Impact of Atrial Fibrillation on Exercise Capacity in Heart Failure With Preserved Ejection Fraction
A RELAX Trial Ancillary Study

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Background—Atrial fibrillation (AF) is common among patients with heart failure and preserved ejection fraction (HFpEF), but its clinical profile and impact on exercise capacity remain unclear. RELAX (Phosphodiesterase-5 Inhibition to Improve Clinical Status and Exercise Capacity in HFpEF) was a multicenter randomized trial testing the impact of sildenafil on peak VO2 in stable outpatients with chronic HFpEF. We sought to compare clinical features and exercise capacity among patients with HFpEF who were in sinus rhythm (SR) or AF.

Methods and Results—RELAX enrolled 216 patients with HFpEF, of whom 79 (37%) were in AF, 124 (57%) in SR, and 13 in other rhythms. Participants underwent baseline cardiopulmonary exercise testing, echocardiogram, biomarker assessment, and rhythm status assessment before randomization. Patients with AF were older than those in SR but had similar symptom severity, comorbidities, and renal function. β-blocker use and chronotropic indices were also similar. Despite comparable left ventricular size and mass, AF was associated with worse systolic (lower EF, stroke volume, and cardiac index) and diastolic (shorter deceleration time and larger left atria) function compared with SR. Pulmonary artery systolic pressure was higher in AF. Patients with AF had higher N-terminal pro-B-type natriuretic peptide, aldosterone, endothelin-1, troponin I, and C-telopeptide for type I collagen levels, suggesting more severe neurohumoral activation, myocyte necrosis, and fibrosis. Peak VO2 was lower in AF, even after adjustment for age, sex, and chronotropic response, and V̇E/V̇CO2 was higher.

Conclusions—AF identifies an HFpEF cohort with more advanced disease and significantly reduced exercise capacity. These data suggest that evaluation of the impact of different rate or rhythm control strategies on exercise tolerance in patients with HFpEF and AF is warranted.

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Key Words: atrial fibrillation ■ exercise ■ heart failure

Atrial fibrillation (AF) and heart failure (HF) commonly coexist and the presence of each worsens the outcome of the other.1 The prevalence of AF in HF with preserved left ventricular ejection fraction (HFpEF; LVEF≥50%) is similar to that observed in patients with HF and reduced EF (HFrEF).2 In HFrEF, patients with AF have worse exercise capacity than those in sinus rhythm (SR),3 and small studies suggest that rhythm control improves exercise capacity.4–6 However, patients with HFpEF have been under-represented in AF studies and it remains unclear whether the presence of AF further compromises exercise performance in HFpEF. Likewise, there is limited information on the profile of the patient with HFpEF and AF, particularly in stringently defined HFpEF subjects with truly normal LVEF.7

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The RELAX (Phosphodiesterase-5 Inhibition to Improve Clinical Status and Exercise Capacity in HFpEF) trial enrolled 216 patients with HFpEF who met rigorous entry criteria designed to ensure the presence of HF and cardiac limitation to exercise.8 Rhythm status, echocardiography, biomarker assessment, and cardiopulmonary exercise testing (CPXT) were performed at baseline. We hypothesized that HFpEF patients with AF would display more advanced HF and greater
impairment of exercise capacity when compared with HFpEF patients in SR. As HFpEF is associated with chronotropic incompetence,\(^9\) while patients with AF display an increased heart rate (HR) response during exercise,\(^10\) we also evaluated the relationship between rhythm status and chronotropic response during exercise in HFpEF.

**Methods**

RELAX was a multicenter randomized (1:1) placebo-controlled trial testing the impact of chronic PDE5 (phosphodiesterase 5) inhibition (sildenafil) on exercise capacity in patients with HFpEF.\(^6\) The trial was conducted by the Heart Failure Clinical Research Network (HFN) and funded by the National Heart, Lung, and Blood Institute. All patients provided written informed consent and the trial was approved by the institutional review board at each participating site. Notably, sildenafil did not improve exercise capacity in HFpEF patients in RELAX and there was no evidence of an interaction between sildenafil and rhythm status.\(^8\)

**Study Participants**

RELAX enrolled patients with objective evidence of HF, LVEF≥50%, reduced exercise capacity, as evidenced by reduced (≤50% predicted) peak oxygen consumption (peak VO\(_2\)) at screening CPXT\(^11\) and evidence of elevated filling pressures (elevated pulmonary capillary wedge pressure measured invasively or N-terminal pro-B-type natriuretic peptide ≥400 pg/mL). Additional entry criteria have been reported previously.\(^3\) Rhythm status was classified as rhythm present on baseline electrocardiography. A history of AF was also recorded.

