Heart failure with preserved ejection fraction (HFpEF) is an increasingly common diagnosis, accounting for 50% of HF cases. Several studies have described the epidemiological characteristics of the HFpEF population: a predominance of older age, women, and history of hypertension and metabolic syndrome. However, the precise mechanism underlying HFpEF is still not well known. The lack of understanding of the physiopathological pathways that lead to the disease may have contributed to the difficulty in finding specific treatments. Several therapies have been assayed with disappointing results, and to date there are no evidence-based therapeutic guidelines for this population.

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Background—Pulmonary hypertension (PH) and collagen metabolism abnormalities are prevalent in patients with heart failure with preserved ejection fraction (HFpEF). Peripheral endothelial dysfunction (PED) has been described in HF and in pulmonary arterial hypertension. Our aim is to determine whether PH is associated with PED and impaired collagen metabolism in patients with HFpEF.

Methods and Results—Flow-mediated dilation of the brachial artery, matrix metalloproteinase-2 and matrix metalloproteinase-9, tissue metalloproteinase inhibitor 1, and C-terminal propeptide of type I procollagen were determined in 28 patients with HFpEF and 42 hypertensive controls. Patients with systolic pulmonary artery pressure >35 mm Hg on echocardiogram underwent a right heart catheterization. Patients with HFpEF had more severe PED than controls: flow-mediated dilation 1.95% (−0.81 to 4.92) versus 5.02% (3.90 to 10.12), \( P = 0.002 \). Twenty patients with PH underwent right heart catheterization: mean pulmonary artery pressure 38 (27–52) mm Hg, wedge capillary pressure 18 (16–22) mm Hg, pulmonary vascular resistance 362 (235–603) dyn s cm\(^{-5}\). There was a significant inverse correlation between flow-mediated dilation and pulmonary vascular resistance in patients with HFpEF and PH (\( r = −0.679; P = 0.002 \)). Patients with HFpEF showed higher matrix metalloproteinase-2 and C-terminal propeptide of type I procollagen values than hypertensive controls. Patients with HFpEF and higher C-terminal propeptide of type I procollagen values also had higher mean pulmonary artery pressure (\( r = 0.553; P = 0.014 \)), transpulmonary gradient (\( r = 0.560; P = 0.013 \)), and pulmonary vascular resistance (\( r = 0.626; P = 0.004 \)).

Conclusions—In patients with HFpEF, there is a significant correlation between PED and pulmonary vascular resistance. Collagen metabolism was more impaired in patients with HFpEF and PH. PED and collagen metabolism assessment could be useful tools to identify patients with HFpEF at risk of developing PH. (Circ Heart Fail. 2014;7:791-798.)

Key Words: pulmonary circulation • vascular resistance

Heart failure with preserved ejection fraction (HFpEF) is an increasingly common diagnosis, accounting for 50% of HF cases. Several studies have described the epidemiological characteristics of the HFpEF population: a predominance of older age, women, and history of hypertension and metabolic syndrome. However, the precise mechanism underlying HFpEF is still not well known. The lack of understanding of the physiopathological pathways that lead to the disease may have contributed to the difficulty in finding specific treatments. Several therapies have been assayed with disappointing results, and to date there are no evidence-based therapeutic guidelines for this population.

Diastolic dysfunction and vascular stiffness have been described in this population and related to an imbalance in extracellular matrix collagen metabolism. Peripheral endothelial dysfunction (PED) has been reported in patients with HF and associated with poor outcomes. Recent studies report a high prevalence of pulmonary hypertension (PH) in HFpEF, which is in turn related to a worse prognosis although the mechanisms underlying the high prevalence of PH are unknown. Classical studies suggest that increased pulmonary vascular resistance (PVR) is related to abnormalities in smooth muscle tone caused by pulmonary endothelial function as a consequence of NO and endothelin-1 imbalances. Those imbalances may also affect the peripheral vessels endothelium.
Our aim was to analyze the association among PED, collagen metabolism, and PH in patients with HFrEF. Our working hypothesis was that patients with HFrEF have endothelial dysfunction that affects both the pulmonary and the peripheral vasculature. A PED assessment could reflect pulmonary endothelial dysfunction and, therefore, be related to the presence of PH. Abnormalities in endothelial function could account for a vasoreactive component in PH and HFrEF, in addition to the postcapillary contribution. Imbalanced collagen metabolism could be related to endothelial dysfunction and consequently, PH.

