Distensibility of the Aorta and Carotid Artery and Left Ventricular Mass From Childhood to Early Adulthood

Hanna Mikola, Katja Pahkala, Tapani Rönnemaa, Jorma S.A. Viikari, Harri Niinikoski, Eero Jokinen, Pia Salo, Olli Simell, Markus Juonala, Olli T. Raitakari

Abstract—In adults, arterial distensibility decreases with age and relates to changes in cardiac left ventricular mass. Longitudinal data on changes in arterial distensibility from childhood to adulthood are lacking. Our aim was to study the effect of age and sex, and low-saturated fat dietary counseling on arterial distensibility from childhood to early adulthood. In addition, we assessed the association of arterial distensibility with left ventricular mass. Distensibility of the abdominal aorta and common carotid artery was measured repeatedly at ages 11, 13, 15, 17, and 19 years (n=395–472) in an atherosclerosis prevention trial (Special Turku Coronary Risk Factor Intervention Project [STRIP]). Aortic and carotid distensibility decreased with age (both \( P<0.0001 \)). In boys, distensibility values were generally lower (\( P<0.0001 \)) and showed steeper decrease by age (age and sex interaction: both \( P<0.01 \)). The low-saturated fat dietary counseling given in STRIP was not significantly associated with arterial distensibility. Left ventricular mass increased with age (\( P<0.0001 \)), and it was greater in boys (\( P<0.0001 \)). In conclusion, a marked age-related decrease in vascular distensibility was found already at this young age, and this decrease was more pronounced in boys than girls. The longitudinal progression of arterial and carotid distensibility was related with changes in left ventricular mass.

Clinical Trial Registration—URL: http://www.clinicaltrials.gov. Unique identifier: NCT00223600.

Key Words: atherosclerosis • child • prevention & control • ultrasonography

Conduit arteries, such as aorta and carotid artery, function as a physiological buffer during cardiac contraction because of their distensible walls. Arterial stiffness increases with advancing age in adults. Arteries stiffen because mechanical stress causes fatigue and fracture of elastin lamellae in arterial wall, especially at older ages. Arterial stiffness may also be caused by atherosclerosis and relates with traditional cardiovascular disease risk factors in adults and associates with elevated cardiovascular disease risk in healthy persons. Childhood cardiovascular disease risk factors, such as elevated blood pressure, are suggested to predict carotid artery stiffness in adulthood. In adults, arterial stiffening has also been associated with left ventricular hypertrophy. Local arterial stiffness, arterial distensibility, can be estimated with ultrasound and is defined as the change in arterial diameter during systole and diastole divided by pulse pressure.

We have previously reported that childhood exposure to tobacco smoke decreases aortic distensibility in healthy children at the age of 11 years. Recently, we showed a favorable association of fitness and ideal cardiovascular health score with arterial distensibility in adolescents. Two recent cross-sectional studies in children and adolescents have reported arterial stiffening with age. However, longitudinal data on changes in distensibility from childhood to adulthood are still lacking. Especially, data on aortic distensibility would be of great interest because postmortem analyses indicate that atherosclerotic alterations are first seen in the abdominal aorta.

Therefore, this study analyzed longitudinal data on aortic and carotid artery distensibility and cardiac left ventricular mass (LVM) from the Special Turku Coronary Risk Factor Intervention Project for children (STRIP). The study is a longitudinal dietary intervention trial begun in infancy with an aim to prevent atherosclerosis. Distensibility of the abdominal aorta and common carotid artery was measured repeatedly at the age of 11, 13, 15, 17, and 19 years and LVM beginning of age 15 years. Our aim was to study the effect of age and sex, and low-saturated fat dietary counseling on changes in arterial distensibility from childhood to early adulthood. We also studied the association of arterial distensibility with LVM in adolescence.
Methods

Design and Subjects
The STRIP is a prospective, randomized intervention trial.15,16 Briefly, families of 5-month-old infants were recruited to the study at the well-baby clinics in Turku, Finland, between February 1990 and June 1992 (extended methods, please see online-only Data Supplement). This study cohort comprised those children for whom vascular ultrasound data (distensibility) was available at ages of 11, 13, 15, 17, and 19 years. The cohort characteristics are shown in Table S1 in the online-only Data Supplement. The STRIP study was conducted according to the guidelines of the Declaration of Helsinki, and the study protocol was approved by the local ethics committee. Written informed consent was obtained from the parents in the beginning of the study and from the children at the age of 15 years.

