Ambient Temperature and Biomarkers of Heart Failure: A Repeated Measures Analysis

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BACKGROUND: Extreme temperatures have been associated with hospitalization and death among individuals with heart failure, but few studies have explored the underlying mechanisms.

OBJECTIVES: We hypothesized that outdoor temperature in the Boston, Massachusetts, area (1- to 4-day moving averages) would be associated with higher levels of biomarkers of inflammation and myocyte injury in a repeated-measures study of individuals with stable heart failure.

METHODS: We analyzed data from a completed clinical trial that randomized 100 patients to 12 weeks of tai chi classes or to time-matched education control. B-type natriuretic peptide (BNP), C-reactive protein (CRP), and tumor necrosis factor (TNF) were measured at baseline, 6 weeks, and 12 weeks. Endothelin-1 was measured at baseline and 12 weeks. We used fixed effects models to evaluate associations with measures of temperature that were adjusted for time-varying covariates.

RESULTS: Higher apparent temperature was associated with higher levels of BNP beginning with 2-day moving averages and reached statistical significance for 3- and 4-day moving averages. CRP results followed a similar pattern but were delayed by 1 day. A 5°C change in 3- and 4-day moving averages of apparent temperature was associated with 11.3% (95% confidence interval (CI): 1.1, 22.5; p = 0.03) and 11.4% (95% CI: 1.2, 22.5; p = 0.03) higher BNP. A 5°C change in the 4-day moving average of apparent temperature was associated with 21.6% (95% CI: 2.5, 44.2; p = 0.03) higher CRP. No clear associations with TNF or endothelin-1 were observed.

CONCLUSIONS: Among patients undergoing treatment for heart failure, we observed positive associations between temperature and both BNP and CRP—predictors of heart failure prognosis and severity.

KEY WORDS: biomarkers, climate variability, heart failure, outdoor air, susceptibility. Environ Health Perspect 120:1083–1087 (2012). http://dx.doi.org/10.1289/ehp.1104380 [Online 15 May 2012]
York Heart Association 1994). The exclusion criteria were unstable angina or myocardial infarction in the past 3 months, major cardiac surgery within the past 3 months, history of cardiac arrest in the past 6 months, history of cardiac resynchronization therapy in the past 3 months, unstable serious ventricular arrhythmias, unstable structural valvular disease, current participation in a conventional cardiac rehabilitation program, diagnosis of peripartum cardiomyopathy within the preceding 6 months, inability to perform a bicycle stress test, lower extremity amputation or other inability to ambulate because of conditions other than heart failure, severe cognitive dysfunction (Mini-Mental State Examination score ≤ 24; Folstein et al. 1975), inability to speak English, or regular practice of tai chi.

Pollution and weather data. Ambient temperature, relative humidity, dew point temperature, and barometric pressure were obtained from the National Weather Service (National Climatic Data Center 2011) daily summaries of meteorological data measured at Logan International Airport (Boston, MA). Apparent temperature is a metric used to describe how people perceive the combination of temperature and humidity (Steadman 1984). The values for apparent temperature are based on the measures of ambient and dew point temperature and were calculated using the following formula:

\[
y_{at} = X_{di} \beta + \alpha_i + e_{it}, \tag{2}
\]

where \(y_{at}\) is the outcome \(y\) at time \(t\) for the \(i\)th subject, \(X_{di}\) is a matrix of time-varying predictors, \(\alpha_i\) is a random intercept for each subject, and \(e_{it}\) is the error term. In the primary analyses, ambient and apparent temperature were modeled as continuous linear functions. All models were adjusted for time and seasonality using a harmonic function \(\sin(2\pi \times \text{day of year}/365.25)\) and cosine \(\cos(2\pi \times \text{day of year}/365.25)\), day of week, and body weight at each visit as a marker of hydration status. Models of ambient temperature were additionally adjusted for corresponding moving-average values of relative humidity and barometric pressure. Models of apparent temperature were adjusted for barometric pressure only because the formula for apparent temperature accounts for the dew point temperature. We also tested for effect modification by diabetes status, sex, and randomization to the tai chi treatment arm of the study using cross-product terms and examining statistical significance at \(p < 0.05\).

