Exercise echocardiography in aortic stenosis with preserved ejection fraction

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ABSTRACT

The appropriate timing of intervention and follow-up in asymptomatic patients with aortic stenosis remains controversial. Risk stratification is a key, especially with the use of a multimodality imaging approach, including exercise stress echocardiography. This review focuses on the use of exercise echocardiography in asymptomatic patients with moderate and severe aortic stenosis with preserved left ventricular ejection fraction. It describes the exercise echocardiography protocol, parameters to be evaluated, and its role in guiding the timing of intervention and follow-up in these patients. (Anatol J Cardiol 2020; 23: 312-7)

Keywords: exercise echocardiography, aortic stenosis, outcome

Introduction

Aortic stenosis (AS) is the most frequent valvular heart disease in Western countries (1). In both European and American guidelines, surgical (SAVR) or transcatheter aortic valve replacement/intervention (TAVI) is indicated in patients with severe AS with symptoms of left ventricular dysfunction defined as a left ventricular ejection fraction (LVEF) <50% (2, 3). The appropriate timing for intervention in asymptomatic patients with severe AS remains controversial, especially considering the important advances in transcatheter therapies recently. In contrast, more recent studies have shown that patients with moderate AS are also at increased risk of death (4). In the era of multimodality imaging, exercise echocardiography holds a relevant place in the management of asymptomatic patients with moderate and severe AS, by providing important information for defining the optimal timing of intervention and selecting patients at risk, in need of a more frequent follow-up.

Exercise echocardiography protocol

Both treadmill and bicycle exercise echocardiography can be performed, but semi-supine bicycle exercise on the tilted table is the preferred method in Europe as it allows for continuous two-dimensional (2D) and Doppler echocardiographic evaluation of the valve, ventricle, and its hemodynamic consequences during exercise (5). A symptom-limited graded exercise test is recommended. Classically, the initial workload of 25 W is maintained for 2 min, and the workload is increased every 2 min by 25 W, but an increase by 10 W can be more appropriate in elderly patients. The total exercise time, maximum workload, reason for stopping the test, peak heart rate, and blood pressure are recorded. Complete resting echocardiography is performed at rest, prior to exercise, with the aim of evaluating the severity of AS and its consequences (extravalvular cardiac damage or stage of AS). With each stage of AS (stage 0 no damage, stage 1 left ventricular damage, stage 2 left atrium and mitral valve damage, stage 3 pulmonary circulation and tricuspid valve damage,
stage 4 right ventricle damage or subclinical heart failure), there is a progressive increase in mortality rate in both symptomatic and asymptomatic patients (6). Thus, evaluating the stage of the disease could be helpful in further risk stratification of asymptomatic patients with AS (7). As aforementioned, an LVEF <50% represents an indication for intervention in patients with severe AS (2,3), but this value is questioned by the results of more recent studies, suggesting that intervention should be considered at an earlier stage in these patients. In the HAVEC registry, patients with an LVEF between 50% and 60% had a less favorable outcome and had more heart-failure-related deaths than those with an LVEF >60% (8).

Global longitudinal strain (GLS) can detect subclinical LV systolic dysfunction, before a decrease in LVEF has occurred. The inclusion in the rest protocol of LV-GLS and valvuloarterial impedance (Zva) (defined as systolic arterial pressure + mean aortic valve gradient/LV stroke volume index) has been shown to have incremental prognostic value. In a recent study on 504 patients with asymptomatic severe AS and preserved LVEF, a LV-GLS value <-17% and Zva >4.5 mm Hg/mL/m² were associated with an increased risk of death at 5 years (9). The echocardiographic parameters that should be evaluated at each stage of exercise stress echocardiography are presented in Figure 1. Ideally, continuous wave Doppler of the aortic valve at exercise should be performed from the window from which the maximum velocity was obtained at rest (5).