To test our hypothesis, we studied a group of patients with HFrEF and PH, assessing peripheral endothelial function, collagen metabolism, and invasive pulmonary hemodynamics, and compared the results with a group of asymptomatic controls with systemic hypertension.

Methods

Study Population

Consecutive adult patients with HFrEF referred to our clinic for HF or PH were prospectively enrolled. Inclusion criteria were ≥1 hospital admission for HF in the previous year, normal left ventricular (LV) systolic function (LVEF, ≥50%), and diagnosis of HFrEF according to current recommendations.1 Exclusion criteria were untreated ischemic heart disease or valvular heart disease; constrictive parameters; restrictive cardiomyopathies; fibroproliferative systemic diseases including systemic sclerosis, renal failure (creatinine, ≥2.5 mg/dL), and lung fibrosis; and significant vascular or parenchymal lung disease: thromboembolic lung disease, pulmonary arterial hypertension, and obstructive or restrictive lung disease (first second forced expiratory volume, <55%; forced vital capacity, 60%; and total lung capacity, <60%). A group of patients with systemic hypertension who had never presented symptoms or signs of HF were prospectively enrolled as controls. Inclusion criteria were asymptomatic adults with ≥5 years' history of systemic arterial hypertension. Exclusion criteria were the same as those for patients with HFrEF.

The institutional Ethics and Research committee of our hospital approved this study. All patients gave written informed consent.

Controls and patients underwent echocardiogram, endothelial function assessment, and blood collection on the same day, 1 month after discharge if they had been hospitalized. Studies were performed in a blind fashion. Patients with PH who consented, underwent right heart catheterization in the next 2 weeks after noninvasive evaluation. Images and sera were stored for blinded analysis in a second phase.

Echocardiogram

Controls and patients underwent echocardiography evaluation using a commercially available ultrasound system (IE33; Philips Medical Systems, Andover, MA). All parameters were measured in 3 cardiac cycles (5 cycles in subjects with atrial fibrillation [AF]) and averaged. Right and LV dimensions, left atrium diameter and area, and right ventricular function estimated by tricuspid annular plane systolic excursion were reported. LVEF was assessed by the Simpson method from 2-dimensional (2D) apical 2- and 4-chamber views. Preserved systolic function was defined as EF≥50%. LV diastolic function was assessed with mitral inflow velocities (E, A and A, V) and average of septal and lateral mitral annulus early diastolic velocity by tissue Doppler (e'). E/A and E/e' ratios were reported. Systolic pulmonary artery pressure (PAP) was estimated by Doppler echocardiography from the systolic right ventricular to right atrial pressure gradient, applying the Bernoulli equation to tricuspid regurgitant wave velocity. Right atrial pressure was estimated using the inferior vena cava diameter and inspiratory oscillations (range, 5–20 mm Hg), which was added to the calculated gradient to estimate systolic PAP. None of the participants had significant right ventricular outflow tract obstruction.

Right Heart Catheterization

Patients with HFrEF showing systolic PAP ≥25 mm Hg on echocardiogram were proposed to undergo a right heart catheterization. The patient was placed in the supine position, in a fasting state, without premedication. A 7F thermodilation balloon-tipped catheter (Baxter 139F75) was inserted percutaneously into the brachial, jugular, or femoral vein and advanced under fluoroscopy through the right heart cavities into the pulmonary artery. The pulmonary capillary wedge position was confirmed by the change from the typical pulmonary artery waveform to the typical pulmonary artery wedge pressure waveform on inflation of the balloon catheter. Pressure transducers were balanced against atmospheric pressure, and the zero reference level was 5 cm below the sternal angle. The following measurements were recorded as the mean of 3 consecutive beats in patients on sinus rhythm (5 beats in AF): right atrial pressure; systolic, diastolic, and mean PAP; pulmonary artery wedge pressure at end-expiration; and cardiac output as determined by the average of 3 thermal dilution curves. Cardiac cycles with fusion of 2 consecutive diastolic waves, as a consequence of a short relative risk interval, were excluded from analysis. The following parameters were calculated: cardiac index as cardiac output divided by corporal surface area, transpulmonary gradient (TPG) as mean PAP minus pulmonary artery wedge pressure, and PVR as TPG divided by cardiac output.

