Arterial dysfunction in syndrome X: results of arterial reactivity and pulse wave propagation tests

M Kidawa, M Krzeminska-Pakula, J Z Peruga, J D Kasprzak

Objective: To assess arterial distensibility using pulse wave velocity (PWV) measurements and its relation with endothelium dependent vasodilatation (EDV) in patients with cardiological syndrome X.

Methods: The study group consisted of 93 patients: 52 with syndrome X (34 women, 18 men, mean (SD) age 45 (3) years) and 40 healthy volunteer controls (27 women, 13 men, mean (SD) age 41 (2) years) without risk factors of atherosclerosis and with negative ECG exercise test and normal proximal coronaries on transoesophageal echocardiography. Patients with arterial hypertension, diabetes mellitus, valvar disease, or cardiomyopathy were excluded. PWV was measured by a Complior Colson device was calculated for each patient. EDV was assessed from two dimensional Doppler measurement using an Acuson Sequoia with 8 MHz linear transducer at rest, during postischaemic reactive hyperaemia, and after an oral dose of 400 µg of glyceryl trinitrate.

Results: PWV was significantly higher in patients with syndrome X than in healthy subjects (9.3 (0.7) m/s vs 8.2 (0.9) m/s, respectively, p < 0.001). Baseline brachial artery diameter was similar in the syndrome X and control groups (4.0 (0.6) mm vs 4.08 (0.64) mm, NS). EDV was impaired in patients with syndrome X compared with controls (6.6 (3.0)% vs 11.1 (3.9%), p < 0.001). Endothelium independent vasodilatation was similar in both groups. In patients with syndrome X there was a positive correlation between PWV and the degree of EDV (r = 0.864, p < 0.001). The cut off value for PWV was 8.5 m/s, with a sensitivity of 62% and a specificity of 91%.

Conclusions: EDV but not glyceryl trinitrate induced vasodilatation is decreased in patients with syndrome X. There is strong correlation between PWV and the degree of endothelial dysfunction of peripheral arteries in patients with syndrome X. PWV assessment may be useful to identify abnormal vascular physiology in these patients.

The speed of pulse wave propagation throughout the arterial tree depends on the elastic and geometric properties of the arterial wall. Since blood is an incompressible fluid enclosed in the system of elastic arteries, the energy released by ventricular ejection is propagated mainly along the arterial wall. An increase in pulse wave velocity (PWV) may be used as an early indicator of arterial stiffening, characteristic of the development of atherosclerosis. The aim of this study was, by assessing endothelial function of the brachial artery, to investigate whether endothelial dysfunction in patients with syndrome X is a generalised process. To examine the systemic vascular bed we also measured pulse wave propagation as a marker of arterial distensibility. Our secondary objective was to investigate possible correlation between endothelial function and PWV measurements in patients with syndrome X.

METHODS

Patient population

The study population consisted of 52 patients with angina, without prior myocardial infarction (mean (SD) age 45 (3) years, 34 women, 18 men) who underwent coronary angiography in our cardiology department during 1998 and 1999. They fulfilled the characteristic criteria for the diagnosis of syndrome X: angina-like chest pains, positive ECG exercise test, normal coronary arteries on angiography, and no metabolic disorders.

Exclusion criteria were a previous diagnosis of dilated or constrictive cardiomyopathy, a previous myocardial infarction.

Abbreviations: EDV, endothelium dependent vasodilatation; GTN, glyceryl trinitrate; PWV, pulse wave velocity
arterial hypertension, metabolic disorders such as diabetes mellitus, dyslipidaemia, and insulin resistance syndrome, ECG conductivity and rhythm disorders, valvar heart disease, Barlow’s syndrome, or any other known functional peripheral arterial disorders. None of our patients was treated at the time of syndrome, or any other known functional peripheral arterial dysfunction, and ejection fraction.

