Effects of Hypertension and Obesity on the Sympathetic Activation of Heart Failure Patients

Guido Grassi, Gino Seravalle, Fosca Quarti-Trevano, Raffaella Dell’Oro, Gianbattista Bolla, Giuseppe Mancia

Abstract—Previous studies have shown that congestive heart failure is characterized by sympathetic and reflex dysfunctions. Whether these alterations are potentiated in the presence of obesity and hypertension, two conditions that also display neuroadrenergic abnormalities and markedly increase the risk of heart failure, is unknown. In 14 healthy control subjects (C; age, 55.1±3.0 years; mean±SEM), 13 lean hypertensive subjects (H), 15 obese normotensive subjects (O), 14 lean normotensive subjects with congestive heart failure (CHF, New York Heart Association class II), 14 lean hypertensive subjects with CHF (CHFH), 14 obese normotensive subjects with CHF (CHFO), and 13 obese hypertensive subjects with CHF (CHFOH), all age-matched with C, we measured mean blood pressure (Finapres), heart rate (ECG), and muscle sympathetic nerve traffic (MSNA, microneurography) at rest and during baroreflex testing. Compared with C, body mass index was similarly increased in O, CHFO, and CHFOH, whereas mean blood pressure was similarly increased in HF, CHFH, and CHFOH, and left ventricular ejection fraction (echocardiography) was similarly reduced in CHF, CHFH, CHFO and CHFOH. Compared with C, MSNA was significantly increased in O, H, and CHF (43.0±2.2 versus 54.1±2.8, 53.1±2.5, and 57.4±2.8 bursts/100 heart beats, P<0.01). When O or H was combined with CHF, the MSNA increase was significantly more pronounced and maximal when O and H were concomitantly associated with CHF. Baroreflex sensitivity was reduced in O and H, with a further reduction in CHF and a minimal value in CHFOH. These data show that the sympathetic activation characterizing CHF is markedly potentiated when O and H alone or combined together are associated with a low cardiac output state and that this may depend on an arterial baroreflex impairment. (Hypertension. 2003;42:666-674.)

Key Words: hypertension, essential □ obesity □ congestive heart failure □ sympathetic nervous system □ autonomic nervous system □ baroreceptors

Patients with congestive heart failure are characterized by an increase in sympathetic activity whose magnitude is proportional to the heart failure severity, as assessed by clinical or hemodynamic criteria.1–5 They are also characterized, proportional to the heart failure severity,1,4–5 the reasons for which are poorly understood. This is an important limitation because in heart failure, sympathetic activity is an independent predictor of death second to few or no other factors.6–9

In the present study, we examined whether the increase in sympathetic activity seen in heart failure states of moderate severity depends on the concomitant presence of two conditions known to stimulate sympathetic activity in absence of heart failure, obesity and hypertension.10–16 That is, whether in lean and/or normotensive patients with heart failure, sympathetic activity is less than in patients with heart failure displaying an increase in body weight and/or blood pressure (BP). To this aim, sympathetic nerve activity was quantified by microneurography and plasma norepinephrine (NE) in several groups of age-matched patients who had heart failure of similar severity that differed in the presence or absence of obesity, hypertension, or hypertension and obesity combined. The study included an assessment of the baroreceptor ability to restrain sympathetic nerve traffic because the sympathetic activation typical of all 3 conditions has been frequently ascribed to an impairment of the baroreflex.11,13,15

Methods

Study Population

The study population consisted of 97 male subjects (age ranging from 51 to 61 years) recruited for this investigation between 1998 and 2002. Recruitment criteria consisted of the presence or absence of (1) congestive heart failure as determined by symptoms and alterations in echocardiographic left ventricular structure and function, (2) hypertension as determined by an elevation in BP values (≥140 mm Hg systolic and/or 90 mm Hg diastolic), and (3) normal body weight (body mass index <25 kg/m²) or obesity (body mass index ≥30 kg/m²). Subjects were excluded from the study if they had (1) secondary hypertension, (2) atrial fibrillation or other major...
Baseline Demographic, Anthropometric, Echocardiographic, and Hemodynamic Variables in the Different Groups of Patients