Peripheral Endothelial Function

Controls and patients underwent peripheral endothelial function evaluation using a commercially available ultrasound system (Sonos 5500; Agilent Technologies, Andover, MA). The method has been previously described.10 Briefly, all participants fasted and avoided exercise, stimulants, and medications for 24 hours before the test. They were placed in a quiet, darkened, temperature-controlled room, and all measurements were taken at a similar time of day. Their right arm rested comfortably in a cradle support of the imaged artery for ≥10 minutes before the measurements. A pressure cuff was placed 2 cm distal to the elbow crease. A stereotactic adjustable prop holder was used to achieve a steady image throughout the study, and the sample volume of the pulsed wave Doppler was placed in the middle of the artery as a reference marker. Longitudinal images were obtained by high-resolution ultrasound.

The standard 4-step protocol was used:

1. First baseline scan was recorded.
2. Endothelium-dependent vasodilation was assessed: pressure cuff was inflated ≤300 mm Hg for 5 minutes and released, leading to reactive hyperemia. Pulsed wave Doppler signal of brachial artery flow and 2D images were scanned 55 to 65 s after cuff release.
3. Second baseline scan was obtained after 10 minutes rest to allow vessel recovery.
4. Endothelium-independent vasodilation was assessed: 400 μg of sublingual nitroglycerin was administered and a fourth scan was obtained 3 minutes later.

Images were analyzed by 2 independent observers and averaged. Arterial diameters were determined in an end-diastole frame with dedicated software (QLab; Philips Healthcare, Eindhoven, The Netherlands), placing calipers from the trailing edge of the anterior wall interface to the leading edge of the posterior wall interface and averaging 5 cardiac cycles in patients with sinus rhythm and 10 in patients with AF. Peak brachial artery flow velocity was determined with pulse-Doppler sampling volume in the vessel lumen midline with software correction for the incident angle, at rest and for the first 15 s after forearm cuff release. Shear rate was calculated as 4×peak flow velocity/arterial diameter.

Flow-mediated vasodilation (FMD) was used as an index of endothelium-dependent dilation and was calculated as the maximal absolute and percentage change in brachial artery diameter after reactive hyperemia divided by that obtained from the first baseline scan (steps 1 and 2). Normal threshold for our laboratory was considered FMD>5%. Nitroglycerin-mediated dilation was used as an...
index of endothelium-independent vasodilation and was calculated as the maximal absolute and percentage change in brachial artery diameter after nitroglycerin administration (steps 3 and 4). Using this methodology and a nested ANOVA, interobserver and intraobserver variance for brachial artery diameter measurement has been reported as 0.00012 (0.02% of total variability) and 0.00075 (0.13% of total variability), respectively.¹¹

**Collection of Blood Samples and Analysis of Extracellular Matrix Proteins**

Circulating matrix metalloproteinase-2 and -9 (MMP-2 and MMP-9), tissue metalloproteinase inhibitor 1 (TIMP-1) and C-terminal propeptide of type I procollagen (CICP) levels were measured when patients were stable, at least a month after hospital discharge. Blood was withdrawn from an antecubital vein into non-heparinized tubes. It was kept at room temperature for ≥20 minutes to allow clot formation and then centrifuged at 3000 rpm for 15 minutes at 4°C. Immediately after centrifugation, serum samples were aliquoted and stored at −80°C until assay. Commercially available ELISA kits were used for serum quantification, and their minimum analytic detection limit (DL) was as listed: DMP2F0 for MMP-2 DL=0.047 ng/mL, DMP900 for MMP-9 DL=0.156 ng/mL, DTM100 for TIMP-1 DL=0.08 ng/mL, DMP2F0 for MMP-2 DL=0.047 ng/mL, DMP900 for MMP-9 DL=0.156 ng/mL, DTM100 for TIMP-1 DL=0.08 ng/mL, R&D Systems, Inc, Minneapolis, MN), and Microvue 8033 for CICP, DL=0.2 ng/mL (Quidel Corporation, San Diego, CA).