In a sensitivity analysis, we adjusted for corresponding moving averages of PM2.5 and ozone in separate models. We also included both linear and quadratic terms for relative humidity and pressure. To further explore potential nonlinear relationships, we used the mgcv package for generalized additive models (version 1.6; R Foundation for Statistical Computing) to fit penalized splines. We hypothesized that changes in temperature could be associated with different physiologic intra-assay and interassay for these kits were 8.8–11.6% and 9.9–12.2%, respectively, for BNP; 4.2–6.4% and 4.8–10.0%, respectively, for CRP; 3.1% and 6.7%, respectively, for endothelin-1; and 5.3% and 8.4%, respectively, for TNF.

### Biomarkers

Blood samples were drawn from participants in a nonfasting state at the time of the study visit. BNP was analyzed in whole blood collected in EDTA (ethylene-diamine-tetraacetic acid) using a commercially available point-of-service meter (fluorescence) and the QuantiGLO ELISA (Siemens AG), and for lin-1 using DPC Siemens chemiluminescent Immulite high sensitivity hsCRP immunoassay (Diagnostic Products Corporation). Serum samples were also analyzed for CRP using DPC Biosite Diagnostics, San Diego, CA). Serum samples were also analyzed for CRP using DPC-Biosite Diagnostics, San Diego, CA). Serum samples were also analyzed for CRP using DPC-Biosite Diagnostics, San Diego, CA).

### Table 1. Patient characteristics at initial visit.

| Characteristic                          | Mean ± SD or no. of participants |
|----------------------------------------|----------------------------------|
| Age (years)                            | 67 ± 12.0                         |
| Sex (female)                           | 36                               |
| Nonwhite ethnicity                     | 14                               |
| Income > $50,000                       | 42                               |
| Refused to answer                      | 14                               |
| Smoking†                               | 10                               |
| Alcohol use ‡                          | 48                               |
| Left ventricular ejection fraction     | 29.0 ± 7.6                        |
| NYHA class heart failure               |                                  |
| I                                      | 20                               |
| II                                     | 63                               |
| III                                    | 17                               |
| Cardiovascular comorbidities           |                                  |
| Myocardial infarction                  | 58                               |
| Diabetes mellitus                      | 35                               |
| Hypertension                           | 70                               |
| Previous procedures                    |                                  |
| Coronary artery bypass graft           | 36                               |
| Valve repair/replacement               | 14                               |
| Stent                                  | 49                               |
| Medications                            |                                  |
| Beta blockers                          | 86                               |
| ACE-inhibitors/angiotensin receptor    | 85                               |

*‡ = 100 participants. †Current use (yes).

### Table 2. Pollution and meteorology for study visit days (n = 285).

| Pollution and weather                        | Mean ± SD | Median | Minimum | Maximum |
|----------------------------------------------|-----------|--------|---------|---------|
| Ambient temperature (°C)                     | 13 ± 9    | 14     | -11     | 27      |
| Relative humidity (%)                        | 66 ± 15   | 66     | 30      | 99      |
| Barometric pressure (mmHg)                   | 761 ± 7   | 760    | 740     | 776     |
| Ozone (ppb)                                  | 24 ± 10   | 22     | 30      | 66      |
| PM2.5 (µg/m³)                                | 8.7 ± 5.3 | 7.2    | 0.2     | 22.5    |
responses in summer and winter. Therefore, we performed sensitivity analyses by subsetting to season when visits began, defined as warm (March through August) or cool (September through February) seasons and also tested for interactions using a cross-product term and examining statistical significance of this term at $p < 0.05$. In a sensitivity analysis, we also fit linear-mixed models with random effects for all four biomarkers using the lme package. No material difference was observed, so we present results for fixed effects only. All results are presented as a percent change for a 5°C increase in either ambient or apparent temperature measure with 95% confidence interval (CI). This increment was chosen to be representative of day-to-day variability in temperature in the Boston area.

