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Different right ventricular contractility in limited cutaneous systemic sclerosis- associated pulmonary arterial hypertension and idiopathic pulmonary arterial hypertension

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Abstract

Introduction: Since systemic sclerosis (SSc) also involves the heart, we evaluated possible differences in right ventricular (RV) pump function between SSc-associated pulmonary arterial hypertension (SScPAH) and idiopathic PAH (IPAH).

Methods: In 13 limited cutaneous SScPAH and 17 IPAH-patients, RV pump function was described by the pump function graph, which relates mean RV pressure (mPrv) and stroke volume index (SVI). Differences in pump function result in shift or rotation of the pump function graph. Mean Prv and SVI were measured by standard catheterization. The mean of the hypothetical RV isovolumic pressure (mPrv_{iso}) was estimated using a single-beat method. The pump function graph was approximated by a parabola: $mPrv = mPrv_{iso} [1 - (SVI/SVI_{max})^2]$, enabling calculation of SVI_{max}, the hypothetical maximal SVI at zero mPrv.

Results: There were no differences in SVI and SVI_{max}. Both mPrv and mPrv_{iso} were significantly lower in SScPAH than in IPAH (mPrv: 30.7 ± 8.5 vs. 41.2 ± 9.4 mmHg, $p = 0.006$; mPrv_{iso}: 43.1 ± 12.4 vs. 53.5 ± 10.0 mmHg, $p = 0.04$). Since higher pressures were found at similar SVI, the difference in pump function graph results from a lower contractility in SScPAH than in IPAH.

Conclusion: RV contractility is lower in SScPAH than in IPAH.

Pulmonary function testing (\dot{V} max 229 and 6200; SensorMedics; Yorba Linda, CA) and high resolution computed tomography (HRCT; CT Somatom Plus 4; Siemens; Erlangen; Germany) were used to exclude underlying fibrotic lung disease as a cause of pulmonary hypertension.

Analysis

Haemodynamic parameters

Cardiac output (CO) was calculated by the Fick method and PVR was calculated by $(mPpa - PCWP)/CO$. The RV pressure waveform was averaged to obtain mPrv. Stroke volume index (SVI) was calculated as cardiac index (CI) divided by heart rate (HR). Total pulmonary arterial compliance was calculated as stroke volume (SV) divided by pulse pressure (PP)[9,10]. PP was calculated as systolic Ppa minus diastolic Ppa. Pressure measurements were recorded digitally at a sampling frequency of 250 Hz using a customized LabView data-acquisition system (National Instruments Netherlands B.V., Woerden, the Netherlands).

Pump Function Graph

For the characterization of RV pump function, we constructed a pump function graph. The pump function graph describes pump function quantitatively by the relationship between mPrv and cardiac output. Experimentally, this relationship has been determined by making the heart beat against a series of different arterial loads. Here we use stroke volume index (SVI) instead of cardiac output to avoid possible confounding effects of differences in heart rate and to normalize for body size. A pump function graph with the effects of alterations in diastolic filling and contractility is shown schematically in Figure 1.

From the digitally recorded RV pressure waveform and SVI, we were able to obtain individual pump function graphs as follows. The pump function graph was approximated by a parabola [11]:

$$mPrv = mPrv_{iso} [1 - (SVI/SVI_{max})^2]$$

with mPrv the (time) average of the RV pressure waveform, $mPrv_{iso}$ the average of the RV pressure waveform of an isovolumic beat and SVI_{max} the intercept with the SVI axis, i.e., the hypothetical maximal SVI at zero mPrv. The mPrv and SVI were measured at catheterisation and give the working point (Figure 1).

