Estimated peak functional capacity: an accurate method for assessing change in peak oxygen consumption after cardiac rehabilitation?


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Full Title: Are estimates of peak functional capacity an accurate method for estimating change in peak oxygen consumption after cardiac rehabilitation?

Short Title: Estimated functional capacity: A poor surrogate of VO$_{2\text{peak}}$ changes after cardiac rehabilitation


Clinicatrial.gov identifier: NCT01761448

*Address for correspondence

$^1$ Sport and Exercise Science
School of Biomedical Science
Catherine Cookson Building
Faculty of Medical Sciences
Newcastle University
Newcastle upon Tyne
NE2 4HH

Tel: 01482 466314
Fax: 01482 463855
Email: S.Nichols@hull.ac.uk

Sport, Health and Exercise Science
University of Hull
Cottingham Road
These authors take responsibility for all aspects of the reliability and freedom from bias of the data presented and their discussed interpretation.
Abstract:

**Objective:** Maximal cardiopulmonary exercise testing (CPET) is the “gold standard” method of determining VO$_{2peak}$. When CPET is unavailable, VO$_{2peak}$ may be estimated from treadmill or cycle ergometer workloads and expressed as estimated metabolic equivalents (METs). Cardiac rehabilitation (CR) programmes use estimated VO$_{2peak}$ (METs) to report changes in cardiorespiratory fitness (CRF). However, the accuracy of determining changes in VO$_{2peak}$ based on estimated functional capacity is not known.

**Methods:** 27 patients with coronary heart disease (88.9% male; age 59.5 ± 10.0 years, body mass index 29.6 ± 3.8 kg·m$^{-2}$) performed maximal CPET before and after an exercise based CR intervention. VO$_{2peak}$ was directly determined using ventilatory gas exchange data and was also estimated using the American College of Sports Medicine (ACSM) leg cycling equation for METs. Agreement between changes in directly determined VO$_{2peak}$ and VO$_{2peak}$ estimated from METs was tested using Bland-Altman limits of agreement (LoA), and intraclass correlation coefficients.

**Results:** Directly determined VO$_{2peak}$ did not increase significantly following CR (0.5 ml·kg$^{-1}$·min$^{-1}$ (2.7%); p=0.332). In contrast, estimated VO$_{2peak}$ increased significantly (0.4 METs; 1.4 ml·kg$^{-1}$·min$^{-1}$; 6.7%; p=0.006). The mean bias for estimated VO$_{2peak}$ versus directly-determined VO$_{2peak}$ was 0.7 ml·kg$^{-1}$·min$^{-1}$ (LoA -4.7 to 5.9 ml·kg$^{-1}$·min$^{-1}$). Aerobic efficiency, (ΔVO$_2$/ΔWR slope) was significantly associated with estimated VO$_{2peak}$ measurement error.
**Conclusion:** Changes in estimated VO$_{2peak}$ determined using the ACSM equation for leg cycling are not accurate surrogates for directly determined changes in VO$_{2peak}$. Reporting mean CRF changes using estimated METs may over-estimate the efficacy of CR and lead to a different interpretation of study findings compared to directly determined VO$_{2peak}$.

Key Words: CHD, Coronary Heart Disease, Cardiac Rehab, Cardiovascular Rehab, Exercise Testing, Cardiopulmonary Exercise Testing, Metabolic Equivalents, METs

Clinicaltrial.gov identifier: NCT01761448
Introduction

Structured exercise training is a core component of most cardiac rehabilitation (CR) programmes. The efficacy of exercise-based CR is predicated on appropriately personalised exercise training. Exercise prescriptions should be based on an individualised assessment that includes an initial exercise test. Maximal cardiopulmonary exercise testing (CPET) is the “gold standard” method for determining cardiorespiratory fitness (CRF). Information obtained during CPET provides some of the most accurate data on which to base an exercise prescription and to determine changes in CRF following the completion of a CR programme.