**Results**

In Table 1, we show the characteristics of the study population. Participants were predominantly male (64%) and white (86%). The age at baseline ranged from 34 to 96 years (mean ± SD of 67.4 ± 12). Table 2 summarizes the daily meteorological data during the study period. Ambient temperature ranged from −11 to 27°C throughout the study period (mean ± SD of 12.5 ± 9.0) and was highly correlated with apparent temperature (Spearman correlation $> 0.9$). The median of the within-person range in ambient temperature across study visits was 13°C. The largest within-person range in both ambient and apparent temperature was observed for participants who began the study in mid-September, when Boston weather patterns may still be quite like summer, and who completed the study in mid-December. Distributions of the biomarkers and their correlations are described in Table 3 by visit. All 100 participants in the study provided baseline blood samples for the BNP assessment. Three samples were available for 89 of these participants. There were four participants who provided only one sample. Endothelin-1 measures typically occurred at visits 1 and 3, but 8 samples were analyzed at visit 2 when visit 1 or visit 3 data were unavailable. Figure 1 shows the results from the fully adjusted models of apparent temperature. Higher apparent temperature was associated with higher levels of BNP beginning with 2-day moving averages and reached statistical significance for 3- and 4-day moving averages. Specifically, we observed that a 5°C change in 3- and 4-day moving averages of apparent temperature were positively associated with an 11.3% higher (95% CI: 1.1, 22.5; $p = 0.03$) and an 11.4% higher (95% CI: 1.2, 22.5; $p = 0.03$) BNP, respectively. CRP results followed a similar pattern, but were delayed by 1 day; CRP levels were significantly higher after 4-day moving averages, and a 5°C change in apparent temperature was associated with 21.6% higher CRP (95% CI: 2.5, 44.2; $p = 0.03$). No clear association was observed between apparent temperature and endothelin-1 or TNF. Inclusion of outliers did not materially change these findings. Similar results were observed for ambient temperature for all outcomes (data not shown). We found no evidence of effect modification by season, diabetes status, sex, or randomization to tai chi treatment using cross-product terms and a $p$-value of 0.05 as the criterion for significance (data not shown).

In the analyses examining exposure–response relationships between temperature and biomarkers, we did not observe substantial deviations from linearity [see Supplemental Material, Figure S1 (http://dx.doi.org/10.1289/ehp.1104380)]. We observed no clear evidence of nonlinear relationships, and none of the spline terms were statistically significant (all $p > 0.05$). Adjustment for PM$_{2.5}$ or ozone as potential confounders did not substantially alter our results (data not shown).

**Discussion**

In this analysis of the association between temperature measures and biomarkers related to inflammation and cardiovascular function in a population of heart failure patients, we observed higher levels of BNP beginning with 2-day moving averages. These results reached statistical significance for moving averages of 3 and 4 days. CRP results followed a similar pattern but were delayed by 1 day. These two biomarkers reflect interrelated mechanisms known to be associated with heart failure prognosis and symptom severity. CRP is a marker of systemic inflammation and is associated with risk of heart failure decompensation (Sato et al. 1999), whereas BNP is more specifically a marker of increasing hemodynamic load used in diagnosis and risk stratification among patients with congestive heart failure (Koglin et al. 2001). Pre discharge BNP is a strong independent predictor of postdischarge outcome (Logeart et al. 2004) and long-term prognosis (Latini et al. 2002).

To our knowledge, this is the first evidence that within-person BNP levels may be elevated during episodes of increased temperature. The results reported in this study are scaled to a 5°C change. Because we were examining associations across a season, the within-person differences in temperature could be quite large. We selected a 5°C change to represent the typical day-to-day variability in temperature within the Boston area. This is well within the range of data that we observe and represents a relatively small within-person change.

