**Research Article**

**Pulmonary Function and Arterial Stiffness in Chronic Heart Failure**

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Arterial stiffness contributes to heart failure and is decreased by angiotensin receptor blockers (ARBs). This cross-sectional study aimed to assess associations of lung function and ARB with arterial stiffness in patients with chronic heart failure. 354 outpatients (168 males; 186 females; 68.2 ± 7.2 years old) with chronic heart failure were evaluated. Lung function parameters, including forced vital capacity (FVC), forced expiratory volume in 1 s (FEV₁), and FEV₁ to FVC ratio (FEV₁/FVC), were assessed. The cardio-ankle vascular index (CAVI) was used to estimate arterial stiffness. Unadjusted correlation analyses revealed a positive association of CAVI with ARB but not ACEI, and a negative correlation with FEV₁ (r = −0.2987, p < 0.0001). Multiple stepwise regression analyses showed that ARB and FEV₁ (p < 0.0001) were independent predicting factors for CAVI. These findings suggest that reduced pulmonary function is associated with increased CAVI. Pulmonary function protection could be used to improve the prognosis in heart failure, but additional studies are necessary.

1. Introduction

Increasing evidence demonstrates the positive associations of arterial stiffness with multiple cardiovascular diseases, including heart failure [1–3]. Meanwhile, arteriosclerosis progression increases arterial stiffness [4]. This in turn puts important pressure on the weakened heart, increasing the forward pressure wave signal, which precipitates ventricular ejection termination [1, 5]. In addition, arterial stiffness affects diastolic function as well as ventricular relaxation [6]. Based on these findings, arterial stiffness currently constitutes a hot topic in the field of heart failure prevention research.

Impaired pulmonary function is well known in individuals suffering from chronic heart failure. For instance, a study assessing 20 stable ambulatory individuals presenting congestive heart failure caused by cardiomyopathy indicated that tidal expiratory flow limitation is common [7]. In addition, patients with stable mitral valve disease display reduced forced expiratory volume in 1 s (FEV₁) and forced vital capacity (FVC), and increased residual volume (RV), which were associated with valvular disease severity [8]. The cardiothoracic ratio was shown to be inversely correlated with total lung capacity as well as with vital capacity [9]. Overall, patients with chronic heart failure present restrictive ventilatory defect and altered diffusing capacity. Previous reports suggested that altered pulmonary function is related to arterial stiffness in both healthy subjects and other populations, including children [10] and patients with hypertension [11], diabetes, kidney ailments, and lung diseases [12]. However, the relationship between lung function and arterial stiffness in individuals suffering from chronic heart failure is currently unknown.

Multiple studies reported the protective effects of angiotensin receptor blockers (ARBs) against arterial stiffness [13]. Indeed, ARB treatment, as low-dose monotherapy or combined with a calcium channel blocker (CCB), has beneficial effects on arterial stiffness in patients with hypertension who do not achieve blood pressure control with routine monotherapy. However, the relation between ARB-reduced arterial stiffness and heart failure remains unclear.

Arterial stiffness is readily assessed by novel devices in clinic. Previous studies used pulse wave velocity as an index of arterial stiffness, but this index is influenced by blood pressure at the time of the measurement and may be
influenced if blood pressure varies during the measurement [14]. A new index, namely, the cardio-ankle vascular index (CAVI), was developed for assessing arterial wall stiffness parameter [15]. As CAVI is independent of blood pressure, it is increasingly employed in evaluating arterial stiffness. The importance of arterial stiffness measured by CAVI in diabetes [16], atherosclerosis [17], hypertension [18], and kidney diseases [19] was revealed in several clinical studies, indicating that CAVI is high in atherosclerotic disease. Elevated PWV [1, 2, 20–22] and CAVI [23–25] were observed in people suffering from heart failure. However, the factors contributing to elevated CAVI in heart failure remain unclear.

Therefore, the current study aimed to assess potential associations among pulmonary function, ARB, and arterial stiffness as evaluated using CAVI instead of PWV in individuals suffering from chronic heart failure. We found that decreased pulmonary function is associated with elevated CAVI, while ARB was correlated to declined CAVI. Overall, pulmonary function protection and ARB use may improve and ameliorate heart failure prognosis.

2. Methods

2.1. Ethical Approval. This study was approved by the ethics committee of Zhejiang Hospital, with exemption from informed consent requirement. It was according to the provisions of the Declaration of Helsinki (as revised in Brazil in 2013).

2.2. Study Population. From April 2008 to March 2010, 354 consecutive outpatients above 18 years, previously diagnosed with stable chronic heart failure, were recruited at the Heart Failure Clinic of Zhejiang Hospital. Chronic heart failure was diagnosed according to ESC and AHA/ACC recommendations [26]. Individuals with history of acute myocardial infarction or ischemic stroke in the past 3 months, dementia, severe chronic pulmonary disease, and end-stage kidney disease were excluded. In addition, patients with lung cancer and emphysema diagnosed by computerized tomography were also excluded.