Ultrasound Measurements of the Abdominal Aorta, Common Carotid Artery, and LVM
Distensibility of the abdominal aorta and common carotid artery was studied with ultrasonograph (Acuson Sequoia 512 mainframe; Acuson, Mountain View, CA) at the age of 11, 13, 15, 17, and 19 years. Measures of arterial distensibility were available for 68%, 84%, 94%, 94%, and 93% at these ages. Distensibility of the aorta and common carotid artery was assessed using M-mode ultrasound images and concomitant measurement of blood pressure in the brachial artery. We additionally calculated the distensibilities using estimated central blood pressure values (see below). Diameter of the aorta and common carotid artery was measured with ultrasonic calipers twice at end diastole and twice at end systole. The mean of the end-diastolic and end-systolic diameters, along with blood pressure, was used to calculate the arterial distensibility. Distensibility was defined as [(Ds–Dd)/Dd]/(BPs–BPd)×1000, where Ds indicates the end-diastolic and Dd the end-diastolic diameter of the artery, BP stands for systolic and BPd for diastolic blood pressure. Distensibility measures the ability of the arteries to expand as a response to pulse pressure caused by cardiac contraction and relaxation.17 Lower distensibility signifies increased vascular stiffness.

Guidelines recommend using local pressures for determination of arterial distensibility.1 Because of pulse pressure amplification between central and peripheral arteries, the use of brachial pressures as a surrogate for aortic or carotid pressures may over estimate pulse pressure in central arteries.18 Because of the lack of direct measurement of central aortic blood pressure in this study, we estimated the central pulse pressure values for 17- and 19-year-olds by using the ratio of peripheral to central pulse pressure reported in the AngloCardiff Collaborative Trial19 that measured both brachial and central pressures in adolescents and young adults. The formula to calculate estimated central pulse pressure for girls was [(brachial BP–BPd)×25]/41 and for boys [(brachial BP–BPd)–29]/50.19 Using the estimated central pulse pressures, we calculated the modified aortic and carotid distensibility values.

To assess reproducibility of the ultrasound measurements, we have examined 57 individuals (young adults) at 2 time points 3 months apart. The between-visit coefficient of variation was 2.7% for carotid artery diastolic diameter 16.3% for carotid artery distensibility.2

Echocardiography was performed at the age of 15, 17, and 19 years, and successful left ventricular measurements were obtained from 418, 394, and 420 adolescents. Transhauracic 2-dimensional echocardiography was performed with Acuson Sequoia 512 (Acuson, Mountain View, CA) ultrasonography, using 3.5 MHz scanning frequency phased-array transducer. Linear measurements of end-diastolic interventricular septal wall thickness (IVSd), end-diastolic posterior wall thickness (PWTd), and end-diastolic left ventricular internal diameter (LVIDd) were obtained from M-mode tracings. The uncorrected formula to calculate LVM was 1.04 [(LVIDd+PWTd+IVSd)−LVIDd]3. LVM correction was made according to the formula recommended by American Society of Echocardiography: 0.8 (1.04 [(LVIDd+PWTd+IVSd)−LVIDd])1/3+0.6 g.20,21 LVM was indexed to body surface area (BSA).

Physical Examination
The physical examination consisted of the measurement of height, weight, systolic and diastolic blood pressure and waist circumference, and classification of pubertal stage (extended methods, please see the online-only Data Supplement).

Arterial Pulse Wave Velocity and Stroke Volume
As an additional measure of aortic stiffness, a whole-body impedance cardiography device (CircMon, JR Medical Ltd) was used to determine pulse wave velocity (PWV) and stroke volume at age 19 years (extended methods, please see online-only Data Supplement).

Statistical Methods
Repeated measures ANOVA with time as repeating factor was used to study the association of STRIP study group with arterial distensibility. Because the study group was neither associated with distensibility of the aorta nor carotid artery, the STRIP intervention and control groups were studied combined. Repeated measures ANOVA was also used to study the association of sex and age with arterial distensibility, its components and LVM. In addition, repeated measures ANOVA with pubertal stage as repeating factor was used to study the association of pubertal stage with aortic and carotid distensibility. If a child stayed in a certain puberty stage for several years, the measures within pubertal stage were averaged for the analyses. The shapes of significant interactions were studied with t tests for differences between sexes within each age point. Stability within distensibility during time and associations between distensibility of aortic and carotid artery was measured using Pearson correlations. Values for aortic and carotid distensibility were log-transformed before analyses owing to skewed distribution. Results were considered statistically significant at values of P<0.05. Analyses were performed with the SAS 9.3 (SAS Institute, Cary, NC).

