Dietary Nitrate Increases Exercise Tolerance in Patients with Non-Ischemic, Dilated Cardiomyopathy-a Double-Blind, Randomized, Placebo-Controlled, Crossover Trial.

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Dietary nitrate increases exercise tolerance in patients with non-ischemic, dilated cardiomyopathy—a double-blind, randomized, placebo-controlled, crossover trial

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Non-ischemic dilated cardiomyopathy (NIDCM) is defined as left ventricular dysfunction in the absence of causative coronary artery disease. It typically presents with impaired effort tolerance, which is a major prognostic factor. Nitric oxide (NO), a potent systemic vasodilator, is vital for skeletal muscle contraction and contributes to matching of blood flow and oxygen delivery necessary in active skeletal muscle. NIDCM is associated with dysregulated NO production, including decreased endothelial NOS expression and NO release. Furthermore, NO therapy has been shown to improve systemic circulation in NIDCM by reducing right ventricular after-load.

There are 2 pathways facilitating NO synthesis in vivo. The L-arginine–NO synthase pathway is well characterized and, until recently, was considered the sole source of endogenous NO. A second, NO synthase–independent pathway has recently been discovered and was found to be involved in simple reduction of dietary, inorganic nitrate to nitrite and NO. Acute nitrate consumption has been shown to increase blood nitrate/nitrite levels and exercise performance in healthy, athletic, pulmonary vascular disease (PVD), chronic obstructive pulmonary disease (COPD) and heart failure (HF) subjects. We hypothesized that dietary nitrate supplementation could acutely improve exercise capacity in NIDCM.

We recruited a group of ambulatory outpatients with NIDCM (New York Heart Association Functional Class II or III) who were on optimized therapy. Exclusion criteria were use of organic nitrate therapy, and diabetes or conditions affecting mobility. Our study received local institutional review board approval.

Subjects were tested on 2 separate days, 7 days apart, in a crossover fashion after consuming a light, self-selected, low-nitrate breakfast and taking usual medications. On both days, in an identical manner and at the same time of day, we performed resting blood pressure (BP) measures, blood draws and incremental shuttle-walk tests (ISWTs) before and 3 hours after beverage consumption, as this time-line has been shown to correspond to near peak blood nitrite concentrations after nitrate consumption.

Upon completion of Day 1 pre-supplementation assessments, subjects were randomized in a double-blind, crossover trial design to consume 140 ml of either nitrate-rich beet-root juice (NO3; 12.9 mmol nitrate) or nitrate-depleted beet-root juice (PL; < 0.5 mmol nitrate). The PL preparation is identical in taste and appearance but has had the nitrate removed by anion exchange, as described in a previous study. At each visit, subjects underwent baseline assessments followed by consumption of 140 ml of beverage (NO3 or PL) and rested quietly for 150 minutes, when all measures were repeated. Thus, subjects underwent assessments on 4 occasions separated by a 7-day washout period (Figure 1), during which they were advised not to change behaviors that would influence NO pharmacokinetics or exercise capacity, specifically diet, exercise and medication.

Immediately before and after each of the 4 ISWTs, subjects rated their dyspnea and leg fatigue on the Borg scale and had oxygen saturation (SpO2) and heart rate (HR) measured. BP was measured at the brachial artery using a manual sphygmomanometer and stethoscope before all 4 ISWTs.

Measurement of NO derivatives (nitrate/nitrite) in biologic fluids reflects NO bioavailability and was analyzed using the current “gold standard,” ozone-based chemiluminescence analysis, on an NO analyzer (NOA280i; Sievers).

We based the sample size on our recent study with an identical protocol among COPD subjects where a significant treatment effect of nitrate on ISWT was observed on a sample of 11 subjects. ΔNO3 and ΔPL data were compared by using 2-tailed, paired t-tests for normally distributed data and Wilcoxon’s test for non-normally distributed data. Correlations were assessed using Pearson’s correlation coefficient. The presence of a carryover effect was assessed using 2-tailed, unpaired t-tests by comparing the observed ISWT difference among those who received NO3 following...
by PL with those who received the opposite. All statistical tests were conducted at the 2-sided 0.05 significance level using SPSS for Windows (version 15.0).