The levels of the inflammatory markers we observed in our study population of individuals with heart failure were elevated, as expected in a population of heart failure patients. For example, a BNP level of 100 pg/mL is typically used as a clinical cutoff for diagnosis of heart failure and decompensation, and the prognostic value of elevated plasma BNP in symptomatic systolic heart failure has been consistently reliable in various clinical settings (Cheng et al. 2001). For context, the magnitude of the association between temperature and

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**Table 3. Description of inflammatory markers at each visit.**

| Biomarkers     | Visit 1 | | | Visit 2 | | | Visit 3 | |
|----------------|---------|----------------|----------------|---------|----------------|----------------|---------|----------------|----------------|
|                | Median  | Geometric      | 25th, 75th percentile | Median  | Geometric      | 25th, 75th percentile | Median  | Geometric      | 25th, 75th percentile |
| BNP (pg/mL)    | 100     | 112.48         | 103.5 (44.3, 284.5) | 92      | 97.71          | 90.4 (40.9, 238)  | 93      | 106.54         | 110 (46.7, 223)    |
| CRP (mg/L)     | 81      | 2.81           | 3.1 (0.94, 6.89)    | 76      | 2.17           | 1.84 (0.92, 5.61) | 73      | 2.58           | 1.88 (0.92, 7.86)  |
| Endothelin-1 (pg/mL)* | 90 | 2.31           | 2.32 (1.80, 2.90)  | 8a      | 1.813          | 1.77 (1.56, 2.03) | 90      | 2.42           | 2.39 (1.94, 2.92)  |
| TNF (pg/mL)*   | 95      | 1.70           | 1.65 (1.11, 2.07)  | 89      | 1.65           | 1.59 (1.14, 2.19) | 86      | 1.62           | 1.47 (1.19, 2.02)  |

*Outlier observations are included. *Endothelin-1 measures typically occurred at visits 1 and 3, but 8 samples were analyzed at visit 2 when visit 1 or visit 3 data were unavailable.
BNP observed in this study indicates that 10°C higher temperature is associated with approximately one-third of the impact of a transient increase in sodium load from 1,610 mg/day to 5,750 mg/day for subjects with established heart failure, a stimulus that may trigger decompensation in some patients (Damgaard et al. 2007).

Most prior studies of environmental determinants in heart failure patients have focused on hospitalizations and mortality rather than symptoms and preclinical changes. Studies that have examined seasonal trends in hospital admissions and mortality for heart failure have typically observed a winter peak (Barnett et al. 2008; Boulay et al. 1999; Stewart et al. 2002). In a recent study, Gotsman et al. (2010) examined the association between temperature and prognosis in heart failure patients. They showed greater rates of hospitalization in the winter time but also found that warmer weather and admission during summer months were positively associated with symptom severity, prognosis, and reduced survival. To our knowledge, there is only one panel study that has directly examined health effects of temperature in heart failure patients. In this study, which was conducted in Montreal, Quebec, Goldberg et al. (2008) found an inverse association between oxygen saturation and maximum air temperature and relative humidity. They also found that maximum ambient air temperature, higher relative humidity, and ozone on the concurrent day predicted poorer self-reported general health (Goldberg et al. 2009). In our analyses of associations between temperature and biomarkers of heart failure, we observed positive associations with higher air temperature moving averages but not with relative humidity or ozone. This result may be due to the differences in the outcomes and also the differences in time windows assessed, Goldberg only tested lags of 0–2 days (3-day average). Our findings suggest an association with BNP after only two days, but it is possible that longer integrated averages of temperature over several days, which reflect a period of prolonged elevated temperature, are necessary to observe upregulation of CRP.

We are not aware of any previous studies investigating the effects of temperature with BNP or with CRP in heart failure patients. However, prior studies have reported the associations between temperature and CRP in other populations, and the results have been mixed (Halonen et al. 2010; Hampel et al. 2010; Schneider et al. 2008). Halonen et al. (2010) estimated temperature effects in a relatively healthy cohort of men and also observed inverse associations between temperature and CRP for lags of 0–1 day and for moving averages of up to 4 weeks. Schneider et al. (2008) measured CRP within a population of myocardial infarction survivors and observed inverse associations with temperature for averages and lags < 1 week. However, a more recent study by Hampel et al. (2010) contrasted patients with coronary heart disease and pulmonary disease in their responses to temperature and found no association with CRP among patients with pulmonary disease and lower CRP associated with lower temperature (corresponding to a positive association) for almost all lags among coronary heart disease patients. As has been suggested by these authors, differences in populations and their comorbidities and patterns of medication use may explain discrepant findings (Hampel et al. 2010).