Results

Distensibility of Abdominal Aorta
Aortic distensibility decreased with age and was lower in boys than girls (both P<0.0001; Figure 1A). Age and sex interaction was significant indicating that the effect of age on aortic distensibility was different by sex (P<0.0001). At the age of 11 years, aortic distensibility was similar in boys and girls (P=0.53), whereas at the age of 13 years, the difference between boys and girls was borderline significant (P=0.055) and thereafter boys had significantly lower distensibility than girls (Figure 1A; P<0.0001). The sex difference remained statistically highly significant when the modified aortic distensibility calculated at ages 17 and 19 years using estimated central pulse pressure was compared (see methods; girls: age-adjusted mean±SE 5.46±0.089%/10 mm Hg, boys: 4.34±0.090%/10 mm Hg; P<0.0001).

The components of aortic distensibility, pulse pressure and aortic diameter, were studied to gain more insight on the sex difference in distensibility (Figure 1B). First we adjusted the model including age and sex with pulse pressure and second with arterial diameter. When pulse pressure was added in the model, the sex difference in aortic distensibility disappeared (P=0.14). When adjustment was made for arterial diameter, the sex difference persisted (systolic and diastolic diameter: P for sex <0.0001, P for sex=0.020). The effect of age on pulse pressure differed in boys and girls (age by sex interaction; P<0.0001; Figure 1B). In girls, pulse pressure increased 5.8 mm Hg between age 11 and 19 years, whereas in boys the increase was 17.5 mm Hg.
There was parallel increase by age in pulse pressure and body size, and these relationships were more pronounced in boys (Table S1). Therefore, we examined if the sex differences in pulse pressure and distensibility were driven by larger changes in body size in boys than girls. We additionally analyzed, using cross-sectional data at age 19 years, whether differences in stroke volume would explain the sex difference in distensibility. In these analyses, we found no evidence that the sex difference in distensibility would be explained by body size or stroke volume (extended results, please see online-only Data Supplement).

Aortic distensibility decreased with increasing pubertal stage ($P=0.047$; adjusted for age and sex; Figure S1). Pubertal stage by sex interaction was significant ($P<0.0001$); in sex-stratified analysis, the effect of pubertal stage was no longer significant in boys ($P=0.15$) or in girls ($P=0.24$).

The dietary counseling given in the STRIP study was not associated with aortic distensibility ($P=0.24$, age- and sex-adjusted mean [SE]; intervention: 1.28 [0.014], control: 1.26 [0.013]; log-transformed values).

To study the stability of aortic distensibility, we examined correlations between the distensibility measurements. Aortic distensibility measured at the age of 11 years correlated with subsequent measurements at age 13, 15, 17, and 19 years (Figure S2, all $P<0.05$).

Distensibility of Common Carotid Artery

Similar to aortic distensibility, carotid distensibility decreased with age and was lower in boys than girls (both $P<0.0001$; Figure 2A). To compare our findings with a previous population data, we have shown the distensibility values previously reported in the Young Finns Study in Figure 2A. Age and sex interaction was significant, indicating that the effect of sex was different by age ($P=0.0026$). The difference between boys and girls in carotid distensibility was evident already at the age of 11 years ($P=0.002$) and became even more pronounced with increasing age (13 years: $P=0.0005$; 15–19 years: $P<0.0001$).

The sex difference remained statistically highly significant when the modified carotid distensibility calculated at ages 17 and 19 years using estimated central pulse pressure was compared (see methods; girls: age-adjusted mean±SE 5.88±0.069%/10 mm Hg, boys 5.32±0.068%/10 mm Hg; $P<0.0001$).

The components of carotid distensibility were also studied in more detail (Figure 2B). First, we adjusted the model including age and sex with pulse pressure and second with arterial diameter. When pulse pressure was added in the model, the sex difference became borderline nonsignificant ($P=0.075$). The sex difference persisted when adjustment was made for arterial diameter (systolic and diastolic diameter: both $P$ for sex $<0.0001$).
Pubertal stage was not independently associated with carotid distensibility ($P=0.16$; adjusted for age and sex; Figure S1). Pubertal stage by sex interaction was not significant ($P=0.090$).

