Cardiorespiratory Fitness and Reclassification of Risk for Incidence of Heart Failure

The Veterans Exercise Testing Study

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Background—It is well established that cardiorespiratory fitness (CRF) is inversely associated with cardiovascular and all-cause mortality. However, little is known regarding the association between CRF and incidence of heart failure (HF).

Methods and Results—Between 1987 and 2014, we assessed CRF in 21,080 HF-free subjects (58.3±11 years) at the Veterans Affairs Medical Centers in Washington, DC, and Palo Alto, CA. Subjects were classified by age-specific quintiles of CRF. Multivariable Cox models were used to determine the association between HF incidence and clinical and exercise test variables. Reclassification characteristics of fitness relative to standard clinical risk factors were determined using the category-free net reclassification improvement and integrated discrimination improvement indices. During the follow-up (mean 12.3±7.4 years), 1902 subjects developed HF (9.0%; average annual incidence rate, 7.4 events per 1000 person-years). When CRF was considered as a binary variable (unfit/fit), low fitness was the strongest predictor of risk for HF among clinical and exercise test variables (hazard ratio, 1.91; 95% confidence interval, 1.74–2.09; P<0.001). In a fully adjusted model with the least-fit group as the reference, there was a graded and progressive reduction in risk for HF as fitness level was higher. Risks for developing HF were 36%, 41%, 67%, and 76% lower among increasing quintiles of fitness compared with the least-fit subjects (P<0.001). Adding CRF to standard risk factors resulted in a net reclassification improvement of 0.37 (P<0.001).

Conclusions—CRF is strongly, inversely, and independently associated with the incidence of HF in veterans referred for exercise testing. (Circ Heart Fail. 2017;10:e003780. DOI: 10.1161/CIRCHEARTFAILURE.116.003780.)

Key Words: cardiorespiratory fitness ■ cardiovascular system ■ exercise testing ■ heart failure ■ incidence ■ risk factor

Recent advances in the treatment of cardiovascular disease (CVD) have led to marked improvements in survival among patients experiencing a cardiac event. However, while these advances in treatment have led to a decline in most CVDs, marked growth in the prevalence of heart failure (HF) has occurred over the last 3 decades.1,2 The growing prevalence of HF reflects a combination of increasing incidence, an aging population, and improvements in the treatment of both acute CVD and HF.2 Older Americans are currently hospitalized for HF more than any other medical condition, and with the aging of the population, the impact of HF is expected to increase dramatically.3,3 Given the considerable economic and societal burden of HF, strategies to prevent this condition should be considered.

See Clinical Perspective

In recent years, there has been increasing recognition that higher fitness is associated with improved health outcomes across a broad range of conditions.4,6 Findings from large observational studies strongly support the concept that fitness level determined from a maximal exercise test is a more powerful determinant of freedom from all-cause mortality than the traditional risk factors.4,7-9 Fitness is also inversely associated with the development of numerous health conditions, including CVD, diabetes mellitus, metabolic syndrome, and site-specific cancers.4,6,10,11 These observations have recently led professional organizations to characterize fitness as an important health marker in both asymptomatic populations and patients with HF.12-14 While a strong inverse association between exercise capacity and outcomes in patients with existing HF has been documented,15-17 the association between fitness level and development of HF among individuals free of HF at baseline is largely unexplored. Berry et al18 recently reported an ≈3.5-fold higher rate of hospitalization for HF in the least-fit quartile of subjects versus the highest-fit quartile among >20,000 subjects in the Cooper Center Longitudinal Study. These results underscore the potential importance of midlife fitness level and subsequent HF risk in later life. However, hospitalization rates were derived from Medicare
claims data for a 10-year period; thus, HF outcomes were not captured prior to Medicare eligibility, limiting the sample to relatively older subjects.

Other than control of traditional risk factors (particularly blood pressure), treatment strategies to prevent HF are relatively limited. Given both the societal burden and impact of HF on national healthcare expenditures, the demonstration of an inverse association between fitness and the development of HF, as has been observed for other conditions, would provide clinicians with further evidence to encourage physical activity among their patients and the public. In turn, this could provide an additional strategy to reduce the considerable and growing burden of HF. The aim of the current study was to address the association between fitness and incidence of HF across a broad range of US veterans.