Where CPET is not available, workloads achieved during an incremental exercise test may be used to estimate VO$_{2\text{peak}}$. Estimates of VO$_{2\text{peak}}$ are often expressed as estimated metabolic equivalents (METs). Although recently challenged, equations for estimating VO$_{2\text{peak}}$ and METs are traditionally based on an assumed linear relationship between VO$_2$ and work rate. One MET (corresponding to resting metabolic rate) is assumed to equate to a VO$_2$ of 3.5 ml$\cdot$kg$^{-1}$$\cdot$min$^{-1}$. Increases in estimated functional capacity during an exercise test are commonly expressed in multiples of resting metabolic rate. Peak estimated METs achieved during maximal exercise testing are used to risk-stratify patients, prescribe individual exercise intensities for exercise training, and to determine changes in CRF following exercise interventions. However, estimates of functional capacity may not accurately quantify VO$_{2\text{peak}}$, particularly during treadmill protocols. Whilst the limitations of estimating VO$_{2\text{peak}}$...
from a single exercise test are known, the accuracy of estimated changes in \( VO_{2\text{peak}} \) following an exercise training intervention is unclear.

Large discrepancies between estimated, and directly determined \( VO_{2\text{peak}} \) have previously been reported \(^{14}\) \(^{15}\). However, to our knowledge, the only relevant investigation into the suitability of estimating \( VO_{2\text{peak}} \) change from peak METs found no correlation (\( r=0.24; \ p=0.100 \)) in 50 patients with coronary heart disease (CHD) undertaking maximal treadmill testing (Milani et al. 1995). Stuto, et al. (2013) also present data showing that the increase in directly determined \( VO_{2\text{peak}} \) following CR (14.7\%) was not accurately reflected by a much lower improvement in functional capacity (3.85\%) following CR. Thus, in this elderly cohort of patients attending CR, change in estimated peak METs do not appear to reflect improvement in directly determined \( VO_{2\text{peak}} \). However this was not specifically addressed by Stuto, et al. \(^{16}\). We therefore aimed to investigate the accuracy of estimating changes in \( VO_{2\text{peak}} \) using the American College of Sports Medicine \(^{7}\) leg cycling equation in patients with CHD.

**Methods**

**Study design**

Ethical approval was provided by the Yorkshire and the Humber NHS Research Ethics Committee (12/YH/0072). All patients provided written informed consent. All patients had agreed to participate in routine CR as delivered by their local National Health Service provider, and were a minimum of 28 days’ post cardiac event at the time of
baseline assessment (Visit 1). Patients were included if they had completed maximal
CPET before (visit 1) and following the completion of their CR exercise programme
(visit 2). Clinical information collected included cardiac diagnosis, past medical history,
medications, smoking status, resting heart rate, blood pressure, waist circumference
measurement, and body mass index (BMI). Ejection Fraction (EF) was determined
from a resting echocardiogram. Patients with New York Heart Failure Classification
(NYHA) IV, a left ventricular ejection fraction <30%, or a pacemaker/implantable
cardioverter defibrillator, were excluded.

Cardiac Rehabilitation Programme

Patients were recruited from four different CR centres in Yorkshire and Northern
Lincolnshire (UK) between January and March 2013. CR provision remains inequitable
across the UK. The diversity of practice was reflected by the characteristics of the
CR programmes included in this study. All CR programmes used interval circuit training
with alternating cardiovascular and active recovery exercises. Exercise was prescribed
at 40-70% of estimated heart rate reserve [HRR] using formulae recommended by the
Association of Chartered Physiotherapist in Cardiac Rehabilitation. The programme
length varied from 4-24 sessions conducted over a 4-12 week period. The median
number of exercise sessions during follow up was 15 (range: 0 to 62).

Cardiopulmonary Exercise Testing

At baseline and after completion of training, patients undertook symptom-limited
maximal CPET following a 25W, two-minute stage, incremental electronically-braked
cycle ergometer protocol (GE Healthcare e-Bike, Chalfont St Giles, United Kingdom). Patients started pedalling at 25W without a prior unloaded cycling phase. Breath-by-breath metabolic gas measurements were collected via an Innocor (Innovision, Glamsbjerg, Denmark) metabolic cart. Calibration was performed prior to each exercise test according to the manufacturer’s instructions. ECG and heart rate (HR) were continuously recorded using a GE Case System (GE Healthcare, Chalfont St Giles, United Kingdom) BP was monitored at two minute intervals using a Tango automated sphygmomanometer (SunTech Medical, Eynsham, United Kingdom).