Forty healthy volunteers (mean (SD) age 41 (2) years, 27 women, 13 men) without any symptoms or risk factors of coronary artery disease and with a normal ECG and echocardiogram were enrolled in the control group. Each patient from the control group underwent an ECG exercise test, which was negative. Coronary angiography was not performed in this group for ethical reasons. Before enrolment in the control group, each patient underwent transoesophageal echocardiographic examination of proximal parts of the coronary arteries. Those with abnormal findings in transoesophageal echocardiography or turbulent flow suggesting the presence of atherosclerosis in the coronary arteries were excluded from the study.

Study protocol
An exercise test (Bruce protocol) was said to be positive if there was at least 0.2 mV of horizontal ST segment depression or elevation in at least two leads. The ECG exercise test was aborted if the heart rate reached submaximal values, patients were complaining of chest pain, complex forms of cardiac arrhythmias were observed, or criteria for a positive ECG test were reached.

Blood samples were taken from each patient and analysed for serum uric acid, electrolyte, cholesterol, and triglyceride concentrations.

Echocardiographic assessment was performed in all patients according to the standards of the American Society of Echocardiography, with measurements of diastolic and systolic septal and posterior wall thickness, left ventricle diameters, and ejection fraction.

Coronary angiography was performed in patients with syndrome X using the standard Judkins technique on a General Electric Advantax LX system (General Electric Medical Systems, Milwaukee, Wisconsin, USA). All images were digitally stored in DICOM format on an Hewlett Packard Visualise workstation (Hewlett-Packard Co, Palo Alto, California, USA) for further analysis.

Endothelial function was assessed with an 8 MHz linear array transducer and Acuson Sequoia 256 echocardiographic system (Acuson, Mountain View, California, USA) according to the protocol described by Fathi and colleagues \(^{18}\) and Celermajer and associates. \(^{12}\) The right brachial artery was scanned at rest, during reactive hyperaemia, and after administration of sublingual glyceryl trinitrate (GTN). Before the first scan the patient rested in the supine position for at least 10 minutes. Then the brachial artery diameter and blood flow velocity were measured. Blood flow was measured from the pulsed Doppler signal at a maximum incidence angle of 60°, with the Doppler gate positioned in the middle of the arterial lumen. Reactive hyperaemia was induced with inflation of a pneumatic tourniquet to a pressure of 200 mm Hg for five minutes. The artery diameter was measured 45–60 seconds after cuff deflation and flow velocity recordings were started 15 seconds after cuff release. After 15 minutes an additional baseline scan was recorded and then four minutes after 400 µg sublingual GTN was given, the last images were collected. ECG monitoring was continuous during the procedure, and ECG R wave measurements were averaged from four consecutive beats. Arterial diameters were measured from the anterior to the posterior “m” line at the end of diastole. All measurements were taken by two observers who were unaware of clinical details. The previously estimated mean (SD) inter-observer variability of flow mediated dilatation measurement in our echocardiography laboratory was 1.2 (0.4)%.

Vasodilatation was expressed as the percentage increase in artery diameter during reactive hyperaemia (EDV) and after GTN administration (endothelium independent vasodilatation). Reactive hyperaemia was calculated as the maximum flow over the 15 seconds after cuff release divided by the baseline flow values (fig 1).

PWV was measured automatically with a Complior Colson device based on an IBM Aptiva 486 DX personal computer according to the methods described by Asmar and colleagues. \(^{18}\) PWV was calculated from measurements of the pulse transit time between two recording sites, the femoral and carotid external arteries, at a sampling frequency of 500 Hz. During preprocessing analysis the gain of each waveform was adjusted to obtain an equal signal for the two waveforms. During PWV measurements, after pulse waveforms of sufficient quality were recorded, the digitisation process was initiated by the operator and automatic calculation of the time delay between two upstrokes was started (fig 2). The interobserver repeatability (repeatability coefficient) for the automatic PWV calculation in our laboratory was 0.876 (95% confidence interval ± 1.95 repeatability coefficient).