**Statistical Analysis**

Participant characteristics are presented as percentage for qualitative variables and as median and quartiles for quantitative variables. Nonparametric tests were used for comparisons throughout the study. Fisher exact test was used to compare qualitative variables, and Mann–Whitney U test was used to compare quantitative variables. Correlation between plasma biomarkers or FMD and pulmonary hemodynamics was evaluated by linear regression analysis. Because there were extreme values for PVR and TPG, a sensitivity analysis for these variables was performed. All statistical analyses were performed using IBM SPSS 18 software (IBM Corporation, Armonk, NY). Statistical significance was set at 2-sided P<0.05.

**Results**

**Population Characteristics**

Twenty-eight patients with HFpEF were compared with 42 systemic hypertensive controls. Their demographic characteristics are shown in Table 1. As expected, patients with HFpEF had a much higher prevalence of AF (81% versus 2%; P<0.001) and were more often treated with β-blockers, aldosterone-receptor blockers, diuretics, insulin, vitamin K antagonists, and digoxin. The brain natriuretic peptide levels were higher in patients with HFpEF than in controls.

**Echo Parameters**

As shown in Table 2, there were no differences between patients with HFpEF and hypertensive controls in LV dimensions. When compared with hypertensive controls, patients with HFpEF had a larger right ventricle end-diastolic diameter, a worse right ventricular function (assessed by tricuspid annular plane systolic excursion), and signs of a more impaired diastolic function: increased right atrial size, higher E wave velocity, higher E/A ratio, and higher E/e’ ratio.

The PAP estimated from tricuspid regurgitation jets could be analyzed in 33% of hypertensive controls and in 89% of the patients with HFpEF. None of the hypertensive controls and 22 (78%) of the patients with HFpEF showed an estimated systolic PAP>35 mm Hg.

**Pulmonary Hemodynamics**

Twenty patients with HFpEF and PH as determined by echocardiography consented to undergo a right heart catheterization. Their mean PAP was 38 (27–52) mm Hg, wedge capillary pressure was 18 (16–22) mm Hg, cardiac output 4.3 (3.1–5.4) L/min, and PVR 362 (235–603) dyn s cm⁻² (Table 3).

**Peripheral Endothelial Function**

Baseline brachial artery diameter did not differ between hypertensive controls and patients with HFpEF. There was significantly less FMD in the HFpEF group when compared with hypertensive controls, both in absolute and percentage change from baseline diameter (β-coefficient, −0.18 mm [−0.28, −0.07]; P=0.001 and β-coefficient −4.41% [−7.17, −1.65]; Table 1).
Table 2. Echocardiographic Findings of HTN and Patients With HFrEF