The dietary counseling given in the STRIP study was not associated with carotid distensibility ($P=0.84$, age- and sex-adjusted mean [SE]; intervention: 1.31 [0.010], control: 1.31 [0.010]; log-transformed values).

To study the stability of carotid distensibility, we examined correlations between the distensibility measurements. Correlations of carotid distensibility measured at the age of 11 years with subsequent measurements until the age of 19 years are shown in Figure S2 (all $P<0.02$).

We also examined correlations between distensibility of the aorta and carotid artery. The correlations between aortic and carotid distensibility ranged from $r=0.25$ to $r=0.38$ during the follow-up (Table S3, all $P<0.0001$).

**Pulse Wave Velocity**

At age 19 years, boys had higher PWV than girls (median [interquartile range]; girls: 6.30 [4.50] m/s, boys: 6.50 [5.80] m/s; $P=0.0001$ for log-transformed PWV). Participation in STRIP intervention had no association with PWV ($P=0.32$; STRIP study group by sex interaction; $P=0.56$).

**Association Between Arterial Distensibility and LVM**

In girls, LVM increased 3.2 g between the age of 15 and 19 years (106.4–109.6 g), whereas in boys the increase was 13.9 g (131.3–145.2 g). Boys had greater LVM/BSA than girls ($P<0.0001$; Figure 3). Age and sex interaction was not significant, indicating that the effect of age on LVM/BSA was similar in girls and boys ($P=0.79$). Participation in STRIP intervention had no association with LVM/BSA ($P=0.92$; STRIP study group by sex interaction $P=0.19$).

Aortic and carotid distensibility were inversely associated with LVM (aorta: $\beta=-4.28$; SE, 1.75; $P=0.015$; carotid: $\beta=-5.81$; SE, 2.59; $P=0.025$, adjusted for sex and age). Aortic and carotid distensibility were not associated with LVM/BSA (aorta: $\beta=-1.12$; SE, 0.90; $P=0.21$; carotid: $\beta=-1.60$; SE,
1.32; \( P \) =0.23, adjusted for sex and age). Sex-adjusted correlations of aortic and carotid distensibility with LVM/BSA are shown in Table S3.

**Discussion**

To best of our knowledge, this is the first study showing the longitudinal progression of repeatedly measured aortic and carotid distensibility from childhood to early adulthood. Already at this young age, a marked age-related decrease in vascular distensibility was found and it was more pronounced in boys. Regarding carotid distensibility, the sex difference was evident already at the age of 11 years, reflecting that boys may have stiffer arteries even earlier in childhood. Detailed analysis of the components of distensibility suggested that the effect of sex on arterial distensibility is driven by the difference in pulse pressure. These longitudinal data demonstrate that arterial distensibility decreases by age between ages 11 and 19 years. Our results are in line with data from the Young Finns Study (Figure 2A), together indicating that the process continues steadily until middle age. In a recent cross-sectional study examining 2- to 18-year-old children, a systematic decrease in aortic distensibility was seen beginning from the age of 2 years. In contrast, a previous cross-sectional study demonstrated that effect of age on aortic distensibility is not linear; distensibility increased from birth and was greatest at about the age of 18 years. Regarding carotid artery, decrease in distensibility has been reported to begin from the age of 6 years. Thus, guidelines recommend using local pressures in determination of arterial distensibility, the sex difference disappeared when arterial distensibility, blood pressure, is beneficially affected by lifestyle intervention early in life should not be dismissed as a means to promote cardiovascular health.2

In addition to vascular measures, this study shows longitudinally the increase of LVM during the age of 15 to 19 years. Boys had greater LVM than girls throughout the follow-up. In adulthood, it is hypothesized that there are causative links between pulse pressure, arterial stiffness, and LVM. By advancing age, pulse pressure increases because of arterial stiffening. Elevated pulse pressure increases left ventricular afterload and myocardial oxygen demand and reduces coronary perfusion. These changes may lead to left ventricular hypertrophy.2 Our data show that changes in arterial distensibility during childhood are associated with changes in LVM. However, when LVM was indexed to BSA, there was no relationship to distensibility. Therefore, it is unclear whether the relationship between arterial distensibility and LVM is causative in this age group or confounded by body size.