Subsequently, an estimate of the isovolumic RV pressure waveform, Prv_{iso} was obtained by the single-beat method originally proposed by Sunagawa *et al.*[12] and validated for the RV by Brimiouille *et al.*[13]. Its average value is $mPrv_{iso}$ and since

for an isovolumic beat SVI is zero by definition, this yielded the second point of the pump function graph. Finally, SVI_{\max} was obtained by rewriting the above equation as:

$$SVI_{\max} = SVI / \sqrt{1 - mPrv / mPrv_{iso}}$$

and inserting the measured values of SVI and mPrv, and the calculated value of $mPrv_{iso}$. Since SVI_{\max} represents the intercept at the SVI-axis, this yielded the third point of the graph. The three points are indicated in Figure 1.

The single-beat method assumes that the pressure waveform of an isovolumic beat can be described by a sinusoidal function and that it can be obtained by a least-squares fit to the isovolumic phases of the RV pressure waveform of the ejecting beat. Isovolumic contraction was assumed to start at the minimum RV pressure before the steep rise of the pressure (R-wave of ECG), and to end when Prv reached diastolic pulmonary artery pressure. The isovolumic relaxation period was defined from pulmonary artery valve closure, identified by overlaying the pulmonary artery pressure waveform over the RV pressure waveform, till the ventricular pressure reached the diastolic pressure level from which the isovolumic contraction calculations were started. A schematic example is shown in Figure 2. Before the analysis, underdamping catheter artifacts were removed from the pressure waveforms with a Butterworth filter (cut-off frequency 10 Hz) and several cardiac cycles were averaged to obtain an average pressure waveform.

Statistics

Group averaged pump function graphs were obtained by averaging Prv_{iso} and SVI_{\max} . Unpaired Student's *t*-test and Mann-Whitney *U* test were performed to compare data of both groups.

All data are presented in tables as mean ± SD in tables and in figures as mean ± SE or median values and interquartile ranges. A *P* value of < 0.05 was considered statistically significant.

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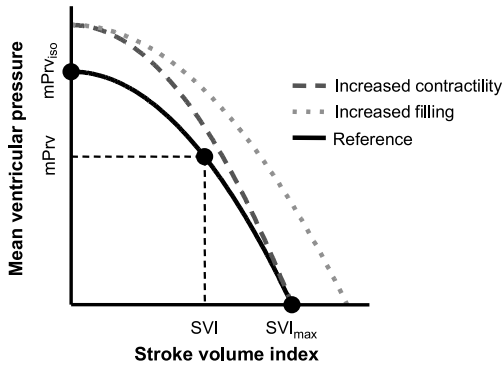


Figure 1

A schematically drawn ventricular pump function graph, relating mean ventricular output (SVI) and mean ventricular pressure, and characterizing the heart as a pump. Alteration in contractility results in a rotation around the intercept on the output axis (SVI_{max}), while increased filling increases both $mPrv_{iso}$ and SVI_{max} . The three data points are the mean isovolumic RV pressure ($mPrv_{iso}$) at zero SVI, constructed using single beat method, the measured mean RV pressure and measured mean SVI (working point) and the (derived) maximum output SVI_{max} at zero pressure.

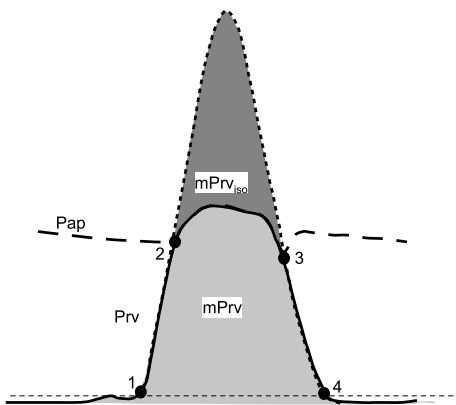


Figure 2

Schematic example of the derivation of an isovolumic beat. Isovolumic contraction is assumed to start at the minimum right ventricle pressure (Prv), before the steep rise of the pressure (indicated by point 1), and to end when it reaches diastolic pulmonary artery pressure (Pap , indicated by point 2). The isovolumic relaxation period is defined from the pulmonary artery valve closure (point 3), identified from deviation of Prv and Pap , till the ventricular pressure reaches the diastolic pressure level (point 4). The area under the Prv curve is used to calculate $mPrv$; the total area under the short dashed line (Prv_{iso}) is used to calculate the mean isovolumic RV pressure ($mPrv_{iso}$).