Methods

Study Design and Sample
The cohort was drawn from the Veterans Exercise Testing Study, an ongoing, prospective evaluation of Veteran subjects referred for exercise testing for clinical reasons, designed to address exercise test, clinical, and lifestyle factors and their association with health outcomes. The Veterans Exercise Testing Study cohort includes >25000 male veterans who had undergone a maximal treadmill test at the VA Washington DC Medical Center or the VA Palo Alto Health Care System between 1987 and 2014. Subjects who met the following criteria were excluded from the study: (1) existing HF at the time of the test; (2) those unable to complete the test for orthopedic, neurological, or similar reasons; (3) those with an implanted pacemaker; (4) subjects who were unstable or required emergent intervention; and (4) those with an exercise capacity <2 metabolic equivalents (METs). After these exclusions, the final sample included 21080 subjects (13264 black and 4870 white). The study was approved by the respective Institutional Review Boards at each institution, and all subjects gave written informed consent prior to undergoing their exercise test.

Detailed information on relevant demographic, clinical, and medication information, risk factors, and comorbidities as defined by International Classification of Diseases coding for all participants were obtained from the VA Computerized Patient Record System at the time of the exercise test. International Classification of Diseases Ninth Revision coding included categories 428.0 to 428.43, including acute and chronic systolic, diastolic, or unspecified HF. Each individual was asked to verify this information, including history of chronic diseases and smoking habits. Historical information that was recorded included previous myocardial infarction by history or presence of Q waves, cardiac procedures, HF, hypertension, hypercholesterolemia (>220 mg/dL, statin use, or both), claudication, chronic obstructive pulmonary disease, cancer, renal disease, diabetes mellitus, stroke, smoking status (current and past), and use of cardiac medications.

Exercise Assessments
Subjects underwent symptom-limited treadmill testing using an individualized ramp treadmill protocol at Palo Alto or a Bruce protocol in Washington DC. Standard criteria for termination were used, including moderately severe angina, >2.0 mm horizontal or downsloping ST depression, a sustained decrease in systolic blood pressure, or serious rhythm disturbances. The Borg 6–20 perceived exertion scale was used to quantify degree of effort. Blood pressure was taken manually, and exercise capacity (in METs) was estimated from peak treadmill speed and grade using the ramp protocol and exercise time using the Bruce protocol (VO2 max=14.76–(1.379×time)+(0.451×time2)–(0.012×time3)). Subjects were encouraged to exercise until volitional fatigue in the absence of symptoms or other indications for stopping. No test was classified as indeterminate, medications were not withheld, and age-predicted maximal target heart rates were not used as end points. The exercise tests were performed, analyzed, and reported using a standard protocol incorporating a computerized database with all definitions and measurements prospectively defined. The primary outcome was incidence of HF, determined through review of Computerized Patient Record System and defined as a primary diagnosis of HF using International Classification of Diseases coding. Follow-up was completed through December 31, 2014.

The cohort was stratified into 5 age categories (<40, 40–49, <50, 50–59, 60–69, and ≥70 years). We then identified those with a MET level ≤20%, 21% to 40%, 41% to 60%, 61% to 80%, and >80% of predicted METs achieved within their respective age category as described previously. The following 5 fitness categories were then established based on age-stratified quintiles of peak METs achieved: least-fit (mean 4.3±1.2 METs; n=4094); low-fit (6.0±1.2 METs; n=4683); moderate-fit (7.3±1.2 METs; n=4148); high-fit (8.7±1.3 METs; n=4673); and high-fit (11.8±2.4 METs; n=3518).

Statistical Analysis
Follow-up time is presented as median, as well as mean±SD, determined from the date of the exercise test to the date of the event (incidence of HF). Rate of HF incidence was calculated as the ratio of time to HF diagnosis to the person-years of observation. Continuous variables are presented as mean±SD and categorical variables as relative frequencies (%). Comparisons between categorical variables were assessed using χ2 tests. Simple and multivariable linear regression was applied to evaluate differences between fitness categories for variables included in Tables 1 and 2. Age and body mass index were used as covariates for the dependent variables (resting heart rate, systolic and diastolic blood pressure, blood lipids, blood glucose, and exercise capacity).

Exercise capacity was expressed as a continuous variable in METs, as well as the 5 categories mentioned earlier. Survival analysis was performed using Cox proportional hazards analysis to determine which clinical and exercise test variables were independently associated with incidence of HF. Relative risks for mortality were determined using the 5 categories of fitness, with the least-fit group as the reference. For binary analyses, we combined the 2 lowest fitness categories to form the unfit group and the 3 highest fit to form the fit group. We then introduced this categorical variable into the fully adjusted proportional hazards model to further assess the impact of fitness on the incidence of HF with that of other risk factors (categorical covariates). Survival analysis was performed unadjusted, adjusted for age, and fully adjusted, including age, body mass index, ethnicity, sex, CVD, risk factors (hypertension, type 2 diabetes mellitus, dyslipidemia, and smoking), cardiac medications, hypoglycemic agents, chronic kidney disease, and HIV/AIDS. The proportional hazards assumption was evaluated and confirmed using scaled Schoenfeld residuals. Survival curves were constructed to compare fitness categories over the follow-up period, and the log-rank test was used to compare fitness categories over time. Survival analyses were performed using SPSS software version 22.0 (IBM SPSS Statistics for Windows, Version 22.0; IBM Corp, Armonk, NY).