<table>
<thead>
<tr>
<th></th>
<th>C (n=14)</th>
<th>H (n=13)</th>
<th>O (n=15)</th>
<th>CHF (n=14)</th>
<th>CHFH (n=14)</th>
<th>CHFO (n=14)</th>
<th>CHFOH (n=13)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, y</td>
<td>55.1±3.0</td>
<td>54.9±2.8</td>
<td>55.3±2.8</td>
<td>57.0±2.7‡‡§</td>
<td>55.1±3.1‡‡§</td>
<td>56.5±3.0‡‡§</td>
<td>56.9±3.2‡‡§</td>
</tr>
<tr>
<td>LVEF, %</td>
<td>67.4±1.9</td>
<td>67.6±1.8</td>
<td>68.0±1.7</td>
<td>39.5±2.6†‡‡§</td>
<td>38.7±2.5‡‡§</td>
<td>38.8±2.7†‡‡§</td>
<td>38.1±2.8†‡‡§</td>
</tr>
<tr>
<td>LVEDD, mm</td>
<td>51.8±1.2</td>
<td>52.0±1.4*</td>
<td>51.6±1.6‡</td>
<td>63.3±2.3‡§</td>
<td>63.7±2.4¶</td>
<td>63.8±2.4</td>
<td>64.2±2.7¶‡</td>
</tr>
<tr>
<td>LVMI, g/m²</td>
<td>100.6±4.1</td>
<td>112.1±5.0</td>
<td>103.2±4.4†‡‡§</td>
<td>99.6±4.3‡</td>
<td>114.2±5.1§</td>
<td>110.5±4.2†‡‡§</td>
<td>116.3±6.0†‡‡§</td>
</tr>
<tr>
<td>BMI, kg/m²</td>
<td>23.9±1.0</td>
<td>24.0±0.9‡</td>
<td>32.5±1.2†‡</td>
<td>23.7±0.8‡</td>
<td>24.0±0.9¶</td>
<td>32.8±1.3</td>
<td>33.0±1.2†‡</td>
</tr>
<tr>
<td>S-MBP, mm Hg</td>
<td>88.9±2.5</td>
<td>111.1±2.3†</td>
<td>90.2±2.6‡</td>
<td>88.0±2.3‡</td>
<td>112.6±2.8¶</td>
<td>91.3±2.4</td>
<td>113.8±2.7</td>
</tr>
<tr>
<td>F-MBP, mm Hg</td>
<td>88.3±2.4</td>
<td>110.7±2.6</td>
<td>89.5±2.5</td>
<td>86.7±2.5†‡‡§</td>
<td>111.4±2.9‡§</td>
<td>89.5±2.6‡¶</td>
<td>112.1±3.0†§¶#</td>
</tr>
<tr>
<td>Respiratory rate, breaths/min</td>
<td>19.0±1.3</td>
<td>19.4±1.4</td>
<td>19.6±1.8</td>
<td>19.8±2.0</td>
<td>19.7±2.1</td>
<td>20.2±2.6</td>
<td>20.4±2.2</td>
</tr>
</tbody>
</table>

LVEF indicates left ventricular ejection fraction; LVEDD, left ventricular end-diastolic diameter; LVMI, left ventricular mass index; BMI, body mass index; S-MBP, sphygmonanometric mean blood pressure; F-MBP, finger mean blood pressure. Group designations: C indicates control; H, hypertension; O, obesity; CHF, congestive heart failure; CHFH, CHF and hypertension; CHFO, CHF and obesity; and CHFOH, CHF, obesity, and hypertension. *P<0.05; †P<0.01 vs C; ‡P<0.01 vs H; §P<0.01 vs O; ¶P<0.05; ¶¶P<0.01 vs CHF; #P<0.05; **P<0.01 vs CHFH.

Results

As shown in the Table, the 7 groups of subjects had a similar mean age. Compared with control subjects, body mass index was similarly increased in the 3 groups of subjects with obesity (obese normotensive patients, patients with obesity and heart failure, and patients with obesity, hypertension, and heart failure), whereas BP was similarly increased in the 3 groups of subjects with hypertension (lean hypertensive patients, patients with hypertension and heart failure, and patients with obesity, hypertension, and heart failure). Compared with control subjects, obese normotensive subjects, and with lean hypertensive subjects, LVEF and LVEDD were similarly reduced and increased, respectively, in the 4 groups of patients with heart failure, who also showed a marked increase in PRA (Figure 1). This was not the case for the markers of sympathetic activity,
however, which showed several between-groups differences. (1) Compared with control subjects, MSNA values were greater in obese normotensive subjects, lean hypertensive subjects, and patients with heart failure. (2) In patients with heart failure, the increase was more pronounced with the concomitance of obesity or hypertension and maximal when both conditions were present. NE values showed a similar trend, although the between-group differences were less frequently statistically significant. In the entire study population, there was a significant although modest direct relation between MSNA and PRA values ($r = 0.31$, $P < 0.02$). This was also the case for NE and PRA ($r = 0.25$, $P < 0.05$).