Results

General Patient Characteristics

General patient characteristics are given in Table 1. Patients with SScPAH were significantly older with a mean age difference of 27 years. The SScPAH group consisted of 100% female patients, whereas in the IPAH group 77% of the patients were female. All the SScPAH patients suffered from the limited cutaneous form of systemic sclerosis.

Table 1. General patient characteristics

	SScPAH N=13	IPAH N=17	P
Age, yrs	68.6 ± 12.4	41.9 ± 16.0	< 0.001
Female, n (%)	13 (100)	13 (77)	< 0.001*
Limited cutaneous SSc, n (%) [†]	13 (100)	-	-
Diffuse cutaneous SSc, n (%) [†]	0 (0)	-	-
SSc disease duration, yrs [‡]	9.6 ± 6.8 (n=12)	-	-
Raynaud phenomenon duration, yrs	18 ± 15	-	-
Antibody profile: anti-centromere/anti-Scl-70/ anti-U1-RNP, no. (%)	7/1/1 (50/7/7)	-	-
Body surface area, m ²	1.7 ± 0.2	1.9 ± 0.3	0.005
Systolic ABP, mmHg	129 ± 22	119 ± 23	0.49
Diastolic ABP, mmHg	74 ± 13	73 ± 11	0.78
6-minute walk distance, m	277 ± 116	358 ± 110	0.08
SvO ₂ , %	62.0 ± 6.5	63.5 ± 6	0.68
NT-proBNP, pg/ml	3546 ± 3035 (n=10)	1384 ± 1160 (n=9)	0.24
TLC %	89.9 ± 16.6	99.9 ± 11.8	0.26
TLCO %	42.8 ± 12.6	65.7 ± 16.1	0.002

Values expressed as mean ± SD or otherwise as stated. Abbreviations: SScPAH: systemic sclerosis-associated pulmonary arterial hypertension; IPAH: idiopathic pulmonary arterial hypertension; anti-U1-RNP: anti-U1 ribonucleoprotein autoantibody; ABP: arterial blood pressure; SvO₂: mixed venous oxygen saturation; NT-proBNP: non-terminal-pro brain natriuretic peptide; TLC %: percentage of predicted total lung capacity; TL_{CO} %: percentage of transfer factor for carbon monoxide. *Chi square statistic. † According to reference 8. ‡ Since first non-Raynaud symptom.

The 6-minute walk distance was not significantly different between the groups, as were values for mixed venous oxygen saturation and NT-proBNP. Evaluation of pulmonary function showed that pulmonary gas exchange in SScPAH patients, quantified by the transfer factor for carbon monoxide (TLCO), was significantly lower compared to IPAH patients, in agreement with previously reported values[14,15]. Mean values of total lung capacity and evaluation by HRCT in the SScPAH group indicated that the pulmonary hypertension cannot be explained by

severe pulmonary fibrosis: HRCT showed a typical pattern of pulmonary fibrosis in the dorsobasal lung fields in 7 of the 13 SScPAH patients; these patients had TLC levels of > 70% of predicted and SaO₂ levels of 92% and higher.

Haemodynamic invasive parameters and pump function graphs

Haemodynamic parameters are listed in Table 2. All patients had PVR values higher than 240 dynes×s×cm⁻⁵. A significantly lower mPpa was found in the SScPAH group compared to the IPAH group. The mPrv was significantly lower in the SScPAH group than in the IPAH group, while SVI was not significantly different (Figure 3). There was no significant difference in total arterial load as neither PVR nor total arterial compliance was different between the groups (Figure 4).

