

Basic science behind the cardiovascular benefits of exercise

Mathew G Wilson,^{1,2,3} Georgina M Ellison,⁴ N Tim Cable^{2,5,6}

¹Department of Sports Medicine, ASPETAR, Qatar Orthopaedic and Sports Medicine Hospital, Doha, Qatar

²Research Institute of Sport and Exercise Sciences, Liverpool John Moores University, Liverpool, UK

³Research Institute of Sport and Exercise Sciences, University of Canberra, Canberra, Australia

⁴Faculty of Life Sciences & Medicine, Centre of Human and Aerospace Physiological Sciences & Centre for Stem Cells and Regenerative Medicine, King's College London, London, UK

⁵Department of Sport Sciences, Aspire Academy, Doha, Qatar

⁶Department of Sports Science, Exercise and Health, University of Western Australia, Australia

Correspondence to

Professor Mathew G Wilson, ASPETAR, Qatar Orthopaedic and Sports Medicine Hospital, PO Box 29222, Doha 29222, Qatar; mathew.wilson@aspetar.com

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ABSTRACT

Cardiorespiratory fitness is a strong predictor of cardiovascular (CV) disease and all-cause mortality, with increases in cardiorespiratory fitness associated with corresponding decreases in CV disease risk. The effects of exercise upon the myocardium and vascular system are dependent upon the frequency, intensity and duration of the exercise itself. Following a prolonged period (≥ 6 months) of regular intensive exercise in previously untrained individuals, resting and submaximal exercising heart rates are typically 5–20 beats lower, with an increase in stroke volume of $\sim 20\%$ and enhanced myocardial contractility. Structurally, all four heart chambers increase in volume with mild increases in wall thickness, resulting in greater cardiac mass due to increased myocardial cell size. With this in mind, the present paper aims to review the basic science behind the CV benefits of exercise. Attention will be paid to understanding (1) the relationship between exercise and cardiac remodelling; (2) the cardiac cellular and molecular adaptations in response to exercise, including the examination of molecular mechanisms of physiological cardiac growth and applying these mechanisms to identify new therapeutic targets to prevent or reverse pathological remodelling and heart failure; and (3) vascular adaptations in response to exercise. Finally, this review will briefly examine how to optimise the CV benefits of exercise by considering how much and how intense exercise should be.

INTRODUCTION

The cardiovascular (CV) benefits of regular physical exercise are well documented. Cardiorespiratory fitness is a strong predictor of CV disease and all-cause mortality,^{1,2} with increases in cardiorespiratory fitness associated with corresponding decreases in CV disease risk.³ Indeed, a 41% reduction in mortality was reported in 786 former Tour de France cyclists compared with the general French male population.⁴ The effects of exercise upon the myocardium and vascular system are dependent upon the frequency, intensity and duration of the exercise itself. Following a prolonged period (≥ 6 months) of regular intensive exercise in previously untrained individuals, resting and submaximal exercising heart rates are typically 5–20 beats lower, with an increase in stroke volume of $\sim 20\%$ and enhanced myocardial contractility.⁵ Structurally, all four heart chambers increase in volume with mild increases in wall thicknesses, resulting in greater cardiac mass due to increased myocardial cell size.

With this in mind, the present paper aims to review the basic science behind the CV benefits of exercise. Attention will be paid to understanding (1) the relationship between exercise and cardiac

remodelling; (2) the cardiac cellular and molecular adaptations in response to exercise, including the examination of molecular mechanisms of physiological cardiac growth and applying these mechanisms to identify new therapeutic targets to prevent or reverse pathological remodelling and heart failure; and (3) vascular adaptations in response to exercise. Finally, this review will briefly examine how to optimise the CV benefits of exercise by considering how much and how intense exercise should be.

Cardiac structure and functional adaptations in response to exercise

Exercise and cardiac remodelling

The term 'athlete's heart' refers to a constellation of adaptations that affect the structure, electrical conduction and function of the heart that facilitate appropriate increases in cardiac output during exercise. There is a plethora of studies demonstrating dilatation of all four cardiac chambers and an increase in the maximal wall thickness in trained individuals compared with sedentary controls. While CV adaptation depends on the modality, intensity and volume of conditioning, even in previously sedentary individuals, intensive and prolonged endurance training leads to cardiac remodelling mimicking parameters commonly observed in athletes.⁶

Athlete's heart dogma suggests that endurance athletes present with eccentric hypertrophy, while athletes whose training is predominately resistance based present concentric hypertrophy. A recent meta-analysis of 92 prospective echocardiographic or cardiac MR (CMR) studies involving elite male athletes, however, demonstrated that while both endurance and resistance-trained athletes demonstrate larger LV structures than sedentary controls (with greater volumes observed in endurance athletes), LV wall thicknesses were similar between both groups thwarting support for concentric hypertrophy in resistance-only athletes (table 1).⁷ Limited echocardiographic data are available on the right cardiac chambers, though data from CMR studies suggest a balanced structural adaptation between LV and RV chambers in both young and veteran athletes.^{8,9}