A major limitation of this study is that the pulse pressure used to derive distensibility was measured from the brachial artery, not from the artery in question. The use of brachial pressures may overestimate pulse pressure in central arteries. Previous studies have shown an excellent correlation between invasively measured blood pressures from ascending aorta and noninvasively measured blood pressures from brachial artery; however, the differences can be substantial and vary between sexes, females having lower pulse pressure amplification. Thus, guidelines recommend using local pressures in determination of arterial distensibility.4 Therefore, to compensate lack of central blood pressure measurement, we calculated modified aortic and carotid distensibility variables using estimated central pulse pressures that were estimated by the data published by the Anglo-Cardiff Collaborative Trial. The sex difference in distensibility remained when the modified variables were used, suggesting that the lower distensibility observed in boys was not because of use of brachial blood pressure. It is important to note, however, that this approach does not indicate central blood pressure values at individual level. In addition, we measured aortic stiffness with an alternative study. As demonstrated by the data from this study and the cross-sectional Young Finns Study (Figure 2A), the decline in carotid distensibility seems rather linear between ages 11 and 39 years.
method. In 19-year-olds, the aortic PWV was measured using a whole-body impedance cardiography device. In line with the lower distensibility measures, we observed significantly higher PWV values in boys compared with girls, thus indicating increased stiffness in males. Correlations between repeated distensibility measures were relatively weak, as reported also previously. This may be linked to physiological fluctuation in the constitutive factors, especially blood pressure, instead of measurement error.

Perspectives

In conclusion, this study shows for the first time the longitudinal progression of both aortic and carotid distensibility from childhood to early adulthood. Arterial distensibility decreased during age, and boys had markedly stiffer arteries than girls. Our findings suggest that the effect of sex on distensibility is driven by the difference in pulse pressure. In this study, the effect of dietary counseling was not reflected on arterial distensibility. Risk factors operating in early life and lifetime risk driven by the difference in pulse pressure. In this study, the effect of sex on distensibility is driven by the difference in pulse pressure. In this study, the effect of sex on distensibility is driven by the difference in pulse pressure.

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Disclosures

None.

References

What Is New?

- This study shows for the first time the longitudinal progression of both aortic and carotid distensibility from childhood to early adulthood.
- The study reveals effect of age and sex, and low-saturated fat dietary counseling on changes in arterial distensibility and left ventricular mass.

What Is Relevant?

- Already at this young age, a marked age-related decrease in arterial distensibility was found and it was more pronounced in boys.
- Our findings suggest that the effect of sex on distensibility is driven by the difference in pulse pressure.

Arterial distensibility decreased with age, and boys had markedly stiffer arteries than girls. Our findings suggest that the effect of sex on distensibility is driven by the difference in pulse pressure. Lower aortic and carotid distensibility was related to greater left ventricular mass, suggesting that changes in arterial distensibility during childhood may influence cardiac adaptation.
Distensibility of the Aorta and Carotid Artery and Left Ventricular Mass From Childhood to Early Adulthood

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DISTENSIBILITY OF THE AORTA AND CAROTID ARTERY AND LEFT VENTRICULAR MASS FROM CHILDHOOD TO EARLY ADULTHOOD

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Short title: Distensibility and LVM in adolescence
Methods, page 5.

Design and subjects

The STRIP is a prospective, randomized intervention trial.1, 2 Briefly, families of 5-month-old infants were recruited to the study at the well-baby clinics in Turku, Finland, between February 1990 and June 1992. At the age of 7 months, 1062 infants were randomized to an intervention group (n=540) or to a control group (n=522). The intervention group has repeatedly received individualized dietary and lifestyle counseling. Dietary counseling of the intervention families was given by a nutritionist at every visit and mainly aimed at replacement of saturated fat with unsaturated fat in child’s diet.3 This study cohort comprised those children for whom vascular ultrasound data (distensibility) was available at ages of 11, 13, 15, 17 and 19 years. The cohort characteristics are shown in Table S1. The STRIP study was conducted according to the guidelines of the Declaration of Helsinki and the study protocol was approved by the local ethics committee. Written informed consent was obtained from the parents in the beginning of the study and from the children at the age of 15 years.

