Valor pronóstico de la ecocardiografía de ejercicio en cinta rodante

Introducción y objetivos. Aunque la ecocardiografía de ejercicio es útil para el diagnóstico de la enfermedad coronaria, hay menos datos referentes a su valor pronóstico. El objetivo de este estudio fue esclarecer: a) si hay un valor incremental de la ecocardiografía en el pico del ejercicio respecto a las variables clínicas, la prueba de esfuerzo y la ecocardiografía en reposo, y b) si el número y la localización de los territorios afectados, así como el tipo de respuesta al ejercicio, influyen en la estratificación.

Pacientes y método. En 2.436 pacientes referidos para ecocardiografía de ejercicio se realizó un seguimiento de 2,1 ± 1,5 años. Hubo 120 eventos (infarto no fatal o muerte cardiovascular) antes de la revascularización.

Resultados. La ecocardiografía fue anormal en 1.203 pacientes (49%). Hubo 89 eventos en pacientes con resultado normal (2,5%; p < 0,001). Mediante un análisis multivariable de variables clínicas, de la prueba de esfuerzo y de la ecocardiografía en reposo y ejercicio encontramos que las variables asociadas con el riesgo de eventos eran: ser varón (riesgo relativo [RR] = 1,7; p < 0,001), presión arterial (RR = 0,9; IC del 95%, 0,9-1,0; p = 0,02), el índice de motilidad segmentaria basal (RR = 2,5; IC del 95%, 1,5-4,1; p < 0,001) y el número de territorios afectados (RR = 1,4; IC del 95%, 1,2-1,7; p < 0,001).

Conclusiones. La ecocardiografía en el pico del ejercicio incrementa el valor pronóstico de las variables clínicas, la prueba de esfuerzo y la ecocardiografía de reposo.

Palabras clave: Ecocardiografía de ejercicio. Valor pronóstico. Cinta rodante.
Exercise echocardiography (EE) has advanced significantly from the diagnostic point of view, and several recent studies (most carried out at the same center) have shown that the extent of resting or exercise-induced ventricular dysfunction is a robust predictor of cardiac death and myocardial infarction.1–10 The purpose of this study was to investigate whether the number and location of diseased territories during the exercise peak, as well as the type of response to exercise (ischemia, necrosis or remote ischemia) influenced risk stratification more than clinical, stress test, and resting echocardiography variables in patients with known or suspected coronary artery disease (CAD). We also investigated whether EE supplemented resting echocardiography in patients with a history of acute myocardial infarction (AMI) as recorded in the medical history.

We studied 2479 patients who had undergone treadmill EE at our institution during a 4.2-year period from December 1997 to March 2002. Patients with significant valve disease (n=13) or with proven hypertrophic or dilated cardiomyopathy (n=30) were excluded, with the final group composed of 2436 patients who were followed until 31 December 2002. The patients’ medical history revealed a history of myocardial infarction in 741 patients (30%), that was acute in 386 (16%) with elevation of ST segment in ≥2 mm in ST segment, significant arrhythmia, severe hypertension (systolic blood pressure >240 mm Hg or diastolic blood pressure >110 mm Hg) and hypotensive response (decrease ≥20 mmHg from baseline). The ECG was considered positive in the case of horizontal or downsloping elevation or depression of ST segment ≥1 mm at 80 ms after the J point, and non-diagnostic when the baseline ECG was abnormal or the patient was receiving digoxin. Two-dimensional echocardiography with fundamental or harmonic imaging was performed in the standard apical and parasternal views at baseline, at the exercise peak, and immediately after exercise. Peak EE was done when there were signs or symptoms of exhaustion or some criterion for termination had been reached. All images were acquired on-line and saved to optical disc for subsequent analysis.

