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Germany). The obtained PTT values (74.86 ± 8.63 ms) were compared with PTT evaluated on the same subjects by means of applanation tonometry applied simultaneously on the same locations (75.85 ± 8.61 ms). The two techniques were highly correlated (r = 0.97; p<0.001 ; Spearman rho 0.88) and values were not statistically different (p=0.377). Our preliminary results demonstrate that laser-based non-contact measurement of pulse transit time is feasible in young healthy volunteers, and yields values that are equivalent to those measured using arterial applanation tonometry. Clinical application of this appealing non-invasive method can overcome practical and technical limitations inherent to currently used methods such as arterial applanation tonometry, ultrasound, plethysmography, requiring physical contact of the probe with the patient.

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NON-INVASIVE QUANTITATIVE ASSESSMENT OF ATHEROSCLEROSIS WITH THE PULSE WAVE VELOCITY
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Arterial stiffness is a predictor of atherosclerosis. This study was conducted to develop a method of coronary atherosclerosis severity assessment by means of brachial-ankle pulse wave velocity (baPWV). MATERIALS AND METHODS. We assessed the severity of stenosis (1 group - less than 75% stenosis, 2gr. - 75% to 99% stenosis, and 3gr. - complete occlusion, respectively). The baPWV value was significantly greater in 2VD (n = 46, baPWV = 13,82 ± 2,40 m/sec, p = 0,049) and 3VD groups (n = 44, baPWV = 14,38 ± 2,97 m/sec, p = 0,0028) than that in 1VD group (n = 36, baPWV = 12,49 ± 2,17 m/sec). No significant difference was observed between PWV value in 2VD and 3VD groups. To further investigate the relationship between baPWV values and CAG findings, we assessed the severity of stenosis (1 group - less than 75% stenosis, 2gr. - 75% to 99% stenosis, and 3gr. - complete occlusion, respectively). The baPWV value was significantly greater in 2 (n = 56, baPWV = 13,84 ± 2,25 m/sec, p = 0,025) and 3 groups (n = 45, baPWV = 14,16 ± 3,32 m/sec, p = 0,007) than that in 1 group (n = 25, baPWV = 12,23 ± 1,42m/sec). No significant difference was observed between baPWV value in 2 and 3 groups. CONCLUSION. baPWV significantly increases with the number of affected vessels and severity of stenosis which indicates that it is a powerful diagnostic instrument for determining coronary artery atherosclerosis in males.

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CONVERSION BETWEEN DEFINITIONS OF PULSE WAVE VELOCITY
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Background: Different methodologies for determination of carotid-femoral pulse wave velocity (PWV) exist. Distance (L) can be measured from carotid-sternum to sternum-femoral distances (L subtracted). Transit time is feasible in young healthy volunteers, and yields values that are comparable to those measured using arterial applanation tonometry. The obtained PTT values (74.86 ± 8.63 ms) were compared with PTT evaluated on the same subjects by means of applanation tonometry applied simultaneously on the same locations (75.85 ± 8.61 ms). The two techniques were highly correlated (r = 0.97; p<0.001 ; Spearman rho 0.88) and values were not statistically different (p=0.377). Our preliminary results demonstrate that laser-based non-contact measurement of pulse transit time is feasible in young healthy volunteers, and yields values that are equivalent to those measured using arterial applanation tonometry. Clinical application of this appealing non-invasive method can overcome practical and technical limitations inherent to currently used methods such as arterial applanation tonometry, ultrasound, plethysmography, requiring physical contact of the probe with the patient.

Method: Three cohorts of altogether 598 subjects (mean age 58,9 years) were studied. PWV was measured by Sphygmocor device. The c-f distance was measured with tape. 2. estimated: height was multiplied by 0.27 (= median ratio of measured c-f distance to body height).

Results: Difference in PWV calculated by the two methods (measured minus estimated) increased with PWV: it was -0.2 m/s for PWV 5 m/s and +1.8 m/s for PWV 15 m/s. In multiple regression analysis, this difference depended highly significantly (p=0.0001) on PWV, weight (positive associations) and height (negative association); there were weak positive associations (p=0.05) with male gender, high LDL level and presence of cardiovascular disease and no associations with age, smoking, hypertension or diabetes.

Conclusions: When PWV is estimated from body height, the highest PWV values show regression to the mean. Besides PWV, anthropometric parameters are major determinants of the differences between the two methods. Estimation of c-f distance from body height would simplify the procedure and bias due to obesity and body disproportion would probably be minimized. For future use of aortic PWV, the best method of the distance assessment should be studied in larger cohorts with known cardiovascular morbidity/mortality endpoints.

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DETERMINATION OF PRESSURE INDEPENDENT ARTERIAL STIFFNESS BY CORRECTING PULSE WAVE VELOCITY FOR PRESSURE-AREA RELATIONSHIP
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Background: Intrinsinc (pressure independent) arterial stiffness is becoming increasingly important as treatment target in hypertensive patients but is still dificult to assess non-invasively. We measured pulse wave velocity (PWV) and the pressure-area (p-A) relation to determine both apparent and intrinsic stiffness.

Method: Non-invasive PWV (nPWV) was measured by multiple-M-mode ultrasound in a phantom. The incisura of the diameter waveform was used as time-reference point for calculating nPWV. A catheter was placed in the phantom to measure the pressure waveform simultaneously. Additionally, in hypertensive patients carrying a baroreceptor stimulator, finger-presssure and nPWV at the condition carotid artery were measured simultaneusly. For both phantom and subject studies, intrinsic PWV (PWVint) was derived employing the Bramwell-Hill equation with the incremental distensibility, dA/(A*dp), based on either a linear or exponential p-A relation.

Results: In the phantom setup, nPWV (12.1±0.8 m/s) increased with increasing pressure (r = 0.67, p<0.0001). Because a linear p-A relation was observed, intrinsic PWV was calculated as PWVint = A/Dp*/PWV^2 and will be independent of pressure (r = 0.001). During baroreceptor stimulation MAP decreased from 138±22 to 109±11 mmHg and nPWV decreased from 10.5±1.5 to 6.6±1.3 m/s (p=0.03). In these patients the observed p-A rela- relationship was exponential and PWVint was therefore calculated using PWVint = Dp*/Dp^2. PWVint did not decrease upon stimulation (p=0.23).

Conclusion: Commonly apparent PWV is measured. Intrinsic stiffness can be calculated using nPWV and assuming a linear or exponential p-A relation. An