Methods, page 7

Physical examination

The physical examination consisted of the measurement of height, weight, systolic and diastolic blood pressure and waist circumference, and classification of pubertal stage. Height was measured to the nearest 0.1 cm using Harpenden stadiometer (Holtain, Crymych, United Kingdom). Weight was measured to the nearest 0.1 kg using an electronic scale (Soehnle S10; Soehnle, Murrhardt, Germany). BMI was calculated as kilograms per meter squared (kg/m²). BSA was calculated according to Du Bois formula:

\[
BSA = 0.007184 \times \text{weight}^{0.425} \times \text{height}^{0.725}.
\]

Waist circumference, midway between iliac crest and lowest rib at the midaxillary line, was measured with a flexible measuring tape. During the ultrasound study, blood pressure was measured after 10 minutes rest 3 times from the right arm with a standard sphygmomanometer and the mean of the 3 measurements was used in the analyses. Pubertal status was classified using Tanner staging (M1 through M5 in girls; G1 through G5 in boys), M1/G1 were considered prepubertal and other stages pubertal.5

Methods, page 7

Arterial pulse wave velocity and stroke volume

As an additional measure of aortic stiffness, a whole-body impedance cardiography device (CircMon, JR Medical Ltd) was used to determine pulse wave velocity (PWV) and stroke volume at age 19. CircMon includes a whole-body impedance cardiography channel, a distal impedance plethysmogram channel, and an ECG channel. When the pulse pressure wave enters the aortic arch and the diameter of the aorta changes, the whole-body impedance decreases. The CircMon software measures the time difference between the onset of the decrease in the whole-body impedance signal and subsequently in the distal plethysmogram signal from a popliteal artery at knee joint level. The measurement is triggered by the R wave of the ECG. PWV can be determined from the distance and the time difference between the 2
recording sites. A detailed description of the method and the validation study has been reported previously (repeatability index: 99%, reproducibility index: 87%).

Results, page 9:

There was parallel increase by age in pulse pressure and body size and these relations were more pronounced in boys (Table S1). Therefore, we examined if the sex differences in pulse pressure and distensibility were driven by larger changes in body size in boys than girls. To address this, we analyzed the association between sex and pulse pressure when the model was adjusted for weight and height. We found that the sex difference remained significant when weight and height were included in the analysis (P<0.0001). In Table S2, the unadjusted and weight and height adjusted mean values (LS means) for pulse pressure are shown. The data indicate that the sex difference in pulse pressure is not only a reflection of greater increase in body size in boys than in girls.

Additionally, due to the close link between pulse pressure and distensibility, we studied whether the sex difference in distensibility persisted after adjustment for weight and height. For both aortic and carotid distensibility, male sex remained significantly associated with lower aortic and carotid distensibility after adjustment for weight and height (both P<0.0001).

One of the determinants of pulse pressure is stroke volume and these data were available at one time point (age 19). We found that there was a significant association between stroke volume and pulse pressure (β=0.13, SE 0.028, P<0.0001), but stroke volume was not associated with aortic or carotid distensibility (data not shown). We additionally found that boys had greater stroke volume than girls (boys mean±SE: 95.15 ±14.86 ml; girls: 74.45±12.97 ml, P<0.0001). Sex difference in the distensibilities, however, persisted after adjustment for stroke volume (aortic distensibility; β=-0.77, P<0.0001, carotid distensibility; β=-0.40, P<0.0001).
REFERENCES


Table S1. Characteristics of the study cohort by age and sex. Data are given as mean±SD or %.

