Cyclic Nucleotide Phosphodiesterase Type 5 Activity Limits Blood Flow to Hypoperfused Myocardium During Exercise

Jay H. Traverse, MD; Ying Jie Chen, MD, PhD; Ruisheng Du, PhD; Robert J. Bache, MD

Background—Nitric oxide (NO) causes vasodilation by stimulation of guanylate cyclase in vascular smooth muscle to produce cGMP. The resultant vasodilator effect is regulated by a family of cGMP phosphodiesterases (PDEs). Sildenafil, a selective inhibitor of PDE5 used for treatment of erectile dysfunction, has been found to cause relaxation of isolated epicardial coronary artery segments. The present study examined the effects of sildenafil on coronary blood flow and hemodynamics during exercise in normal and ischemic heart.

Methods and Results—In chronically instrumented normal dogs, sildenafil 2 mg/kg PO caused a slight but significant increase in left anterior descending (LAD) coronary blood flow during resting conditions, with a nonsignificant trend toward increased coronary flow during treadmill exercise. Exercise in the presence of LAD stenosis that decreased distal coronary pressure to 57±2 mm Hg reduced LAD flow during exercise from 69±8 to 41±7 mL/min (P<0.05), with hypoperfusion most severe in the subendocardium. At the same distal coronary pressure, sildenafil increased LAD flow in the ischemic region to 50±11 mL/min (P<0.05). Increase in ischemic region blood flow produced by sildenafil was uniform across the LV wall, given that no change occurred in the transmural distribution of perfusion.

Conclusions—Inhibition of PDE5 with sildenafil caused vasodilation of coronary resistance vessels with an increase of blood flow into an ischemic myocardial region during exercise in the presence of coronary artery stenosis. (Circulation. 2000;102:2997-3002.)

Key Words: sildenafil ■ stenosis ■ cGMP ■ exercise ■ blood flow ■ ischemia

Nitric oxide (NO) produced by the vascular endothelium plays a significant role in regulation of vasomotor tone in coronary circulation. NO causes vasodilation by stimulating guanylate cyclase in vascular smooth muscle to generate cGMP, which activates a cGMP-dependent protein kinase.1 Levels of cGMP in vascular smooth muscle are tightly regulated by several cyclic nucleotide phosphodiesterase enzymes (PDEs) that catalyze cGMP degradation and terminate this second messenger signal.2 Sildenafil (Viagra, Pfizer) is a highly selective inhibitor of PDE5 that recently has been approved for treatment of erectile dysfunction.3 Sildenafil potentiates the activity of cGMP in the corpus cavernosum, thereby augmenting vasodilator activity of neuronally mediated NO production.4 Sildenafil has also been demonstrated to increase cGMP levels and cause smooth muscle relaxation in isolated segments of epicardial coronary artery.5 However, the effect of sildenafil on coronary resistance vessels has not been studied. Consequently, we undertook the present study to determine whether selective inhibition of PDE5 with sildenafil results in changes of coronary blood flow or myocardial oxygen consumption (MVO2) at rest or during treadmill exercise in chronically instrumented dogs. Because of the strong association between erectile dysfunction and coronary artery disease, we also examined the effect of sildenafil on regions of myocardium that became ischemic during exercise in the presence of flow-limiting coronary artery stenosis.

Methods

Studies were performed in 12 adult mongrel dogs that weighed 25 to 30 kg each and were trained to run on a treadmill. All studies were performed in accordance with the "Position of the American Heart Association on Research Animal Use" adopted by the association in November 1984 and were approved by the Animal Care Committee of the University of Minnesota.

Surgical Instrumentation

Animals were premedicated with acepromazine (10 mg IM), anesthetized with sodium pentobarbital (30 mg/kg IV), intubated, and ventilated with room air supplemented with oxygen. A left thoracotomy was performed in the 5th intercostal space. A heparin-filled polyvinylchloride catheter, 3.0 mm OD, was introduced into the internal thoracic artery and advanced into the ascending aorta. The pericardium was opened and a second catheter placed into the left atrium through the appendage. A similar catheter was introduced into

Received March 23, 2000; revision received June 12, 2000; accepted June 30, 2000.
From the Department of Medicine, Division of Cardiology, University of Minnesota Medical School (J.H.T., Y.J.C., R.D., R.J.B), and the Minneapolis Heart Institute (J.H.T.), Abbott Northwestern Hospital, Minneapolis, Minn.
Presented in part at the 72nd Annual Scientific Session of the American Heart Association, Atlanta, Ga, November 7–10, 1999, and published in abstract form (Circulation. 1999;100[suppl I]:I-489.).
Correspondence to Robert J. Bache, MD, Division of Cardiology, Department of Medicine, University of Minnesota Medical School, Box 508 UMHC, 420 Delaware St SE, Minneapolis, MN 55455. E-mail bache001@tc.umn.edu
© 2000 American Heart Association, Inc.