The images were analyzed using a quad screen format to compare the same views at baseline and exercise peak. The left ventricle was divided into 16 segments,11–13 with each segment assigned to 1 of the 3 coronary arterial territories.14 The onset of regional dysfunction (hypokinesia, akinesia, or dyskinesia) or worsening from hypokinesia to akinesia or dyskinesia was considered an ischemic response. The persistence of baseline regional dysfunction affecting at least one segment or worsening from akinesia to dyskinesia was considered necrosis with no ischemia, except in the case of isolated hypokinesia of the posterobasal segment,15 and septal hypokinesia in patients with complete left bundle branch block, pacemaker, or recent heart surgery. In these cases, hypokinesia was considered normal. In patients with global ventricular dysfunction of unknown origin, a response of progressive improvement was considered normal and a diagnosis of dilated cardiomyopathy was suggested.16 In all other patients, EE positive for CAD was defined as ischemia or necrosis in 1 coronary arterial territory.17–19 The following types of

| Time of EE, 24% of the patients were taking nitrates; 8%, calcium antagonists; 4%, beta-blockers; 22%, angiotensin-converting enzyme inhibitors; 9%, diuretics, and 4%, digoxin. |   |

### INTRODUCTION

Exercise echocardiography (EE) has advanced significantly from the diagnostic point of view, and several recent studies (most carried out at the same center) have shown that the extent of resting or exercise-induced ventricular dysfunction is a robust predictor of cardiac death and myocardial infarction.1–10 The purpose of this study was to investigate whether the number and location of diseased territories during the exercise peak, as well as the type of response to exercise (ischemia, necrosis or remote ischemia) influenced risk stratification more than clinical, stress test, and resting echocardiography variables in patients with known or suspected coronary artery disease (CAD). We also investigated whether EE supplemented resting echocardiography in patients with a history of acute myocardial infarction (AMI) as recorded in the medical history.

We studied 2479 patients who had undergone treadmill EE at our institution during a 4.2-year period from December 1997 to March 2002. Patients with significant valve disease (n=13) or with proven hypertrophic or dilated cardiomyopathy (n=30) were excluded, with the final group composed of 2436 patients who were followed until 31 December 2002. The patients’ medical history revealed a history of myocardial infarction in 741 patients (30%), that was acute in 386 (16%) with elevation of ST segment in ≥2 mm in ST segment, significant arrhythmia, severe hypertension (systolic blood pressure >240 mm Hg or diastolic blood pressure >110 mm Hg) and hypotensive response (decrease ≥20 mmHg from baseline). The ECG was considered positive in the case of horizontal or downsloping elevation or depression of ST segment ≥1 mm at 80 ms after the J point, and non-diagnostic when the baseline ECG was abnormal or the patient was receiving digoxin. Two-dimensional echocardiography with fundamental or harmonic imaging was performed in the standard apical and parasternal views at baseline, at the exercise peak, and immediately after exercise. Peak EE was done when there were signs or symptoms of exhaustion or some criterion for termination had been reached. All images were acquired on-line and saved to optical disc for subsequent analysis.

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response were considered for each patient: normal (same or greater thickening and systolic wall motion with exercise), isolated ischemia (normal thickening/systolic motion at baseline and appearance of regional or global dysfunction with exercise), necrosis (persistence of baseline regional dysfunction with exercise or worsening from akinesia to dyskinesia), necrosis with remote ischemia (presence of baseline regional dysfunction and onset of new dyskinesia in a different territory), and ischemia and necrosis affecting the same territory (presence of baseline regional dysfunction that worsens in the same territory due to worsening from hypokinesia to akinesia or dyskinesia, or greater extension of dysergia but without affecting territories other than the one affected at baseline). Patients were classified according to the number of abnormal territories (0, 1, 2, or 3) during exercise. Regional wall motion (RWM) was calculated at rest and during exercise, scoring normal motion as 1, hypokinesia as 2, akinesia as 3, and dyskinesia as 4. The resting and exercise ejection fraction (EF) was measured through visual estimation by an observer. Data are provided for between-observer variablity in the visual estimation of EF at our center from an analysis of 60 studies selected at random (20 with fundamental imaging, 40 with harmonic) and assessed on 2 occasions 36 months apart.

