Enhanced Sympathetic and Ventilatory Responses to Central Chemoreflex Activation in Heart Failure

Krzysztof Narkiewicz, MD, PhD; Catherine A. Pesek, DO; Philippe J.H. van de Borne, MD, PhD; Masahiko Kato, MD; Virend K. Somers, MD, PhD

Background—Sympathetic activation and respiratory abnormalities may each be implicated in the pathophysiology of congestive heart failure (CHF). Chemoreflexes are an important mechanism regulating both sympathetic drive and breathing. We therefore tested the hypothesis that chemoreflex function is altered in CHF.

Methods and Results—We compared ventilatory, sympathetic, heart rate, and blood pressure responses to hypoxia, hypercapnia, and the cold pressor test in 9 patients with CHF and 9 control subjects matched for age and body mass index. Baseline muscle sympathetic nerve activity (MSNA) was higher in the patients with CHF compared with control subjects (47±8 versus 23±3 bursts per minute, $P<0.01$). During hypercapnia, patients with CHF had greater increases in minute ventilation (6.7±1.4 versus 2.7±0.9 L/min, $P=0.03$) and heart rate (7.0±2.1 versus 0.6±1.2 bpm, $P=0.02$). Despite higher ventilation, which inhibits sympathetic activity, the MSNA increase in patients with CHF was also greater than that in control subjects (58±12% versus 21±9%, $P=0.03$). Ventilatory, autonomic, and blood pressure responses to hypoxia and the cold pressor test in CHF patients were not different from those in control subjects.

Conclusions—Chronic heart failure is characterized by a selective potentiation of ventilatory and sympathetic responses to central chemoreceptor activation by hypercapnia. (Circulation. 1999;100:262-267.)

Key Words: hypercapnia ■ hypoxia ■ reflex ■ nervous system ■ heart failure

Activation of the sympathetic nervous system is an important component of the pathophysiology of chronic heart failure.1–5 Direct intraneural recordings have shown that heart failure is accompanied by increased efferent sympathetic nerve activity to skeletal muscle.6–9 The cause of the heightened sympathetic drive is not known. Possible mechanisms include impaired inhibitory cardiac and arterial baroreflex function,9,10 abnormalities in central neural control,1 and augmented sympathetic excitatory chemoreceptor11–15 and somatic reflexes.1,16

The role of chemoreflex mechanisms in heart failure has recently received considerable attention.11–14,17,18 Chemoreflexes are the dominant control mechanisms regulating ventilatory responses to changes in arterial oxygen and CO2 content.19–22 The peripheral chemoreceptors, located in the carotid bodies, respond primarily to hypoxia.23,24 Central chemoreceptors, located on the ventral surface of the medulla, respond primarily to hypercapnia.25 Both these chemoreceptor mechanisms also exert powerful influences on neural circulatory control, especially in situations involving marked changes in arterial oxygen and/or CO2. Chemoreflex activation causes increases in sympathetic activity, heart rate (HR), blood pressure, and minute ventilation.26,27 Increased minute ventilation and increased blood pressure inhibit the sympathetic response to chemoreflex activation.26–28 Thus, chemoreflexes elicit several cardiovascular and respiratory responses, with complex interactions between the responses themselves. To define any abnormalities in chemoreflex function, it is therefore crucial to consider the individual contributions of the key components of the integrated chemoreflex response.

Previous studies examining chemoreflex function in congestive heart failure (CHF) have examined almost exclusively the ventilatory responses and are inconclusive.11–14,17 Sympathetic and hemodynamic responses to peripheral and central chemoreflex activation in patients with CHF are not known.

We tested the hypothesis that chemoreflex function is altered in CHF. We measured ventilatory, sympathetic, and hemodynamic responses to peripheral chemoreceptor activation by hypoxia and to central chemoreceptor activation by hypercapnia in patients with heart failure. These responses were compared with those obtained in normal control subjects matched for age, body mass index (BMI), and sex. To ensure that any abnormalities in chemoreflex function did not represent a generalized and nonspecific abnormality in response to excitatory stimuli, we also compared the responses to the cold pressor test, which served as an internal control.29,30

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262
Methods

Subjects
We studied 9 patients with chronic heart failure (8 men and 1 woman; mean age, 43 ± 9 years; mean BMI, 28 ± 7 kg/m²). All patients had supporting clinical, chest roentgenographic, and echocardiographic evidence of impaired ventricular function. The cause of heart failure was idiopathic dilated cardiomyopathy in 7 patients, valvular heart disease in 1 patient, and alcohol-related cardiomyopathy in 1 patient. In all patients, angiography was performed to rule out coronary artery disease as an underlying cause of heart failure. Left ventricular ejection fraction, determined by a resting radionuclide ventriculogram, was 28 ± 4% (mean ± SEM). One patient was in NYHA functional class I, 5 were in class II, and 3 were in class III. All patients were treated with diuretics. Six patients received ACE inhibitors, 5 patients were treated with digitalis, and 2 patients received carvedilol. For reasons of patient safety, medications were not withheld for the purpose of this study. No patients had Cheyne-Stokes breathing or history suggestive of obstructive sleep apnea.

