Free Fatty Acid Depletion Acutely Decreases Cardiac Work and Efficiency in Cardiomyopathic Heart Failure

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Background—Metabolic modulators that enhance myocardial glucose metabolism by inhibiting free fatty acid (FFA) metabolism may improve cardiac function in heart failure patients. We studied the effect of acute FFA withdrawal on cardiac function in patients with heart failure caused by idiopathic dilated cardiomyopathy (IDCM).

Methods and Results—Eighteen fasting nondiabetic patients with IDCM (14 men, 4 women, aged 58.8 ± 8.0 years, ejection fraction 33 ± 8.8%) and 8 matched healthy controls underwent examination of myocardial perfusion and oxidative and FFA metabolism, before and after acute reduction of serum FFA concentrations by acipimox, an inhibitor of lipolysis. Metabolism was monitored by positron emission tomography and [15O]H2O, [11C]acetate, and [11C]palmitate. Left ventricular function and myocardial work were echocardiographically measured, and efficiency of forward work was calculated. Acipimox decreased myocardial FFA uptake by >80% in both groups. Rate–pressure product and myocardial perfusion remained unchanged, whereas stroke volume decreased similarly in both groups. In the healthy controls, reduced cardiac work was accompanied by decreased oxidative metabolism (from 0.071 ± 0.019 to 0.055 ± 0.016 min⁻¹, P < 0.01). In IDCM patients, cardiac work fell, whereas oxidative metabolism remained unchanged and efficiency fell (from 35.4 ± 12.6 to 31.6 ± 13.3 mm Hg · L · g⁻¹, P < 0.05).

Conclusions—Acutely decreased serum FFA depresses cardiac work. In healthy hearts, this is accompanied by parallel decrease in oxidative metabolism, and myocardial efficiency is preserved. In failing hearts, FFA depletion did not downregulate oxidative metabolism, and myocardial efficiency deteriorated. Thus, failing hearts are unexpectedly more dependent than healthy hearts on FFA availability. We propose that both glucose and fatty acid oxidation are required for optimal function of the failing heart. (Circulation. 2006;114:2130–2137.)

Key Words: cardiomyopathy ■ fatty acids ■ heart failure ■ metabolism

T

he heart is unique among organ systems in its continuous need for high-energy phosphates to maintain contractile function. It can switch between different substrates depending on substrate availability, hormonal milieu, oxygen availability, and metabolic demands. Myocardial glucose and free fatty acid (FFA) metabolism are tightly coupled, with increased FFA metabolism inhibiting myocardial glucose metabolism and vice versa. We have previously demonstrated that limitation of FFA availability by acipimox, an inhibitor of lipolysis, increases myocardial glucose uptake to the same extent as euglycemic hyperinsulinemia.

Cardiac glucose metabolism directly or indirectly by inhibiting FFA metabolism may be beneficial to the failing heart. This is linked to the fact that glucose is a more energy-efficient fuel than FFA. Although the maximum oxygen saving that can be calculated from a total switch from oxidation of FFA as sole fuel to total glucose oxidation is only just over 11%, experimental data show that increasing circulating FFA levels within the physiological range increases oxygen uptake by 27%. High FFA concentrations in human heart failure are associated with increased levels of mitochondrial uncoupling proteins, which can produce substantial oxygen waste. Furthermore, a metabolic switch from predominant myocardial FFA to glucose metabolism may partly explain beneficial effects of β-blockade in heart failure patients. Thus, a reduction of circulating FFA levels is expected to become an effective treatment for human heart failure. Specifically, an

Editorial p 2092
Clinical Perspective p 2137

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Received June 11, 2006; revision received August 11, 2006; accepted August 16, 2006.
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Circulation is available at http://www.circulationaha.org