**Follow-up**

Events were followed up and assessed through a review of the medical histories and death certificates. We had access to hospital admissions, out-of-hospital consultations, and emergency room services of all SERGAS centers; no patients were lost during follow-up. If no data were available for a patient at the end of the study (31 December 2002), the health card database was consulted to determine whether the patient had died or moved to a location outside the autonomous community. In the event of death of unknown origin, precise information on the cause (cardiovascular, neoplasm, etc) was obtained from the Death Register of Galicia. Only hard events were considered, with these defined as death of cardiovascular origin, precordial pain or dyspnea in 1582 patients (91%), angina because of exhaustion in 2212 patients (91%), arrhythmias in 3 patients (0.1%). The stress test was discontinued because of exhaustion in 2212 patients (91%), angina in 63 (3%), lower limb pain in 148 (6%), and arrhythmias in 3 patients (0.1%).

**Exercise Echocardiography Data**

The EE was considered normal in 1233 patients (51%) and abnormal in 1203 (49%). There were baseline alterations in regional motion in 652 patients (27%). Among the 1203 patients with an abnormal EE, 282 had only necrosis (23%); 547, ischemia (45%); 284, remote ischemia (24%), and 90, ischemia and necrosis in the same territory (7%). In the patients with normal EE, involvement of 1 territory was found in 566 (47%), 2 territories in 230 (19%), and 3 territories in 407 patients (34%). Among patients with abnormal EE, the EE was positive for disease in the left anterior descending artery territory in 870 (72%) and positive for disease in the
right coronary artery or circumflex artery territory in 913 (76%).

In patients with a history of AMI as recorded in the medical history, EE was normal in 917 (13%) and abnormal in 644 (87%). Abnormal EE was categorized as necrosis in 30%, ischemia in 22%, remote ischemia in 24%, and necrosis associated with ischemia in the same territory in 10%. Multi-territory disease was reported in 411 patients (42%).

**Revascularization Procedures**

A total of 454 patients (20%) were revascularized during follow-up, 152 surgically and 302 by angioplasty. Of these, 427 patients who were revascularized before a hard event were excluded. The reasons for revascularization were coronary event in 917 patients (20%) and EE result in 644 (87%). Abnormal EE was categorized as necrosis in 30%, ischemia in 22%, remote ischemia in 24%, and necrosis associated with ischemia in the same territory in 10%. Multi-territory disease was reported in 411 patients (42%).

**Events**

Over a mean follow-up of 2.1±1.5 years (median, 2.0 years; maximum, 5 years) there were 167 cardiovascular events: cardiovascular death in 112 patients and nonfatal AMI in 55. There were significant differences in baseline characteristics between the 2269 patients who had no events during follow-up and the 167 who had some event: age (61±11 vs 64±10 years; \(P<.0001\)), male sex (64% vs 81%; \(P<.001\)), diabetes (18% vs 24%; \(P=.05\)), smoking (28% vs 35%; \(P<.05\)), previous revascularizations (15% vs 22%; \(P=.01\)), pre-cordial pain or dyspnea as reason for request (66% vs 54%; \(P<.01\)), history of AMI as reason for request (29% vs 42%; \(P<.0001\)), and patients revascularized during follow-up (17% vs 44%; \(P<.05\)). Table 1 contains the exercise data for patients with and without hard cardiovascular events.

### Table 1. Exercise Echocardiography and Echocardiographic data in Patients With and Without Hard Cardiovascular Events in the Follow-up