Circulation is available at http://www.circulationaha.org
the left ventricle (LV) at the apical dimple. A solid-state micromonometer (Konigsberg Instruments Inc, model P5) was also introduced into the LV at the apex. The proximal left anterior descending coronary artery (LAD) was dissected free, and a Doppler velocity probe (Craig Hartley; 2.5- to 3.5-mm ID) was placed around the vessel. Immediately distal to the velocity probe, a hydraulic occluder (3.0-mm OD) was placed around the artery. A heparin-filled silicone-rubber catheter (0.3-mm ID) was then placed into the LAD distal to the occluder for measurement of coronary pressure. After they recovered from surgery, animals were returned to the animal house. One hour later, hemodynamic measurements and coronary blood flow were recorded during resting conditions and the exercise protocol was repeated as described above.

### Experimental Protocol

After they recovered from surgery, animals were returned to the laboratory for study. Aortic, left ventricular, and coronary pressures were measured with pressure transducers at mid-chest level (Spectramed Inc, model TNP-R). The fluid-filled catheter in the LV was used to calibrate the Konigsberg micromonometer. LV pressure was recorded both at normal and high gain for measurement of end-diastolic pressure (LVEDP). LAD coronary blood flow was measured with the Doppler velocity probe. Data were recorded on an 8-channel direct-writing recorder (Coulbourne Instruments Inc). After all recording instruments were connected, each dog was placed on the treadmill. Fifteen minutes later, resting hemodynamics were recorded and 3 cm³ of blood was withdrawn from the aortic and coronary venous catheters and placed on ice for blood gas analysis (n=12). Exercise was then begun at 6.4 km/h with a 10% grade. After 4 minutes of exercise, hemodynamic measurements were obtained and blood samples were withdrawn from aortic and coronary venous catheters for blood gas analysis. In 9 dogs, exercise was continued while the LAD occluder was inflated to create a stenosis that decreased coronary pressure to 55 to 60 mm Hg. After 4 minutes of exercise-induced ischemia, radioactive microspheres were administered into the left atrium for measurement of myocardial blood flow. Dogs continued to exercise for 2 minutes after microsphere administration. Two hours after completion of the control measurements, dogs were given sildenafil 2 mg/kg by mouth. One hour later, hemodynamic measurements and coronary blood flow were recorded during resting conditions and the exercise protocol was repeated as described above.

### Measurement of Regional Myocardial Blood Flow

Myocardial blood flow was measured with 15-µm diameter microspheres labeled with ¹⁴¹Ce, ⁵¹Cr, ⁴⁸Sr, ⁹⁵Nb, or ⁴⁶Sc (NEN Co) as previously described. After completion of the exercise studies, animals were euthanized with an overdose of pentobarbital and the heart removed and fixed in 10% buffered formalin. LV was sectioned into 5 transverse rings from base to apex. Third and fourth rings distal to the coronary stenosis were sectioned into 5 radial segments that were subdivided into 4 equal layers from epicardium to endocardium, weighed, and placed into vials for counting in a gamma spectrophotometer (Packard Instrument Co) at window settings that corresponded to the peak energies of each radionuclide.

### Determination of Plasma Sildenafil Level

At the conclusion of exercise, 3 mL of blood was withdrawn from the aortic catheter and immediately centrifuged at 3000 rpm for 10 minutes at 4°C. Plasma was frozen at −70°C for determination of sildenafil concentration by use of high-performance liquid chromatography with mass spectrometric detection.