DOI: 10.1161/CIRCULATIONAHA.106.645184

2130
TABLE 1. Subject Characteristics

<table>
<thead>
<tr>
<th></th>
<th>IDCM Patients (n=18)</th>
<th>Healthy Controls (n=8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age, y</td>
<td>59±7.8</td>
<td>55±12</td>
</tr>
<tr>
<td>Sex, men/women</td>
<td>14/4</td>
<td>6/2</td>
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<tr>
<td>Current smokers, n/N</td>
<td>6/18</td>
<td>0/8</td>
</tr>
<tr>
<td>NYHA functional class</td>
<td>2.2±0.3</td>
<td>...</td>
</tr>
<tr>
<td>Hypertension, n/N</td>
<td>5/18</td>
<td>0/8</td>
</tr>
<tr>
<td>Hypercholesterolemia, n/N</td>
<td>10/18</td>
<td>0/8</td>
</tr>
<tr>
<td>Body mass index, kg · m⁻²</td>
<td>28±4.7</td>
<td>26±4.8</td>
</tr>
<tr>
<td>Medications, % (n/N)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACE inhibitors</td>
<td>89 (16/18)</td>
<td>...</td>
</tr>
<tr>
<td>β-Blockers</td>
<td>94 (17/18)</td>
<td>...</td>
</tr>
<tr>
<td>Diuretics</td>
<td>56 (10/18)</td>
<td>...</td>
</tr>
<tr>
<td>Digoxin</td>
<td>28 (5/18)</td>
<td>...</td>
</tr>
<tr>
<td>Angiotensin II blocker</td>
<td>17 (3/18)</td>
<td>...</td>
</tr>
<tr>
<td>Echocardiographic data</td>
<td></td>
<td></td>
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<tr>
<td>EF, %</td>
<td>33±9.1</td>
<td>66±5.8*</td>
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<tr>
<td>LVEDD, mm</td>
<td>74±10</td>
<td>54±4.4*</td>
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<tr>
<td>LVESD, mm</td>
<td>61±10</td>
<td>34±3.5*</td>
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<tr>
<td>LV mass index, g · m⁻²</td>
<td>142±36</td>
<td>75±12*</td>
</tr>
<tr>
<td>Mitral regurgitation</td>
<td>2.1±0.3</td>
<td>2.0±0.5</td>
</tr>
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</table>

Values are mean±SD unless otherwise indicated. *P<0.0001 between the groups.

acute reduction in myocardial fatty acid oxidation could be expected to “rapidly improve left ventricular function and mechanical efficiency.”

The effect of acute restriction of FFA availability on cardiac function in patients with heart failure due to idiopathic dilated cardiomyopathy (IDCM) is unknown. Positron emission tomography (PET), in combination with echocardiography, allows accurate noninvasive measurement of myocardial efficiency11-13 and substrate metabolism rates14,15 before and after interventions. The main purpose of this study was to test the hypothesis that acute FFA depletion would result in an increased myocardial efficiency of forward work in patients with heart failure. We noninvasively evaluated the acute effects of FFA withdrawal by inhibiting lipolysis with a nicotinic acid derivative, acipimox, and monitoring the effects on myocardial oxidative and FFA metabolism, left ventricular (LV) function, and efficiency in patients with IDCM and in normal controls.

Methods

Study Subjects

Eighteen patients with IDCM and 8 healthy control patients were enrolled in the study after a screening visit consisting of a medical history, physical examination, and oral glucose tolerance test (Table 1). All patients had at least a 10-month history of IDCM, were clinically stable, and were receiving stable medical therapy for at least 3 months before the study day. The mean New York Heart Association (NYHA) functional class was 2.2 in the patient group. All but one of the patients (17/18) were on β-blocker medication. Exclusion criteria included diabetes (type I, II) and secondary heart failure (such as ischemic heart disease, primary valvular disease, or alcohol abuse). Ischemic heart disease was ruled out by angiography (10/18), nuclear imaging (2/18), or exercise testing (6/18). None of the healthy volunteers had a history of cardiac symptoms or disease or was taking any medication. Patients and controls were comparable in age and body mass index. Typical for the disease, LV ejection fraction (EF) was clearly reduced, and LV end diastolic dimension (LVEDD) and end systolic dimension (LVESD), as well as LV mass index, were strikingly higher in IDCM patients as compared with the control group. The degree of mitral valve regurgitation was mild in the patients, and none of the patients had primary mitral valve disease. The study protocol was approved by the Ethics Committee of Southwest Finland Healthcare District. All subjects gave written informed consent.