<table>
<thead>
<tr>
<th></th>
<th>HTN Controls</th>
<th>HFrEF</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ejection fraction, %</td>
<td>60 (60–65)</td>
<td>58 (55–62)</td>
<td>0.016</td>
</tr>
<tr>
<td>LVHDD, mm</td>
<td>48 (45–53)</td>
<td>50 (47–54)</td>
<td>0.203</td>
</tr>
<tr>
<td>LVESD, mm</td>
<td>30 (27–33)</td>
<td>32 (28–35)</td>
<td>0.163</td>
</tr>
<tr>
<td>RVHDD, mm</td>
<td>34 (30–36)</td>
<td>40 (37–44)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>ISV, mm</td>
<td>12 (11–13)</td>
<td>12 (12–14)</td>
<td>0.071</td>
</tr>
<tr>
<td>LPW, mm</td>
<td>11 (11,12)</td>
<td>12 (11–13)</td>
<td>0.093</td>
</tr>
<tr>
<td>Left atrium, mm</td>
<td>38 (35–41)</td>
<td>50 (42–57)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Left atrium area, cm²</td>
<td>19 (16–21)</td>
<td>26 (23–33)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>E wave velocity, cm/s</td>
<td>61 (53–72)</td>
<td>117 (80–149)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Mitral E/A ratio</td>
<td>7.7 (6.9–9.7)</td>
<td>12.8 (9.4–17.8)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Tissue Doppler e’</td>
<td>8.3 (6.9–10.5)</td>
<td>9.4 (8–11.8)</td>
<td>0.089</td>
</tr>
<tr>
<td>Mitral E/e’ ratio</td>
<td>7.1 (5.6–9.7)</td>
<td>12.8 (9.4–17.8)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>TAPSE, mm</td>
<td>23 (20–26)</td>
<td>16 (13–21)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Mean TR jet, %</td>
<td>33</td>
<td>89</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Mean estimated S-PAP, mm/Pa</td>
<td>32 (28–34)</td>
<td>62 (55–88)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Values are given as median and quartiles. Ejection fraction, preserved ejection fraction; HTN, hypertension; ISV, interventricular septum; LVHDD, left ventricle posterior wall; LVESD, left ventricle end-systolic diameter; RVHDD, right ventricle end-diastolic diameter; S-PAP, systolic pulmonary artery pressure; TAPSE, tricuspid annular plane systolic excursion; and TR, tricuspid regurgitation.

P<0.002, respectively). After adjusting for age, sex, and nitrate use, differences remained significant (absolute FMD, P=0.001; β-coefficient 0.2 mm [0.08–0.32] and percentage FMD, P=0.001; β-coefficient, 5.18% [2.14–8.22]). Nitroglycerin-mediated dilation was similar in both groups (Table 4).

Among the 20 patients with HFrEF and PH who underwent right heart catheterization, subsequent analysis of the association between absolute and percentage FMD and PVR disclosed an inverse correlation (r=−0.679; P=0.002 and r=−0.623; P=0.006, respectively); in other words, the less the brachial artery diameter in response to flow, the higher the PVR (Figure 1A).

Absolute and percentage FMD also showed a significant correlation with systolic PAP (r=−0.585; P=0.011 and r=−0.507; P=0.033, respectively), systolic PAP (r=−0.573; P=0.013 and r=−0.514; P=0.029, respectively), mean PAP (r=−0.509; P=0.009 and r=−0.521; P=0.027, respectively; Figure 1B), cardiac output (r=0.520; P=0.037 and r=0.497; P=0.044, respectively), and TPG (r=−0.523; P=0.026 and r=−0.456; P=0.057, respectively). One patient showed high PVR and TPG and was considered an outlier. After excluding this patient from analysis, the correlation with PVR remained significant (absolute FMD, r=−0.586; P=0.013 and percentage FMD, r=−0.493; P=0.044) but not the correlation with TPG. No association was found with pulmonary artery wedge pressure.

Extracellular Matrix Proteins

Patients with HFrEF had higher MMP-2 and CICP values than hypertensive controls (β-coefficient, 36.09 ng/mL [12.26–59.93]; P=0.004 and β-coefficient, 18.36 ng/mL [6.15–30.57]; P=0.044, respectively; Figure 2). After adjusting for age and sex, differences remained significant (MMP-2 β-coefficient, 38.14 ng/mL [12.83–63.45]; P=0.004 and CICP β-coefficient, 21.17 ng/mL [15.55–57.90]; P=0.004). There were no differences in MMP-9 (β-coefficient, −87.26 ng/mL [−296.44 to 121.92]; P=0.404) or TIMP-1 values (β-coefficient, 21.17 ng/mL [15.55 to 57.90]; P=0.254) between groups.

In the 20 patients who underwent a right heart catheterization, CICP values showed a positive linear correlation with mean PAP (r=0.513; P=0.029), TPG (r=0.522; P=0.026), and PVR (r=0.577; P=0.009; Figure 3). MMP-2, MMP-9, TIMP-1, and brain natriuretic peptide levels were not significantly correlated with pulmonary hemodynamic parameters. One patient showed high PVR and TPG and was considered an outlier. After excluding this patient from analysis, the correlation with PVR and TPG was not statistically significant.