Statistical analysis was performed with the Statistica 5.0 data analysis program using non-parametrical U Mann-Whitney tests. Correlations were calculated with the Spearman test. All results are expressed as mean (SD).

The investigation conforms with the principles outlined in the Declaration of Helsinki.
RESULTS
Table 1 shows demographic and biochemical data.

Because of the enrolment criteria, patients in the control group were younger than those in the syndrome X group (mean (SD) 41 (2) years v 45 (3) years, respectively) to minimise the risk for silent coronary disease.

Blood analysis showed significantly higher plasma concentrations of total cholesterol, low density lipoprotein fraction, and triglycerides in the syndrome X population than in controls. High density lipoprotein concentrations were much lower in the syndrome X group. However, all of these values were within the normal ranges (table 1).

ECG exercise tests were positive only in patients with syndrome X. In the syndrome X group, baseline heart rate was significantly higher and total exercise phase was significantly shorter than in the controls (table 1). In 29 patients with syndrome X, chest pain occurred during the test at a mean (SD) exercise time of 4.9 (1) minutes.

Echocardiographic examination confirmed that both groups had normal cardiac size and function with clinically insignificant differences between the groups. The ejection fraction was slightly lower in patients with syndrome X than in the control group.

Arterial vasodilator tests
Under baseline conditions there were no significant differences in measurements of brachial artery diameter (4.0 (0.6) mm v 4.08 (0.64) mm, NS) and baseline blood flow velocities (74.1 (14.2) cm/s v 73 (13.9) cm/s, NS) between the syndrome X and control groups, respectively. After oral administration of GTN the mean increase in blood flow velocity and in arterial diameter was similar in both groups and there was no significant difference in endothelium independent vasodilatation (mean (SD) percentage arterial diameter increase 18.1 (5.1)% v 19.6 (5.1)% in controls, p < 0.001). After the induction of reactive hyperaemia the mean (SD) increase in arterial diameter was significantly lower in patients with syndrome X than in controls (0.27 (0.12) mm v 0.44 (0.16) mm, respectively), which showed that EDV was significantly impaired in patients with syndrome X (6.6 (3.0)% v 11.1 (3.9)% in controls, p < 0.001) (fig 3).

During hyperaemia the increase in blood flow velocity was similar in the syndrome X and control groups.

PWV measurements
In the syndrome X group pulse wave propagation time between measurement sites was significantly shorter than in the control group (65.1 (6.2) ms v 76.1 (8.2) ms, respectively, p < 0.001). Comparing with the syndrome X group, PWV values were significantly lower in controls (9.3 (0.7) m/s v 8.2 (0.9) m/s, p < 0.001), as fig 4 shows.

A PWV of 8.5 m/s allows for differentiation between groups with a sensitivity of 62% and a specificity of 91%.

Further analysis showed the presence of a strong inverse correlation between PWV and EDV (fig 5). The regression equation is PWV = 15.07 − 0.75 × EDV, Pearson’s r = −0.864, p < 0.01.

In our study we did not find any significant correlation between PWV and age, sex, or mean blood pressure in the studied groups.