Study Design

All patients were instructed to follow their normal medication regimen on the study day. The detailed imaging protocol is displayed in Figure 1. Myocardial perfusion and oxidative and FFA metabolism were measured with PET and [¹¹C]palmitate, respectively. Cardiac dimensions and function were measured by echocardiography. Imaging studies were performed first in the fasting state (after 10 to 12 hours of fasting) and repeated after acute reduction of serum FFA levels by acipimox (250 mg orally twice, 1 hour between doses: Olbetam, Pharmacia). ECG, heart rate, and blood pressure were monitored throughout the studies. Plasma glucose levels were determined just before [¹¹C]palmitate scan, and FFA levels were determined during (0, 15, 30 minutes) [¹¹C]palmitate scan. In addition, fasting plasma lactate and serum insulin levels were measured. Insulin sensitivity was estimated with the homeostasis model assessment (HOMA index), which is known to correlate well with the whole-body glucose uptake values measured with euglycemic hyperinsulinemia.16,17

Echocardiograms

All echocardiograms and all analyses were performed by the same experienced investigator (E.E.) using a commercially available ultrasound scanner (Acuson Sequoia 512, Siemens, Mountain View, Calif). Standard views of the LV were assessed by 2-dimensional and M-mode techniques. LVEDD and LVESD, interventricular septal and posterior wall thicknesses, and LVEF were measured according to the American Society of Echocardiography recommendations.18 LV mass was calculated by using the cube formula and the correction formula proposed by Devereux et al.19 LV mass was divided by body surface area to yield LV mass index. The LV stroke volume was measured from the LV outflow tract with the use of pulsed Doppler measurements. Mitral regurgitation was identified by color flow Doppler. A standard 0-to-4 scoring system, where 0 indicates none or trivial and 4 indicates severe regurgitation, was used. Forward LV work was calculated as: systolic blood pressure
Measurement of Myocardial Perfusion and Oxidative and FFA Metabolism

The positron-emitting tracers \([15O]H_2O\), \([11C]acetate\), and \([11C]\)palmitate were produced as previously described. An LV cavity ROI was drawn and used as the input function for determination of the LV time–activity curve. The myocardial FFA uptake index was calculated by multiplying the \([11C]\)palmitate uptake index by the mean serum FFA concentration during the \([11C]\)palmitate scan. The myocardial \([11C]\)palmitate \(\beta\)-oxidation rate constant was calculated as previously described. Biexponential curve was fitted on the early part of the downsloping phase of the time–activity curve.

Biochemical Analysis

Plasma glucose was determined by a glucose oxidase method (GM7 Analysery, Analox Instruments, Hammersmith, UK). Serum-free insulin concentrations were measured by using a double-antibody radioimmunoassay (Insulin RIA kit, Pharmacia, Uppsala, Sweden). After precipitation with polyethylene glycol, the HOMA index was calculated as (fasting serum insulin \(\times\) fasting plasma glucose)/22.5. Serum FFAs were determined with an enzymatic colorimetric method (Nefa C Test, Wako Chemicals GmbH, Neuss, Germany). Plasma lactate was determined by enzymatic analysis.

Statistical Analysis

Values are expressed as mean\(\pm\)SD. To compare results between healthy and failing hearts, the unpaired Student \(t\) test was applied in normally distributed parameters, and the Wilcoxon rank-sum exact test was applied in non-normally distributed parameters. The paired Student \(t\) test was used for intragroup comparisons between parameters before and after acipimox administration. Linear regression analysis (Pearson and Spearman when appropriate) was used to calculate correlations between continuous variables in patients and healthy volunteers. A probability value \(P<0.05\) was considered statistically significant. All statistical tests were performed with SAS/STAT statistical analysis system (SAS Institute, Inc, Cary, NC).

The authors had full access to and take full responsibility for the integrity of the data. All authors have read and agree to the manuscript as written.

Results

Biochemical and Hemodynamic Parameters

At baseline, biochemical parameters were similar between the groups (Table 2). After acipimox administration, serum FFA levels decreased strikingly and similarly in the both groups (Table 2). After acipimox administration, serum FFA levels decreased strikingly and similarly in the both groups (Table 2).
groups the marked suppression of FFA uptake with a modest constant in fasting state (white bars) and after acipimox administration (black bars) in IDCM patients and controls. Note in both groups the marked suppression of FFA uptake with a modest increase in the $\beta$-oxidation rate constant.