Participants in the highest tertile of MMP-2 levels had significantly less absolute FMD than those in the first tertile (0.13
There was a moderate inverse correlation between MMP-2 or CICP values and lower FMD ($r = -0.276; P = 0.034$ and $r = -0.306; P = 0.018$, respectively). No association was found between FMD and MMP-9 or TIMP-1 values.

**Discussion**

This study shows that patients with HFpEF have impaired peripheral endothelial function when compared with patients with systemic hypertension and diastolic dysfunction who had never presented HF symptoms. In patients with HFpEF and PH, invasive pulmonary hemodynamics disclosed a remarkable precapillary component (shown by increased TPG and PVR). In these patients, we described for the first time an inverse correlation between PVR and peripheral endothelial function. Patients with increased collagen metabolism proteins showed higher PAP, TPG, and PVR and worse PED.

HFpEF is an increasingly prevalent pathology whose underlying mechanisms are not yet understood. The development of PH in a patient with hypertension and diastolic dysfunction might be related to the development of HF symptoms. Some studies have reported a surprisingly high prevalence of PH among patients with HFpEF at baseline or during exercise and described an important vasoreactive component. Moreover, the presence of PH has been associated with an increased mortality in this population. For these reasons, some authors have studied the potential benefit of pulmonary vasodilators in HFpEF, with controversial results, mainly because of different inclusion criteria related to the presence of PH.

**Peripheral Endothelial Dysfunction**

Studies of patients with HF have described PED in the presence of preserved and reduced EF, as well as pulmonary arterial hypertension. The presence of PED has been identified as an independent predictor of cardiovascular events and mortality in the population with HF, HFpEF, and reduced EF, but the mechanism that mediates this association is poorly understood.

Using invasive measurements, we identified an important precapillary component in PH secondary to HFpEF in addition to the postcapillary contribution of pulmonary venous congestion. Our findings indicate a relationship between an impaired peripheral endothelial function and the presence and degree of PH in this subset of patients. This relationship has been described in idiopathic pulmonary arterial hypertension, in PH associated with congenital heart disease and in connective tissue diseases, such as scleroderma, but has never before been reported in HFpEF. The presence of PED may be associated with impaired pulmonary endothelial function and could account for the precapillary component of the PH that has been described in these patients. The worse prognosis of patients with HFpEF and PED compared with patients without PED could be at least partly related to the association between PED and PH.

**Extracellular Collagen Metabolism**

Previous studies have shown a progressive increase in extracellular matrix protein circulating levels in healthy controls, patients with hypertension, and patients with HFpEF.

Figure 1. Relationship between peripheral endothelial dysfunction and pulmonary hemodynamics. Percentage and absolute changes in flow-mediated dilation (FMD) disclosed an inverse correlation with pulmonary vascular resistance (PVR; A) and mean PAP (B), showing that the less the brachial artery dilation in response to flow, the higher the PVR and mean pulmonary artery pressure (PAP).
increased collagen turnover has been linked to a more severe diastolic dysfunction and arterial stiffness; therefore, it has been proposed as an etiopathogenic mechanism for HFrEF. Also, high levels of circulating extracellular matrix proteins have been related to the presence of severe pulmonary arterial hypertension. Consistent with previous reports, patients with HFrEF in our study showed significantly higher levels of MMP-2 and CICP compared with systemic hypertensive controls. We could also establish a statistical relationship between increased circulating extracellular matrix protein levels, higher PH invasively determined parameters, and a more impaired peripheral endothelial function. More studies are needed to assess whether collagen metabolism may play a role in the development of endothelial dysfunction and PH, or whether it is just a nonspecific marker of overall HFrEF severity.

