Physical Fitness and Risk for Heart Failure and Coronary Artery Disease

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Background—Multiple studies have demonstrated strong associations between cardiorespiratory fitness and lower cardiovascular disease mortality. In contrast, little is known about associations of fitness with nonfatal cardiovascular events.

Methods and Results—Linking individual participant data from the Cooper Center Longitudinal Study with Medicare claims files, we studied 20,642 participants (21% women) with fitness measured at the mean age of 49 years and who survived to receive Medicare coverage from 1999 to 2009. Fitness was categorized into age- and sex-specific quintiles (Q) according to Balke protocol treadmill time with Q1 as low fitness. Fitness was also estimated in metabolic equivalents according to treadmill time. Associations between midlife fitness and hospitalizations for heart failure and acute myocardial infarction after the age of 65 years were assessed by applying a proportional hazards model to the multivariate failure time data. After 133,514 person-years of Medicare follow-up, we observed 1,051 hospitalizations for heart failure and 832 hospitalizations for acute myocardial infarction. Compared with high fitness (Q4–5), low fitness (Q1) was associated with a higher rate of heart failure hospitalization (14.3% versus 4.2%) and hospitalization for myocardial infarction (9.7% versus 4.5%). After multivariable adjustment for baseline age, blood pressure, diabetes mellitus, body mass index, smoking status, and total cholesterol, a 1 unit greater fitness level in metabolic equivalents achieved in midlife was associated with ≈20% lower risk for heart failure hospitalization after the age of 65 years (men: hazard ratio [95% confidence intervals], 0.79 [0.75–0.83]; P<0.001 and women: 0.81 [0.68–0.96]; P=0.01) but just a 10% lower risk for acute myocardial infarction in men (0.91 [0.87–0.95]; P<0.001) and no association in women (0.97 [0.83–1.13]; P=0.68).

Conclusions—Fitness in healthy, middle-aged adults is more strongly associated with heart failure hospitalization than acute myocardial infarction outcomes decades later in older age. (Circ Heart Fail. 2013;6:627-634.)

Key Words: heart failure ■ myocardial infarction ■ physical fitness

Higher cardiorespiratory fitness (fitness) is a reflection of habitual physical activity in adults.1,2 Fitness is strongly associated with lower cardiovascular disease mortality, with multiple studies demonstrating a consistent, inverse association between fitness and mortality even after adjustment for traditional risk factor burden.3,4 This association persists across the lifespan, with a single measurement of fitness in midlife strongly associated with the lifetime risk for cardiovascular mortality decades later.5 However, the association between fitness and nonfatal cardiovascular events is not well understood,6,10 reflecting the lack of data on nonfatal cardiovascular events among established cohorts with objectively measured fitness levels.

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The mechanism through which low fitness associates with adverse cardiovascular outcomes across the lifespan likely reflects in part the subsequent development of traditional risk factors, such as diabetes mellitus and hypertension.11,12 Although higher fitness is associated with lower levels of subclinical atherosclerosis,13–15 exercise also has measurable, biological effects on cardiovascular structure and function16,17 that are highly responsive to short-term changes in exercise.18,19 In addition, lifelong exercise training seems to limit age-related cardiac stiffening, resulting in a more compliant left ventricle in older age and possibly reducing the risk of heart failure with preserved ejection fraction.17,20 Although much of the focus on the mechanisms of benefit of exercise and fitness have focused on prevention of atherosclerosis and its complications, the specific effects of exercise on cardiac structure and function suggest that low fitness might be particularly important for long-term heart failure risk. Therefore, we hypothesized that lower levels of fitness in healthy, middle-aged adults would be more strongly associated with heart failure hospitalization than with hospitalization for acute myocardial infarction (MI).

In this study, we merged the Cooper Center Longitudinal Study (CCLS) with individual claims data from the Center for...
Medicare and Medicaid Services, allowing for the assessment of the correlation between midlife fitness and the long-term risk for heart failure and acute MI.

Methods
Among 73,439 participants in the CCLS who received a complete clinical examination at the Cooper Clinic in Dallas, TX, between 1970 and 2009, 24,903 were eligible to receive Medicare coverage between 1999 and 2009 as described previously. After excluding 2981 (12%) participants lacking traditional Medicare Fee-for-Service coverage (ie, Medicare Advantage participants lacking claims files), 382 participants with a self-reported prior MI at study entry, 844 participants whose CCLS examination occurred after enrollment into Medicare Fee-for-Service, and 54 participants aged 65 years (ie, Medicare coverage for disability, end-stage renal disease, etc), we were left with a final study sample of 20,642 CCLS participants for the present analysis. No individual was excluded on the basis of his or her performance on the exercise treadmill portion of the examination.