To evaluate the cardiac pump function, we constructed pump function graphs as described above. Examples of individual pump function graphs of an SScPAH patient and an IPAH patient are depicted in Figure 5. The averaged pump function graphs are shown in Figure 6. The mPrv_{iso} was found to be significantly lower for SScPAH patients compared to IPAH patients. SVI_{max} did not differ between the two groups. Thus, compared to the SScPAH patients the IPAH patients demonstrated a higher pump function graph, 'rotated' around the same point of the horizontal axis intercept, i.e. SVI max.

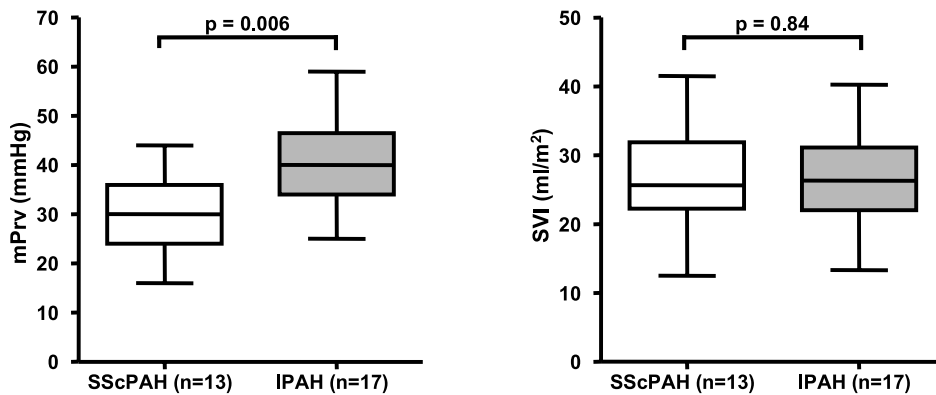


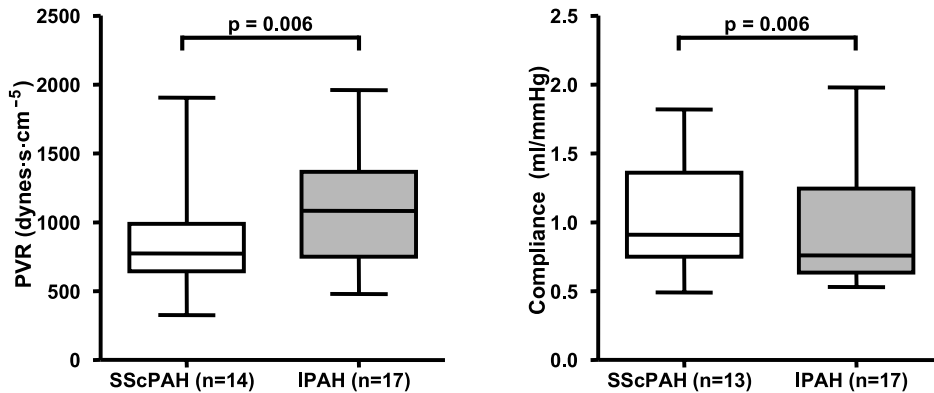
Figure 3

Mean right ventricular pressure (mPrv), left, and stroke volume index (SVI), right, in systemic sclerosis-associated pulmonary arterial hypertension (SScPAH) and idiopathic pulmonary arterial hypertension (IPAH). Data are presented as a boxplot, where the black horizontal bar is the median, the box is the interquartile range and the vertical lines extend to the smallest and largest observations.