**Limitations**

First, we were able to demonstrate an association between FMD and PH, but the observational design of the study does not allow us to suggest a causal relationship. Second, the small sample size of our study is because of its invasive nature. However, in contrast to most of the previous studies where indirect measurements are shown, we provide more reliable data. Moreover, our results are consistent with previous literature on HFrEF or PH. Third, there were some differences in baseline characteristics between HFrEF and controls about sex, medical treatment, and AF prevalence. Although peripheral endothelial function measurements were made after 6 hours of medication washout, hypertensive controls, and patients with HFrEF differed in their baseline pharmacological treatment. Spironolactone, β-blockers, calcium blockers, angiotensin-converting enzyme inhibitors, and angiotensin receptor blocker have been reported to improve endothelial function and were in fact more common in the HFrEF group; consequently, differences between the groups in peripheral endothelial function could have been underestimated. Fourth, our population had higher PAP and PVR values when compared with previous studies, which may indicate a selection bias related to the high complexity of our center and the referral of patients with more severe HF. Prevalence of

**Figure 2.** Comparison of serum extracellular matrix protein levels. Patients with heart failure with preserved ejection fraction (HFrEF) showed significantly higher circulating levels of C-terminal propeptide of type I procollagen (CICP) and matrix metalloproteinase (MMP)-2 when compared with hypertensive (HTN) controls.

**Figure 3.** Correlation between serum extracellular matrix proteins and pulmonary hemodynamics. In patients with heart failure and preserved ejection fraction who had pulmonary hypertension, C-terminal propeptide of type I (CICP) levels showed a significant positive correlation with mean pulmonary artery pressure (PAP), transpulmonary gradient (TPG), and pulmonary vascular resistance (PVR) values.
AF was also higher than previously reported for patients with HFPpEF, perhaps accounting for the severity of the disease in our cohort. The potential influence of AF on our results must be acknowledged because pulse irregularity has been reported to be a risk factor for PED independently of HF phenotype. It is difficult to discern how much of the differences in FMD are specific to the presence of HFPpEF or related to AF. The relationship between FMD and PVR in our patients supports the idea that PED may be related to PH in HFPpEF, but the influence of AF in this finding is unclear and should be addressed in future studies.

Conclusions

This study provides evidence that patients with HFPpEF have an impaired peripheral endothelial function when compared with hypertensive controls, and that it is associated with the presence of PH and high PVR. Extracellular collagen metabolism abnormalities can be detected in this population. Routine assessment of peripheral endothelial function and extracellular collagen metabolism could help us to identify a subgroup of patients with HFPpEF at higher risk for the development of PH and provide a rationale for treating this selected group with pulmonary vasodilators.

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Disclosures

None.

References


**CLINICAL PERSPECTIVE**

Heart failure with preserved ejection fraction (HFpEF) is an increasingly common diagnosis and is often associated with pulmonary hypertension. Peripheral endothelial dysfunction (PED) and collagen metabolism abnormalities have been described in this population. Our aim was to determine whether pulmonary hypertension is associated with PED and impaired collagen metabolism in patients with HFpEF. A group of 28 patients with HFpEF was compared with a group of 42 hypertensive controls: echocardiograms, PED studies, and analyses of collagen metabolism were performed. Patients with HFpEF who showed pulmonary artery pressure ≥35 mm Hg by echocardiogram also underwent right heart catheterization. Patients with HFpEF had impaired PED and collagen metabolism compared with hypertensive controls. Interestingly, we were able to describe for the first time a correlation between PED and pulmonary vascular resistance, assessed by invasive pulmonary hemodynamics, in patients with HFpEF and pulmonary hypertension. Weaker correlations were also found between collagen metabolism and pulmonary hemodynamics. Our results are important because pulmonary hypertension has important prognostic implications in heart failure. Therefore, noninvasive assessment of endothelial function and collagen metabolism could help us to identify a subgroup of patients with heart failure at higher risk for the development of out of proportion pulmonary hypertension and provide rationale for future treatment strategies in this selected group.
Pulmonary Hypertension Is Related to Peripheral Endothelial Dysfunction in Heart Failure With Preserved Ejection Fraction
Marta Farrero, Isabel Blanco, Montserrat Batlle, Evelyn Santiago, Montserrat Cardona, Barbara Vidal, M. Angeles Castel, Marta Sitges, Joan Albert Barbera and Felix Perez-Villa

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