### Data Analysis

Heart rate and pressures were measured from strip chart recordings. LAD coronary blood flow was calculated from the coronary Doppler flow shift with the equation

\[ q = \frac{f}{d^3} \times f \times s \]

where \( q \) is coronary blood flow (in milliliters per minute), \( d \) is the internal diameter (ID) of the vessel (in millimeters), and \( f \) is Doppler frequency shift (in kilohertz). On the basis of our previous observations, ID was taken to be 80% of external diameter of the artery. Rate-pressure product was calculated as heart rate multiplied by LV systolic pressure. Data are expressed as mean±SEM. Individual comparisons of significant differences between control and sildenafil groups were performed by use of Wilcoxon signed-rank test. P<0.05 was required for statistical significance.

### Results

#### Normal Coronary Artery Inflow

### Hemodynamics

Hemodynamic data at rest and during exercise under control conditions and after administration of sildenafil are shown in Table 1. Resting heart rate during control conditions was 110±8 bpm, mean aortic pressure was 109±4 mm Hg, and LVEDP was 7±2 mm Hg. After administration of sildenafil, resting arterial pressure and LVEDP were unchanged, but there was a significant increase in heart rate to 124±8 bpm (P<0.05). Exercise caused significant increases in aortic pressure, LV systolic pressure, and LVEDP compared with rest (P<0.05). Sildenafil did not significantly change aortic or LV systolic or diastolic pressures during exercise, but heart rate was significantly higher than during control exercise.

### Coronary Blood Flow

Coronary blood flow during rest and exercise at baseline and after sildenafil are shown in Figure 1. Under baseline condi-
tions, resting LAD coronary blood was 42 ± 5 mL/min and increased during exercise to 69 ± 8 mL/min (P < 0.01). After sildenafil, resting coronary blood flow increased to 50 ± 8 mL/min (P < 0.05 versus control rest). During exercise after sildenafil, coronary flow increased to 78 ± 14 mL/min, which tended to be greater than during control exercise (P = 0.10).

**Coronary Blood Flow**

During control exercise, coronary stenosis decreased mean LAD blood flow to 41 ± 7 mL/min (P < 0.01 versus control exercise). At an identical level of distal coronary pressure, sildenafil significantly increased LAD blood flow to 50 ± 11 mL/min (P < 0.05).

**Regional Myocardial Blood Flow**

Myocardial blood flow was measured with microspheres during exercise in the presence of coronary stenosis in 7 dogs. During control exercise, mean blood flow in the normal zone was 2.42 ± 0.38 mL/min/100 g (P < 0.01), whereas subendocardial/epicardial (ENDO/EPI) flow ratio was 1.34 ± 0.08. Blood flow in the anterior region perfused by the stenotic LAD was decreased to 1.00 ± 0.19 mL/min/100 g (P < 0.01), whereas ENDO/EPI flow ratio was decreased to 0.38 ± 0.07. Sildenafil caused a significant increase in blood flow to the region perfused by the LAD, to 1.11 ± 0.18 mL/min/100 g (P < 0.05), with no change in the ENDO/EPI flow ratio (0.36 ± 0.05; Figure 2). Normal-zone myocardial blood flow tended to increase to 2.85 ± 0.32 mL/min/100 g after sildenafil, although this change was not significant. Normal-zone ENDO/EPI ratio was unchanged (1.29 ± 0.11) after sildenafil.

**Plasma Sildenafil Levels**

Plasma sildenafil levels ranged from 248 to 779 nmol/L (mean, 520 ± 86 nmol/L). Because sildenafil is 84% bound to plasma protein in the dog, this represents a mean plasma-free sildenafil concentration of 66.4 ± 12.4 nmol/L.

**Coronary Stenosis**

Hemodynamics

Hemodynamics during exercise in the presence of coronary stenosis before and after sildenafil are shown in Table 2. During control exercise, mean aortic pressure was 123 ± 6 mm Hg and heart rate was 207 ± 7 bpm; these values were not significantly different during exercise after sildenafil. Inflation of the occluder during control exercise decreased distal coronary pressure in the LAD to 57 ± 2 mm Hg. Application of stenosis resulted in a significant increase in LVEDP, to 17 ± 3 mm Hg (P < 0.05 versus control exercise). Distal coronary pressure in the LAD was identically decreased during exercise with sildenafil.

**Myocardial Oxygen Consumption**

$\dot{MVO}_2$ was computed in 7 animals at rest and during exercise before and after sildenafil (Figure 1). During control conditions, coronary venous oxygen tension was 23 mm Hg at rest and decreased significantly to 18 ± 2 mm Hg during exercise. Sildenafil tended to increase coronary venous oxygen tension during resting conditions to 28 ± 7 mm Hg, but this was not significant. After sildenafil, exercise caused a significant decrease of coronary venous $P_O_2$ to 18 ± 2 mm Hg, which was identical to that observed during control exercise.