We also studied 9 sex-, age- and BMI-matched healthy control subjects (mean age, 41 ± 6 years; mean BMI, 28 ± 6 kg/m²). No control subjects were receiving any medications or had any chronic disease. Informed written consent was obtained from all subjects. The study was approved by the Institutional Human Subjects Review Committee.

Measurements
HR was measured continuously by an ECG. Blood pressure was measured each minute by an automatic sphygmomanometer (Life Stat 200, Physio-Control Corp). Oxygen saturation was monitored with a pulse oximeter (Nellcor Inc). End-tidal CO₂ was monitored with a Hewlett-Packard 47210A Capnometer. Minute ventilation was determined by use of a KL Engineering S430 monitor. Breathing was via a mouthpiece with a nose clip to ensure exclusive mouth breathing. Muscle sympathetic nerve activity (MSNA) was recorded continuously by obtaining multiunit recordings of postganglionic sympathetic activity to muscle blood vessels, measured from a muscle fascicle in the peroneal nerve posterior to the fibular head as described previously.21

Protocol and Procedures
The protocol used to determine chemoreflex responses to isocapnic hypoxia and hyperoxic hypercapnia was identical to that used in previous studies.26,27 In brief, subjects were exposed to a hypoxic gas mixture to induce peripheral chemoreflex activation (10% O₂ in N₂ with CO₂ titrated to maintain isocapnia) and a hypercapnic gas mixture to induce central chemoreflex activation (7% CO₂/93% O₂). During hypoxic stimulation of peripheral chemoreceptors, perturbation of central chemoreceptors was minimized by the maintenance of isocapnia.23 During hypercapnic stimulation of central chemoreceptors, perturbation of peripheral chemoreceptors was minimized by hyperoxia.28 The sequence of hypoxic and hypercapnic interventions was randomized. At least 15 minutes separated the end of 1 intervention from the beginning of the next.

Baseline measurements were taken during a 5-minute period of stable ventilation while subjects breathed room air with a mouthpiece. Then, with a 3-way valve, subjects were exposed to either the hypoxic or hypercapnic stressor for 3 minutes. We were unable to obtain stable nerve recordings in 1 patient with CHF. Consequently, sympathetic responses to hypoxia and hypercapnia were obtained in 8 CHF patients and 9 control subjects. Seven CHF patients and 8 control subjects underwent a subsequent cold pressor test. The cold pressor test, a stimulus for ventilation and sympathetic excitation, involves immersing the subject’s hand in ice water for 2 minutes.29,30

Analyses
Sympathetic bursts were identified by careful inspection of the voltage neurogram. The amplitude of each burst was determined, and sympathetic activity was calculated as bursts per minute multiplied by mean burst amplitude and expressed as units per minute.

| TABLE 1. Resting Measurements in Free-Breathing Normal Control Subjects and Patients With CHF |
|-----------------|------------------|------------------|------|
| Measurement     | Normal Control Subjects | Patients With CHF | P    |
| Oxygen saturation, % | 98.2 ± 0.4       | 95.7 ± 0.8       | 0.02 |
| SBP, mm Hg      | 111 ± 5          | 111 ± 5          | 0.98 |
| DBP, mm Hg      | 68 ± 4           | 69 ± 3           | 0.86 |
| MAP, mm Hg      | 84 ± 4           | 83 ± 4           | 0.96 |
| HR, bpm         | 61 ± 4           | 78 ± 4           | 0.01 |
| MSNA, bursts/min| 23 ± 3           | 47 ± 8           | 0.01 |
| MSNA, bursts/100 beats | 39 ± 4       | 61 ± 10          | 0.047 |

SBP indicates systolic blood pressure; DBP, diastolic blood pressure; and MAP, mean arterial pressure.

Measurement of nerve activity at baseline before each intervention was expressed as 100%. Changes in integrated MSNA allow evaluation of within-subject changes in sympathetic traffic during the same recording session. Sympathetic activity was also expressed as bursts per minute and bursts per 100 heartbeats, which allows comparison of sympathetic discharge between individuals, thus permitting a comparison of resting MSNA between CHF patients and control subjects.