$P<0.01$, patients and controls, respectively). Glucose levels remained in the normal range in both groups, although glucose levels decreased slightly in the patient group ($P<0.01$) and tended to decrease in the control group ($P=0.089$). Hemodynamic parameters at baseline and after acipimox administration were similar between the groups except that heart rate was slightly lower in the healthy controls after acipimox administration ($P<0.01$) (Table 2). Acipimox administration had no influence on heart rate or blood pressure in either group.

Myocardial FFA Uptake and $\beta$-Oxidation Rate Constant

Myocardial FFA uptake and $\beta$-oxidation rate constant at baseline as well as the response to acipimox administration were comparable between the groups (Figure 2). Acipimox reduced myocardial FFA uptake strikingly in both groups as expected (from $5.58\pm2.02$ to $1.02\pm0.39 \mu$mol $\cdot$ 100 g$^{-1}$ $\cdot$ min$^{-1}$, $P<0.0001$, and from $6.17\pm1.07$ to $0.98\pm0.61 \mu$mol $\cdot$ 100 g$^{-1}$ $\cdot$ min$^{-1}$, $P<0.02$, not significant between the groups). Myocardial $\beta$-oxidation rate constant, in turn, increased significantly in both groups (from $0.040\pm0.009$ to $0.049\pm0.011$ min$^{-1}$, $P<0.002$, and from $0.039\pm0.005$ to $0.044\pm0.007$ min$^{-1}$, $P<0.05$, patients and controls, respectively, not significant between the groups).

Myocardial Perfusion, Oxidative Metabolism, Work, and Estimate of Efficiency

Myocardial perfusion was similar in both groups at baseline and remained unchanged after acipimox administration (Table 3). At baseline, LV oxidative metabolism, stroke volume, and total cardiac work were similar between the groups. Myocardial work per gram of tissue ($2.14\pm0.72$ versus $3.74\pm3.35$ mm Hg $\cdot$ L $\cdot$ g$^{-1}$ $\cdot$ min$^{-1}$, $P<0.001$) as well as efficiency of forward work ($35.4\pm12.3$ versus $54.3\pm8.9$ mm Hg $\cdot$ L $\cdot$ g$^{-1}$, $P<0.001$) were clearly lower in the patient group as compared with controls (Table 3).

After acipimox administration, LV oxidative metabolism decreased in the control group ($-22\%$, $P<0.01$ versus baseline), but it remained unchanged in the patient group ($+1.5\%$, not significant). The different responses to acipimox were significant ($P<0.01$) between the groups (Figure 3A). In both groups, acipimox decreased stroke volume ($-7.9\%$ in patients and $-8.4\%$ in controls, not significant between the groups) and cardiac output ($-11\%$ in both groups). In the control group, the efficiency of forward work tended to increase ($+18\%$, $P=0.082$ versus baseline), whereas in IDCM patients efficiency decreased significantly ($-11\%$, $P<0.05$ versus baseline). Thus, the response of cardiac efficiency to acipimox in patients was different from that in healthy controls ($P<0.01$ for change between the groups, Figure 3B).

To investigate further the potential contributing factors to the effects of FFA withdrawal, the association of efficiency

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Patients</th>
<th>Controls</th>
<th>Change, %</th>
<th>Patients</th>
<th>Controls</th>
<th>Change, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basal perfusion, mL.g$^{-1}$.min$^{-1}$</td>
<td>0.77±0.23</td>
<td>0.71±0.15</td>
<td>-4.6</td>
<td>0.85±0.31</td>
<td>0.74±0.14</td>
<td>-1.6</td>
</tr>
<tr>
<td>LV $K_{max}$, min$^{-1}$</td>
<td>0.062±0.015</td>
<td>0.063±0.018</td>
<td>+1.5</td>
<td>0.071±0.019</td>
<td>0.055±0.016†</td>
<td>-22‡</td>
</tr>
<tr>
<td>Stroke volume, mL</td>
<td>74.8±19.1</td>
<td>69.4±22.1</td>
<td>-7.9§</td>
<td>84.5±9.4</td>
<td>77.7±15.2</td>
<td>-8.4</td>
</tr>
<tr>
<td>Cardiac output, L.min$^{-1}$</td>
<td>4.95±1.12</td>
<td>4.39±1.31</td>
<td>-11§</td>
<td>4.55±0.75</td>
<td>4.10±1.18</td>
<td>-11</td>
</tr>
<tr>
<td>LV work power, mm Hg.L.min$^{-1}$</td>
<td>584±154</td>
<td>527±197</td>
<td>-9.8</td>
<td>537±119</td>
<td>492±159</td>
<td>-9.2</td>
</tr>
<tr>
<td>LV work power/g, mm Hg.L.g$^{-1}$.min$^{-1}$</td>
<td>2.14±0.72*</td>
<td>1.91±0.77*</td>
<td>-9.8</td>
<td>3.74±0.94</td>
<td>3.35±0.78</td>
<td>-9.2</td>
</tr>
<tr>
<td>Efficiency, mm Hg.L.g$^{-1}$</td>
<td>35.4±12.3*</td>
<td>31.6±13.3*</td>
<td>-11§</td>
<td>54.3±8.9</td>
<td>62.8±12.1</td>
<td>+18‡</td>
</tr>
</tbody>
</table>