Cardiac remodelling in lifelong exercisers

Ageing is associated with changes to the CV system that underpin a reduced functional capacity, although regular endurance exercise training may slow this progressive decline in CV function. Using CMR, our group observed that male veteran endurance athletes (56 ± 6 years) involved in lifelong (43 ± 6 years) exercise had smaller LV and RV end-diastolic and end-systolic volumes, with matched wall thicknesses and LV mass compared with younger male endurance athletes (31 ± 5 years)⁹ (table 2). Yet compared with



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Table 1 LV structural and functional data in male endurance-trained, resistance-trained and sedentary control subjects

Parameter	Endurance-trained (ET)	Resistance-trained (RT)	Sedentary controls (CT)	p Value (all groups)	Post hoc significant differences	Heterogeneity test		
						Heterogeneity	I ² (%)	p Value
LV mass (g)	232 (200–260) [n=64; 1099]	220 (205–234) [n=25; 510]	166 (145–186) [n=59; 1239]	<0.001	ET, RT>CT	21	99.8	<0.001
IVSWT (mm)	11.0 (10.8–11.3) [n=68; 1802]	11.0 (10.3–11.8) [n=19; 408]	9.2 (8.9–9.5) [n=63; 1352]	<0.001	ET, RT>CT	98	99.2	<0.001
PWT (mm)	10.6 (10.3–10.9) [n=57; 1928]	10.4 (9.8–10.9) [n=14; 370]	8.8 (8.6–9.1) [n=53; 1433]	<0.001	ET, RT>CT	87	99.2	<0.001
LVEDD (mm)	54.8 (54.1–55.6) [n=61; 1548]	52.4 (51.2–53.6) [n=17; 384]	50.1 (49.5–50.7) [n=56; 1174]	<0.001	ET>RT, CT RT>CT	95	99.1	<0.001
LVEDV (ml)	171 (157–185) [n=34; 493]	131 (120–142) [n=14; 189]	135 (125–145) [n=34; 539]	<0.001	ET>RT, CT	23	99.2	<0.001
LV SV (mL)	106 (97–116) [n=28; 479]	86 (77–95) [n=9; 125]	83 (77–90) [n=27; 590]	<0.001	ET>RT, CT	16	98.7	<0.001
LV EF (%)	63 (61–64) [n=42; 1330]	66 (62–70) [n=7; 85]	64 (62–65) [n=37; 878]	0.365	NA	2.0	97.7	<0.001
LV E/A	2.0 (1.9–2.1) [n=34; 844]	1.9 (1.7–2.0) [n=8; 214]	1.8 (1.7–1.9) [n=34; 868]	0.014		8.5	98.8	<0.001
LV E'	13.6 (12.3–14.9) [n=7; 204]	*	11.0 (9.4–12.6) [n=4; 183]	0.014		18	98.6	<0.001

Data are mean (95% CIs); [number of studies; number of participants].

*Insufficient data.

Data from ref. 7.

E/A, peak early to atrial Doppler transmitral flow velocities; E', peak septal early diastole longitudinal tissue velocity; EDD, end-diastolic dimension; EDV, end-diastolic volume; IVSWT, interventricular septal wall thickness; PWT, posterior wall thickness; SV, stroke volume
NA, not applicable as main effect not significant ($p>0.05$).

age-matched controls (60 ± 5 years), veteran athletes had larger absolute and indexed LV and RV end-diastolic and end-systolic volumes, wall thicknesses and LV and RV stroke volumes. Despite known age-related reductions in cardiomyocyte numbers, these data support findings of maintained LV mass and cardiac compliance in trained veterans, likely through hypertrophy of the remaining cells and an increase in interstitial tissue.

Upper limits of cardiac remodelling in athletes

While the majority of athletes exhibit structural and electrical changes that are considered physiological, there are, however, an extremely small proportion of athletes who develop pronounced morphological changes that overlap with phenotypic expressions of cardiac pathology associated with sudden cardiac death, namely hypertrophic cardiomyopathy, dilated cardiomyopathy and arrhythmogenic RV cardiomyopathy. From four large echocardiographic studies examining 5053 elite, predominately male athletes,^{10–13} 134 (2.7%) demonstrated a maximal wall thickness ≥ 12 mm, of which 27 athletes (0.5%) presented ≥ 13 mm. In absolute terms and regardless of an athlete's body surface area, the upper limit of physiological hypertrophy in athletes is considered ≥ 13 mm for maximal wall thickness and ≥ 65 mm for LV internal diameter in diastole. Values above these should be viewed with suspicion; heightened if the athlete also presents with personal symptoms suggestive of an underlying cardiac condition, a family history of sudden cardiac death and/or an abnormal ECG. In conclusion, while there is no upper threshold where the CV health benefits observed with regular exercise are diminished, there does, however, appear to be an upper limit to physiological cardiac remodelling.