**Baseline Studies**

The RELAX study design has been reported previously.\(^6,8,12\) Pertinent to this analysis, patients underwent baseline transthoracic echocardiography performed according to a standard protocol\(^11\) with measurements performed at the HFN echocardiography core laboratory (Mayo Clinic, Rochester, MN). Values reported in AF represent an average of 3 to 5 beats. Plasma biomarker measurement included markers of neurohumoral activation (aldosterone, N-terminal pro-B-type natriuretic peptide, endothelin-1), cardiac injury or inflammation (troponin I, C-reactive peptide), renal function (cystatin C, uric acid), and fibrosis (procollagen III N-terminal peptide [NT-procollagen III], galectin 3, C-telopeptide for type I collagen). Assays were performed at the HFN biomarker core laboratory (University of Vermont, Burlington, VT).\(^12\) Details of the RELAX CPXT protocol and HFN CPXT core laboratory (Massachusetts General Hospital, Boston, MA) methodologies have been reported.\(^12\)

Briefly, symptom-limited CPXT with simultaneous expired ventilatory gas analysis was performed by treadmill or bicycle ergometry. Percent-predicted peak VO\(_2\) was calculated according to published age and sex-normalized values.\(^11\) Age, sex, body weight, and mode-specific predicted peak VO\(_2\) was also calculated using the Wasserman equation.\(^14,15\) Entry criteria specified maximal effort as evidenced by a peak respiratory exchange ratio>1.0. The ventilatory anaerobic threshold was determined by the V-slope method.\(^16\) Peak oxygen pulse, reflecting oxygen consumption per heart beat during exercise, was obtained from the ratio of peak VO\(_2\) to peak exercise HR. Peak circulatory power was defined as the product of peak VO\(_2\) and peak systolic blood pressure, while circulatory stroke work was derived from the ratio of circulatory power to peak exercise HR.\(^17\) The VO\(_2\) VCO\(_2\) slope for the entire duration of exercise was calculated based on 10 s averaged \(V_O^e\) (L/min) and \(V_CO^e\) (L/min) data.\(^18\)

Resting HR was documented after 5 minutes in a stationary position before CPXT. Peak HR was defined as HR at peak VO\(_2\). Chronotropic response was expressed as the change in HR from rest to peak exercise. Age-predicted maximal HR was defined with the Astrand (220-age),\(^19\) and Brawner (164−[0.7xage])\(^20\) formulae, and each used to calculate a chronotropic index (CI) reflecting the percentage of HR reserve used (change in HR from rest to peak exercise/age-predicted maximal HR minus resting HR). Clinically significant chronotropic incompetence was defined as a CI <0.8 for patients not taking \(\beta\)-blockers and <0.62 in patients reporting active \(\beta\)-blocker use (Astrand formula). No \(\beta\)-blocker correction was used for chronotropic incompetence defined by the Brawner formula. HR recovery was taken as the absolute difference in HR between peak exercise and at 1 minute during exercise unloading or cessation. A HR recovery ≤18 bpm was considered abnormal.\(^21\)

**Statistical Analysis**

Continuous data are presented as mean±SD or median (25th–75th percentiles) as appropriate; categorical data are presented as frequency (%) within each group (AF versus SR). Baseline characteristics and CPXT parameters for the RELAX study population stratified by rhythm status were compared using the t test or Wilcoxon rank-sum test for continuous variables, and \(\chi^2\) test for categorical variables. Univariable and multivariable linear regression analyses for prespecified pertinent variables were performed to define the association between rhythm status and peak VO\(_2\). To adjust for the pathophysiological role of chronotropic response to exercise, a linear regression model was used to examine the relationship between CI and peak VO\(_2\) or peak workload with an interaction term included for rhythm status, thereby comparing the slope of the VO\(_2\)-CI or workload-CI relationship between patients in AF and SR. Normality of model residuals was tested using the Kolmogorov–Smirnov test and visually assessed for symmetry. Analyses were performed using SAS version 9.2; \(P<0.05\) (2-sided) was considered statistically significant.