2.3. Clinical and Biological Indexes. A standard questionnaire recording age, sex, smoking, drinking, comorbidities, medication, and medical history was used. The same experienced doctor assessed brachial blood pressure for all patients, three times consecutively by mercury sphygmomanometry, after at least 5 min of rest. Venous blood specimens were used for plasma glucose concentration measurements as well as serum level assessment of total cholesterol and triglycerides. Serum creatinine and plasma BNP and hs-CRP were assessed using routine techniques.

2.4. Echocardiography. M-mode and two-dimensional echocardiography were performed using an ultrasound system (Hewlett Packard, USA) equipped with a 2.5 MHz transducer. M-mode echocardiography was used to assess left ventricular (LV) end-diastolic dimension (LVEDD) and LV end-systolic dimension (LVESD). LV ejection fraction (LVEF) was employed as an index of LV systolic function. LV diastolic function (LVDF) indices were next assessed by determining transmural flow velocity using the routine Doppler echocardiographic technique; E velocity and A velocity were obtained as previously described [27], and E/A ratios were derived.

2.5. CAVI Measurement. CAVI was assessed on a VaSera VS-1000 vascular screening system (Fukuda Denshi, Japan), as described previously [11]. This index helps assess stiffness of the aorta, femoral artery, and tibial artery and is in principle independent from blood pressure. After automatic measurement, right and left CAVI were obtained and averaged.

2.6. Lung Function Measurement. Lung function assays were carried out using a computerized spirometer (Jaeger, MS-PET, Germany). The patient was in the sitting position, with nose clips. FVC and FEV1 from most accurate assays [28] were recorded. FEV1 to FVC ratios (FEV1/FVC) were calculated.

2.7. Statistical Analysis. The SAS software (SAS, USA) was used for all statistical analyses. Means and proportions were assessed by standard normal z-test and Fisher’s exact test, respectively. Nonnormally distributed continuous data were submitted to logarithmic transformation for normalization. Variables significant in correlation analyses at \( p < 0.05 \) were entered in multivariable linear analyses, performed to determine independent predictors of CAVI. A \( p \) value below 0.05 was deemed to reflect statistical significance.

3. Results

3.1. Patient Features. Among the 363 individuals with diastolic heart failure, nine were excluded, including three who declined pulmonary function tests and six without satisfactory carotid waveforms. Thus, 354 cases were included in the final analyses. Their clinical features are reported in gender Table 1. The 168 male and 186 female patients had similar ages; no significant differences were observed in systolic and diastolic blood pressure, total cholesterol level, E/A ratio, hypertension, and atrial fibrillation diagnoses, as well as the percentages of patients taking ACEI/ARB, beta-blockers, diuretics, and aspirin (all \( p > 0.05 \)). Compared with women, men had higher BMI, hs-CRP, serum triglycerides, and creatinine and LVEDD, LVESD, FVC, FEV1, and coronary heart disease rates, with lower heart rate, BNP, fasting glucose, prevalence of diabetes mellitus, FEV1, and FEV1/FVC, as well as CAVI (all \( p < 0.05 \)). Of the 168 men, 33 (19.6%) were current smokers (>1 cigarette/day, >1 year) and 51 (30.4%) had consumed alcohol for >10 years (alcohol intake >5 g/day). Less women had smoking (12, 6.4%) and drinking (6, 3.2%) habits (both \( p < 0.05 \)).

3.2. Association of Arterial Stiffness Parameters with Clinical Indexes. The associations of CAVI parameters with other clinical indexes in all subjects are summarized in Tables 2 and 3. Univariate analyses demonstrated positive associations of CAVI with age \( (r = 0.346) \), systolic blood pressure \( (r = \)
In this report, we showed that pulmonary function and ARB were significantly associated with changes of arterial stiffness. Interestingly, age ($\beta = 0.039 \pm 0.009$), BMI ($\beta = -0.057 \pm 0.0174$), ARB ($\beta = -0.301 \pm 0.129$), FEV1 ($\beta = -0.025 \pm 0.112$), E/A ratio ($\beta = -0.808 \pm 0.337$), and BNP ($\beta = -0.006 \pm 0.002$) (all $p < 0.05$) were found to be independent determinants of CAVI (Table 3). After adjustment for medication and history of hypertension and coronary heart disease, similar results were obtained (data not shown).

### 4. Discussion

In this report, we showed that pulmonary function and ARB were significantly associated with changes of arterial stiffness.
Table 2: Correlation analyses for CAVI.