Exercise was terminated if a patient experienced chest pain or achieved any of the test termination criteria outlined by the American Thoracic Society (2003). Data were exported as breath-by-breath values and post-processed to generate 15 second averages using Microsoft Excel (Microsoft, Redmond WA, USE). \( \text{VO}_{2\text{peak}} \) and peak respiratory exchange ratio (RER) were both averaged over the final 30 seconds of CPET. \( \text{VO}_{2\text{peak}} \) was standardised to body mass and reported as (ml·kg\(^{-1}\)·min\(^{-1}\)). The ventilatory anaerobic threshold (VAT) was determined using the V-slope method and also reported standardised to body mass. The slope of \( \text{VO}_2 \) as a function of work rate (\( \Delta\text{VO}_2/\Delta\text{WR} \) slope), a measure of aerobic efficiency, was determined using linear regression from data obtained throughout the CPET. \( \Delta\text{VO}_2/\Delta\text{WR} \) slope values <8.4 mL/min\(^{-1}\)/W were considered abnormal. Estimated peak METs were calculated using the ACSM leg cycling equation:

\[
\text{VO}_2 = \frac{(1.8 \times \text{kg·m·min}^{-1})}{\text{BM}} + (7.0)
\]

Where kg·m is Kilogram metres (and where 1W is equal to 6.12 kg·m·min\(^{-1}\)) and BM is
patient body mass. The term ‘directly-determined’ $\text{VO}_{2\text{peak}}$ and ‘estimated $\text{VO}_{2\text{peak}}$’ are used to distinguish between the two variables.

Patients were asked to rate their perceived exertion (RPE) at the end of every two-minute stage during and at peak exercise using the 6-20 Borg score (Borg, 1982). Instructions for the use of the Borg score were given to patients prior to CPET using a standardised list of terms.

Statistical Analysis

Statistical analysis was performed using SPSS version 22 (IBM, New York, USA). Data were visually assessed for normality and heteroscedasticity. Categorical data are reported as percentages. Continuous normally distributed variables are displayed as mean with 95% confidence intervals (95% CI) or standard deviation (±) where specified. Statistically significant differences ($p < 0.05$) were calculated using repeated measures analysis of variance (ANOVA) and repeated measures analysis of covariance (ANCOVA). Partial eta$^2$ ($\eta_p^2$) effect sizes were also calculated with 0.01, 0.06 and 0.14 representing small, medium, and large effect sizes respectively (Richardson, 2011). Pearson correlations were used to assess the strength of the relationship between variables. An $r$ value of <0.25, 0.26 to 0.50, 0.51 to 0.75, and, >0.75 were considered weak, moderate, fair and strong associations, respectively\textsuperscript{20}. Intraclass correlation coefficients (ICC) and Bland-Altman analysis were used to assess agreement between measurement methods\textsuperscript{21, 22}. The maximum acceptable difference between assessment methods was set at 3.5 ml$\cdot$kg$^{-1}$\cdot$min$^{-1}$ (1 MET). A 1 MET increase in
functional capacity has been shown to carry significant survival benefits (12%) (Myers et al., 2002). A measurement error greater than 1 MET would not only suggest that estimates of VO$_{2peak}$ do not reliably interpret patient risk, but also that they are poor markers for monitoring CRF change. A consensus on ICC strength has not been reached, but we defined moderate agreement as an ICC of 0.6–0.75, good agreement between 0.75 and 0.9 and excellent >0.9.  

**Results**

**Patient Characteristics**

Patient characteristics and medications at baseline are reported in Table 1. $n=44$ patients conducted a baseline maximal CPET. $n=17$ were lost to follow-up. $n=27$ were included for analysis. (88.9% male; age 59.5 ± 10.0 years, body mass index [BMI] 29.6 ± 3.8 kg·m$^{-2}$). The median number of exercise sessions conducted at follow up was 15 (range: 0 to 62). Five patients failed to attend at least one exercise session.