**Results**

**Patient Characteristics**

RELAX enrolled 216 patients with HFpEF (mean age, 69±10 years; 48% women) of whom 79 (37%) had AF, 124 (57%) were in SR, and 13 (6%) were in other rhythms (excluded from this analysis). Patients in AF were older than those in SR, but had similar reported symptom severity (New York Heart Association class, Minnesota living with heart failure questionnaire total score), distribution of comorbidities, hemoglobin, and renal function (Table 1). Loop diuretic and digoxin therapy were more frequent, angiotensin-converting enzyme inhibitor or angiotensin receptor blocker use was less frequent, and \(\beta\)-blocker use was similar among patients in AF when compared with those in SR.

LV dimensions and LV mass index were comparable between AF and SR; however, AF was associated with worse systolic function at rest (lower LVEF, stroke volume, endocardial, and midwall fractional shortening). Although E/e' was similar between groups, other parameters of LV diastolic function were significantly worse in AF (shorter deceleration time, higher right atrial pressure, and larger left atrial volume index). Pulmonary artery systolic pressures were also higher in AF. Neurohumoral activation was more severe in AF relative to SR (elevated plasma N-terminal pro-B-type natriuretic peptide, aldosterone, and endothelin-1; Figure 1). Troponin I levels were higher in AF than in SR, consistent with greater myocardial necrosis (Figure 1). Plasma markers of fibrosis (NT-procollagen III, C-telopeptide for type I collagen, and galectin 3) were higher in AF than in SR, consistent with greater myocardial necrosis (Figure 1). Plasma markers of fibrosis (NT-procollagen III, C-telopeptide for type I collagen, and galectin 3) were higher in AF than in SR; however, only C-telopeptide for type I collagen reached statistical significance (Table 1).

**Exercise Performance**

Fewer patients in AF performed bicycle ergometry (52% AF versus 68% SR; \(P=0.02\)). Both groups performed a maximal
Continuous variables are shown as mean±SD (median [25th–75th percentiles] for biomarkers); categorical variables are shown as count (percentage).

Resting VO2 was higher in patients with AF when compared to patients in SR. However, peak VO2, scaled to body mass (standard), was significantly reduced in AF and confirmed by a lower percent-predicted peak VO2 (Wasserman formula; Table 2). The most common reason for exercise cessation was dyspnea in AF (49% AF versus 37% SR) and fatigue among patients in SR (31% AF versus 52% SR). Exercise duration was shorter for AF than for SR (mean, 9.0 versus 10.1 min; P=0.02) but not after age–sex adjustment (P=0.14).

Resting VO2 was higher in patients with AF when compared to patients in SR. However, peak VO2, scaled to body mass (standard), was significantly reduced in AF and confirmed by a lower percent-predicted peak VO2 (Wasserman formula; Table 2). VO2 at ventilatory anaerobic threshold tended to be lower in AF although as a proportion of peak VO2 was similar between groups. Peak exercise workload was also lower in AF relative to SR. On multivariable analysis, AF was associated with a reduced peak VO2 even after adjustment for age, sex, LVEF, and exercise modality (Table 3).

Minute ventilation was similar in AF and SR but the VE/VCO2 slope was elevated in AF. Even after age–sex adjustment, patients with AF demonstrated a significantly reduced peak exercise systolic blood pressure (P<0.0001; Table 3). Patients with AF had lower pulse pressure, lower circulatory power, and stroke work; O2 pulse was also or tended to be lower (Table 3). Six-minute walk distance, representing submaximal exercise capacity, also displayed a lower trend in AF versus SR (Table 2).