Twelve subjects were recruited. There was 1 drop-out due to loss to follow-up. Thus, 11 subjects completed the study (Table 1). After NO₃ consumption, mean ISWT distance increased by 65 ± 41 meters (431 to 496 meters, 15%), whereas there was a decrease of 5 ± 35 meters (437 to 433 meters, 1%) after PL (p = 0.0056). The mean and individual ISWT distances after NO₃ and PL are shown in Figure 2a.

Figure 1  Trial design. Assessments included resting blood pressure, blood draw, resting, pre-ISWT dyspnea and arterial oxygen concentration, ISWT, post-ISWT dyspnea and arterial oxygen concentration. BRJ, beet-root juice; PL, placebo.
Ten of the 11 subjects walked further after NO3 (30 to 140
meters), whereas 1 had a decreased exercise capacity (–10
meters). However, after PL, only 4 subjects had increased
walking capacity (10 to 80 meters), but 7 walked shorter
distances (–10 to –60 meters). There was no significant
difference regarding SpO2, HR, dyspnea or leg fatigue score
(data not shown). Also, there was no difference in ISWT
distance, regardless of treatment sequence (p = 0.24),
suggesting no carryover effect of the intervention. Table 2

We also observed an 18% increase in ISWT distance with
NO3 (–1.5% to 39%), whereas PL led to a 2% decrease
(–17.6% to 11.6%). Similar to the NO response, there was
marked variation regarding ISWT response to NO3. It is
probable that differences in baseline fitness/NO bioavail-
ability, medications and NIDCM severity contribute to this
variation. Nevertheless, 10 of 11 subjects had increased
ISWT distance post-NO3.

Exercise capacity is regarded as a principal variable for
the evaluation of new therapeutic approaches in NIDCM.
Further, we have demonstrated that exercise capacity
represents an important prognostic factor related to future
mortality in NIDCM.1 Controversy remains regarding the
optimal test to assess exercise capacity in NIDCM. Herein
we have utilized the ISWT as our primary end-point,
which represents a standardized procedure and has been
shown to strongly predict maximal aerobic capacity and
future outcome in HF.

Our observations are supported by recent trials in HF
patients. One trial used constant-intensity cycle cardiol-
monary exercise testing to assess 17 HF patients with
preserved ejection fraction. Although there was no change
in exercise efficiency (primary end-point), there were
significant increases in exercise oxygen consumption, total
work performed, exercise duration and plasma NO
metabolites.2 A second trial used isokinetic dynamometry
to assess 9 HF patients with NIDCM and showed acutely
increased peak knee extensor power.3 It is of interest to
compare these results with the present data.

Figure 2  Absolute changes in ISWT, plasma nitrate, plasma nitrite. Dotted lines represent each individual; bold line represents the group
mean (a) or median (b and c). (a) Incremental shuttle-walk test distance. (b) Plasma nitrate. (c) Plasma nitrite. (d) Correlation between
absolute change in plasma nitrite and ISWT distance (r = 0.0007, * p < 0.005).
Table 1: Baseline Characteristics of Overall Chronic Obstructive Disease Patients (n = 11).

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>75 ± 11 (63–80)</td>
</tr>
<tr>
<td>Males [%]</td>
<td>56 (43–80)</td>
</tr>
<tr>
<td>Current smoker [%]</td>
<td>4 (36)</td>
</tr>
<tr>
<td>Life long non-smoker</td>
<td>6 (55)</td>
</tr>
<tr>
<td>Ex-smoker</td>
<td>1 (9)</td>
</tr>
</tbody>
</table>

| BMI (kg/m²)            | 32.4 ± 4.6 (25.7–40.8) |
| Waist circumference (cm)| 112 ± 11 (97–125)    |
| Systolic blood pressure (mm Hg) | 134 ± 18 (118–158) |
| Diastolic blood pressure (mm Hg) | 81 ± 12 (73–92)   |
| Heart rate (BPM)       | 73 ± 18 (63–89)    |
| SBP/DBP ratio          | 16 (14–18)        |
| NYHA functional class  | III (91)         |
| Exercise capacity (%)  | 25 (20–35)        |
| Smoking status [%]     | 35 (30–40)        |
| Obese [%]              | 3 (27)           |
| Diabetes [%]           | 18 (15–21)       |
| Echocardiograms        | 2 (18)           |
| Tricuspid regurgitation | 2 (18)           |
| Mitral regurgitation   | 1 (9)            |
| Aortic stenosis        | 2 (18)           |
| Left atrial area (cm)  | 20.4 ± 10.1 (15.9–27.1) |
| Left atrial volume (mL) | 60 ± 30 (45–75)  |
| Left ventricular systolic function [peak systolic pressure] | 84 ± 58 (70–100) |
| LVEF [%]               | 51 ± 9 (39–62)   |
| LVEDD (cm)             | 5 ± 1 (4–6)      |
| LVESD (cm)             | 3 ± 1 (2–4)      |
| BNP (ng/liter)         | 11 (9–15)        |
| 6MWD (m)               | 310 ± 90 (120–540) |

