| Yes | 13.9% (21) | 86.1% (151) | |
| Positive ET† | | | |
| No | 7.4% (42) | 92.6% (570) | 0.718 |
| Yes | 8.6% (36) | 91.4% (70) | |

\*CAD - coronary artery disease; †ET - exercise test.
on the diastolic filling. In exercise-induced tachycardia, the diastole is shortened. If diastole is accompanied by left ventricular relaxation and filling abnormalities, the lowest filling rates are achieved and become inadequate to supply the cardiac output required during exercise, with a subsequent increase in filling pressures and decrease in the maximal capacity. The more abnormal the baseline diastolic function, the lower the exercise capacity.

Several studies have demonstrated a good correlation between tissue Doppler of the mitral annulus and functional exercise capacity, probably due to the association of the E/e' ratio with left ventricular filling pressures. However, most of these studies were conducted in populations at high cardiovascular risk or in patients with proven cardiovascular disease. Recently, Grewal et al. observed a good correlation between the E/e' ratio and exercise capacity in a population at a moderate cardiovascular risk.

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Table 5 - Clinical and echocardiographic determinants of low exercise capacity (logistic regression)

<table>
<thead>
<tr>
<th>Independent parameters</th>
<th>MET &lt; 7 (n=48)</th>
<th>MET ≥ 7 (n=592)</th>
<th>OR</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>62±11</td>
<td>48 ± 2</td>
<td>1.09</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Female gender</td>
<td>39 (15.2%)</td>
<td>217 (84.8%)</td>
<td>11.37</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Mitrval A wave velocity (cm/s)</td>
<td>82 ± 25</td>
<td>61 ± 17</td>
<td>1.03</td>
<td>0.004</td>
</tr>
</tbody>
</table>

Graph 1 - Relationship between increased left ventricular filling pressure and functional capacity.

Graph 2 - Relationship between left ventricular diastolic function and functional capacity. DF - diastolic function.
Our study population was characterized as at low cardiovascular risk; 62% of the individuals had a normal diastolic function, and 60% showed a low probability of CAD. Nonetheless, we could find correlations between diastole and exercise capacity.

In our protocol model, the number of patients with normal diastolic function was high, and the fact that the predominant diastolic dysfunction was relaxation abnormality (30% of the patients) may explain why the low functional capacity, but not the E/e’ ratio, is associated with increased A wave velocity in conventional mitral Doppler. A wave velocity increases in patients with diastolic dysfunction with relaxation abnormality and becomes a significant parameter in a population with 30% of the patients classified in this degree of diastolic dysfunction.

Firstenberg et al’s study showed absence of correlation between E/e’ ratio and left ventricular filling pressures in individuals without cardiovascular diseases, and this corroborates the findings of the present protocol, in which most of the patients did not present with cardiovascular disease (60%). The physiological basis for this lack of correlation may be reinforced by recent evidences that suggest that the early diastolic velocity of the septal annulus (e’) is significantly influenced by the preload in normal ventricles, but this does not occur in ventricles with abnormal diastolic function, especially abnormalities in ventricular relaxation.

Advanced age was another independent factor related to low functional capacity. Decrease in functional capacity is evidenced as from 50 years of age, and becomes more evident after 75 years of age in both genders. In our study, the mean age of the individuals in the MET < 7 group was 62.1 years, thus corroborating the findings previously described. Multiple factors are related to this decreased functional capacity, such as decrease in joint motion, muscle mass, strength, coordination, and endurance, as well as the presence of chronic diseases.

Another clinical variable related to low functional capacity in our study was the female gender. The factors that explain this difference between genders are a reduced capacity of oxygen transportation, smaller muscle mass, higher percentage of fat, and lower cardiorespiratory fitness observed in women.

The major limitations of this study are its retrospective design; the use of only some parameters in the analysis of the diastolic function on echocardiogram; indirect assessment of physical capacity by exercise test instead of cardiopulmonary exercise test; and the fact that the interval between tests was 30 days at most. We should also mention that laboratory data and pulmonary functional capacity data were not available, since innumerous individuals were being followed-up in other services. However, the population studied is at a low risk for CAD and is representative of patients who undergo frequent assessments of the cardiovascular risk, which makes the parameters found useful in the clinical practice.

**Conclusion**

Diastolic dysfunction as determined by echocardiography, female gender, and age are associated with a lower exercise capacity in a population at a low risk for CAD with preserved left ventricular function.

**Potential Conflict of Interest**

No potential conflict of interest relevant to this article was reported.

**Sources of Funding**

There were no external funding sources for this study.

**Study Association**

This study is not associated with any post-graduation program.

**References**