**Coronary Blood Flow**

During control exercise, coronary stenosis decreased mean LAD blood flow to 41 ± 7 mL/min (P < 0.01 versus control exercise). At an identical level of distal coronary pressure, sildenafil significantly increased LAD blood flow to 50 ± 11 mL/min (P < 0.05).

**Regional Myocardial Blood Flow**

Myocardial blood flow was measured with microspheres during exercise in the presence of coronary stenosis in 7 dogs. During control exercise, mean blood flow in the normal zone was 2.42 ± 0.38 mL/min/100 g, whereas subendocardial/epicardial (ENDO/EPI) flow ratio was 1.34 ± 0.08. Blood flow in the anterior region perfused by the stenotic LAD was decreased to 1.00 ± 0.19 mL/min/100 g (P < 0.01), whereas ENDO/EPI flow ratio was decreased to 0.38 ± 0.07. Sildenafil caused a significant increase in blood flow to the region perfused by the LAD, to 1.11 ± 0.18 mL/min/100 g (P < 0.05), with no change in the ENDO/EPI flow ratio (0.36 ± 0.05; Figure 2). Normal-zone myocardial blood flow tended to increase to 2.85 ± 0.32 mL/min/100 g after sildenafil, although this change was not significant. Normal-zone ENDO/EPI ratio was unchanged (1.29 ± 0.11) after sildenafil.

**Plasma Sildenafil Levels**

Plasma sildenafil levels ranged from 248 to 779 nmol/L (mean, 520 ± 86 nmol/L). Because sildenafil is 84% bound to plasma protein in the dog, this represents a mean plasma-free sildenafil concentration of 66.4 ± 12.4 nmol/L.

**TABLE 2. Hemodynamic Measurements During Treadmill Exercise in Presence of LAD Stenosis During Control Conditions and After Sildenafil (2 mg/kg)**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Mean Aortic Pressure, mm Hg</th>
<th>Heart Rate, bpm</th>
<th>LVEDP, mm Hg</th>
<th>LAD Coronary Pressure, mm Hg</th>
<th>Rate Pressure Product $^{\times 100}$, mm Hg × bpm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exercise + stenosis</td>
<td>123 ± 6</td>
<td>207 ± 7</td>
<td>17 ± 3*</td>
<td>57 ± 2</td>
<td>30.3 ± 2.5</td>
</tr>
<tr>
<td>Exercise + stenosis + SIL</td>
<td>118 ± 5</td>
<td>214 ± 6</td>
<td>14 ± 4*</td>
<td>57 ± 3</td>
<td>32.0 ± 2.0</td>
</tr>
</tbody>
</table>

*P < 0.05 vs control exercise. SIL indicates sildenafil.
Discussion

In the present study, sildenafil caused modest vasodilation of coronary resistance vessels during resting conditions, with a nonsignificant trend toward an increase in coronary blood flow during treadmill exercise in the normal heart. These effects occurred with no change in MV˙O₂, which indicates that sildenafil exerted a weak primary vasodilator influence on coronary resistance vessels. In a myocardial region that became ischemic during exercise in the presence of coronary artery stenosis, sildenafil caused a significant increase in coronary blood flow. This increase in blood flow occurred with no change in distal coronary pressure, which suggests that sildenafil caused vasodilation of resistance vessels in the ischemic myocardial region. Implications of these findings are discussed below.

Systemic Hemodynamics

In healthy men, sildenafil caused a small decrease in resting blood pressure with no change in heart rate.10 In men with stable angina pectoris who underwent pulmonary artery catheterization, intravenous sildenafil 40 mg produced a 27% decrease in resting pulmonary artery pressure and a 7% decrease in cardiac output. In the present study, a nonsignificant trend was present toward a decrease in resting mean aortic and LV systolic pressure 1 hour after sildenafil. In contrast to the patient studies, we observed a modest increase in heart rate after sildenafil. This probably represented a reflex response to the decrease in systemic vascular resistance, although a direct chronotropic effect of PDE inhibition cannot be excluded. Interestingly, sildenafil did not alter the increase in aortic and LV systolic pressures in response to exercise. During exercise with coronary stenosis, a significant increase occurred in LVEDP compared with control exercise consistent with the development of myocardial ischemia. Sildenafil tended to blunt the increase in LVEDP during exercise in the presence of stenosis, although this difference was not significant.