Data are presented as the mean±SD. LV $K_{max}$ indicates index of myocardial oxidative metabolism from $[^{14}C]$acetate study.

* $P<0.001$ between groups, †$P<0.01$ vs baseline, ‡$P<0.01$ vs change in the patient group, §$P<0.05$ vs baseline.
with measured parameters was studied. In patients in whom efficiency decreased more strikingly (more than median, n = 9), myocardial FFA uptake was significantly lower during FFA deprivation (0.86±0.44 versus 1.18±0.26 minutes⁻¹, P<0.05). In addition, the increase in β-oxidation rate constant was more striking, though only of borderline statistical significance (37±26 versus 13±22%, P=0.056), in those patients with more pronounced decrease in efficiency (Table 4). Fasting lactate levels were significantly lower (P<0.05) and HOMA index tended to be lower (P=0.08) in patients with greater depression in efficiency in response to FFA limitation. β₁-Adrenoceptor occupancy or the severity of LV dysfunction did not correlate with response to FFA deprivation (data not shown). In the control group (but not the cardiomyopathic group), the HOMA index correlated positively with changes in stroke volume (R=0.75, P<0.05, Figure 4A) and the efficiency of forward work (R=0.75, P<0.05, Figure 4B).

**Discussion**

The main and unexpected finding of the present study is that acute suppression of FFA availability in patients with cardiomyopathic heart failure leads to further depression of cardiac work, with unchanged rates of oxidative metabolism, so that myocardial efficiency of forward work deteriorates further (Table 3, Figure 3). In contrast and as expected from current physiological understanding,⁴ acute suppression of FFA metabolism in the healthy heart saves oxygen without any decrease in myocardial efficiency (Figure 3), which is probably explained by switching substrate metabolism toward the more energy-efficient glucose.¹⁴ In the healthy hearts, the acute FFA depletion reduced the oxygen demand by 22% (Figure 3), similar to the 27% oxygen saving noted in mice.⁸ Thus, the unexpected results of the present study argue against the important hypothesis that switching myocardial substrate metabolism acutely from FFA to glucose may be beneficial for the failing heart.¹⁴-⁹ It is worth noting, however, that conclusions only on acute but not long-term metabolic modulation can be made on the basis of this study.

**FFA Oxidation**

Sack and coworkers demonstrated that, in severely failing human hearts (mean EF, 21%), myocardial FFA oxidation enzyme genes are downregulated.²⁷ However, the present study suggests that, in modestly severe heart failure, myocardial FFA oxidation enzymes can be acutely upregulated when