We did not observe any evidence of associations with either TNF or endothelin-1 and temperature. Endothelin-1 is released from endothelial cells and has strong vasoconstrictive properties. Higher levels of endothelin-1 have been associated with heart failure severity and higher mortality rates (Bolger et al. 2002; Wei et al. 1994; Yang et al. 2005). In this analysis of only two measures per subject, we may not have had sufficient power to detect within-person changes. We note that 90% of endothelin-1 is synthesized in the endothelium and acts on the vascular smooth muscle locally (Levin 1995). TNF is a cytokine associated with inflammatory properties that also has been associated with severity and risk stratification of heart failure in a number of studies (Levine et al. 1990; Sharma et al. 2000). Our results are consistent with those of Halonen et al. (2010) who did not observe any significant association between temperature and TNF among older men also residing within the same region as our study participants.

Although we addressed the shape of the exposure–response relationship using penalized splines in additional analyses, we did not observe any statistically significant deviation from linearity. The only models with estimated degrees of freedom (df) > 1 were for endothelin-1, and these associations were nonsignificant (the estimated 1-day moving average df was 2.3; p = 0.4). In our analyses, neither PM2.5 nor ozone confounded the association between temperature and biomarkers and were not significantly associated with biomarker levels. We previously observed no consistent association between BNP and PM2.5 in a similar population of heart failure patients in the Boston area (Wellenius et al. 2007). Similar results were also observed in Aberdeen, Scotland, where there was no change in the number of hematological parameters measured in response to air pollution exposures in a panel of 132 heart failure patients (Barclay et al. 2009). However, our findings differ from other studies that have shown that PM2.5 is associated with changes in inflammatory biomarker levels in older aging populations (Dubowsky et al. 2006; Wilker et al. 2011), individuals with diabetes (O’Neill et al. 2007), and persons with coronary artery disease (Delfino et al. 2008). Heart failure patients may spend less time outside and have different time-activity and exposure patterns from healthy individuals and from those with other chronic conditions (Oka et al. 1993; van den Berg-Emons et al. 2001). These differences could also potentially explain our findings of no substantial deviations from linearity in the exposure–response relationship, if these patients with chronic heart failure are more vulnerable to extreme heat and spend little time outdoors during periods of extreme cold.

Potential limitations of this study include a limited number of repeated measures on study participants. This study specifically enrolled patients with heart failure and systolic dysfunction. Therefore, the results may not be generalizable to patients with heart failure and preserved systolic function. Additionally, the purpose of the original study was to examine effects of tai chi. This intervention was found to be associated with improved quality-of-life measures, but randomization to tai chi was not associated with statistically significant changes in the levels of these biomarkers (Yeh et al. 2011), and we did not observe any evidence of effect modification by tai chi randomization status in our analysis. We are also limited in our ability to assess spatial heterogeneity of the temperature metric, because we used only one stationary site for our analyses. Most (88%) participants in our study population lived within 40 km of Boston and our central site monitor; therefore, we expected to have limited misclassification for our within-person analyses. However, this study did not collect information on air-conditioner usage and availability, which also may be a source of variability in heat-related physiologic responses (Curriero et al. 2002; O’Neill et al. 2005; Ostro et al. 2010).

As mentioned above, time-activity patterns (Oka et al. 1993; van den Berg-Emons et al. 2001) could potentially confound or modify associations between temperature and these biomarkers, but we did not have sufficient data to address this topic. It is also possible that hemococoncentration could, in part, explain the associations between temperature and biomarkers, in situations where participants become more dehydrated in warmer weather. Data on blood urea nitrogen or hemocrit were not available in this study, but we did include body weight at each visit as a marker of hydration status in heart failure patients and found that the changes in the estimated association between temperature and the biomarkers were negligible (< 5%).