Table 1
Basic data in patients with syndrome X and the control group

<table>
<thead>
<tr>
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<th>Syndrome X group</th>
<th>Control group</th>
<th>p Value</th>
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<tbody>
<tr>
<td>Number of patients</td>
<td>52</td>
<td>40</td>
<td>NS</td>
</tr>
<tr>
<td>Women</td>
<td>34</td>
<td>27</td>
<td>NS</td>
</tr>
<tr>
<td>Average age (years)</td>
<td>45 (3)</td>
<td>41 (2)</td>
<td>0.01</td>
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<td>Smokers</td>
<td>3</td>
<td>0</td>
<td>0.01</td>
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<tr>
<td>Positive family history for IHD</td>
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<td>0</td>
<td>0.01</td>
</tr>
<tr>
<td>Systolic blood pressure (mm Hg)</td>
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<td>124.8 (7.2)</td>
<td>NS</td>
</tr>
<tr>
<td>Diastolic blood pressure (mm Hg)</td>
<td>77.1 (6.3)</td>
<td>77.1 (6.2)</td>
<td>NS</td>
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<tr>
<td>Total cholesterol (mmol/l)</td>
<td>4.72 (0.19)</td>
<td>4.88 (0.22)</td>
<td>NS</td>
</tr>
<tr>
<td>LDL cholesterol (mmol/l)</td>
<td>2.72 (0.32)</td>
<td>2.71 (0.33)</td>
<td>NS</td>
</tr>
<tr>
<td>HDL cholesterol (mmol/l)</td>
<td>1.52 (0.14)</td>
<td>1.53 (0.15)</td>
<td>NS</td>
</tr>
<tr>
<td>Triglycerides (g/l)</td>
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<td>1.01 (0.13)</td>
<td>NS</td>
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<td>Resting heart rate (beats/min)</td>
<td>75.6 (7.8)</td>
<td>71.0 (9.7)</td>
<td>0.01</td>
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<td>Maximum heart rate (beats/min)</td>
<td>151 (10)</td>
<td>164 (12)</td>
<td>0.01</td>
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<td>Maximum ST depression (mm)</td>
<td>2.4 (0.4)</td>
<td>0.9 (0.4)</td>
<td>0.01</td>
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<tr>
<td>Exercise test duration (min)</td>
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<td>9.2 (0.9)</td>
<td>0.01</td>
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<tr>
<td>Ischaemic pain present (number)</td>
<td>29</td>
<td>0</td>
<td>NA</td>
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</table>

Values are mean (SD). HDL, high density lipoprotein; IHD, ischaemic heart disease; LDL, low density lipoprotein; NA, not applicable; NS, not significant.

Figure 3
Comparison of mean increase in brachial artery diameter after reactive hyperaemia between the syndrome X and control groups.

Figure 4
Mean (SD) pulse wave velocity (m/s) measurements in the study groups.
explained. The absence of atherosclerotic changes in coronary arteries was associated with impaired EDV.

Smoking, susceptibility of low density lipoprotein to oxidation, prandial hypertriglyceridaemia, active and passive cigarette smoking, high density lipoprotein cholesterol, acute post-prandial hypertriglyceridaemia, active and passive cigarette smoking, susceptibility of low density lipoprotein to oxidation, hypertension, and early stages of atherosclerosis are associated with impaired EDV and increased arterial wall stiffness in such patients. A strong inverse correlation between PWV and EDV may indicate such a relation. The cut off value of PWV was measured retrospectively and further prospective studies should be performed to investigate the usefulness of this parameter in identifying patients with syndrome X.

Conclusions

EDV is impaired in peripheral arteries of patients with syndrome X, and a significant rise in PWV reflects the increased arterial wall stiffness in such patients. A strong inverse correlation between PWV and EDV may indicate generalised arterial dysfunction in these patients. PWV measurements may be useful in differentiating patients with syndrome X from healthy subjects.

Acknowledgements

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REFERENCES


Figure 5 Correlation between pulse wave velocity (PWV) and endothelium dependent vasodilatation (EDV), where PWV = 15.07 – 0.75 × EDV, Pearson’s r = 0.864, p < 0.01.
endothelial function in the human coronary and peripheral circulations.

normal coronary angiograms.

dependent coronary vasodilatation in patients with angina pectoris and having coronary artery disease.

endothelial dysfunction in patients with angina pectoris and normal coronary angiograms.

endothelial-independent function is impaired in patients with angina pectoris and normal coronary angiograms.

endothelium-independent vasodilation in patients with angina pectoris and normal coronary angiograms.

endothelial function in patients with coronary arteries: comparison with subjects with insulin resistance syndrome and normal controls.

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Doppler in the differentiation of angiographically normal coronary arteries: Images in cardiology.

the following co-authors should have been included in the author list: Arribas A, Gonzalez-Santos JM, Collado JR. The error is regretted.