1. Exercise echocardiography in asymptomatic patients with severe aortic stenosis

SAVR or TAVI is indicated in symptomatic patients with severe AS (2, 3). However, due to the advanced age of patients and slow disease progression, with patients unintentionally limiting their activities, it is often difficult to identify the apparently “asymptomatic” patients based on clinical history alone. This is why both European and American guidelines recommend exercise testing in asymptomatic patients with severe AS (2, 3). Exercise testing is contraindicated in patients with severe AS with definite or probable cardiac symptoms (2, 3), but it is safe in asymptomatic patients and provides better risk stratification than conventional echocardiography (10, 11). Simple exercise testing is often difficult to interpret in physically inactive or older patients and patients with confounding diseases (lung disease, comorbidities), and it is particularly in these patients that exercise echocardiography, cardiopulmonary exercise testing (CPET), and biomarkers should be considered. Compared to simple exercise testing, exercise echocardiography can evaluate both the symptomatic status and hemodynamic consequences of AS and provides additional prognostic information (12-14). An abnormal exercise stress echocardiography is associated with an eightfold higher risk of major adverse cardiac events, including a 5.5-fold higher risk of sudden death and increased long-term mortality risk, while a normal test provides reassurance with an excellent 1-year prognosis without the need for surgical intervention (10, 15).

Figure 1. Parameters that can be evaluated during exercise stress echocardiography in patients with aortic stenosis, adapted from Lancellotti et al. (24) with permission

AS - aortic stenosis; Ch - chamber; E - early diastolic wave velocity; LV - left ventricle; LV-GLS - left ventricular global longitudinal strain; MG - mean pressure gradient; MR - mitral regurgitation; SV - stroke volume; TTG - transtricuspid pressure gradient; Zva - valvuloarterial impedance

Exercise ECG parameters

In patients with asymptomatic severe AS, approximately two-thirds of exercise echocardiographic results are abnormal. Exercise-induced limiting symptoms (dyspnea at low workload, angina, dizziness, and syncope) occur in approximately 30–40% of apparently asymptomatic patients with AS (10). The occurrence of exercise-limiting symptoms predicts the rapid development of symptoms in daily life, cardiac death (including sudden death), and need for AVR (10, 16), particularly in young physically active patients (<70 years) (16). In a study on 533 asymptomatic patients with severe AS and preserved LVEF, patients who achieved <85% predicted METs had a more than twofold increase in the risk of death, whereas a slower heart rate recovery at 1-min post-exercise was associated with an almost doubling of the risk of adverse events during follow-up (15). The occurrence of rapidly reversible dyspnea at high workloads (close to the age-sex predicted maximum workload) is on the contrary considered normal.
According to the International Guidelines on Valvular Heart Disease, an abnormal exercise test showing symptoms clearly related to AS [class I, level of evidence C in the European Society of Cardiology (ESC) guidelines and class I, level of evidence B in the American College of Cardiology/American Heart Association (ACC/AHA) guidelines], decrease in systolic blood pressure below baseline by 20 mm Hg (class IIa, level of evidence C in the ESC guidelines, and IIa, level of evidence B in the ACC/AHA guidelines), and decrease in exercise tolerance (class IIa, level of evidence B in the ACC/AHA guidelines) are potential indicators for intervention in "apparently" asymptomatic patients with severe AS and preserved LVEF (2, 3).

**Echocardiographic parameters**

Regardless of the resting echocardiographic data and exercise ECG results, exercise-induced changes in indices of AS severity and cardiac function are independent determinants of poor prognosis in patients with asymptomatic severe AS (11). An increase in mean transaortic pressure gradient by ≥18–20 mm Hg during exercise is associated with an increased risk of cardiac death, development of spontaneous symptoms, and need for AVR (12-14, 17-19). Such an increase in pressure gradient reflects the presence of either a more severe AS (the more severe the stenosis at rest, the higher the increase in gradient for a given flow rate during exercise) or noncompliant and rigid aortic valve (no or minimal enlargement of aortic valve orifice area during test) or both. The exercise-induced changes in mean transaortic pressure gradient should be interpreted considering the exercise-induced changes in LV stroke volume and function. The absence of LV contractile reserve with exercise (absence of an exercise-induced increase in EF) may reflect more advanced disease with LV afterload mismatch and/or exhaustion of coronary flow reserve with exercise. These patients are more likely to exhibit an abnormal response to exercise and have an increase in cardiac events during follow-up (14, 17, 19).