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<td>60.7 (10.1)</td>
<td>62.8 (11.8)</td>
</tr>
<tr>
<td>Boys</td>
<td>38.6 (7.0)</td>
<td>49.0 (9.8)</td>
<td>61.4 (11.6)</td>
<td>69.3 (10.4)</td>
<td>73.5 (11.3)</td>
</tr>
<tr>
<td><strong>BMI, kg/m²</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Girls</td>
<td>18.1 (2.9)</td>
<td>19.5 (3.3)</td>
<td>20.7 (3.1)</td>
<td>21.7 (3.3)</td>
<td>22.4 (3.9)</td>
</tr>
<tr>
<td>Boys</td>
<td>17.7 (2.5)</td>
<td>19.0 (2.9)</td>
<td>20.2 (3.3)</td>
<td>21.4 (2.9)</td>
<td>22.4 (3.3)</td>
</tr>
<tr>
<td><strong>Waist circumference, cm</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Girls</td>
<td>63.6 (7.5)</td>
<td>69.8 (8.8)</td>
<td>71.4 (7.4)</td>
<td>72.3 (7.6)</td>
<td>74.2 (9.5)</td>
</tr>
<tr>
<td>Boys</td>
<td>64.3 (7.2)</td>
<td>70.3 (8.5)</td>
<td>74.6 (8.5)</td>
<td>76.7 (7.2)</td>
<td>80.3 (8.2)</td>
</tr>
<tr>
<td><strong>Stage of puberty (M/G), range 1-5</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Girls</td>
<td>1.8 (1-4)</td>
<td>3.1 (1-5)</td>
<td>4.2 (3-5)</td>
<td>5.0 (4-5)</td>
<td>5.0 (5)</td>
</tr>
<tr>
<td>Boys</td>
<td>1.6 (1-3)</td>
<td>3.0 (1-5)</td>
<td>4.1 (2-5)</td>
<td>4.9 (4-5)</td>
<td>4.9 (4-5)</td>
</tr>
<tr>
<td><strong>Systolic blood pressure, mmHg</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Girls</td>
<td>104.3 (7.8)</td>
<td>105.5 (8.1)</td>
<td>108.3 (7.7)</td>
<td>110.0 (8.6)</td>
<td>110.8 (9.7)</td>
</tr>
<tr>
<td>Boys</td>
<td>104.9 (8.4)</td>
<td>108.5 (8.0)</td>
<td>118.0 (9.0)</td>
<td>121.4 (10.0)</td>
<td>125.4 (11.6)</td>
</tr>
<tr>
<td><strong>Diastolic blood pressure, mmHg</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Girls</td>
<td>63.3 (5.2)</td>
<td>61.4 (4.5)</td>
<td>61.4 (4.8)</td>
<td>63.3 (5.6)</td>
<td>64.4 (6.0)</td>
</tr>
<tr>
<td>Boys</td>
<td>63.3 (5.5)</td>
<td>61.9 (5.0)</td>
<td>62.5 (5.1)</td>
<td>64.5 (5.7)</td>
<td>66.5 (6.5)</td>
</tr>
<tr>
<td><strong>Pulse pressure, mmHg</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Girls</td>
<td>41.0 (6.2)</td>
<td>44.2 (6.3)</td>
<td>46.9 (6.1)</td>
<td>46.7 (6.2)</td>
<td>46.5 (6.5)</td>
</tr>
<tr>
<td>Boys</td>
<td>41.6 (6.2)</td>
<td>46.5 (6.7)</td>
<td>55.4 (6.9)</td>
<td>57.0 (7.8)</td>
<td>59.0 (8.7)</td>
</tr>
</tbody>
</table>
Table S2. Mean unadjusted and weight and height adjusted pulse pressure (PP) values by sex and age.

<table>
<thead>
<tr>
<th>Age</th>
<th>Girls PP unadjusted</th>
<th>Girls PP adj weight height</th>
<th>Boys PP unadjusted</th>
<th>Boys PP adj weight height</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>40.96</td>
<td>40.53</td>
<td>41.54</td>
<td>41.65</td>
</tr>
<tr>
<td>13</td>
<td>44.18</td>
<td>43.92</td>
<td>46.58</td>
<td>46.61</td>
</tr>
<tr>
<td>15</td>
<td>46.91</td>
<td>47.52</td>
<td>55.39</td>
<td>54.43</td>
</tr>
<tr>
<td>17</td>
<td>46.71</td>
<td>48.02</td>
<td>56.91</td>
<td>55.37</td>
</tr>
<tr>
<td>19</td>
<td>46.48</td>
<td>48.55</td>
<td>58.89</td>
<td>56.75</td>
</tr>
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</table>
Table S3. Sex-adjusted correlation between aortic (Adist) and carotid distensibility (Cdist) and left ventricular mass indexed to body surface area (LVM/BSA).

<table>
<thead>
<tr>
<th>Correlation between variables</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>11y</td>
</tr>
<tr>
<td>Adist vs. Cdist</td>
<td>0.34</td>
</tr>
<tr>
<td>(n=395)</td>
<td>(n=470)</td>
</tr>
<tr>
<td>P&lt;0.0001</td>
<td>P&lt;0.0001</td>
</tr>
<tr>
<td>Adist vs. LVM/BSA</td>
<td>-0.14</td>
</tr>
<tr>
<td>(n=392)</td>
<td>(n=378)</td>
</tr>
<tr>
<td>P=0.0069</td>
<td>P=0.19</td>
</tr>
<tr>
<td>Cdist vs. LVM/BSA</td>
<td>-0.15</td>
</tr>
<tr>
<td>(n=416)</td>
<td>(n=389)</td>
</tr>
<tr>
<td>P=0.0023</td>
<td>P=0.60</td>
</tr>
</tbody>
</table>
Figure S1. Mean±SD aortic (Adist) and carotid distensibility (Cdist) by pubertal status (Tanner 1-5) in girls and boys.
Figure S2. Correlations of aortic (Adist) and carotid distensibility (Cdist) measured at the age of 11 years with subsequent measurements at the age of 13, 15, 17 and 19 years.
血管（摘要）