CCLS Clinical Examination
Details of the clinical examination and the study cohort have been published previously. Participants completed a comprehensive clinical examination, which included a self-reported personal and family history, standardized medical examination by a physician, fasting blood levels of total cholesterol, triglycerides, and glucose, as well as a maximal treadmill exercise test. Body mass index was calculated from measured height and weight.

As reported previously, fitness was measured in the CCLS by a maximal treadmill exercise test using a Balke protocol. In this protocol, treadmill speed is set initially at 88 m/min. In the first minute, the grade is set at 0% followed by 2% in the second minute and an increase of 1% for every minute thereafter. After 25 minutes, the grade remains unchanged but the speed is increased 5.4 m/min for each additional minute until the test is terminated. Participants were encouraged not to hold onto the railing and were given encouragement to exert maximal effort. The test was terminated by volitional exhaustion or exertion. The test time using this protocol correlates highly with directly measured maximal oxygen uptake (rs=0.92).

In accordance with standard approaches to the analysis of fitness data, treadmill times were compared with age- and sex-specific normative data on treadmill performance within the CCLS, allowing each individual’s treadmill time to be classified into an age- and sex-specific quintile of fitness. These quintiles of fitness measures were then combined into 3, mutually exclusive fitness groupings: low fitness: quintiles 1 and 2; moderate fitness: quintiles 2 to 3; and high fitness: quintiles 4 to 5. Using well-characterized regression equations, treadmill times from the Balke protocol allow for estimation of fitness level in metabolic equivalents (METs).

Medicare Claims Data
Medicare inpatient claims data were obtained from the Center for Medicare and Medicaid Services (CMS) for surviving participants who were aged 65 years and who were thus eligible for Medicare benefits during the period from 1999—the first year CMS data are currently available for public use—through 2009. CMS data contain 100% of claims paid by Medicare for covered healthcare services. A beneficiary may be tracked over time to elicit a history of all the utilization of healthcare services. Inpatient hospitalization files from CMS provide all individual records for each medical service billed to Medicare, the date of service, primary diagnosis, and secondary diagnoses (ie, International Classification of Diseases [ICD]-9 code), procedure (ICD-9 procedure code), beneficiary demographic information, and numerous additional data.

In accordance with standard approaches, heart failure hospitalization was defined as a primary diagnosis of heart failure as indicated by ICD-9 codes 428, 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, and 404.93. Acute MI was defined as the primary or secondary hospitalization as indicated by ICD-9 codes 410.0 to 410.9.

Statistical Analyses
The data contain Medicare claims on all CCLS patients who were aged 65 years during the period 1999–2009. The data are subject to censoring on the right and the left, with the possibility of multiple events per patient. Because of the unique structure of the Medicare claims files, we used attained age as the time scale. We estimated the association between fitness and hospitalization for acute MI or heart failure by applying a proportional hazards model to the multivariate failure time data, as described by Prentice et al. To assess the association between fitness and either heart failure or MI, participants were allowed to transition through multiple states: from healthy to heart failure, from healthy to acute MI, and from acute MI to heart failure, where healthy was defined as the absence of any prior hospitalization for heart failure or acute MI. Separate risk sets were maintained for each possible transition. So, for example, a healthy participant was included in the risk set for transition to heart failure and the risk set for transition to MI until either of these events or a censoring event occurred. We used the robust sandwich estimate of the covariance matrix to account for correlation of score residuals of the same participant in different strata. As noted below, only 10% of heart failure cases were associated with antecedent MI resulting in limited statistical power for this analysis, particularly in women. Therefore, we do not report the association between fitness and the transition from acute MI to heart failure.

Men and women were analyzed separately for each outcome in models adjusted for age, baseline fitness, systolic blood pressure, diabetes mellitus (yes/no), current smoking (yes/no), total cholesterol, and body mass index. In all analyses, death obtained from Medicare claims files was treated as a censoring event.