HRs at rest and at peak exercise were similar between patients in AF and in SR (Table 2; Figure 2A). Likewise, despite a lower mean age-predicted maximal HR (Astrand/Brawner formula) for patients with AF, the chronotropic response as reflected by the CI (Table 2) and the prevalence of chronotropic incompetence (Figure 2B) were equal between groups. Albeit a majority of patients reported β-blocker use (Table 1), the median CI was similar among patients with AF with and without β-blockers (0.85 versus 0.9; P=0.90), and higher in patients in SR on β-blockers compared with those without (0.74 versus 0.42; P<0.0001). The relationship between peak VO2 or peak workload and CI did not differ between HFpEF patients in AF or SR (Figure 2C and 2D), and AF remained associated with a lower peak VO2 even after adjustment for CI (Table 3).
Although a majority of patients with HFpEF had abnormal HR recovery consistent with autonomic dysfunction, the severity of impaired HR recovery was similar between groups.

**Discussion**

This analysis of the RELAX HFpEF cohort demonstrates that important phenotypic differences exist between HFpEF patients with and without AF and is the first comprehensive analysis of the impact of AF on exercise capacity in HFpEF. Consistent with our hypothesis, HFpEF patients in AF were older and exhibited worse LV systolic and diastolic function at rest, more severe neurohumoral activation, and greater impairment of exercise capacity compared with HFpEF patients in SR. Peak VO2 was lower in AF, despite adjustment for pertinent variables, and was not accompanied by a higher chronotropic response as has been seen in patients with HFrEF and AF. Ventilatory efficiency was lower (steeper V̇E/V̇CO2 relationship) in AF, suggesting greater impairment of pulmonary perfusion during exercise. Peak exercise systolic blood pressure, circulatory power, and circulatory stroke work were lower and peak O2 pulse tended to be lower in AF, suggesting impaired systolic reserve function. These findings demonstrate that mechanisms beyond altered chronotropic response mediate the more impaired exercise tolerance in patients with HFpEF and AF and suggest that AF is a marker of a more advanced HFpEF phenotype.

In patients with HFrEF, AF is associated with more severe symptoms and LV systolic impairment. In HFrEF, a rhythm control strategy does not result in better outcomes than rate control, and β-blockers may have reduced pharmacological efficacy contrary to established benefits for patients in SR.

Importantly, characteristics associated with AF in HFpEF are less well documented, despite the high prevalence of AF in HFpEF and evidence of equivalent or perhaps stronger association with morbidity and mortality in HFpEF than in HFrEF. Existing studies are highly discrepant, have limited phenotypic characterization, and enrolled patients during a hospitalization for HF which may not accurately reflect the HFpEF population at large. Although the CHARM-Preserved trial studied stable HFpEF outpatients with and without AF, the prevalence of coronary artery disease was higher than typically observed in HFpEF, and HFpEF was defined by a LVEF >40%, thereby including patients with potential HFrEF pathophysiology.

RELAX enrolled stable patients with chronic HFpEF in SR and AF, ≥3 months out from any HF hospitalization, exhibiting a LVEF ≥50% consistent with current diagnostic criteria. In this setting, AF was associated with older age and worse LV systolic and diastolic function, mirroring observations in HFrEF but contrary to sparse available data in HFpEF and AF, where systolic function (LVEF) has been reported as similar to SR. Furthermore, in contrast to the findings of Linssen et al, and perhaps because of the exclusion of patients with LVEF 40%–49%, we found N-terminal pro-B-type natriuretic peptide to be significantly elevated in AF relative to patients with HFpEF-SR. This corroborates baseline findings in the I-Preserve population and may pertain to AF or more severe HF in patients with HFpEF-AF. More severe HF is also suggested by elevation in other heretofore unstudied biomarkers of HF severity in patients with HFpEF-AF (aldosterone, endothelin-1, and troponin I), greater diuretic use, and a lower cardiac index. A higher resting V̇O2 was observed in AF which,

Figure 1. Biomarkers of neurohumoral activity in patients with heart failure and preserved ejection fraction in atrial fibrillation and sinus rhythm. A, Plasma N-terminal pro-B-type natriuretic peptide (NT-proBNP). B, Aldosterone. C, Endothelin-1. D, Troponin I. E, Uric acid. F, C-reactive protein. White bars (atrial fibrillation), black bars (sinus rhythm). Median (75th percentile) is shown.
Table 2. Cardiopulmonary Exercise Test Data