<table>
<thead>
<tr>
<th></th>
<th>Patients Without Events (n=2269)</th>
<th>Patients With Events (n=167)</th>
<th>(P)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline HR, bpm</td>
<td>79±14</td>
<td>80±13</td>
<td>NS</td>
</tr>
<tr>
<td>Maximum HR, bpm</td>
<td>145±21</td>
<td>136±21</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Baseline SBP, mm Hg</td>
<td>138±19</td>
<td>135±18</td>
<td>NS</td>
</tr>
<tr>
<td>Maximum SBP, mm Hg</td>
<td>174±29</td>
<td>163±31</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Change in SBP, mm Hg</td>
<td>36±24</td>
<td>28±23</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>HR × maximum SBP×1000</td>
<td>25 440±5912</td>
<td>22 264±368</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>METs</td>
<td>9.4±3.1</td>
<td>7.7±3.2</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Theoretical maximum HR, %</td>
<td>0.92±0.12</td>
<td>0.87±0.13</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Angina during test</td>
<td>307 (14%)</td>
<td>34 (20%)</td>
<td>0.02</td>
</tr>
<tr>
<td>ECG</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>357 (16%)</td>
<td>41 (25%)</td>
<td>.05</td>
</tr>
<tr>
<td>Negative</td>
<td>1217 (53%)</td>
<td>50 (30%)</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Nondiagnostic</td>
<td>695 (31%)</td>
<td>70 (45%)</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Baseline EF, %</td>
<td>57±10</td>
<td>50±13</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Peak EF, %</td>
<td>40±14</td>
<td>47±17</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>(\Delta) in EF</td>
<td>2.9±8.4</td>
<td>–2.7±9.3</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Abnormal EE</td>
<td>1069 (47%)</td>
<td>134 (80%)</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>EE response</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal</td>
<td>1200 (53%)</td>
<td>33 (20%)</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Ischemia</td>
<td>491 (22%)</td>
<td>56 (34%)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Necrosis</td>
<td>253 (11%)</td>
<td>29 (17%)</td>
<td>0.3</td>
</tr>
<tr>
<td>Remote ischemia</td>
<td>239 (11%)</td>
<td>45 (27%)</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Ischemia + necrosis in the same territory</td>
<td>86 (4%)</td>
<td>4 (2%)</td>
<td>NS</td>
</tr>
<tr>
<td>Peak RWM</td>
<td>1.1±0.29</td>
<td>1.38±0.42</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>(\Delta) of RWM</td>
<td>0.12±0.23</td>
<td>0.24±0.30</td>
<td>&lt;.0001</td>
</tr>
</tbody>
</table>

*AMI indicates acute myocardial infarction; ECG, electrocardiogram; EE, exercise echocardiography; EF, ejection fraction; HR, heart rate; METs, metabolic equivalents; NS, nonsignificant; RWM, regional wall motion; SBP, systolic blood pressure.*
events. Of the 167 cardiovascular events, 120 occurred before any revascularization procedure was done and were used to estimate event-free survival by Kaplan-Meier and to construct survival curves. The causes of these 120 hard events were nonfatal AMI in 45 patients (38%) and death in 75 (62%). The causes of cardiovascular death were proven fatal AMI in 6, fatal deterioration of heart failure in 8, sudden death in 6, stroke in 6, and gangrene in 2. Of the 39 patients after excluding other causes of noncardiovascular death from the death certificates, the causes of cardiovascular death were proven fatal AMI in 6, fatal deterioration of heart failure in 8, sudden death in 6, stroke in 6, and gangrene in 2. Out-of-hospital cardiovascular death was considered to have occurred in 39 patients after excluding other causes of noncardiovascular death from the death certificates. Heart transplantation in 4 patients and first discharge of defibrillator in another 4, were also considered hard events. The EE was positive in 89 of the 120 patients with events (74%), in 24 (20%) of the patients with necrosis, in 29 (20%) of those with ischemia, in 33 (28%) of those with remote ischemia, and in 3 (3%) patients with ischemia and necrosis in the same territory. Multi-territory disease was detected in 59 of these patients (49%).

**Clinical, Stress Test, and Resting and Exercise Echocardiography Variables for Prediction of Cardiovascular Events**

Table 2 shows the clinical, stress test, and echocardiography variables associated with the risk of cardiovascular events. Event-free survival and number of events in patients with normal EE versus those with involvement of 1, 2, and 3 territories are shown in Figure 1. Figure 2 shows event-free survival and number of events in patients with normal EE versus patients with EE who had necrosis, ischemia, or remote ischemia and Figure 3 indicates event-free survival according to RWM during exercise.