To further evaluate the role of fitness in predicting incidence of HF, we assessed reclassification characteristics of fitness relative to the standard clinical risk factors mentioned earlier using the continuous category-free net reclassification improvement index (NRI) and the integrated discrimination improvement (IDI). These analyses were modified for right censored survival data according to the methods proposed by Pencina et al. We corrected for overoptimism using 1000 bootstrap replicates and report the median results and bootstrap estimated 95% confidence intervals. NRI and IDI analyses were performed using R (R Foundation for Statistical Computing, Vienna, Austria).

Results

Demographic and Clinical Characteristics and Follow-Up Data
For the 21080 participants, the mean age at the time of the exercise test was 58.2±11.0 years. The mean follow-up time
was 12.3±7.4 years, with a median of 11.7 years (6.5 and 17.2 years for the 25th and 75th percentiles, respectively), comprising a total of 258,678 person-years. There were 1902 HF events (9.0%), with an average annual incidence rate of 7.4 events per 1000 person-years. There were no interactions between site and fitness (P=0.40) or race and fitness (P=0.82); therefore, the data were not stratified by race or site.

Descriptive clinical and demographic data for the entire cohort and for those developing and not developing HF are presented in Table 1. Those who developed HF were older, were less fit (5.9±2.2 versus 7.7±2.9 METs; P<0.001), had higher systolic and diastolic blood pressures, and were more likely to be diabetic, dyslipidemic, and smokers, and had a higher prevalence of chronic kidney disease when compared with those who did not develop HF. Demographic, clinical, and exercise test characteristics comparing quintiles of fitness are presented in Table 2. Notable differences among higher-fit versus lower-fit subjects included lower body mass index, resting heart rate, triglycerides, and fasting glucose levels among higher-fit individuals, and higher prevalence of hypertension, diabetes mellitus, smoking, and medication use among lower-fit individuals.

### Predictors of HF Incidence

Significant predictors for developing HF among clinical, demographic, and exercise test variables are presented in Table 3. When fitness status was considered as a binary variable (unfit/fit), low fitness was a strong predictor of risk for HF (hazard ratio, 1.91; 95% confidence interval, 1.74–2.09; P<0.001) and was a stronger predictor of risk than traditional risk factors, including hypertension, diabetes mellitus, smoking, and sleep apnea. Each 1-MET increment in exercise capacity achieved was associated with a 19% reduction in risk for developing HF. Hazard ratios for the 5 fitness categories (unadjusted, age-adjusted, and fully-adjusted models) are shown in Table 4. In the fully adjusted model, and with the least-fit group as the reference, the risk for developing HF was 36% lower for the low-fit individuals (hazard ratio, 0.64; 95% confidence interval, 0.57–0.71; P<0.001). The risk declined progressively by 41% for the moderate-fit, 67% for the fit, and 76% for the high-fit individuals (Table 4 and Figure 1). When this analysis was repeated among subjects taking and not taking β-blockers, similar results were observed. The cumulative hazards for CHF risk for fitness categories across the follow-up period in the entire sample are illustrated by survival curves in Figure 2. Risk for incidence of HF was significantly higher as fitness level was lower (P<0.001).

NRI and IDI results are shown in Table 5. The addition of fitness to traditional risk factors resulted in a net reclassification of 37% (0.37±0.03; P<0.0001). The improved reclassification was largely because of superior ability to correctly classify absence of HF with the addition of fitness (0.65±0.01). The IDI was also net positive (0.03±0.03; P<0.01).