Demographic data and baseline characteristics were compared by use of an unpaired t test. Responses to hypoxia, hypercapnia, and the cold pressor test were analyzed by repeated-measures ANOVA with time (baseline versus intervention) as within-factor and group (the CHF patients versus the control subjects) as between-factor variables. The key variable was the group-by-time interaction. Data are presented as mean ± SEM. A value of P<0.05 was considered significant.

Results

Resting Values
Compared with normal control subjects, CHF patients had lower oxygen saturation, faster HR, and increased MSNA (Table 1). Blood pressures in CHF patients were similar to values obtained in the control subjects (Table 1).

Responses to Hypercapnia
The baseline levels and increases in end-tidal CO₂ during hypercapnia were similar in CHF patients and control subjects (Table 2). Hypercapnia induced significant HR increases in CHF patients but not in control subjects (Table 2 and Figures 1 and 2). Patients with CHF and control subjects both showed increases in minute ventilation, blood pressure, and MSNA during hypercapnia. However, the increases in minute ventilation and MSNA during hypercapnia were significantly greater in the CHF patients (Table 2 and Figures 1 and 2).

Responses to Hypoxia
The change in oxygen saturation during hypoxia was similar in patients with CHF and control subjects (Table 3). Autonomic, ventilatory, and blood pressure changes during hypoxia in the CHF patients were not significantly different from those observed in control subjects (Table 3).

Effects of the Cold Pressor Test
The ventilatory, HR, blood pressure, and MSNA responses to the cold pressor test were similar in the CHF patients and control subjects (Table 4).
One novel finding of this study is that CHF is associated with potentiation of central chemoreflex sensitivity. This is evident in the increased ventilatory, HR, and sympathetic neural responses to hypercapnia. Second, responses to both peripheral chemoreflex activation and the cold pressor test are not altered in patients with CHF. Thus, potentiation of chemoreflex function in CHF is selective for the central chemoreflex.

The increased sympathetic drive during hypercapnia in heart failure was evident despite significant increases in blood pressure (8 ± 2 mm Hg) and despite the potentiated ventilatory response. Increases in blood pressure and minute ventilation would each be expected to attenuate the sympathetic response to hypercapnia.32,33 Very high baseline levels of sympathetic activity would also be expected to limit further increases in sympathetic drive.34 Despite these considerations, hypercapnia elicited a >50% increase in the already-high levels of sympathetic nerve traffic in the CHF patients. The hypercapnic stimulus therefore represents a very potent mechanism for sympathetic activation in the setting of CHF.

Although our data are consistent with prior studies of the ventilatory response to hypercapnia,11,12 we did not observe any potentiation of ventilatory responses to hypoxia. Several factors may be implicated in the discrepancy between our results and those of previous studies.12–14 First, the studies reporting increased peripheral chemoreflex sensitivity in CHF12–14 used transient inhalations of pure nitrogen. In this

### Table 2. Effects of Hypercapnia in Control Subjects and Patients With CHF

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Normal Subjects</th>
<th>Patients With CHF</th>
<th>Interaction, Group-by-Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
<td>Hypercapnia</td>
<td>Baseline</td>
</tr>
<tr>
<td>Oxygen saturation, %</td>
<td>98.7 ± 0.4</td>
<td>99.9 ± 0.1</td>
<td>97.1 ± 0.7</td>
</tr>
<tr>
<td>End-tidal CO₂, mm Hg</td>
<td>36 ± 2</td>
<td>51 ± 1</td>
<td>36 ± 1</td>
</tr>
<tr>
<td>Minute ventilation, L/min</td>
<td>7.4 ± 0.5</td>
<td>10.1 ± 0.8</td>
<td>7.2 ± 0.6</td>
</tr>
<tr>
<td>HR, bpm</td>
<td>61 ± 2</td>
<td>62 ± 4</td>
<td>79 ± 4</td>
</tr>
<tr>
<td>MAP, mm Hg</td>
<td>84 ± 3</td>
<td>90 ± 4</td>
<td>85 ± 4</td>
</tr>
<tr>
<td>MSNA, bursts/min</td>
<td>24 ± 3</td>
<td>23 ± 2</td>
<td>42 ± 8</td>
</tr>
<tr>
<td>Integrated MSNA, %</td>
<td>100</td>
<td>121 ± 9</td>
<td>100</td>
</tr>
</tbody>
</table>

MAP indicates mean arterial pressure. Baseline values were obtained immediately before hypercapnia while subjects breathed room air with a mouthpiece. Probability values are for the group-by-time interaction term (ANOVA). Values are mean ± SEM.

### Discussion

One novel finding of this study is that CHF is associated with potentiation of central chemoreflex sensitivity. This is evident in the increased ventilatory, HR, and sympathetic neural responses to hypercapnia. Second, responses to both peripheral chemoreflex activation and the cold pressor test are not altered in patients with CHF. Thus, potentiation of chemoreflex function in CHF is selective for the central chemoreflex.