**Predictors of Cardiovascular Death and AMI by Multivariate Analysis**

Table 3 contains the result of the four steps of the incremental model, including independent predictors for each step. In the final model, the independent pre-

### TABLE 2. Risk of Hard Cardiovascular Events (Cardiovascular Death and Nonfatal Infarction) in Univariate Analysis of Clinical Variables, Stress Test, and Exercise Echocardiography*

<table>
<thead>
<tr>
<th>Variables</th>
<th>Wald</th>
<th>P</th>
<th>RR</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Baseline clinical characteristics</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age†</td>
<td>10</td>
<td>.002</td>
<td>1.34</td>
<td>1.12-1.60</td>
</tr>
<tr>
<td>Male sex</td>
<td>16</td>
<td>&lt;.0001</td>
<td>2.45</td>
<td>1.50-3.81</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>6</td>
<td>.02</td>
<td>1.65</td>
<td>1.09-2.48</td>
</tr>
<tr>
<td>History of AMI</td>
<td>20</td>
<td>&lt;.0001</td>
<td>2.27</td>
<td>1.59-3.26</td>
</tr>
<tr>
<td>History of revascularization</td>
<td>9</td>
<td>.003</td>
<td>1.85</td>
<td>1.23-2.79</td>
</tr>
<tr>
<td><strong>Stress test</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Angina</td>
<td>4</td>
<td>.05</td>
<td>1.64</td>
<td>0.98-2.71</td>
</tr>
<tr>
<td>Change in ST segment‡</td>
<td>10</td>
<td>.002</td>
<td>1.46</td>
<td>1.15-1.86</td>
</tr>
<tr>
<td>Theoretical maximum HR, %</td>
<td>18</td>
<td>&lt;.0001</td>
<td>0.05</td>
<td>0.01-0.20</td>
</tr>
<tr>
<td>METs§</td>
<td>37</td>
<td>&lt;.0001</td>
<td>0.84</td>
<td>0.79-0.89</td>
</tr>
<tr>
<td>HR × maximum SBP ×1000§</td>
<td>45</td>
<td>&lt;.0001</td>
<td>0.90</td>
<td>0.87-0.93</td>
</tr>
<tr>
<td><strong>EE variables</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abnormal EE</td>
<td>44</td>
<td>&lt;.0001</td>
<td>4.00</td>
<td>2.64-6.00</td>
</tr>
<tr>
<td>Ischemia</td>
<td>32</td>
<td>&lt;.0001</td>
<td>2.82</td>
<td>1.97-4.04</td>
</tr>
<tr>
<td>Remote ischemia</td>
<td>50</td>
<td>&lt;.0001</td>
<td>4.28</td>
<td>2.86-6.40</td>
</tr>
<tr>
<td>Baseline ejection fraction$</td>
<td>79</td>
<td>&lt;.0001</td>
<td>0.95</td>
<td>0.93-0.96</td>
</tr>
<tr>
<td>Peak ejection fraction§</td>
<td>100</td>
<td>&lt;.0001</td>
<td>0.95</td>
<td>0.94-0.96</td>
</tr>
<tr>
<td>∆ in ejection fraction§</td>
<td>47</td>
<td>&lt;.0001</td>
<td>0.94</td>
<td>0.93-0.96</td>
</tr>
<tr>
<td>Baseline RWM$</td>
<td>90</td>
<td>&lt;.0001</td>
<td>6.63</td>
<td>4.50-9.88</td>
</tr>
<tr>
<td>Peak RWM$</td>
<td>116</td>
<td>&lt;.0001</td>
<td>7.14</td>
<td>4.91-10.37</td>
</tr>
<tr>
<td>∆ in RWM$</td>
<td>21</td>
<td>&lt;.0001</td>
<td>4.52</td>
<td>2.37-8.60</td>
</tr>
<tr>
<td>Number of territories affected</td>
<td>78</td>
<td>&lt;.0001</td>
<td>1.92</td>
<td>1.60-2.22</td>
</tr>
<tr>
<td>Multivessel disease</td>
<td>61</td>
<td>&lt;.0001</td>
<td>4.19</td>
<td>2.92-6.00</td>
</tr>
<tr>
<td>Involvement of ADA territory (± other territories)</td>
<td>53</td>
<td>&lt;.0001</td>
<td>3.90</td>
<td>2.70-5.63</td>
</tr>
<tr>
<td>Involvement of RCA/Cx territory (± other territories)</td>
<td>43</td>
<td>&lt;.0001</td>
<td>3.42</td>
<td>2.37-4.94</td>
</tr>
</tbody>
</table>

*AMI indicates acute myocardial infarction; CI, confidence interval; Cx, circumflex artery; EE, exercise echocardiography; HR, heart rate; LAD, left anterior descending artery; METs, metabolic equivalents; RCA, right coronary artery; RR, risk relative; RWM, regional wall motion; SBP, systolic blood pressure.
†According to decade.
‡According to mm of change.
§According to 1 U.
IIAccording to 1000 U.

