Regional aortic compliance studied by magnetic resonance imaging: the effects of age, training, and coronary artery disease

R H MOHIADDIN, S R UNDERWOOD, H G BOGREN, D N FIRMIN, R H KLIPSTEIN, R S O REES, D B LONGMORE

From the National Heart and Chest Hospitals, London

SUMMARY Arterial compliance was measured in 70 healthy volunteers, 13 athletes, and 17 patients with coronary artery disease. Magnetic resonance images were acquired at end diastole and end systole through the ascending aorta, the aortic arch, and the descending thoracic aorta. Regional compliance was derived from the change in luminal area in a slice of known thickness and from the pulse pressure. Total arterial compliance was also measured from the left ventricular stroke volume and the pulse pressure. In the volunteers, mean (SD) regional compliance (µl/mm Hg) was greatest in the ascending aorta (37 (18)), lower in the arch (31 (15)), and lowest in the descending aorta (18 (8)), and it decreased with age. Compliance in the athletes was significantly higher than in their age matched controls (41 (16) versus 22 (11) µl/mm Hg). In the patients with coronary artery disease it was significantly lower (12 (4) v 18 (10)) than in age matched controls. Total arterial compliance also fell with age in those with coronary artery disease although there was more variation.

The results suggest a possible role for compliance in the assessment of cardiovascular fitness and the detection of coronary artery disease.

A popular saying is that a man is as old as his arteries. The commonest arterial disease is "hardening of the arteries" or atherosclerosis which leads, among other things, to a loss of elasticity. Arterial elasticity is measured as compliance, which is the change in volume per unit change in pressure, and compliance measurements may be valuable for both detection and monitoring of disease.

Magnetic resonance imaging is a direct non-invasive way of studying regional aortic compliance and total arterial compliance. We used it to study changes in compliance with age and aortic compliance in athletes and in patients with coronary artery disease.

Patients and methods

We studied 70 healthy volunteers without symptoms of cardiovascular disease (mean age 38, range 16–83), 13 athletes (mean age 43, range 29–56), and 17 patients with coronary artery disease without previous infarction (mean age 53, range 30–76). Three of the athletes were of international standard (one Olympic gold medal) and the others were club athletes. The average distance run daily was nine miles.

We used a Picker International Vista MR2055 machine operating at 0.5 T to acquire images at end diastole and end systole in three oblique planes perpendicular to the midpoints of the ascending aorta, the aortic arch, and the descending thoracic aorta (fig 1). A spin echo sequence (TE 40 ms) was used with two averages of 128 phase encoding steps, a pixel size of 1.17 mm × 1.17 mm, and a slice thickness of 10 mm. The end diastolic images were acquired 100 ms before the average RR interval, and the end systolic images at the end of the T wave of the electrocardiogram. Acquisition time was three to four minutes per image depending upon heart rate.

The lumen of the aorta was outlined manually on the computer screen, and regional aortic compliance was calculated from the change in volume between diastole and systole. The pulse pressure was
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Fig 1. Oblique image of the ascending aorta, aortic arch, and descending thoracic aorta showed the sites at which compliance was measured.

Results

Figure 2 shows images at end diastole and end systole through the ascending and descending aorta in a volunteer aged 38. The mean (SD) percentage change in ascending aortic area in volunteers aged less than 50 was 30 (13)%, which was significantly greater than the known reproducibility of area measurements by this technique (6%).

Mean (SD) regional compliance measurements in the healthy volunteers (mean (SD) age 37) were (30.9 (15.3)) in the ascending aorta, 21.4 (10.7) in the aortic arch, 17.8 (8.3) in the descending aorta, and total arterial compliance was 1854 (489) μl/mm Hg. Mean compliance in the ascending aorta was higher than in the arch (p < 0.01 by the multiple comparison test) and in the descending aorta (p < 0.01). The

<table>
<thead>
<tr>
<th>Age matched volunteers</th>
<th>Compliance</th>
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<tbody>
<tr>
<td>Patients with coronary artery disease</td>
<td>47 (11) 17.6 (10.3)</td>
</tr>
<tr>
<td>Athletes</td>
<td>41 (9) 21.8 (11.2)</td>
</tr>
</tbody>
</table>

**p < 0.01, ***p < 0.001.**
Fig 2 Diastolic (a) and systolic images (b) of the ascending and descending aorta showing the change in aortic area of a 38 year old normal volunteer.
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Fig 3  Compliance in the ascending aorta displayed on a logarithmic scale and plotted against age. The regression equation is \( y = -0.01x + 1.79 \), and the 95% confidence intervals for the normal volunteers are shown (\( r = -0.91, p < 0.001, \text{SEE} = 0.09 \)).

Fig 4  Compliance of the aortic arch displayed on a logarithmic scale and plotted against age. The regression equation is \( y = -0.01x + 1.65 \) and the 95% confidence intervals for the normal volunteers are shown (\( r = -0.84, p < 0.001, \text{SEE} = 0.12 \)).

Fig 5  Compliance in the descending aorta displayed on a logarithmic scale and plotted against age. The regression equation is \( y = -0.008x + 1.5 \), and the 95% confidence intervals for the normal volunteers are shown (\( r = -0.74, p < 0.001, \text{SEE} = 0.14 \)).

Fig 6  Total arterial compliance in the normal volunteers plotted against age. The regression equation is \( y = -0.003x + 3.39, r = -0.42, p < 0.02, \text{SEE} = 0.11 \).