To assess the association between midlife fitness levels and risk for cardiovascular events across time, we constructed Kaplan–Meier curves for each outcome separately in both men and women with age as the time scale. Failure was defined as the development of a heart failure hospitalization or acute MI hospitalization in separate analyses. To compare the association between fitness levels measured at particular ages in midlife and subsequent heart failure risk, we stratified the analysis according to the age at which fitness was measured (ie, age 40–49, 50–59, and 60–69 years). Finally, to determine the effects of absolute fitness differences in early middle-age, we compared the distribution of fitness levels measured at age 40 to 49 years between those with and without a subsequent hospitalization for heart failure at age 265 years. We compared these distributions in men and women separately using the rank-sum test. All statistical analyses were performed using SAS for Windows (release 9.2; SAS Institute, Inc, Cary, NC).

Results
Baseline characteristics for the study sample demonstrate a low level of traditional risk factors at entry into the CCLS in both men and women (Table 1). As expected, both estimated fitness levels and the level of most traditional risk factors were higher in men compared with women. In both men and women, higher fitness levels were associated with lower levels of all traditional risk factors.

After 133,514 person-years of Medicare exposure time, we observed 1051 heart failure hospitalizations and 832 hospitalizations for acute MI among 20,642 participants in the CCLS-Medicare cohort. In both men and women, heart failure hospitalization after acute MI represented a minority of heart failure hospitalization events (men, 9.6%; women, 11.3%).

There were significant differences in the observed event rates of each outcome according to baseline fitness level (Table 2).
In both men and women, compared with low fitness measured at baseline, the presence of high fitness was associated with ≈3-fold gradient in heart failure hospitalization rates (hazard ratio [95% confidence interval], 0.31 [0.24–0.41] and 0.38 [0.20–0.71] in men and women, respectively). In contrast, there was <1-fold gradient in risk for acute MI hospitalization (0.56 [0.43–0.71] and 0.62 [0.33–1.17] in men and women, respectively; Table 2 and Figures 1 and 2). When these data were stratified by age at entry, we observed a similar pattern of results across all quintiles of fitness levels measured at ages 40 to 49, 50 to 59, and 60 to 69 years (Figure 3).

There were significant differences in the distribution of fitness levels measured in early middle-age (ie, age 40–49 years) between participants who did and did not develop heart failure at age ≥65 years. In particular, we observed a difference of 2 METs at age 40 to 49 years between those who did and did not develop heart failure at age ≥65 years (men: 10.3 versus 12.3 METs; women: 7.6 versus 9.7 METs; Figure 4; P<0.001 for both).

After multivariable adjustment, low fitness remained strongly associated with heart failure risk in both men and women. In contrast, the association between low fitness and acute MI was less

Table 1. Baseline Characteristics According to Category of Baseline Fitness From Data Acquired at the Baseline Clinical Examination

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fitness Quintile 1 (n=3011)</td>
<td>Fitness Quintiles 2–3 (n=6851)</td>
</tr>
<tr>
<td></td>
<td>Fitness Quintiles 4–5 (n=6441)</td>
<td>Fitness Quintiles 1 (n=600)</td>
</tr>
<tr>
<td></td>
<td>Fitness Quintiles 2–3 (n=1631)</td>
<td>Fitness Quintiles 4–5 (n=2108)</td>
</tr>
<tr>
<td>Baseline age in CCLS, y</td>
<td>46.0 (8.5)</td>
<td>49.1 (8.6)</td>
</tr>
<tr>
<td>Age at Medicare entry, y</td>
<td>67.7 (4.8)</td>
<td>68.0 (4.9)</td>
</tr>
<tr>
<td>Median (25th percentile–75th percentile) age at Medicare entry*</td>
<td>65 (65–69)</td>
<td>65 (65–69)</td>
</tr>
<tr>
<td>Systolic blood pressure, mm Hg</td>
<td>124.7 (14.6)</td>
<td>122.6 (14.1)</td>
</tr>
<tr>
<td>Total cholesterol, mg/dL</td>
<td>221.9 (41.5)</td>
<td>216.4 (39.5)</td>
</tr>
<tr>
<td>Body mass index, kg/m²</td>
<td>28.6 (4.5)</td>
<td>26.6 (3.2)</td>
</tr>
<tr>
<td>Smokers, %</td>
<td>31.2</td>
<td>19.3</td>
</tr>
<tr>
<td>Diabetes mellitus, %</td>
<td>5.5</td>
<td>2.9</td>
</tr>
<tr>
<td>METs</td>
<td>8.4 (1.2)</td>
<td>10.3 (1.2)</td>
</tr>
</tbody>
</table>

Data presented as mean (SD) or % except as noted. CCLS indicates Cooper Center Longitudinal Study; and METs, metabolic equivalents.