Effect of PDE5 Inhibition on Normal Coronary Circulation

PDE5 inhibition would be expected to augment the effects of endogenous NO on coronary circulation. Previous studies with PDE5 inhibitors zaprinast and E4021 demonstrated an increase in cGMP levels in isolated coronary arteries and a dose-dependent increase in epicardial artery diameter in awake swine.5,11 Conversely, competitive inhibition of NO synthesis with monomethyl-L-arginine caused a decrease in coronary artery diameter but did not decrease coronary blood flow.12 These findings support the concept that in the normal heart, NO contributes to tonic vasodilation of coronary arteries. Using intravital microscopy, Jones et al13 observed that inhibition of endogenous NO production with N-nitro-L-arginine methyl ester caused constriction of small coronary resistance arteries (100 to 400 μm) in open-chest dogs, but this was offset by vasodilation of the arterioles (<100 μm) and resulted in no significant change in blood flow. This suggests that metabolic vasodilator adjustments at the level of the coronary arterioles are able to counter vasoconstriction of resistance arteries that occurs when endogenous NO production is blocked, thereby maintaining coronary blood flow appropriate to the metabolic demands of the myocardium.

Although NO production is not critical for maintenance of coronary blood flow, infusion of authentic NO or administration of NO donors can cause increases in coronary flow,14 which indicates that microcirculation is responsive to NO (and hence cGMP) and that NO can override compensatory metabolic vasoregulation. Furthermore, Kuo et al15 observed that NO can exert vasodilator activity at the levels of both resistance arteries (100 to 400 μm) that are not under metabolic control and arterioles (<100 μm), which are under metabolic control, which suggests that a PDE inhibitor such as sildenafil might have the potential to interfere with metabolic vasoregulation and cause an inappropriate increase in coronary blood flow. In fact, in the present study, sildenafil exerted only a very weak vasodilator effect on the coronary resistance vessels during resting conditions. The minimal resistance vessel-dilating effect of sildenafil suggests that this agent would have little likelihood to cause coronary steal in patients with occlusive coronary artery disease.

The increased cardiac work during exercise is accompanied by an increase in coronary blood flow that results in increased endothelial shear, which would be expected to cause vasodilation by an NO-dependent mechanism. However, inhibitors of NO synthesis do not decrease coronary blood flow during exercise, which demonstrates that NO is not obligatory for coronary resistance vessel dilation during exercise in normal heart.16 In the present study, PDE5 inhibition with sildenafil resulted in a nonsignificant trend toward increased coronary blood flow during exercise with a tendency toward increased subendocardial flow. Although we did not assess contractility, there was no change in coronary venous Po₂ or MV˙O₂, which suggests that this dose of sildenafil had negligible effects on PDE3, which degrades cAMP, and is consistent with previous observations in isolated dog trabecular muscle, in which sildenafil had no effect on contractility.17 The minimal effect of sildenafil on blood flow in the normally perfused region may be the result of alternative pathways for degradation of cGMP. In addition to PDE5, other PDE isoenzymes have been identified in vascular smooth muscle, of which the main cGMP-hydrolyzing activity in coronary vascular smooth muscle is accomplished by PDE1 and PDE5. IC₅₀ of sildenafil for inhibition of human PDE1 and PDE5 is 280 and 3.5 nmol/L,
respectively, which indicates high selectivity for PDE5. Mean plasma-free sildenafil concentration of 66.4 ± 12.4 nmol/L in the present study would have provided a high degree of blockade of PDE5 with relatively little inhibition of PDE1. The modest effect of sildenafil on coronary flow may have occurred because sildenafil principally inhibits PDE5, with much less effect on PDE1, which provides an alternative pathway for degradation of cGMP.