<table>
<thead>
<tr>
<th>Variable</th>
<th>Atrial Fibrillation (n=79)</th>
<th>Sinus Rhythm (n=124)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exercise duration, min</td>
<td>9.0±3.0</td>
<td>10.1±3.0</td>
<td>0.02</td>
</tr>
<tr>
<td>6MWD, m</td>
<td>283±107</td>
<td>313±109</td>
<td>0.055</td>
</tr>
<tr>
<td>Rest V$\text{O}_2$, mL/kg per min</td>
<td>3.1±0.6</td>
<td>2.9±0.8</td>
<td>0.049</td>
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<tr>
<td>Rest pulse pressure, mm Hg</td>
<td>51±15</td>
<td>59±19</td>
<td>0.001</td>
</tr>
<tr>
<td>Peak RER</td>
<td>1.1±0.1</td>
<td>1.1±0.1</td>
<td>0.62</td>
</tr>
<tr>
<td>Peak Borg score</td>
<td>6.8±2.5</td>
<td>6.8±2.3</td>
<td>0.91</td>
</tr>
<tr>
<td>Peak SBP, mm Hg</td>
<td>138±30</td>
<td>163±29</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Peak DBP, mm Hg</td>
<td>69±14</td>
<td>74±15</td>
<td>0.02</td>
</tr>
<tr>
<td>Peak pulse pressure, mm Hg</td>
<td>69±26</td>
<td>89±24</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Peak V$\text{O}_2$, mL/kg per min</td>
<td>11.7±2.7</td>
<td>12.8±3.2</td>
<td>0.008</td>
</tr>
<tr>
<td>V$\text{O}_2$ at VAT, mL/kg per min</td>
<td>7.2±1.8</td>
<td>7.7±1.9</td>
<td>0.07</td>
</tr>
<tr>
<td>V$\text{O}_2$ at VAT (% of peak V$\text{O}_2$)</td>
<td>62.6±9.2</td>
<td>60.6±8.6</td>
<td>0.12</td>
</tr>
<tr>
<td>% Age–sex predicted V$\text{O}_2$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wasserman, %</td>
<td>63.6±14.2</td>
<td>68.8±16.0</td>
<td>0.02</td>
</tr>
<tr>
<td>Standard, %</td>
<td>40.4±8.6</td>
<td>42.8±9.6</td>
<td>0.11</td>
</tr>
<tr>
<td>Peak O$_2$ pulse, mL/kg per bpm</td>
<td>0.11±0.03</td>
<td>0.12±0.03</td>
<td>0.07</td>
</tr>
<tr>
<td>Peak O$_2$ pulse, mL/bpm</td>
<td>10.5±3.2</td>
<td>11.6±4.3</td>
<td>0.04</td>
</tr>
<tr>
<td>Peak circulatory power, mm Hg/mL/kg per min</td>
<td>1644±588</td>
<td>2109±751</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Circulatory stroke work, mm Hg/mL/kg per bpm</td>
<td>15.5±5.7</td>
<td>19.4±6.1</td>
<td>&lt;0.0001</td>
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<tr>
<td>Peak workload, Watts</td>
<td>67±29</td>
<td>77±32</td>
<td>0.03</td>
</tr>
<tr>
<td>Peak VO$_2$, mL/kg per min</td>
<td>12.8±3.3</td>
<td>14.1±3.8</td>
<td>0.01</td>
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<td>Peak VE, L/min</td>
<td>43.6±12</td>
<td>47.0±16.0</td>
<td>0.12</td>
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<tr>
<td>VE/VO$_2$ slope</td>
<td>35.1±7.2</td>
<td>32.6±8.1</td>
<td>0.03</td>
</tr>
<tr>
<td>Chronotropic indices</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rest HR (pre-exercise)</td>
<td>72±12</td>
<td>69±14</td>
<td>0.14</td>
</tr>
<tr>
<td>Peak HR, bpm</td>
<td>109±27</td>
<td>111±24</td>
<td>0.69</td>
</tr>
<tr>
<td>Chronotropic response, bpm</td>
<td>37±23</td>
<td>42±20</td>
<td>0.17</td>
</tr>
<tr>
<td>Age-predicted maximal HR, bpm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Astrand formula*</td>
<td>147±9</td>
<td>154±10</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Brawner formula†</td>
<td>113±6</td>
<td>118±7</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Chronotropic index</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Astrand formula*</td>
<td>0.51±0.34</td>
<td>0.50±0.25</td>
<td>0.73</td>
</tr>
<tr>
<td>Brawner formula†</td>
<td>1.10±1.08</td>
<td>0.92±0.61</td>
<td>0.19</td>
</tr>
<tr>
<td>HRR, bpm</td>
<td>11±15</td>
<td>10±9</td>
<td>0.51</td>
</tr>
<tr>
<td>HRR≤18 bpm, n (%)</td>
<td>55 (73)</td>
<td>94 (83)</td>
<td>0.14</td>
</tr>
</tbody>
</table>