In this study of 100 patients with heart failure and systolic dysfunction, we observed significantly higher BNP and CRP, which...
are biomarkers related to heart failure symptoms and prognosis, with 3- to 4-day moving averages of apparent temperature. These findings suggest that changes in temperature and meteorology may alter underlying physiologic responses in this vulnerable population. Because of their compromised hemodynamic response, individuals with heart failure may have increased stress in the ventricles, as reflected by a rapid increase in circulating BNP levels, which may be accompanied or perhaps followed by elevation in systemic inflammatory responses, as indicated by CRP. Given the large public health burden of heart failure, further work is needed to examine the role of ambient temperature in influencing pre-clinical changes that occur before an episode of acute heart failure decompensation.

**References**

Alonso-Martinez JL, Llorente-Diez B, Echeagaray-Agar M, Olaz-Preciado F, Ubirata-Echevarreta M, Gonzalez-Arencibia C. 2002. C-reactive protein as a predictor of improvement and heart failure outcomes in heart failure patients. *Heart Fail Rev* 7(2):201–206.

Anand IS, Latino R, Florin VG, Koskamaa MA, Rector T, Masson S, et al. 2005. C-reactive protein in heart failure: Prognostic value and the effect of valsartan. *Circulation* 112(10):1438–1446.

Aronow WS, Ahn C. 2004. Elderly nursing home patients with congestive heart failure after myocardial infarction living in New York City have a higher prevalence of mortality in cold weather and warm weather months. *J Gerontol A Biol Sci Med Sci* 59(2):146–147.

Barclay JL, Miller BG, Dick S, Danneppek M, Ford I, Hills GS, et al. 2009. A panel study of air pollution in subjects with heart failure: negative results in treated patients. *Occup Environ Med* 66(5):325–334.

Barnett AG, de Looper M, Fraser JF. 2008. The seasonality in heart failure deaths and total cardiovascular deaths. *Aust J Public Health* 32(5):408–413.

Basu R, Feng WY, Ostro BD. 2008. Characterizing temperature and mortality in nine California counties. *Epidemiology* 19(1):138–145.

Bell ML, O’Neill MS, Ranjit N, Borja-Aburto VH, Cifuentes LA, Basu R, Feng WY, Ostro BD. 2008. Characterizing temperature and risk stratification of patients with congestive heart failure. *Am Heart J* 155(2):200–207.

Bohmer R, Zietz N, Tjoa T, Polidori A, Arhami M, Gillen DL et al. 2008. Circulating biomarkers of inflammation, antioxidant activity, and platelet activation are associated with primary combustion aerosols in subjects with coronary artery disease. *Environ Health Perspect* 116:998–906.

Dubowski SD, Suh H, Schwartz J, Coull BA, Gold DR. 2008. Diabetes, obesity, and hypertension may enhance associations between air pollution and markers of systemic inflammation. *Environ Health Perspect* 114:992–998.

Dunlay SM, Weston SA, Redfield MM, Killian JM, VL. 2008. Tumor necrosis factor-α and mortality in heart failure. *A community study. Circulation* 118(6):625–632.

Folstein MF, Folstein SE, McHugh PR. 1975. “Mini-mental state”: A practical method for grading the cognitive state of patients for the clinician. *J Psychiatr Res* 12(3):189–198.

Foronarow DC. 2008. Vulnerability of humans to cold and risk stratification at different body temperatures in congestive heart failure. *Am Heart J* 152(2):200–207.

Gold DR, Lutonja A, Schwartz J, Lovett E, Larson A, Baccarelli A, Koenig W, Schwartz J. 2005. Shortness of breath at night and health status in congestive heart failure: effects of environmental conditions and health-related and dietary factors. *Environ Res* 109(2):166–174.

Gotsman I, Ziva D, Admon D, Lotan C, Keren A. 2010. Seasonal variation in hospital admission in patients with heart failure and its effect on prognosis. *Cardiology* 117(4):367–378.