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dictors of hard cardiovascular events were: male sex, METs achieved, heart rate × maximum blood pressure, baseline RWM, and number of territories affected at exercise peak. The independent predictors of cardiovascular death were METs achieved (relative risk \(RR=0.88; 95\% \text{ CI}, 0.80-0.96; \ P=.004\)), heart rate × blood pressure (RR=0.93; 95\% CI, 0.89-0.98; \ P=.003\), baseline RWM (RR=3.8; 95\% CI, 2.1-7.0; \ P<.0001\), and number of territories affected in the exercise peak (RR=1.5; 95\% CI, 1.1-1.7; \ P=.015\), but not sex (\(\chi^2\) of the final model =169; added value of exercise echocardiograph; \(P=.015\)).
Among the 741 patients with a history of AMI, there were 53 events (7%; 22 nonfatal infarctions, and 31 deaths of cardiovascular origin). The EE was abnormal in 93% of the patients with events, with necrosis in 19 (36%), ischemia in 10 (19%), remote ischemia in 18 (34%), and ischemia and necrosis in the same territory in 2 (4%). Exercise echocardiography indicated multi-vessel disease in 29 (55%). The independent predictive variables of hard events in the final model of patients with AMI were METs achieved, product of heart rate × blood pressure and peak EF (Table 4).

### Predictors of Events in Patients With History of AMI

Between-Observer Variability in Ejection Fraction Calculation

The between-observer variation was 9% ± 9% for baseline EF calculation and 10% ± 10% for peak EF calculation.

### TABLE 3. Multivariate Analysis of:

- **a)** Clinical;
- **b)** Clinical and Stress Test;
- **c)** Clinical, Stress Test, and Resting Echocardiography; and
- **d)** Clinical, Stress Test, Resting Echocardiography, and Exercise Echocardiography

Variables for Prediction of Events in 2436 Patients*

<table>
<thead>
<tr>
<th>Variables</th>
<th>Clinical Model</th>
<th>Clinical Model + ST</th>
<th>Clinical Model + ST + Baseline Echo</th>
<th>Clinical Model + ST + Baseline Echo + Exercise Echo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age†</td>
<td>1.4 (1.2-1.7)</td>
<td>&lt;.0001</td>
<td>6.0 (0.9-1.3)</td>
<td>1.0 (0.9-1.3)</td>
</tr>
<tr>
<td>Male</td>
<td>2.2 (1.4-3.5)</td>
<td>&lt;.0001</td>
<td>2.4 (1.5-3.9)</td>
<td>2.0 (1.2-3.2)</td>
</tr>
<tr>
<td>History AMI</td>
<td>1.9 (1.3-2.8)</td>
<td>&lt;.001</td>
<td>1.7 (1.1-2.4)</td>
<td>.008 (0.9-1.9)</td>
</tr>
<tr>
<td>METs‡</td>
<td>0.87 (0.82-0.93)</td>
<td>&lt;.001</td>
<td>0.90 (0.84-0.97)</td>
<td>0.92 (0.86-0.98)</td>
</tr>
<tr>
<td>HR×SBP×100S</td>
<td>0.94 (0.90-0.97)</td>
<td>&lt;.001</td>
<td>0.94 (0.91-0.98)</td>
<td>0.12 (0.91-0.98)</td>
</tr>
<tr>
<td>Baseline RWM</td>
<td>1.7 (2.4-5.8)</td>
<td>&lt;.0001</td>
<td>3.7 (2.3-4.8)</td>
<td>&lt;.0001</td>
</tr>
</tbody>
</table>

*AMI indicates acute myocardial infarction; CI, confidence interval; EE, exercise echocardiography; Echo, echocardiography; HR, heart rate; METs, metabolic equivalents; RWM, regional wall motion; SBP, systolic blood pressure; ST, stress test; RR, relative risk.