6MWD indicates 6 minute walk distance; DBP, diastolic blood pressure; HR, heart rate; HRR, absolute heart rate recovery at 1 min post exercise; RER, respiratory exchange ratio; SBP, systolic blood pressure; VAT, ventilatory anaerobic threshold; V$\text{O}_2$, carbon dioxide output; VE, minute ventilation; VE/VO$_2$, slope of the relationship between minute ventilation and carbon dioxide output; and V$\text{O}_2$, oxygen consumption.

Continuous variables are shown as mean±SD; categorical variables are shown as count (percentage).

*220–age.19
†164–[0.7×age].20

as in HFrEF, may signify increased resting energy demands or hypermetabolism corresponding to increased HF severity.31,32 These findings support the rationale for aggressive upstream therapy addressing the atrial substrate in patients with HF and AF, which is currently under investigation.33

AF has been associated with reduced functional capacity in HFrEF22 and in patients without structural heart disease34; however, prior studies of exercise tolerance in HFrEF have mostly excluded patients with AF.35,36 Similarly, HFrEF has been under-represented in AF intervention trials;12,14,37 thus the impact of AF on exercise capacity and cardiopulmonary function during exercise in HFrEF remains unclear. Fung et al23 reported the mean 6MWD to be lower in hospitalized HFpEF patients with AF (279±66 m; n=42) when compared with patients in SR (338±86 m; n=104): however, formal cardiopulmonary stress testing was not performed. In the present analysis, we confirm and extend this observation in several respects.

Our novel principal finding is that, compared with SR, HFpEF patients with AF have a lower peak V$\text{O}_2$, both in absolute terms and relative to age, sex, body-size, and exercise mode–adjusted predicted values. Furthermore, we demonstrate that the impaired exercise capacity in AF is not explained by differences in resting LVEF or altered chronotropic response, suggesting a specific effect of AF on cardiac reserve. Rhythm irregularity38 and loss of atrial contribution to LV filling 39 are differences in resting LVEF or altered chronotropic response, a greater impairment of peripheral oxygen availability or utilization in AF may also be important. Endothelial dysfunction40 and peripheral muscle blood flow abnormalities have been correlated with exercise performance in patients with chronic AF although in the absence of structural heart disease.41

The mean V$\text{O}_2$/V$\text{CO}_2$ slope was significantly steeper in HFpEF patients with AF compared with that in patients in SR, reflecting impaired ventilatory efficiency. As the prevalence of lung disease was similar between groups, this likely reflects impaired augmentation of pulmonary perfusion during exercise, a factor
which may contribute to earlier exercise cessation and reduced functional capacity in AF. An increased VE/VCO2 slope has been observed in patients with permanent AF compared with control subjects in SR and accompanying lone AF before cardioversion to SR. However, Ariansen et al reported no difference in ventilatory efficiency between AF and SR when patients with HF were excluded from their analysis. Further, Agostoni et al did not observe an association between AF and VE/VCO2 slope in chronic HFrEF. Therefore, it remains unclear whether the steeper VE/VCO2 slope can be ascribed to a specific effect of AF on exercise hemodynamics. More likely, AF is a marker of reduced pulmonary vascular reserve, as well as more impaired diastolic reserve function in patients with HFpEF, as suggested by the differences in baseline characteristics.