Table 2. Haemodynamics and pump function graph data

	SScPAH N=13	IPAH N=17	P
Heart rate, beats/min	82 ± 13	86 ± 13	0.43
Pra, mmHg	6 ± 4	8 ± 5	0.56
mPrv, mmHg	31 ± 9	41 ± 9	0.006
mPrv _{iso} , mmHg	43 ± 12	54 ± 10	0.043
sPrv, mmHg	43 ± 12	60 ± 10	< 0.0001
dPrv, mmHg	11 ± 5	14 ± 7	0.48
mPpa, mmHg	44 ± 10	60 ± 10	< 0.0001
sPpa, mmHg	70 ± 14	97 ± 19	< 0.0001
dPpa, mmHg	26 ± 6	37 ± 8	< 0.0001
PCWP, mmHg	9 ± 34	8 ± 4	0.62
PVR, dynes·s·cm ⁻⁵	848 ± 397	1079 ± 433	0.13
Compliance, ml/mmHg	1.1 ± 0.4	0.9 ± 0.4	0.30
SVI, ml/m ²	27 ± 7.3	26 ± 8	0.84
SVI _{max} , ml/m ²	53 ± 21	57 ± 16	0.23
CI, l/min.m ²	2.2 ± 0.6	2.3 ± 0.6	0.71

Values expressed as mean ±SD. Definition of abbreviations: Pra, mPrv: mean right atrial and mean right ventricular pressures; mPrv_{iso}: mean of the RV maximal isovolumic beat; sPpa, dPpa, mPa: systolic, diastolic and mean pulmonary artery pressures; PVR: pulmonary vascular resistance; Compliance: total pulmonary arterial compliance; SVI: stroke volume index; SVI_{max}: maximal SVI.

**Figure 4**

The arterial load: Pulmonary vascular resistance (PVR), left, and pulmonary arterial compliance, right, in systemic sclerosis-associated pulmonary arterial hypertension (SScPAH), and idiopathic pulmonary arterial hypertension (IPAH). Data are presented as a boxplot, where the black horizontal bar is the median, the box is the interquartile range and the vertical lines extend to the smallest and largest observations.

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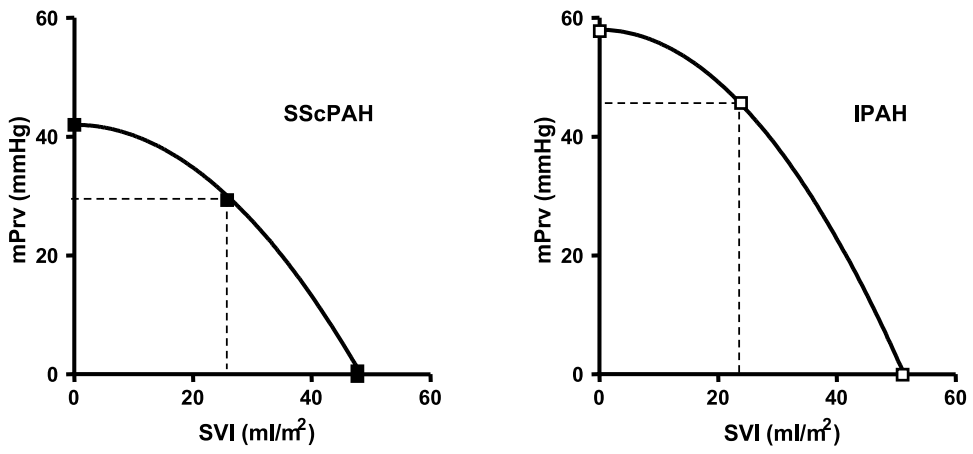


Figure 5
Examples of pump function graphs of two patients. A patient with systemic sclerosis-associated pulmonary arterial hypertension (SScPAH), left, and idiopathic pulmonary arterial hypertension (IPAH), right.