Halonen JI, Zanobetti A, Sparrow D, Vokonas PS, Schwartz J. 2010. Associations between outdoor temperature and markers of inflammation: a cohort study. *Environ Health* 9:42; doi:10.1186/1476-069X-9-42 [Online 23 June 2010].

Hampel R, Breitner S, Rückerl R, Frampton MW, Koenig W, Phipps RP, et al. 2010. Air temperature and inflammatory responses in men with coronary or pulmonary disease during the winter season. *Occup Environ Med* 67(6):408–416.

Hausman JA. 1978. Specification tests in econometrics. *Econometrica* 46(6):1251–1273.

Hausman JA, Taylor W. 1981. Panel data and unobservable individual effects. *Econometrica* 49(4):1377–1398.

Koglin J, Pehlivanli S, Schwaiblmair M, Vogeser M, Cremer P, von Scheidt W. 2001. Role of brain natriuretic peptide in risk stratification of patients with congestive heart failure. *Am J Cardiol* 87(1):1934–1941.

Koken PJ, Piver WT, Ye F, Eilshaiser A, Olsen LM, Portier CJ. 2003. Temperature, air pollution, and hospitalization for cardiovascular diseases among elderly people in Denver. *Environ Health Perspect* 111(3):1312–1317.

Logeart D, Thabut G, Jourdain P, Chavelas C, Beyne P, Lowel H, Jacobim B, et al. 2008. Air temperature and inflammatory responses in myocardial infarction survivors. *Epidemiology* 19(3):391–402.

Shamamian P, Basu R. 2000. The role of inflammatory mediators in chronic heart failure: cytokines, nitric oxide, and endothelin-1. *Int J Cardiol* 72(2):175–186.

Steadmán RG. 1984. A universal scale of apparent temperature. *J Climate Appl Meteorol* 23:1674–1687.

Stewart S, McIntyre K, Capewell S, McMurry JJ. 2002. Heart failure in a cold climate. Seasonal variation in heart failure-related morbidity and mortality. *Am J Cardiol* 95(5):766–767.

Teerlink JR. 2005. Endothelins: pathophysiology and treatment implications in chronic heart failure. *Curr Heart Fail Rep* 2(4):191–197.

van den Berg-Emons H, Bussmann J, Balk A, Keijzer-Oster D, Stam H. 2001. Level of activities participated with mobility during everyday life in patients with chronic congestive heart failure as measured with an “activity monitor”. *Phys Ther* 81(12):1069–1077.

Wei CM, Lerman A, Rodeheffer RJ, McGregor GD, Brandt RR, Wright S et al. 1994. Endothelin in human congestive heart failure. *Circulation* 89(4):1500–1506.

Wellenius GA, Yeh GY, Coull BA, Schuh HH, Phillips RS, Mittelman MA. 2007. Effects of ambient air pollution on functional status in patients with chronic congestive heart failure: a repeated-measures study. *Environ Health* 6:26; doi:10.1186/1476-069X-6-26 [Online 10 September 2007].

Wilker EH, Alexander SE, Suh H, Vokonas PS, Baccarelli A, Schwartz J. 2011. Ambient pollutants, polymorphisms associated with microRNA processing and adhesion molecules: the Normative Aging Study. *Environ Health* 10:45; doi:10.1186/1476-069X-10-45 [Online 21 May 2011].

Yan LC, Leong LS, Liu P, Snyder RC, Hsu SH, Maceira AM, Hecht SS, Hsu HC, Dailey LM, Palevsky HI. 2006. The role of endothelin-1 in myocardial and inflammatory cardiomyopathy: old lessons and new insights. *Can J Physiol Pharmacol* 84(1):47–62.

Yeh GY, McCarthy EP, Wayne PM, Stevenson LW, Wood MJ, Forman D, et al. 2011. Tai chi exercise in patients with chronic heart failure: a randomized clinical trial. *Arch Intern Med* 171(17):1750–1757.

Zanobetti A, Schwartz J. 2008. Temperature and mortality in nine U.S. cities. *Epidemiology* 19(4):563–570.