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TABLE 3. Effects of Hypoxia in Control Subjects and Patients With CHF

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Normal Subjects</th>
<th></th>
<th>Patients With CHF</th>
<th></th>
<th>Interaction, Group-by-Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
<td>Hypoxia</td>
<td>Baseline</td>
<td>Hypoxia</td>
<td>P</td>
</tr>
<tr>
<td>Oxygen saturation, %</td>
<td>98.3±0.4</td>
<td>88.3±1.8</td>
<td>96.4±0.5</td>
<td>86.4±1.6</td>
<td>0.95</td>
</tr>
<tr>
<td>End-tidal CO₂, mm Hg</td>
<td>37±2</td>
<td>37±2</td>
<td>36±1</td>
<td>36±1</td>
<td>0.74</td>
</tr>
<tr>
<td>Minute ventilation, L/min</td>
<td>7.0±0.6</td>
<td>10.3±0.9</td>
<td>7.3±0.7</td>
<td>11.2±1.7</td>
<td>0.79</td>
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<tr>
<td>HR, bpm</td>
<td>61±4</td>
<td>69±5</td>
<td>81±4</td>
<td>87±4</td>
<td>0.57</td>
</tr>
<tr>
<td>MAP, mm Hg</td>
<td>84±5</td>
<td>85±4</td>
<td>85±5</td>
<td>88±4</td>
<td>0.23</td>
</tr>
<tr>
<td>MSNA, bursts/min</td>
<td>20±2</td>
<td>21±2</td>
<td>43±8</td>
<td>47±8</td>
<td>0.57</td>
</tr>
<tr>
<td>Integrated MSNA, %</td>
<td>100</td>
<td>139±16</td>
<td>100</td>
<td>120±10</td>
<td>0.35</td>
</tr>
</tbody>
</table>

MAP indicates mean arterial pressure. Baseline values were obtained immediately before hypoxia while subjects breathed room air with a mouthpiece. Probability values are for the group-by-time interaction term (ANOVA). Values are mean±SEM.

TABLE 4. Effects of Cold Pressor Test in Control Subjects and Patients With CHF

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Normal Subjects</th>
<th></th>
<th>Patients With CHF</th>
<th></th>
<th>Interaction, Group-by-Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
<td>CPT</td>
<td>Baseline</td>
<td>CPT</td>
<td>P</td>
</tr>
<tr>
<td>Minute ventilation, L/min</td>
<td>7.3±0.6</td>
<td>8.4±0.6</td>
<td>7.2±0.4</td>
<td>8.3±1.1</td>
<td>0.98</td>
</tr>
<tr>
<td>HR, bpm</td>
<td>59±4</td>
<td>62±4</td>
<td>80±4</td>
<td>86±5</td>
<td>0.20</td>
</tr>
<tr>
<td>MAP, mm Hg</td>
<td>89±4</td>
<td>100±6</td>
<td>85±5</td>
<td>95±8</td>
<td>0.88</td>
</tr>
<tr>
<td>Integrated MSNA, %</td>
<td>100</td>
<td>236±33</td>
<td>100</td>
<td>178±32</td>
<td>0.42</td>
</tr>
</tbody>
</table>

MAP indicates mean arterial pressure. Baseline values were obtained immediately before cold pressor test (CPT) while subjects breathed room air with a mouthpiece. Probability values are for the group-by-time interaction term (ANOVA). Values are mean±SEM.
high prevalence of obstructive sleep apnea in heart failure.\textsuperscript{43} Nocturnal CO\textsubscript{2} retention and consequent potentiated sympathethic vasoconstriction in heart failure may contribute to sleep apnea–related increases in norepinephrine and decreased heart rate variability in CHF patients.\textsuperscript{44} Second, our findings of an increased ventilatory and sympathetic response to CO\textsubscript{2} in CHF suggest a mechanistic explanation for the recent report by Andreas et al\textsuperscript{45} demonstrating that nocturnal supplementation of both oxygen and CO\textsubscript{2} in CHF patients with Cheyne-Stokes respiration improved Cheyne-Stokes respiration but resulted in a marked and paradoxical increase in plasma norepinephrine.\textsuperscript{45}

In summary, this is the first study to test the integrated autonomic, hemodynamic, and respiratory responses to chemoreflex activation in heart failure and to demonstrate that chronic heart failure is characterized by a potentiation of ventilatory and sympathetic responses to hypercapnia. In contrast, responses to hypoxia and to the excitatory cold pressor stimulus are not altered. This selective potentiation of central chemoreflex sensitivity may be implicated in the pathophysiology of CHF.

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