### Discussion

Although exercise capacity, and specifically directly measured peak Vo2, and other cardiopulmonary exercise test variables, have been widely applied in recent years to stratify risk in patients with existing HF,15 little is known regarding the association between fitness and future incidence of HF. This issue has major public health implications given that HF is the one cardiovascular condition that is increasing in prevalence and that HF remains a major cause of morbidity and hospitalization throughout the Western world, particularly in the elderly.26,27 The current findings suggest that higher levels of fitness are strongly and inversely associated with the development of HF in veterans. This was evidenced by a graded inverse association between MET level achieved and HF incidence (Table 4 and Figures 1 and 2) and the fact that fitness level was the most powerful predictor of HF among clinical, demographic, and exercise variables (Table 3). Each 1-MET
increment in exercise capacity achieved was associated with a 19% reduction in risk for developing HF. Compared with subjects in the least-fit category, achieving the relatively modest fitness level of 6 METs (individuals in the next least-fit category) was associated with a 34% lower risk for HF, while risk for HF was 76% lower for individuals in the highest fitness category (≥12 METs). The impact of fitness on incident HF was independent, as underscored by the fact that adjustment for other risk markers had minimal influence on risk for developing HF (Table 4). Finally, adding fitness to standard risk factors resulted in an NRI of 0.37. Our results extend the recent findings of Berry et al, using Medicare claims data in patients >65 years of age, in that we captured HF incidence from VA computerized records throughout the spectrum of age.

Risk factors for the development of HF include hypertension, smoking, and diabetes mellitus among others, and we generally observed a higher risk profile at baseline among subjects who subsequently developed HF (Table 1). Regular exercise generally has a favorable impact on these risk factors for HF, as well as the development of fitness. Confirming a growing number of studies assessing all-cause mortality in apparently healthy subjects and patients with CVD, fitness level was the strongest risk marker for incident HF in the current study. We also observed that a relatively small (1-MET) increment in exercise capacity had a considerable impact on incidence of HF (≈19% reduction). One to 2 METs is an amount typically achievable through a modest program of physical activity. Thus, improvements in fitness through promoting physical activity have a potentially important role.
Table 3. Significant Predictors for Developing Heart Failure Among Clinical, Demographic, and Exercise Test Variables

<table>
<thead>
<tr>
<th></th>
<th>HR</th>
<th>95% CI</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (per year)</td>
<td>1.05</td>
<td>1.04–1.05</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Family history of CAD</td>
<td>1.26</td>
<td>1.07–1.48</td>
<td>0.004</td>
</tr>
<tr>
<td>Sleep apnea</td>
<td>1.29</td>
<td>1.08–1.55</td>
<td>0.006</td>
</tr>
<tr>
<td>Smoking</td>
<td>1.31</td>
<td>1.19–1.44</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Type 2 diabetes mellitus</td>
<td>1.56</td>
<td>1.4–1.73</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Chronic kidney disease</td>
<td>1.79</td>
<td>1.57–2.05</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Hypertension</td>
<td>1.80</td>
<td>1.59–2.04</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Low fitness</td>
<td>1.91</td>
<td>1.74–2.09</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

All variables are expressed as present/absent with the exception of age. Low fitness defined as <6.0 metabolic equivalents (METs). Model adjusted for age, body mass index, ethnic origin, β-blockers, calcium-channel blockers, angiotensin-converting enzymes, angiotensin receptor blockers, aspirin, diuretics, lipid-lowering agents, hypoglycemic agents, history of smoking, hypertension, diabetes mellitus, chronic kidney failure (stage <4), and HIV/AIDS. CI indicates confidence interval; CAD, coronary artery disease; and HR, hazard ratio.

Table 4. Risk for Developing Heart Failure According to Quintiles of Fitness

<table>
<thead>
<tr>
<th>Fitness Group (Mean METs±SD)</th>
<th>Patients (n)</th>
<th>Unadjusted HR (95% CI)</th>
<th>Age-Adjusted HR (95% CI)</th>
<th>Fully Adjusted HR (95% CI)*</th>
<th>P Value†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Least-fit (4.3±1.3 METs)</td>
<td>4084</td>
<td>1.00 (0.99–1.02)</td>
<td>1.00 (0.99–1.02)</td>
<td>1.00 (0.99–1.02)</td>
<td>…</td>
</tr>
<tr>
<td>Low-fit (6.0±1.2 METs)</td>
<td>4461</td>
<td>0.68 (0.60–0.76)</td>
<td>0.63 (0.56–0.70)</td>
<td>0.64 (0.56–0.72)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Moderate-fit (7.3±1.2 METs)</td>
<td>4148</td>
<td>0.62 (0.55–0.70)</td>
<td>0.61 (0.54–0.69)</td>
<td>0.59 (0.52–0.67)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Fit (8.7±1.4 METs)</td>
<td>4559</td>
<td>0.33 (0.28–0.38)</td>
<td>0.33 (0.29–0.38)</td>
<td>0.36 (0.31–0.42)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>High-fit (11.6±2.5 METs)</td>
<td>3828</td>
<td>0.17 (0.14–0.21)</td>
<td>0.17 (0.14–0.20)</td>
<td>0.25 (0.21–0.31)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

CI indicates confidence interval; HR, hazard ratio; and METs, metabolic equivalents.