†According to decade.

‡According to 1 U.

§According to 1000 U.
DISCUSSION

The most significant findings of this study were:

a) EE supplements the clinical, exercise testing, and baseline echocardiography variables among a population with moderate-to-high pretest prevalence of CAD; b) a response of remote ischemia is significantly associated with poor prognosis, when compared to other types of response; and c) the added value of resting and exercise echocardiography is also observed in the subgroup of patients with a history of AMI.

Prognostic Value of Exercise Echocardiography

The incremental value of EE we found in our study has been previously demonstrated in recent studies, although most were performed at the same center. However, the present study is the first to investigate this aspect in Spain and the first to use echocardiography during the exercise peak, instead of post-exercise or pharmacological echocardiography. We should mention that EE in general is a widely used technique in our setting, and that EE at the exercise peak in particular is commonly used at various centers in Spain. The patients with three coronary territories affected during the exercise peak presented a high risk of events (11% of events at 2 years), when compared with those who had fewer territories affected. Nevertheless, there were no differences between 1 and 2 territories (5% vs 6% of events). Involvement of only 1 territory or even of 2 territories, if dependent on the right coronary or circumflex arteries, was not associated with significant risk in the univariate analysis.

Type of Response

The risk associated with the response of remote ischemia of a necrosis (12% events at 2 years) was significantly higher than the risk associated with other types of response. The risk associated with necrosis was found to be equal to the risk associated with ischemia. More patients with ischemia than with necrosis were excluded due to revascularizations, however, which may explain this lack of difference. Lastly, patients with RWM during the exercise peak >1.5 had a high risk of presenting events, with 10.5% of events in patients with RWM of 1.75-2.00 and 16% in those with RWM>2.0.

Exercise Echocardiography in Patients With a History of AMI

Since EE is particularly indicated in patients with a history of AMI due to the baseline alterations of repolarization that prevent an assessment of the ECG, we were interested in analyzing these patients separately. In these patients we also found that an exercise imaging variable added significant value to the model above the resting echocardiography variables, which were not significant in the final model. However, the EE variable that enhanced the model was peak EF rather than RWM or ischemia, possibly reflecting the difficulty encountered for detecting pre-infarction ischemic areas and the prognostic value of the amount of necrotic myocardium with no contractility reserve.

Limitations

As mentioned above, EE was performed at the exercise peak instead of post-exercise since imaging at the
exercise peak has been shown to have greater sensitivi-
ty.11,12,23 Nevertheless, the superiority of the echocar-
diography variables in the exercise peak over the clini-
cal, ECG, and resting echocardiography variables we
found in this study could be diminished if the EE is
performed after exercise.
Since the EE results were used by the attending
physician, the apparent prognostic information could
be reduced, since most patients with severely positive
tests who were revascularized might have presented
serious events if they had not undergone revasculariza-
tion.

The definition of nonfatal AMI was based on crite-
ria from the pre-troponin era for most patients and
therefore, although we have records on hospitalization
for unstable angina, AMI was only considered to exist
when it was specifically indicated in the medical re-
ports. As a result, we are probably referring to infarc-
tions of a certain entity in which, if the current, more
sensitive criteria had been used, the number of events
would be greater at the expense of nonfatal AMI. Ne-
evertheless, we feel this does not diminish the value
of our study, since EE continued to be associated with
cardiovascular mortality.

Approximately 40% of the EEs were performed
with fundamental imaging. The technology has dra-
matically improved since that time through the de-
velopment of harmonic imaging and continuous image
acquisition, which could result in greater sensitivity of
the technique. Unfortunately, this is a common pro-
blem that affects continuous longitudinal studies con-
ducted in this field.

Clinical Implications
Risk measurement with EE is superior to measure-
ment with clinical, exercise testing, and baseline
ecocardiography variables. Patients who present in-
volvement of 3 territories, remote ischemia, and peak
RWM ≥1.75 on EE are at high risk for hard cardiovas-
cular events.

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