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**TABLE 4. Comparison Between IDCM Patients With Efficiency Decrease After Acipimox Administration**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Efficiency Decrease &gt;10% (n=9)</th>
<th>Efficiency Decrease &lt;10% (n=9)</th>
<th>P Between Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>LV FFA uptake index, fasting, μmol·100g⁻¹·min⁻¹</td>
<td>4.88±1.21</td>
<td>6.27±2.48</td>
<td>0.15</td>
</tr>
<tr>
<td>LV FFA uptake index, acipimox, μmol·100g⁻¹·min⁻¹</td>
<td>0.86±0.44</td>
<td>1.18±0.26</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Change in LV FFA uptake index, %</td>
<td>-82±9.7</td>
<td>-79±7.7</td>
<td>0.47</td>
</tr>
<tr>
<td>LV FFA β-oxidation rate constant, fasting, min⁻¹</td>
<td>0.034±0.006</td>
<td>0.046±0.008</td>
<td>&lt;0.004</td>
</tr>
<tr>
<td>LV FFA β-oxidation rate constant, acipimox, min⁻¹</td>
<td>0.047±0.014</td>
<td>0.051±0.009</td>
<td>0.60</td>
</tr>
<tr>
<td>Change in β-oxidation rate constant, %</td>
<td>37±26</td>
<td>13±22</td>
<td>0.056</td>
</tr>
<tr>
<td>Fasting serum insulin, μU·L⁻¹</td>
<td>7.6±2.9</td>
<td>15±10</td>
<td>0.10</td>
</tr>
<tr>
<td>HOMA index</td>
<td>2.0±1.0</td>
<td>4.1±3.0</td>
<td>0.081</td>
</tr>
<tr>
<td>Fasting plasma lactate, mmol·L⁻¹</td>
<td>1.0±0.2</td>
<td>1.2±0.3</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>β₁-Adrenoceptor occupancy, %</td>
<td>93±7.1</td>
<td>84±18</td>
<td>0.20</td>
</tr>
<tr>
<td>EF, fasting, %</td>
<td>36±7.5</td>
<td>31±10</td>
<td>0.25</td>
</tr>
</tbody>
</table>

Values are mean±SD.
Failing hearts preserve ability to upregulate oxidative FFA uptake, the absolute FFA oxidation is also decreased. It is likely that, given the striking suppression of FFA oxidation fraction was more marked when compared with patients with a lesser decrease in efficiency (Table 4). Furthermore, fasting lactate levels, and therefore the availability of lactate as an alternative fuel, were lower in the former group. These findings further support the proposal that the failing heart of this degree of severity is more rather than less dependent on an adequate availability of FFA as substrate.

Substrate Switching

The present results contrast with those of experimental studies in animals in which acute4 or short periods5 of enhancement of myocardial glucose metabolism improved cardiac function. In patients, Wiggers et al28 demonstrated that acute decreases or increases in FFA availability did not influence contractile function in chronically stunned and hibernating human myocardium, with sustained ability to adapt to extreme short-term changes in substrate supply both at rest and after maximal exercise. The degree of heart failure, as judged by the EFs, did not change during substrate switches. The differing results may be related to the different diseases (ischemic dysfunction versus IDCM). In addition, our study had a larger patient population in which myocardial substrate metabolism was quantified with more comprehensive parameters of oxidative metabolism and myocardial efficiency.

Treatment with β-blockers induces a switch from myocardial FFA toward glucose metabolism.4,10 It can be hypothesized that no additional benefit could be achieved by limiting FFA availability in heart failure patients in whom myocardial FFA uptake was already suppressed by β-blockade. However, in the present study, the degree of β-blockade, as estimated by β1-adrenoceptor occupancy, varied strikingly within the patient group without any clear association with the response to acipimox administration (Table 4).

Theoretically, it could be postulated that insulin resistance, a common comorbidity in heart failure,29,30 could explain the inability of the failing heart to acutely switch from FFAs to glucose when FFA availability is limited. However, the HOMA index, an indicator of insulin resistance, tended to be lower in our patients with more severe deterioration of myocardial efficiency. Furthermore, in the nonfailing control group the HOMA index correlated positively with the change in stroke volume and efficiency of forward work after acipimox administration (Figure 4). This accords with the results of Peterson et al31 in obese young women and suggests that limiting FFA availability may increase myocardial efficiency in nonfailing hearts with insulin resistance.

Limitations

Because of the very demanding study protocol, we could not include a measurement of myocardial glucose oxidation, as the protocol was already long and tedious (Figure 1). However, the unchanged rates of oxidation after acipimox in the cardiomyopathic group without any increase in the HOMA index in patients with the greater decrease in efficiency (Table 4) suggests that there was a reciprocal increase in glucose oxidation. We previously demonstrated that acipimox produces an increase in myocardial glucose uptake equal to that observed during glucose-insulin clamping.3 Furthermore, in knockout models, when FFA uptake by the heart is reduced, uptake of glucose increases.32,33 Of interest, prolonged sustained deprivation of FFA as fuel was associated with cardiac abnormalities in both mouse models. A second limitation is that measurements in the fasting state and after acipimox administration were not performed in a randomized order. This would require a 2-day study protocol, and the metabolic as well as hemodynamic state of patients with moderate heart failure might vary significantly from day to day. Therefore, we preferred this study design as an adequate compromise to test the hypothesis of the study. Third, despite