透析人群主动脉-肱动脉僵硬度不匹配与死亡率的关系

Aortic-Brachial Stiffness Mismatch and Mortality in Dialysis Population
Catherine Fortier, Fabrice Mac-Way, Simon Desmeules, Karine Marquis, Sacha A. De Serres, Marcel Lebel, Pierre Boutouyrie, Mohsen Agharazii

朱彦琪 译  龚秋艳 审校

主动脉（中央弹性动脉）僵硬度上升，同时伴有肱动脉（外周弹性动脉）僵硬度下降，从而导致动脉系统生理僵硬度梯度倒，称为“不匹配”。假设这种动脉僵硬度不匹配，由于增加传入微循环的前向压力，会加重靶器官损害。为验证这一假设，该研究在透析患者中开展一项前瞻性研究，观察主动脉-肱动脉僵硬度不匹配对死亡率的影响。310例透析患者，测量颈-肱动脉脉搏传导速度（CPWV）和颈-挠动脉脉搏传导速度（CrPWV），前者除以后者的比值，即脉搏传导速度比值（PWV比值），作为主动脉-肱动脉僵硬度不匹配的定量指标。中位随访时间29个月，146例患者死亡（47%）。Cox回归分析发现，PWV比值相关的死亡风险比（HR）是1.43（95%可信区间，1.24~1.64，P<0.001），而且在校正了年龄、透析年限、性别、心血管疾病、糖尿病、吸烟和体重多项影响因素后，依然有统计学意义（HR=1.23，95%可信区间 1.02~1.49）。单变量分析发现，反射波增强指数（HR=1.35，95% CI：1.12~1.63）、CPWV（HR=1.29，95% CI：1.11~1.50）、CrPWV（HR=0.80，95% CI：0.67~0.95）每变化一个标准差带来的风险比具有统计学差异，但是校正年龄因素后，统计学意义消失。结论：主动脉-肱动脉僵硬度不匹配是透析患者死亡率上升的独立强相关因素。在其他低危人群中是否存在同样相关性，尚待进一步研究证实。

（Hypertension. 2015;65:378-384.）

血流动力学（摘要）

从儿童期到成年早期主动脉和颈动脉弹性与左心室质量的关系

Distensibility of the Aorta and Carotid Artery and Left Ventricular Mass From Childhood to Early Adulthood
Hanna Mikola, Katja Pahkala, Taapani Rönnermaa, Jorma S.A. Viikari, Harri Niinikoski, Eero Jokinen, Pia Salo, Olli Simell, Markus Juonala, Olli T. Raitakari

孙瑞 译 罗素新 审校

成人动脉弹性随年龄的增长而减退，并与左心室质量相关。但有关动脉弹性从儿童期到成人期变化的纵向资料尚欠缺。本研究旨在研究年龄、性别以及给予低饱和脂肪饮食指导后对儿童至成年早期动脉弹性的影响。另外，也评估了动脉弹性与左心室质量之间的相关性。芬兰的一项预防动脉粥样硬化的试验[图尔库冠心病危险因素干预项目（STRIP）]中，分别在受试者11、13、15、17和19岁时对其腹主动脉和颈动脉的弹性指标进行重复测量。结果显示，主动脉和颈动脉的弹性均随年龄增加而减退（P<0.001）。男孩的动脉弹性指标更低（P<0.0001），且随年龄增加显示出血管弹性减退更迅速（年龄和性别与血管弹性减退的相关性：两者均P<0.01）。在STRIP试验中，给予低饱和脂肪饮食指导与动脉弹性减退无显著相关性。左心室质量随年龄增加而增加（P<0.0001），在男孩中增加更显著（P<0.0001）。总体而言，与年龄相关的血管弹性减退，在年龄较小时就已经存在，并且与男孩相比，男孩的血管弹性减退更明显。主动脉与颈动脉弹性的进行性减退与左心室质量的改变相关。

（Hypertension. 2013;65:146-152.）