*Data presented as median (25th percentile–75th percentile).

In both men and women, compared with low fitness measured at baseline, the presence of high fitness was associated with ≈3-fold gradient in heart failure hospitalization rates (hazard ratio [95% confidence interval], 0.31 [0.24–0.41] and 0.38 [0.20–0.71] in men and women, respectively). In contrast, there was <1-fold gradient in risk for acute MI hospitalization (0.56 [0.43–0.71] and 0.62 [0.33–1.17] in men and women, respectively; Table 2 and Figures 1 and 2). When these data were stratified by age at entry, we observed a similar pattern of results across all quintiles of fitness levels measured at ages 40 to 49, 50 to 59, and 60 to 69 years (Figure 3).
prominent (Table 2). When fitness was analyzed as a continuous variable (ie, per MET), we observed a similar pattern of results. Although diabetes mellitus, systolic blood pressure, and higher body mass index were all associated with heart failure risk in both men and women, the association between body mass index and future heart failure risk seemed more prominent in women (hazard ratio [95% confidence intervals], 1.24 [1.03–1.49]) compared with men (1.11 [1.01–1.22]). Similar findings were observed for diabetes mellitus and future risk for heart failure hospitalization, with more prominent associations for women (3.74 [1.57–8.92]) compared with men (1.71 [1.25–2.34]).

Discussion

In this study, lower fitness in healthy, middle-aged adults was associated with a marked increase in risk for heart failure hospitalization in later life. In addition, the magnitude of the association between low fitness and heart failure hospitalization was nearly twice that observed for the association between fitness and acute MI. Finally, the association between fitness and heart failure was particularly prominent for fitness levels measured in early middle-age, suggesting that heart failure in the elderly is associated with low levels of fitness throughout middle age. These findings suggest the potential contribution of exercise training in midlife for the prevention of heart failure in the elderly.

Our findings could have important public health implications. Heart failure affects an estimated 5.8 million people and accounts for an estimated annual healthcare cost of $34.8 billion. Heart failure is predominantly a disease of the elderly with >80% of all heart failure admissions occurring in those individuals aged >65 years. In contrast to the marked decrease in the burden of coronary artery disease, the prevalence of heart failure remains relatively unchanged, reflecting diverse epidemiological trends, such as the aging population.

However, other than blood pressure treatment, relatively few strategies have been proposed for the prevention of heart failure in the elderly. In the present study, we observed that fitness levels measured in early middle-age were strongly associated with heart failure risk decades later in older age. Furthermore, these differences in midlife fitness levels were not insignificant. For example, men and women with heart failure at age...
Association between midlife fitness and heart failure risk in older age. Multiple studies have observed that the heart stiffens with advanced age, resulting in decreased left ventricular compliance, and contributing to the development of heart failure with preserved ejection fraction in the elderly. However, individuals aged >65 years who report lifelong endurance training have higher left ventricular compliance compared with sedentary older adults. Furthermore, exercise training among sedentary older adults is beneficial in increasing fitness but translates into only trivial differences in left ventricular compliance. Thus, exercise training throughout midlife seems to attenuate the age-related decrease in left ventricular compliance, potentially decreasing the risk for heart failure with preserved ejection fraction in later life.

The association between low levels of fitness and an increased risk for both cardiovascular and noncardiovascular disease death is well established. However, the association between low physical fitness and nonfatal events is less well understood because few datasets with measured physical fitness have followed participants for nonfatal outcomes. In a smaller study of 1166 men from the Kuopio Ischemic Risk Factor Study, higher levels of fitness were associated with a lower risk for acute MI (44 total events). In another study, Sui et al showed association between fitness and nonfatal cardiovascular events using Cooper clinic database. However, this prior analysis focused on atherosclerotic cardiovascular disease events (MI, stroke, and revascularization) and used mailed back health survey responses to identify primary end point events. In the present study, we include 20642 healthy men and women with objectively measured fitness and with 832 acute MI hospitalizations and 1052 heart failure hospitalizations after long-term follow-up. Therefore, the present study represents a substantial contribution to the available literature on the association between fitness and nonfatal cardiovascular events, providing novel insights into the contribution of low fitness in midlife to cardiovascular risk at older ages.