Table 2: Hemodynamic, Biochemical and Physical Parameters Before and After Supplementation With Placebo (PL) or Nitrate-rich Beet-root Juice (NO₃⁻).

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Before PL</th>
<th>3 hours After PL</th>
<th>ΔPL</th>
<th>Before NO₃⁻</th>
<th>3 hours after NO₃⁻</th>
<th>ΔNO₃⁻</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>ISWT (ms)</td>
<td>437 ± 157</td>
<td>433 ± 173</td>
<td>-5 ± 35</td>
<td>431 ± 155</td>
<td>496 ± 141</td>
<td>65 ± 41</td>
<td>0.0056</td>
</tr>
<tr>
<td>Plasma nitrate (μmol/liter)</td>
<td>26.5 (17.8–43.7)</td>
<td>27.3 (21.8–39.9)</td>
<td>0.8 (–4.2–9.5)</td>
<td>30.2 (23.6–26.4)</td>
<td>84.1 (670.7–1,174.7)</td>
<td>811.1 (649.5–1,142.2)</td>
<td>0.003</td>
</tr>
<tr>
<td>Plasma nitrite (nmol/liter)</td>
<td>73.1 (59.8–106.3)</td>
<td>62.9 (53.1–73.4)</td>
<td>-10 (–4.0–1.7)</td>
<td>67.5 (57.8–93.9)</td>
<td>374 (305.6–1,092.5)</td>
<td>319.7 (250.6–978.2)</td>
<td>0.003</td>
</tr>
</tbody>
</table>

*Normally distributed data are displayed as mean ± standard deviation, and p-values are derived from paired t-tests. Non-normally distributed data are displayed as median (Q1 to Q3), and p-values are derived from Wilcoxon’s tests. NO₃⁻ and ΔPL derived from differences between baseline and post-beverage values, and p-values are derived by comparing these Δ values. BPM, beats per minute; DBP, diastolic blood pressure; HR, heart rate; ISWT, incremental shuttle walk test; SBP, systolic blood pressure; SpO₂, oxyhemoglobin saturation.*
As expected, NO₃ supplementation led to a significant increase in plasma nitrite (>8.5-fold) and particularly nitrate (>28-fold). Similar to our COPD trial, we observed marked variation in response to exogenous nitrate despite an identical dose and time interval (Figure 2b and c). We cannot explain these variations, but it is likely that differences in oral bacteria and stomach acidity, age and medication are contributing factors. Further, we recently reviewed data demonstrating a variation in metabolism of exogenously administered nitrate when measured at a single time-point (e.g., 3 hours), yet the extent of nitrite/nitrate production (across 24 hours) was found to be largely similar. The importance of our placebo-controlled design is illustrated by our earlier demonstration of intra-individual variability with repeat doses of NO₃.

Pharmacologic preparations of organic nitrate are used, with varied success, to treat HF and NIDCM. It should be noted that, despite their similar physiologic effects, organic and inorganic nitrate (such as dietary nitrate) possess different chemical structures and pharmacokinetics. The potency of inorganic nitrate is much lower than that of organic nitrate. However, organic nitrate may result in tolerance and, when discontinued, rebound effects are often evoked. In contrast, inorganic, dietary nitrates do not show any signs of tolerance, and physiologic effects may be potentiated with long-term ingestion.

Although our trial has some major limitations, including the acute nature of the assessments and the small sample size, we utilized a robust trial design among a cohort of well-characterized NIDCM subjects. Dietary nitrate has potential as a novel, therapeutic strategy to increase exercise tolerance in NIDCM. Our preliminary results require confirmation among larger samples in the long-term setting.

Disclosure statement

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References