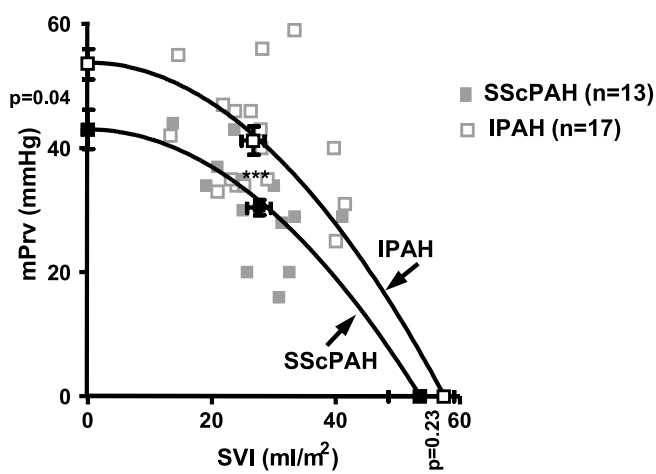


Figure 6.
The averaged ventricular pump function graph for systemic sclerosis-associated pulmonary arterial hypertension (SScPAH) and idiopathic pulmonary arterial hypertension (IPAH). Individual SScPAH patients are represented by the filled squares, individual IPAH patients by the non-filled squares. The three data points with SE bars are plotted for each group: mean isovolumic right ventricular pressure ($mPrv_{iso}$), with stroke volume (SVI) zero, measured $mPrv$ against measured SVI and the maximal SVI, SVI_{max} , at zero $mPrv$. The IPAH pump function graph is located above the SScPAH pump function graph, with a rotation around the SVI_{max} .

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We used the single beat method to derive isovolumic right ventricular pressure from a measured ventricular pressure of an ejecting beat. Sunagawa *et al.* found that for the left ventricle there is a correlation between the isovolumic pressure (P_{iso}) observed during an isovolumic beat and the P_{iso} that is predicted by sine wave extrapolation from the isovolumic parts of an ejecting beat [12]. Brimiouille *et al.* showed that this single-beat method can be used for the right ventricle as well [13]. In this study, we used this method to predict the mean isovolumic pressure of the right ventricle ($mPrv_{iso}$) in individual patients to be able to describe a full pump function graph.

Since PVR and compliance did not differ we conclude that the difference in ventricular pressure between SScPAH and IPAH hearts is based on differences in performance of the heart itself.

The advantage of the use of the ventricular pump function graph is that it is based on standard catheterization measurements, Fick and PRV. However, this method still needs further validation in humans. Validation of the pump function graph method could be performed by the evaluation of difference of contractility between the SScPAH and IPAH groups by construction of a series of RV pressure-volume loops during the temporary occlusion of the inferior vena cava measured by means of a conductance catheter [18]. However, this is an intervention with substantial patient burden. Moreover, volume measurement with the conductance catheter in the RV is a possibility [19] but still not sufficiently evaluated. Another method would be to simultaneously measure RV pressure by right heart catheterisation and RV volume by MRI analysis; this method also needs further validation [20].

The lower contractility in SScPAH might be explained in several ways. Myocardial fibrosis as well as intramyocardial coronary vessel involvement are known to affect the ventricles in SSc [21,22]. Fernandes and co-workers [23] analyzed endomyocardial biopsies from SSc patients, with both limited and the diffuse cutaneous forms of SSc, without signs or symptoms of heart failure and excluded patients with pulmonary or arterial hypertension, left ventricular (LV) hypertrophy, and LV diastolic dysfunction. They demonstrated abnormal collagen deposition in 94% of the cases. Impaired contractility of hearts of patients with SScPAH might then be explained by increased extracellular matrix, which might affect normal contraction of the cardiac myocytes it surrounds [24,25]. Remodelling of the heart due to persistent elevations in ventricular developed pressure leads to changes in the amount of collagen, the collagen phenotype and collagen cross-linking (reviewed by Brower *et al.* [26]). Cross-linking has not been investigated in the hearts of SSc patients, but it is increased in skin with systemic sclerosis [27,28]. It may be speculated that SSc myocardial tissue expresses an increased degree in collagen cross-linking that contributes to an impaired cardiac contractility.

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respect of differences in heart involvement and adaptation in response of elevated PVR between LcSSc and DcSSc.

In conclusion, we have demonstrated, by using standard catheterization data, that SScPAH patients have lower cardiac contractility compared with IPAH patients. Further study of RV function in SScPAH should elucidate the underlying mechanisms.

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