Several rather small studies have shown that longitudinal LV strain seems to be a good parameter in predicting the occurrence of symptoms and cardiac events in asymptomatic patients with AS with preserved LVEF. It has been suggested that an exercise increase in GLS by >-1.4% using 2D speckle tracking analysis might indicate the presence of LV contractile reserve (18). In a recent study, resting and, more significantly, exercise basal longitudinal strain, defined as the average of the six basal segments at peak heart rate, were associated with the risk of cardiac events in patients with asymptomatic moderate and severe AS and preserved LVEF (20). As all these studies were small scale, further studies are needed to determine the best cutoff value of exercise-induced change in GLS to identify patients at increased risk of developing LV systolic dysfunction or cardiac events during follow-up (5).

Pulmonary hypertension (PHT) is a strong predictor of reduced exercise capacity and poor outcome in patients with severe AS (21). In asymptomatic patients, the prevalence of PHT at
rest is relatively low, while the reported prevalence at exercise [systolic pulmonary artery pressure (PAP) > 60 mm Hg] was 55%, and its presence was independently associated with a twofold increased risk of cardiac events at a 3-year follow-up (22).

The evaluation of LV diastolic parameters, mitral regurgitation (MR), and presence of ischemia are part of the stress echocardiography protocol, although their prognostic values have not been evaluated so far (11, 12, 17). Exertional dyspnea could also be explained by diastolic dysfunction and increase in LV filling pressure (estimated by E/e’) and an increase in MR severity with exercise, whereas ischemia could also be the cause of chest pain in patients with AS.

Therefore, due to the lack of large-scale prospective randomized studies, none of these echocardiographic parameters currently represents an indication for intervention in asymptomatic patients with severe AS. Exercise echocardiography could help identify a subset of patients with early and subtle but harmful consequences of AS, who may require AVR earlier and might benefit from a more frequent follow-up. Patients with asymptomatic severe AS and preserved LVEF, who on exercise echocardiography develop a >18–20 mm Hg increase in mean gradient and signs of impaired contractile reserve as assessed by EF and GLS or exercise-induced PHT (exercise systolic PAP >60 mm Hg), should be closely followed (3 months), including careful and objective evaluation of symptoms, serial brain natriuretic peptide assessment, and repeated exercise stress echocardiography. In contrast, patients with appropriate exercise echocardiographic adaptation (i.e. increase by <20 mm Hg in mean aortic pressure gradient, good LV contractile reserve, no exercise PHT) may be safely followed every 6–12 months (Fig. 2 and 3).

2. Exercise echocardiography in patients with moderate aortic stenosis

More recent studies have shown that moderate AS is also associated with poor survival rates, with a marked increased risk of death from all causes and cardiovascular diseases seen once the mean aortic valve gradient is >20 mm Hg (4). There are a few studies on stress echocardiography in patients with moderate AS, suggesting that exercise echocardiography could help in guiding the appropriate clinical follow-up in these patients. Basically, the same echocardiographic parameters described for patients with severe AS can be used in patients with moder-

![Figure 3. Exercise stress echocardiography in an asymptomatic patient with severe aortic stenosis (AS). Rest echocardiographic evaluation (upper panel) confirms the presence of high-gradient severe AS with preserved left ventricular ejection fraction (rest EF estimated at 60%, not shown), preserved LV-GLS, and transtricuspid pressure gradient (TTG) at rest measured at 30 mm Hg. The patient stopped the test prematurely (maximum heart rate, 99 bpm, representing 85% of the maximum predicted heart rate) because of severe dyspnea, which persisted for a long time in the recovery period. There was neither a decrease in systolic blood pressure nor other symptoms. At exercise echocardiography (lower panel), the mean aortic pressure gradient increase was 14 mm Hg, EF reached 67%, and LV-GLS was 22.6%, indicating the presence of contractile reserve. At exercise, the TTG also markedly increase but at an early stage indicated significant pulmonary hypertension. The case of the patient was discussed in the heart team meeting, and surgical aortic valve replacement was scheduled](image-url)
Exercise echocardiography in asymptomatic AS

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