Interestingly, HFpEF patients with AF did not display an exaggerated chronotropic response to exercise compared with patients in SR, contrary to previous findings in lone AF and AF with HFrEF. Peak HR and CI were similar between AF and SR, whereas peak VO2 and workload were lower in patients with AF; however, the relationships between CI and peak VO2 or workload were not significantly different for AF than for SR. Chronotropic incompetence is a common feature in HFpEF patients in SR, and our data demonstrate that HFpEF patients with AF have a similar prevalence of chronotropic incompetence when their prevalence of beta-blocker use is equivalent to SR. Notably, no symptomatic or prognostic benefit has been demonstrated with strict versus lenient HR control in the general AF population including a post hoc analysis of patients with HF post hoc although the latter did not examine the impact of rate control strategy on events stratified by HFpEF and HFrEF. Therefore, although current American College of Cardiology/American Heart Association (ACC/AHA) guidelines recommend HR control in HFpEF patients with AF (class IC), the optimal level of HR control in HFpEF, particularly with respect to exercise capacity, has yet to be established.

Study Limitations
Rhythm was classified by the presence or absence of AF on enrollment electrocardiography. Consequently, HFpEF patients with previous or paroxysmal AF may have been classified as SR although this would likely serve to underestimate the observed differences. Greater frequency of treadmill exercise versus bicycle ergometry in AF would also minimize any differences in peak VO2 from SR as bicycle ergometry is generally associated with a lower peak VO2. Information on right heart structure and function along with duration of AF and decisions on rate or rhythm control were unavailable although antiarrhythmic agents were used in <10% of the overall population. Therefore, these data pertain to patients with and without persistent AF in the context of heterogeneous AF and HF therapeutic strategies.

Conclusions
In patients with HFpEF, AF is associated with important phenotypic and functional differences: older age, impaired LV systolic and diastolic function and functional reserve, more severe neurohormonal activation, and impaired exercise tolerance, supporting AF as a marker of more advanced HF phenotype in HFpEF. Furthermore, in the context of β-blocker

Figure 2. Chronotropic response to exercise in patients with heart failure and preserved ejection fraction in atrial fibrillation (AF) and sinus rhythm (SR). A, Heart rates at rest and at peak exercise. B, Prevalence of chronotropic incompetence during exercise (calculated using standard [Astrand] or Brawner formulae; P values AF vs SR). C, Relationship between chronotropic index (Brawner formula) and peak VO2. D, Relationship between chronotropic index and peak workload. Results for unadjusted linear regression shown for patients in AF (red line) and SR (black line). P values (C) and (D) refer to interaction terms between rhythm status and chronotropic index.
therapy, chronotropic incompetence is equally common in HfPEF patients in AF or SR. Further study is required to determine whether different rate control strategies or indeed, rhythm control in patients with HfPEF and AF may favorably affect exercise tolerance.

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Disclosures
None.

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Exercise Capacity in HFpEF (RELAX) trial enrolled 216 ambulatory patients who met rigorous entry criteria for HFpEF and cardiac limitation to exercise. The aim of this study was to determine clinical, biochemical, and echocardiographic characteristics associated with AF in HFpEF and the impact of AF on baseline exercise capacity in HFpEF patients enrolled in RELAX. We found that patients with HFpEF and AF were older, had worse left ventricular systolic and diastolic function at rest, more severe neurohumoral activation, and greater impairment of exercise capacity. Ventilatory efficiency and systolic reserve function were also lower in HfPEF patients with AF. Moreover, we demonstrated that the lower exercise capacity in AF was not explained by differences in age, sex, resting left ventricular function, or altered chronotropic response, suggesting a specific effect of AF on cardiac reserve. These data serve to underscore the significance of AF in patients with HfPEF and a need to examine whether different therapeutic strategies, including rate or indeed rhythm control, may favorably affect exercise tolerance in this setting.
Impact of Atrial Fibrillation on Exercise Capacity in Heart Failure With Preserved Ejection Fraction: A RELAX Trial Ancillary Study
Rosita Zakeri, Barry A. Borlaug, Steven E. McNulty, Selma F. Mohammed, Gregory D. Lewis, Marc J. Semigran, Anita Deswal, Martin LeWinter, Adrian F. Hernandez, Eugene Braunwald and Margaret M. Redfield

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