<table>
<thead>
<tr>
<th></th>
<th>( R )</th>
<th>( p )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>0.346</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Gender</td>
<td>0.086</td>
<td>0.104</td>
</tr>
<tr>
<td>Body mass index</td>
<td>-0.204</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Systolic BP</td>
<td>0.119</td>
<td>0.026</td>
</tr>
<tr>
<td>Diastolic BP</td>
<td>-0.085</td>
<td>0.114</td>
</tr>
<tr>
<td>Current smoking</td>
<td>0.065</td>
<td>0.220</td>
</tr>
<tr>
<td>hs-CRP</td>
<td>0.216</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Hypertension</td>
<td>-0.014</td>
<td>0.790</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>0.050</td>
<td>0.320</td>
</tr>
<tr>
<td>Coronary heart disease</td>
<td>0.008</td>
<td>0.878</td>
</tr>
<tr>
<td>ACEI</td>
<td>0.028</td>
<td>0.600</td>
</tr>
<tr>
<td>ARB</td>
<td>-0.100</td>
<td>0.056</td>
</tr>
<tr>
<td>FVC</td>
<td>-0.271</td>
<td>0.030</td>
</tr>
<tr>
<td>FEV1</td>
<td>-0.299</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>FEV1/FVC ratio</td>
<td>-0.048</td>
<td>0.376</td>
</tr>
<tr>
<td>LVEF</td>
<td>-0.006</td>
<td>0.917</td>
</tr>
<tr>
<td>E/A ratio</td>
<td>-0.176</td>
<td>0.001</td>
</tr>
<tr>
<td>BNP</td>
<td>0.212</td>
<td>&lt;0.001</td>
</tr>
</tbody>
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ACEI: angiotensin converting enzyme inhibitor; ARB: angiotensin receptor blocker; LAD: left atrial diameter; LVEDD: left ventricular end-diastolic diameter; LVESD: left ventricular end-systolic diameter; E/A ratio: ratio of early/transmitral flow velocity to atrial flow velocity; BNP: B-type natriuretic peptide; hs-CRP: high-sensitivity C-reactive protein; FVC: forced volume capacity; FEV1: forced expiratory volume in 1 s; CAVI: cardio-ankle vascular index.

Table 3: Multivariate linear analyses for CAVI.

<table>
<thead>
<tr>
<th></th>
<th>( \beta \pm SE )</th>
<th>( p )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>0.039 ± 0.009</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Body mass index</td>
<td>-0.057 ± 0.017</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>ARB</td>
<td>-0.301 ± 0.129</td>
<td>0.020</td>
</tr>
<tr>
<td>FEV1</td>
<td>-0.525 ± 0.112</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>E/A ratio</td>
<td>-0.808 ± 0.337</td>
<td>0.017</td>
</tr>
<tr>
<td>BNP</td>
<td>-0.006 ± 0.002</td>
<td>0.0046</td>
</tr>
</tbody>
</table>

ARB: angiotensin receptor blocker; E/A ratio: ratio of early/transmitral flow velocity to atrial flow velocity; BNP: B-type natriuretic peptide; hFEV1: forced expiratory volume in 1 s.

The mechanisms explaining the associations between pulmonary function and arterial stiffness in subjects suffering from chronic heart failure remain largely unknown. Excessive inflammatory responses contribute to arterial injury, which could cause vascular changes and stiffness [36]. In addition, oxidative stress and endothelium dysfunction pathogenetically contribute to the negative correlation between lung function and arterial stiffness in chronic heart failure [37,38]. One may exert an influence on the other or they could be all affected by external factors, such as patient habits and metabolic disruption. This intrinsic association of pulmonary function with arterial stiffness in individuals suffering from heart failure merits further study.

Multiple reports confirmed the protective impact of ARB on arterial stiffness in essential hypertension and diabetes [39, 40]. Guidelines have been provided for heart failure treatment with ACE inhibitors or ARB [41]. However, conflicting data were obtained in randomized controlled trials comparing ARB and ACEI. While the ELITE I study indicated better outcomes of ARB treatment, the ELITE II study indicated similar efficacy for heart failure [42]. This study indicated a relationship between ARB and arterial stiffness, which suggested a potential advantage of ARB in chronic heart failure patients, especially those with arterial stiffness. ARB as an alternative of ACEI may need reconsideration, but additional studies are necessary to address specifically this issue.

A few limitations of this study should be mentioned. First and foremost, it had a cross-sectional design, which cannot determine the chronological order or cause-to-effect relationship among pulmonary function decline, ARB use, and arterial stiffness. Therefore, prospective studies are needed.
In addition, we did not distinguish individuals with preserved or reduced LVEF among subjects suffering from heart failure. Furthermore, all enrolled subjects could perform the pulmonary function test; thus, these findings might not reflect the situation of patients with severe heart failure. There remained the possibility that there might be some different backgrounds between patients with ARB and those with ACEI. Lastly, the sample size was relatively small, and the current data need to be confirmed in larger populations.

5. Conclusion

Pulmonary function and ARB could be associated with arterial stiffness monitored with CAVI in individuals suffering from chronic heart failure. Pulmonary function protection could be used to improve the prognosis in heart failure, but additional studies are necessary.

Competing Interests

The authors declare that there are no competing interests regarding the publication of this paper.

Acknowledgments

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References