PDE5 Inhibition During Exercise With Myocardial Ischemia
In the present study, PDE5 inhibition with sildenafil significantly increased blood flow to the hypoperfused myocardial region subserved by a stenotic coronary artery. Ischemia produced by the stenosis was sufficient to cause a significant increase in LVEDP. Coronary pressure distal to the stenosis was identical before and after sildenafil, so that the increase in myocardial blood flow was the result of an effect of sildenafil at the level of the coronary microvasculature. An increase in blood flow could be the result of either decreased extravascular forces acting on the intramural coronary vessels or secondary to vasodilation of the coronary microvessels. LVEDP tended to be lower after sildenafil; a decrease in diastolic intracavitary pressure would reduce extravascular forces that impede blood flow in the microcirculation. In contrast, a trend existed toward increased heart rate after sildenafil; increase in heart rate would increase extravascular forces opposing coronary blood flow and might cause a decrease in myocardial perfusion. However, neither the change in LVEDP nor the change in heart rate were significant. Consequently, findings support a vasodilator effect of sildenafil on the coronary microvessels.

Myocardial ischemia results in metabolic arteriolar vasodilation. Nevertheless, some degree of vasodilator reserve persists in the coronary resistance vessels during exercise-induced myocardial ischemia, in part because of adrenergic vasoconstrictor tone that can compete with metabolic vasodilation. Thus, blockade of α1-adrenergic receptors results in an increase in coronary blood flow during exercise-induced ischemia. In addition, sympathetic activation of α2- and β2-adrenergic receptors on the coronary endothelium can cause release of NO during exercise. Increased adrenergic activity during exercise-induced ischemia possibly could augment endothelial NO production, thereby amplifying the effect of PDE5 inhibition during ischemia. The finding in the present study that sildenafil increased blood flow in the ischemic myocardial region is analogous to previous reports that nitroglycerin or other NO donors can increase blood flow to a myocardial region that becomes ischemic during exercise in the presence of coronary stenosis. Some evidence exists that NO has increased importance in the presence of myocardial ischemia. Thus, in dogs in which a flow-limiting coronary stenosis resulted in myocardial ischemia during treadmill exercise, inhibition of NO synthesis with LNNA worsened myocardial hypoperfusion but did not decrease blood flow in normally perfused myocardium. Although several phosphodiesterases occur in vascular smooth muscle that can catalyze cGMP, the high specificity of sildenafil for PDE5 suggests that the increase in blood flow in the present study was mediated by inhibition of this enzyme. Evidence also suggests that NO can cause vasodilation by pathways independent of cGMP, but these mechanisms would not contribute to the present findings.

In agreement with previous reports, stenosis resulted in marked redistribution of blood flow away from deeper myocardial layers, with hypoperfusion most severe in subendocardium. Increase of blood flow into the ischemic myocardial region produced by sildenafil was transmurally uniform. This is different from studies in which nitroglycerin and other NO donors resulted in a preferential increase in blood flow to the subendocardium, possibly because of a vasodilator effect on the penetrating arteries that conduct blood from the epicardial arteries to the subendocardial microvasculature. This difference between the effect of NO donors and sildenafil on the transmural distribution of blood flow in the ischemic region suggests that PDE5 activity may not be significantly involved in cGMP degradation in the penetrating coronary arteries.

Conclusions
PDE5 inhibition by sildenafil caused a modest vasodilator effect on coronary resistance vessels in normal heart. However, when coronary stenosis resulted in myocardial hypoperfusion during exercise, sildenafil caused a significant increase in blood flow to the ischemic region at the same distal coronary pressure, as a result of vasodilation of the resistance vessels. These findings suggest that PDE5 contributes to regulation of coronary blood flow in the normal heart and that the NO-mediated activity of PDE5 is enhanced in the presence of myocardial ischemia.

Acknowledgments
The present study was supported by US Public Health Service grants HL-20598 and HL-58067 from the NHLBI and a grant from the Pfizer Corp. Jay H. Traverse was supported by a Scientist Development Award from the American Heart Association. We wish to acknowledge the secretarial assistance of Carol Quirt in preparation of the manuscript and the expert technical help in performing the studies of Melanie Crampton, Shauna Voss, and Paul Lindstrom.

References
Cyclic Nucleotide Phosphodiesterase Type 5 Activity Limits Blood Flow to Hypoperfused Myocardium During Exercise
Jay H. Traverse, Ying Jie Chen, Ruisheng Du and Robert J. Bache

Circulation. 2000;102:2997-3002
doi: 10.1161/01.CIR.102.24.2997

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://circ.ahajournals.org/content/102/24/2997

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published in Circulation 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 Circulation is online at:
http://circ.ahajournals.org/subscriptions/