**Cardiorespiratory Fitness Change**

Table 2 shows changes in key CPET variables. Despite a significant increase in exercise test duration and peak power output [watts], there was no significant change in directly-determined VO$_{2peak}$ (mean change: 2.7%; 0.5 ml·kg$^{-1}$·min$^{-1}$; 95% CI: -0.6 to 1.8
ml·kg⁻¹·min⁻¹). There were no significant changes in peak HR or RPE (indicators of patient effort) between CPETs. Peak RER, however, was significantly higher at visit 2 compared to visit 1. Change in directly determined VO₂peak remained non-significant when RER change was considered as a covariate (mean change 0.6 ml·kg⁻¹·min⁻¹; 95% CI: -0.6 to 1.8 ml·kg⁻¹·min⁻¹ p=0.324).

Consistent with the increased workload, there was a significant increase in estimated peak METs (mean change: 6.7%; 0.4 METs; 95% CI: 0.1 to 0.6 METs). This corresponded to an estimated VO₂peak change of 1.4 ml·kg⁻¹·min⁻¹. The VAT (mean change: 9.9%; 1.4 ml·kg⁻¹·min⁻¹; 95% CI: 0.5 to 2.3 ml·kg⁻¹·min⁻¹), and ventilatory efficiency slope (VE/VCO₂ slope) also significantly improved following CR. The mean ΔVO₂/ΔWR slope was within normal limits at both visits and did not change significantly between visits. However, 19% (n=10) of all exercise tests had a ΔVO₂/ΔWR slope below the lower limit of normal (<8.4 mL/min/W).

Agreement between Directly-Determined VO₂peak and Estimated VO₂peak

Correlations and measures of agreement for CPET variables are presented in Table 3. There was a significant association between directly determined VO₂peak and estimated VO₂peak on both pre and post- cardiac rehabilitation visits Figure 1A and 1B). The mean bias and limits of agreement for estimated VO₂peak on both tests are also presented in Table 3. The association between changes in directly-determined VO₂peak and estimated VO₂peak was substantially reduced (Figure 1C, r=0.527, p=0.05).
The ICC between the two measurements was not non-significant (ICC 0.358; 95% CI -0.442 to 0.711; p=0.138). Bland-Altman Analysis (Figure 2) showed the mean bias for changes in VO_{2peak} was less than the maximal acceptable difference (0.7 ml·kg^{-1}·min^{-1}; 95% CI -0.4 to 1.8 ml·kg^{-1}·min^{-1}; p=0.178; η_p^2 = 0.069). However, the limits of agreement (LoA) were far wider (-4.7 to 5.9 ml·kg^{-1}·min^{-1}; lower LoA 95% CI: -5.1 to -4.3; upper LoA 95% CI: 5.5 to 6.3 ml·kg^{-1}·min^{-1}). VO_{2peak} measurement error was greater than the maximal acceptable difference in 33%. There was a significant, moderate negative correlation between VO_{2peak} measurement error (estimated VO_{2peak} minus directly determined VO_{2peak}) and ΔVO_{2}/ΔWR slope (Figure 3, r=-0.496, p<0.001).

Discussion

We found that estimated METS derived from the ACSM leg cycling equation are significantly and consistently associated with directly-determined oxygen consumption in a representative cohort of patients attending CR. However, the LoA from our Bland-Altman analysis suggest that estimated functional capacity change does not accurately reflect directly determined VO_{2peak} changes following a CR exercise training intervention. This is supported by our failure to find a significant ICC between the two measurements.

Increasing VO_{2peak} through structured exercise training improves survival in patients with CHD and, consequently, improving VO_{2peak} remains a key objective for CR practitioners. Practitioners need to have confidence in the efficacy of the outcome measures they report. Given that CR programme outcome data are often expressed in
estimated METs, there is a requirement to examine the suitability of estimated functional capacity to accurately determine changes in VO_{2peak}.