Figure 1. Baseline plasma renin activity (PRA), plasma norepinephrine (NE), and muscle sympathetic nerve activity (MSNA, expressed as burst incidence over time and corrected for heart rate) values in control subjects (C) and in patients with hypertension (H), obesity (O), congestive heart failure (CHF), congestive heart failure and hypertension (CHFH), congestive heart failure and obesity (CHFO), and congestive heart failure combined with hypertension and obesity (CHFOH). Data are shown as mean±SEM. *$P<0.05$, **$P<0.01$ vs C; †$P<0.05$, ††$P<0.01$ vs H; ‡$P<0.05$, §§$P<0.01$ vs O; §$P<0.05$, §§§$P<0.01$ vs CHF; $\approx P<0.05$ vs CHFH; ‡$P<0.05$ vs CHFO.

Figure 2 shows that in all groups of patients, MSNA and HR decreased linearly as MBP increased progressively from the lowest value observed with the greatest nitroprusside dose to the highest value observed with the greatest phentolamine dose, the 3 hypertensive groups (hypertension alone, hypertension and heart failure, and hypertension and obesity, and heart failure) showing a resetting toward higher BP values compared with 4 normotensive groups (lean normotensive, obesity alone, heart failure alone, obesity and heart failure). Figure 3 shows the changes in MBP, HR, and MSNA induced by phentolamine and nitroprusside in the 7 groups. Compared with control subjects, for similar MBP changes, the HR responses to arterial baroreceptor stimulation and deactivation were reduced in obese normotensive and lean hypertensive subjects, with a further reduction in patients with heart failure and a minimal value in those in whom heart failure was accompanied by obesity and hypertension. This was the case also for the MSNA responses to arterial baroreceptor manipulation with the exception of lean hypertensive subjects, in which they were no less than those of control subjects. Similar data were obtained when calculation of baroreceptor HR and MSNA sensitivity was performed with the use of SBP, DBP, or MBP as indicators of the stimulus to arterial baroreceptors (Figure 4).

Discussion

The present study shows that in congestive heart failure belonging to NYHA class II, sympathetic activity is increased. Data further show, however, that the increase is greater if patients are hypertensive or obese and that the sympathetic activation is even more pronounced if obesity and hypertension are concomitantly present. Thus, the sympathetic activation that occurs in heart failure depends both on heart failure per se and, to a measurable extent, on conditions such as obesity and hypertension that can induce sympathetic activation before heart failure and that do not lose this effect when heart failure occurs. This has clinical relevance because in heart failure, sympathetic activity has an independent negative relation with death. To know that this activity is likely to be greater when BP is high...
and/or body weight is above normal thus offers a piece of information of prognostic significance that may help proper assessment (and proper management) of overall risk in a substantial fraction of patients.

Our study does not clarify the mechanisms responsible for the greater sympathetic activation observed when heart failure is accompanied by obesity and/or hypertension. The data obtained, however, allow some possibilities to be ruled out and others to be meaningfully discussed. First, we can rule out that the greater sympathetic activities seen when heart failure was associated with hypertension and/or obesity were due to a greater heart failure severity because (1) patients were only selected if the heart failure condition belonged to NYHA class II and (2) the groups that were compared had similar average values of LVEF and LVEDD. Second, we can rule out that differences in drug treatment were responsible because patient hospitalization allowed withdrawal of drugs that are known to affect sympathetic cardiovascular influences (digitalis, β-blockers, ACE inhibitors, and calcium antagonists) and to uniformly maintain patients on diuretics only. Third, we can rule out that a between-group imbalance of patients with ischemic heart failure versus idiopathic cardiomyopathy was involved because when the heart failure severity is matched, these two conditions do not trigger a different degree of sympathetic activation. Fourth, we can on the other hand suggest that because of its clear-cut sympatho-stimulating effect, angiotensin II is involved because (1) the increase in resting PRA levels and the impairment of baroreflex ability to modulate MSNA were most pronounced in patients with heart failure with than without obesity and hypertension and (2) in all our subjects, PRA showed a significant albeit limited direct relation with MSNA or NE. We can finally suggest, however, that a more important factor involved in the greater sympathoexcitation seen in patients in whom heart failure was accompanied by hypertension and/or obesity is the arterial baroreflex because the impaired ability of baroreceptors to restrain HR and MSNA, known to account for the neurohumoral activation of heart failure, was more pronounced in presence of obesity and hypertension, reaching its maximum when these two conditions occurred together. It should be emphasized that this leaves open the question of the reasons why the baroreflex is progressively impaired from lean to obese and/or hypertensive patients with heart failure, although we can speculate that a progressive increase in arterial stiffness, on which baroreceptor responses to BP stimuli depend, is responsible. We cannot exclude, however, that factors other than baroreflex impairment are also importantly involved because