*Adjusted for age, body mass index, ethnic origin, sex, β-blockers, calcium-channel blockers, angiotensin-converting enzymes, angiotensin receptor blockers, aspirin, diuretics, lipid-lowering agents, hypoglycemic agents, history of smoking, hypertension, diabetes mellitus, chronic kidney disease (stage <4), and HIV/AIDS.

†For fully adjusted HR.
underscore the message that small increments in exercise capacity yield considerable health outcome benefits in the context of HF prevention.

There are several potential explanations for the lower HF incidence among fitter subjects. Many of the risk factors for CAD and other forms of CVD are the same as those which increase risk for HF, including hypertension, smoking, and diabetes mellitus. Individuals who are relatively fit have a lower risk factor burden when compared with those who are poorly fit, and we generally observed lower fitness and a higher burden of chronic disease among individuals who developed HF (Table 1). Fitter subjects have a marked attenuation in blood pressure trajectory with aging, which could potentially reduce the risk of future HF. Left ventricular compliance is reduced in older individuals, and this can contribute to the development of HF in the elderly. Elderly individuals who are physically active have higher ventricular compliance compared with sedentary individuals. Brinker et al recently studied 2925 men and women from the Cooper Center Longitudinal Study and reported that low fitness was inversely, and independently associated with the incidence of HF in veterans referred for exercise testing. Adding fitness to traditional risk markers significantly reclassifies individuals for risk of developing HF. Even modest levels of fitness have a considerable impact on preventing the development of HF, suggesting the potential for regular physical activity to lower the incidence of HF in later life. Given the growing prevalence of HF and its increasing burden on the US healthcare system, these observations provide an additional impetus for healthcare providers to strengthen the public health message regarding physical activity.

In conclusion, cardiorespiratory fitness is strongly, inversely, and independently associated with the incidence of HF in veterans referred for exercise testing. Adding fitness to traditional risk markers significantly reclassifies individuals for risk of developing HF. Even modest levels of fitness have a considerable impact on preventing the development of HF, suggesting the potential for regular physical activity to lower the incidence of HF in later life. Given the growing prevalence of HF and its increasing burden on the US healthcare system, these observations provide an additional impetus for healthcare providers to strengthen the public health message regarding physical activity.

Table 5. NRI and IDI for Incidence of Heart Failure by Adding Fitness to Standard Risk Factors

<table>
<thead>
<tr>
<th></th>
<th>NRI: Subjects With Events (±SE)</th>
<th>NRI: Subjects Without Events (±SE)</th>
<th>NRI: All Subjects (±SE)</th>
<th>NRI: All Subjects P Value</th>
<th>IDI (±SE)</th>
<th>IDI: All Subjects P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>With Events</td>
<td>−0.27±0.03</td>
<td>0.65±0.01</td>
<td>0.37±0.03</td>
<td>&lt;0.0001</td>
<td>0.03±0.02</td>
<td>0.03±0.02</td>
</tr>
<tr>
<td>Without Events</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Subjects</td>
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</table>

IDI indicates integrated discrimination improvement; and NRI, net reclassification improvement.


**CLINICAL PERSPECTIVE**

It is well established that cardiorespiratory fitness (CRF) is inversely associated with cardiovascular and all-cause mortality, but little is known regarding the association between CRF and incidence of heart failure (HF). Between 1987 and 2014, we assessed CRF in 21 080 HF-free subjects. During average follow-up of over 12 years, 1902 subjects developed HF (9.0%; average annual incidence rate of 7.4 events per 1000 person-years). The results suggest that CRF is strongly, inversely, and independently associated with the incidence of HF and that adding CRF to traditional risk factors significantly reclassifies risk for the development of HF. Each 1-MET increment in CRF was associated with a 19% reduction in risk for developing HF. Adding CRF to traditional risk factors resulted in a net reclassification improvement of 37%. Given both the societal burden and impact of HF on national healthcare expenditures, the demonstration of an inverse association between fitness and the development of HF provides clinicians with further evidence to encourage physical activity among their patients and the public.
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Circ Heart Fail. 2017;10:
doi: 10.1161/CIRCHEARTFAILURE.116.003780
Circulation: Heart Failure is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
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Print ISSN: 1941-3289. Online ISSN: 1941-3297

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