Significant mean improvements in peak exercise time, power output and associated improvements in estimated METs following cardiac rehabilitation were not accompanied by improved mean peak oxygen consumption in the present study. These findings question the appropriateness of using estimated VO_{2peak} (METs) as a surrogate indicator of improvements in VO_{2peak}. Reporting estimated METs alone may lead to inaccurate interpretations of the efficacy of exercise interventions within rehabilitation settings.

Estimating mean changes in VO_{2peak} (through widely applied MET equations) over predicted actual VO_{2peak} by more than two-fold in this patient group. These findings are consistent with previously published data^{13 14} which indicate poor agreement between estimates of VO_{2peak} change and directly determined VO_{2peak} change. However, our findings contradict those of Stuto and colleagues (2013) who demonstrate a lower relative improvement in functional capacity (3.85%) compared to directly determined VO_{2peak} (14.7%). The limited information provided within this study abstract limits comparison of study findings. However, these findings may have important implications when interpreting the CRF benefits of CR.

Improvements in other aspects of cardiorespiratory fitness were observed following exercise training in this cohort. VAT significantly increased following exercise-based CR. Improvements in VAT are associated with increased endurance capacity, less
blood lactate accumulation and associated acid-base metabolic perturbations. Given VO2peak remained unchanged, changes in the VAT are likely to have contributed to improved exercise capacity and estimated MET changes.

The failure of estimated MET change to accurately predict directly determined VO2peak change may in part, be attributed to test familiarisation and improved movement economy leading to a longer test duration. However, the use of a cycle ergometer as opposed to a treadmill may partially mitigate these factors. It is possible that the use of our step protocol (2 minute stages, 25W Increments) may have led to a weaker association between VO2 and work rate. Two minutes may have been inadequate time to attain VO2 steady-state. Less predictable VO2/work rate relationships have been observed in patients with cardiovascular disease. Poor oxygen uptake kinetics resulting from poor muscle oxygen extraction, myocardial dysfunction, chronotropic incompetence and ß-blockade all have the potential to influence the VO2/work rate relationship. Indeed, approximately one fifth of the maximal CPET’s conducted demonstrated poor aerobic efficiency (ΔVO2/ΔWR slope <8.4 mL/min/W). ΔVO2/ΔWR slope was negatively correlated with estimated VO2peak measurement error (r=-0.496, p<0.001) indicating that estimates of VO2peak over-predict directly determined VO2peak when patients are aerobically ‘inefficient’. Inefficient cardiometabolic responses to exercise resulting in delayed oxygen kinetics, may prolong dependence on anaerobic metabolism during sequential work rate transitions. In such instances, the assumptions of linearity between work rate and VO2 would not apply and work rate would therefore not be indicative of VO2. This issue is particularly pertinent above the VAT where VO2 steady-state attainment can take up to 15 minutes due to the
presence of a VO\textsubscript{2} slow component. Steady state attainment above critical power i.e. near peak exercise, is not achieved\textsuperscript{6}. With this in mind, it is doubtful that any practical CPET protocol is truly capable of predicting VO\textsubscript{2peak} based on workload alone. Accurately predicting VO\textsubscript{2peak} or VO\textsubscript{2peak} changes in CHD patients, as evidenced by our findings and others\textsuperscript{13 14 16}, poses significant challenges, particularly at an individual patient level.

Assessing functional capacity (by estimating METs) remains useful in the broad classification of baseline cardiorespiratory fitness and prognostic risk classification among participants attending for cardiac rehabilitation\textsuperscript{33} However, poor agreement between estimated and directly determined changes in VO\textsubscript{2peak} questions the validity of this "widely used metric" in reporting CRF changes within CR settings. Our data require further validation in larger samples of cardiac rehabilitation patients. Practitioners should explore opportunities to integrate scientifically robust exercise testing techniques, such as CPET, in evaluating clinically meaningful improvements in CRF outcomes from exercise rehabilitation.

Acknowledgements: This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors

The authors declare that there are no conflicts of interest
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