**Figure 3.** Changes in heart rate (ΔHR, expressed as b/min) and muscle sympathetic nerve activity (ΔMSNA, expressed as absolute and percent [%] integrated activity [i.a.]) accompanying stepwise increases and reductions in mean blood pressure (ΔMBP) induced by intravenous infusions of phenylephrine and nitroprusside. Data are shown as mean±SEM in the 7 groups of patients of Figure 1. For symbols and explanations see Figure 1.

**Figure 4.** Sensitivities of baroreceptor–heart rate and baroreceptor–muscle sympathetic nerve activity expressed as average ratios between changes in heart rate (ΔHR) or muscle sympathetic nerve activity (ΔMSNA) and changes in systolic blood pressure (ΔSBP), diastolic blood pressure (ΔDBP), and mean blood pressure (ΔMBP) in the 7 groups of patients of Figure 1. MSNA is expressed as percent (%) and absolute integrated activity (i.a.). Data are shown as mean±SEM. For symbols and explanations see Figure 1.
despite different degrees of sympathetic activation, patients with heart failure with hypertension or obesity had similar reduction in baroreflex sensitivity. We can speculate, for example, that since sleep apnea is likely to be progressively more common from control to complicated heart failure conditions,23 chemo-receptor reflexes play a role.24 In addition, other reflexes (cardiopulmonary reflexes), varying degrees of insulin resistance and insulinemia, and greater or smaller participation of central influences are all possible candidates.16,25–26

A final point should be mentioned, namely that in line with observations made in other conditions or diseases,5,11,13,18 the different degrees of sympathetic activation seen in the four heart failure groups were more clear and consistent when quantification of adrenergic activity was based on MSNA than when an indirect marker such as NE was used. This may erase any previous or concomitant influence unrelated to similar differentiation or a greater degree of sympathetic activation in patients with severe congestive heart failure and their relation to mortality. Circulation. 1990;82:1730–1736.

Perspectives

The results of the present study show that the sympathetic influences of conditions preceding and favoring heart failure do not vanish as heart failure occurs and that clinical data allow some differentiation of the neurohumoral profile of this disease. This, however, concerns patients with heart failure of moderate severity. Whether more severe heart failure is characterized by a similar differentiation or a greater degree of sympathetic activation erases any previous or concomitant influence unrelated to heart failure per se remains to be determined. It should also be emphasized, however, that both hypertension and obesity tend to abate as heart failure severity progresses. Thus, their role in differentiating sympathetic activity might be less in advanced than in moderate heart failure.

References

Effects of Hypertension and Obesity on the Sympathetic Activation of Heart Failure Patients
Guido Grassi, Gino Seravalle, Fosca Quarti-Trevano, Raffaella Dell'Oro, Gianbattista Bolla and Giuseppe Mancia

Hypertension. published online October 20, 2003;
Hypertension is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2003 American Heart Association, Inc. All rights reserved.
Print ISSN: 0194-911X. Online ISSN: 1524-4563

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://hyper.ahajournals.org/content/early/2003/10/20/01.HYP.0000098660.26184.63.citation

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published in Hypertension can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the Permissions and Rights Question and Answer document.

Reprints: Information about reprints can be found online at:
http://www.lww.com/reprints

Subscriptions: Information about subscribing to Hypertension is online at:
http://hyper.ahajournals.org//subscriptions/