In the volunteers and after logarithmic transformation the fall seemed to be linear. The 95% confidence intervals of the linear regression equations were used to define a normal range. All but three athletes had compliance above the normal range at each site. Of the patients with coronary artery disease who were aged <50, most had abnormally low compliance in the ascending aorta, aortic arch, and descending aorta. Mean compliance in the patients with coronary artery disease was abnormally low, and inspection of the figures showed that the difference was most pronounced in patients aged <50. Compliance was high in the controls aged >50. Total arterial
compliance also decreased with age in the healthy volunteers, but there was a wide scatter of points (fig 6).

Figure 7 and table 2 show the relation between diastolic aortic area and age, and fig 8 shows the change in pulse pressure with age in the healthy volunteers. Aortic size and pulse pressure both increased with age, pulse pressure mainly because of an increase in systolic pressure.

Discussion

Previous workers have measured human arterial compliance from pressure-volume curves of post-mortem arteries. Arterial compliance has also been estimated in vivo by indirect and invasive techniques, including pulse wave velocity measurements in animals and in humans, the pressure-radius relation by the Peterson transformer coil in animals, x ray contrast angiography in humans, and pulsed ultrasound aortography. The compliance of the whole arterial system has previously been calculated from the left ventricular stroke volume divided by pulse pressure. We showed that both regional aortic compliance and total arterial compliance can be measured in vivo by magnetic resonance, which is simpler and more accurate than other methods.

We showed that regional aortic compliance in healthy volunteers falls with age and is highest in the ascending aorta; this accords with studies that showed that this part of the aorta had the greatest elasticity. With advancing age, there is disruption of the elastic component of the vessel wall, fibrosis and increase in collagen at the expense of smooth muscle cells, cystic medial necrosis (pooling of mucoid material), and medionecrosis (areas with loss of nuclei). The fall in compliance with age may also be related to a deficiency of endothelium derived relaxing factor or to the disappearance of peripheral \( \beta \) adrenergic receptors. The enlargement of diastolic aortic area with age is possibly caused by the structural changes and loss of elasticity in the vascular wall. A previous necropsy study on adult human aortas showed that the enlargement of aortic diameter with age was associated with loss of elasticity. Systolic blood pressure and pulse pressure increase with age. A fall in arterial compliance may be one factor causing systolic hypertension, although the structural changes seen in elderly patients with hypertension have also been reported in normotensive individuals of the same age and to a lesser degree in younger subjects. Decreased compliance may also lead to the decreased baroreceptor sensitivity seen in elderly patients with hypertension. The relation between blood pressure and compliance is complex, however, because hypertension can be a cause as well as a consequence of reduced compliance.

Table 2  Mean (SD) cross sectional area of ascending aorta in each decade in the healthy volunteers

<table>
<thead>
<tr>
<th>Age (decades)</th>
<th>Diastolic aortic area (cm²)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-19</td>
<td>3.8 (0.9)</td>
</tr>
<tr>
<td>20-29</td>
<td>4.3 (1.1)</td>
</tr>
<tr>
<td>30-39</td>
<td>4.9 (0.8)</td>
</tr>
<tr>
<td>40-49</td>
<td>5.3 (2.0)</td>
</tr>
<tr>
<td>50-59</td>
<td>6.9 (0.9)</td>
</tr>
<tr>
<td>60-69</td>
<td>7.0 (1.8)</td>
</tr>
<tr>
<td>70-79</td>
<td>8.1 (0.6)</td>
</tr>
<tr>
<td>80-89</td>
<td>11.0 (2.9)</td>
</tr>
</tbody>
</table>

Fig 7  Correlation between area of the ascending aorta in diastole and age \( (y = 0.09x + 2.1, r = 0.77, \text{SEE} = 1.4 \text{ cm}^2) \).

Fig 8  Correlation between pulse pressure in the normal volunteers and age \( (y = 0.5x + 0.5, r = 0.80, \text{SEE} = 7.2 \text{ mm Hg}) \).
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We found high regional aortic compliance in trained athletes, and it seems likely that this is due to a direct effect of training upon the arterial system, rather than its effects upon the heart. Although the bradycardia and increased stroke volume of training will affect mean aortic diameter and hence compliance, there are also large changes in peripheral resistance that should have a greater effect. The reduction in resistance allows the athlete to generate a maximum cardiac output of up to 40 l/min compared with a maximum of 20 l/min in normal individuals without increasing blood pressure to unacceptable values. These large changes in peripheral resistance may well be accompanied by structural changes in the aorta leading to increased compliance.

Because compliance is a determinant of left ventricular afterload it is important in patients with coronary artery disease. The combination of elastic arteries and resistant arterioles constitutes a hydraulic filter enabling the intermittent capillary output to be converted to a steady capillary flow. Part of the energy of left ventricular contraction produces forward flow during systole, but the remainder is stored as potential energy in the distended arteries. During diastole, elastic recoil converts this potential energy again into forward flow. A fall in aortic compliance, therefore, increases the impedance to ventricular ejection and decreases capillary blood flow. Aortic compliance measured by aortography was reduced in patients with coronary artery disease and we have now shown similar changes non-invasively. Although it is possible that this is due to the mechanical effects of atheroma, it is more likely to reflect the generalised structural changes that occur in association with atheroma and that are similar to those of aging.

Magnetic resonance imaging is a simple non-invasive method of measuring both regional aortic compliance and total arterial compliance. In healthy volunteers, the ascending aorta was the most compliant region and compliance fell more distally. Compliance also fell with age, although above the age of 50 the fall was less steep. Regional aortic compliance is higher than normal in athletes, and lower than normal in patients with coronary artery disease. These changes are likely to be the result of structural changes in the aorta, but the importance of compliance measurements for the monitoring of cardiovascular fitness and for the detection of disease remains to be established.

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