Our findings are consistent with observational studies that have reported an independent association between self-reported physical activity and the subsequent risk of coronary artery disease and heart failure. We extend these prior observations in several notable ways. First, we compare the association between low fitness, rather than self-reported physical activity, and subsequent risk for nonfatal cardiovascular events, providing an opportunity to compare the relative contribution of low fitness with both atherosclerotic and nonatherosclerotic cardiovascular outcomes. Second, because of our sample size and long-term follow-up, we were able to estimate separately the association between fitness levels measured at midlife and both atherosclerotic and nonatherosclerotic nonfatal cardiovascular events decades later.

Several important limitations of our study should be acknowledged. First, participants in the CCLS represent a sample of well-educated individuals with a relatively high socioeconomic status and overall high level of fitness compared with the general population. However, we have recently shown that the association between traditional risk factor burden and lifetime risk observed in this study was strikingly similar to those obtained from a large, more representative
Thus, although the levels of risk factors are lower than the general population, the effects of these risk factors are strikingly similar.

Second, we merged individual-level data with Medicare claims files to compare the association between fitness and cardiovascular outcomes at age 265 years. We were not able to capture cardiovascular outcomes that occurred between study entry and the onset of Medicare eligibility. Nevertheless, this approach has been used by other investigators in a parallel context, providing novel insight into the contribution of traditional risk factors and other Medicare outcomes. Importantly, we observed a similar pattern of results for fitness levels measured in early life (ie, age 40 years) as well as in later life (ie, age 60 years) and closer to Medicare eligibility, suggesting that the association between fitness and nonfatal events is insensitive to the time interval between fitness ascertainment and Medicare eligibility.

Third, additional factors such as medication use were not included in our analysis because these data are limited in the CCLS. Although adjustment for this additional covariate may have influenced the association of fitness with risk of heart failure and MI, we think that the healthy nature of our cohort, exclusion of subjects with significant cardiovascular events at study entry and the onset of Medicare eligibility, and long duration of follow-up minimize the effect of missing medication data.

Fourth, because much of our data is derived from the 1970s, we do not have high-density lipoprotein-cholesterol and low-density lipoprotein-cholesterol on as many participants as we have total cholesterol measurements. Prior literature suggests a more limited contribution of high-density lipoprotein-cholesterol to risk prediction for cardiovascular disease mortality. Furthermore, because our primary objective was to compare the association between fitness and nonfatal events across long periods of follow-up, we elected to use total cholesterol in our multivariable-adjusted model so as to include participants from the beginning of the CCLS where low-density lipoprotein and high-density lipoprotein data are more limited. Finally, we used diagnoses from Medicare claims files rather than adjudicated clinical outcomes and, therefore, some events might not have been captured or might have been misclassified. However, measurement error tends to bias toward the null and encouragingly, the association between fitness and nonfatal cardiovascular events were present, despite the use of administrative data. Also, the use of administrative data for the study of heart failure hospitalization and acute MI is well established. Furthermore, nearly all prior studies on the association between fitness and cardiovascular outcomes are derived from administrative data (ie, the National Death Index). In the present study, we have extended this prior approach by linking the CCLS with an additional source of administrative data, providing a novel and cost-effective approach to the study of fitness in healthy adults that would not be possible otherwise.

In summary, we observed that fitness in healthy, middle-aged adults was more strongly associated with heart failure hospitalization than with coronary artery disease outcomes in later life. These findings suggest the importance of midlife fitness levels and subsequent heart failure risk in later life.

Disclosures
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References


Physical activity and cardiorespiratory fitness are important determinants of long-term cardiovascular disease mortality. Multiple studies have shown a strong and consistent association between a single measurement of fitness in midlife and risk of cardiovascular disease mortality decades later. However, limited data exist on the association between midlife fitness and nonfatal cardiovascular disease events, such as hospitalization for heart failure and myocardial infarction at a later age. The aim of this study was to determine the association between midlife physical fitness levels and the long-term risk for heart failure and acute myocardial infarction using data from Cooper Center Longitudinal Study participants linked to Medicare utilization data. We found that low midlife fitness was associated with a significantly higher risk for heart failure hospitalization and acute myocardial infarction at a later age. Moreover, the magnitude of the association between low fitness and heart failure hospitalization was nearly twice that observed for the association between fitness and acute myocardial infarction. These findings highlight the importance of heart failure risk in the pathway from low fitness to cardiovascular disease mortality. Further research is warranted to determine the biological mechanisms through which fitness in middle-age might influence heart failure risk in the elderly.

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