Figure 4. The association between HOMA index and the change in (A) stroke volume and (B) efficiency of forward work after acipimox administration in healthy volunteers. Note a correlation between an increased HOMA index and changes in stroke volume and efficiency. There were no such correlations in IDCM patients.
the present robust analysis of the palmitate kinetics, the absolute amount of FFA oxidized could not be measured. The estimated myocardial β-oxidation rate constant merely indicates the fraction of intracellular available FFA pool that is entering β-oxidation. Fourth, the controls and patient groups could, by definition, not be properly matched, especially with regard to disease states and medications (Table 1). Fifth, our results pertain to a group of cardiomyopathic patients with moderate heart failure (mean EF, 36%). In more severe failure, the balance between glucose and FFA metabolism may change to be more in favor of glucose.27,34 However, in that case, the adverse effects of acute FFA deprivation should be more rather than less marked.

Conclusions

The results of the present study demonstrate that acute FFA deprivation in patients with cardiomyopathic heart failure, in contrast to healthy controls, uncouples cardiac contractile function from oxidative metabolism, which explains the decreased cardiac efficiency. These findings may indicate that the cardiomyopathic myocyte has lost its ability to adapt to acute extreme substrate level changes when necessary. Although metabolic modulation has raised a great deal of interest as an alternative or additional form of therapy in the failing heart,3–6 the results of the present study suggest that indirect stimulation of myocardial glucose metabolism by acutely limiting FFA availability would not be a promising form of therapy in heart failure due to IDCm. Whether chronic administration of other inhibitors of FFA oxidation, beyond the 8 weeks of benefit already shown in one human study with perhexiline,6 could beneficially influence myocardial efficiency of work and clinical outcome in IDCm patients remains to be demonstrated.

Our results are, at first sight, counterintuitive in view of the current evidence favoring the concept that acute inhibition of myocardial fatty acid oxidation can rapidly improve LV function and mechanical efficiency in heart failure.4 Of interest though, even in chronic heart failure, caution has been expressed about therapy involving chronic alteration of metabolic pathways with the theoretical risk of cardiac dysfunction.35 Rather, our data provide the first evidence in humans for the hypothesis that “the heart functions best when it oxidizes two substrates simultaneously”.36 We suggest that there is an obligatory role for oxidative metabolism of FFA in the failing cardiomyopathic heart.

Sources of Funding

This study was financially supported by Ahvenainen Foundation, Turunen Foundation, Finnish Cultural Foundation, Instrumentarium Foundation, Finnish Cardiovascular Foundation, National Graduate School of Clinical Investigation in Finland, and an EVO grant from Turku University Hospital.

Disclosures

None.

References


Experimental and preliminary clinical studies have demonstrated that metabolic modulators that enhance myocardial glucose metabolism directly or indirectly by inhibiting free fatty acid (FFA) metabolism may be beneficial to the failing heart. Thus, a reduction of circulating FFA levels was expected to become an effective treatment for human heart failure. The main purpose of this study was to test the hypothesis that acute FFA depletion would result in an increased myocardial efficiency of forward work in patients with heart failure caused by idiopathic dilated cardiomyopathy (IDCM). Unexpectedly, the results of the present study demonstrate that acute FFA deprivation in patients with IDCM, in contrast to healthy controls, uncouples cardiac contractile function from oxidative metabolism so that myocardial efficiency deteriorates further. Thus, the results of the present study argue against the hypothesis that limiting FFA availability may be beneficial for the cardiomyopathic heart failure. Whether chronic administration of other inhibitors of FFA oxidation could beneficially influence myocardial efficiency of work and clinical outcome in IDCM patients remains to be demonstrated.
Free Fatty Acid Depletion Acutely Decreases Cardiac Work and Efficiency in Cardiomyopathic Heart Failure
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_Circulation._ 2006;114:2130-2137; originally published online November 6, 2006;
doi: 10.1161/CIRCULATIONAHA.106.645184
_Circulation_ is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2006 American Heart Association, Inc. All rights reserved.
Print ISSN: 0009-7322. Online ISSN: 1524-4539

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/114/20/2130

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