Cardiac cellular and molecular adaptations in response to exercise

Cellular cardiac adaptations: hypertrophy, death and renewal
Cardiac growth has been generally defined as either physiological or pathological. Exercise-induced cardiac growth as a prototype of physiological heart growth is associated with

normal cardiac structure, cell hypertrophy,^{14 15} no cell death or fibrosis,^{16–18} activation of resident cardiac stem cells and cardiomyocyte renewal,^{15 19 20} angiogenesis^{15 21 22} and normal or improved cardiac function.^{15 16} Pathological cardiac remodelling is typically associated with death of cardiomyocytes, fibrotic replacement, cardiac dysfunction and increased risk of heart failure and sudden death (figure 1).^{23 24}

Although very low, the human heart has the capacity to self-renew cardiomyocytes over a lifespan.²⁵ The adult heart harbours a pool of resident endogenous cardiac stem and progenitor cells (eCSCs). These small primitive cells, positive for stem cell surface receptor markers (ie, c-kit, Sca-1) and negative for markers of the haematopoietic lineage (ie, CD45) and mast cells (ie, tryptase), exhibit properties of stem cells; being clonogenic, self-renewing and multipotent, both in vitro and in vivo.^{26 27} We have recently shown that intensity-controlled treadmill exercise in adult rats produces improved cardiac function and increased myocardial mass through cardiomyocyte hypertrophy, and new cardiomyocyte and capillary formation (figure 2). The latter is due to the activation and ensuing differentiation of eCSCs (figure 3).¹⁵ Moreover, endurance swim training in mice induced cardiomyocyte hypertrophy and renewal, which was dependent on a reduction in the expression of the transcription factor C/EBP β .¹⁹

Molecular mechanisms of physiological cardiac growth

The molecular mechanisms and signalling cascades underpinning cardiac adaptations with exercise are shown in table 3. The best characterised signalling cascade responsible for mediating physiological cardiac growth is the insulin-like growth factor-1 (IGF-1)-PI3K(p110 α)-Akt pathway. Indeed, increased cardiac IGF-1 expression and activation of the PI3K (p110 α) pathway has been implicated in increased cardiomyocyte hypertrophy with endurance exercise in athletes.²⁸ Furthermore, overexpression of the IGF-1 receptor (IGF-1R) in cardiomyocytes increases myocyte size, with absence of myocyte death or disarray, and enhanced systolic function, and PI3K and ensuing Akt

Table 2 CMR data indices of LA, LV and RV volumes, mass and systolic function

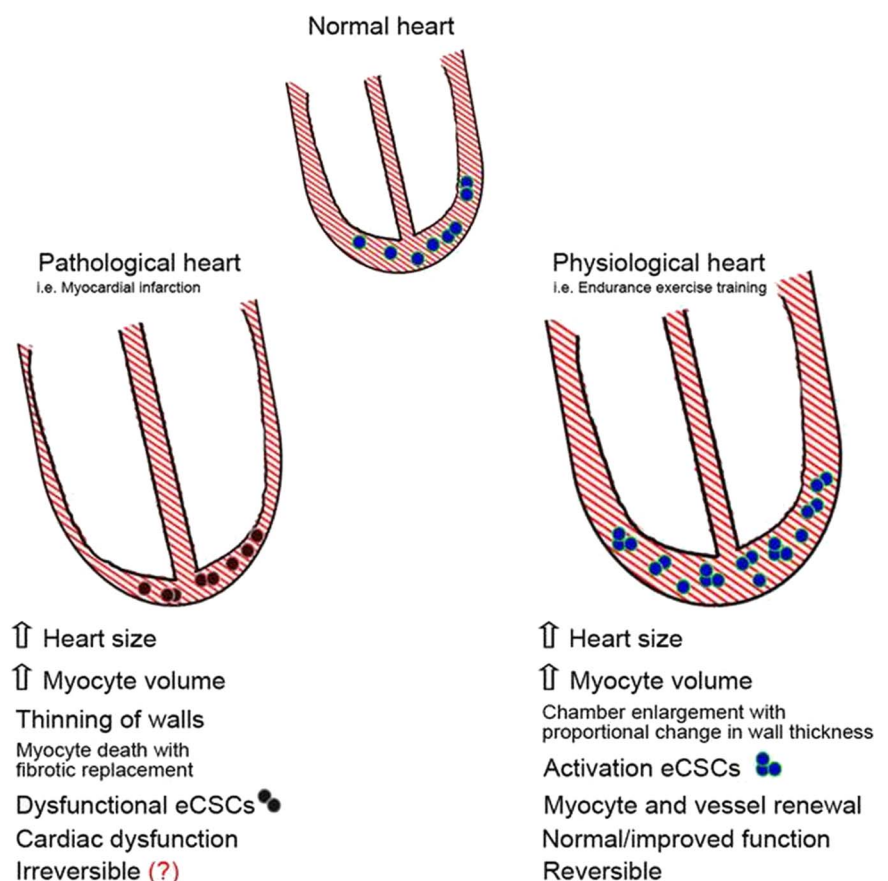
	Veteran athletes (VA)		Age-matched controls (C)		Young athletes (YA)		p Value (VA vs C)	p Value (VA vs YA)
	Absolute	Absolute BSA	Absolute	Absolute BSA	Absolute	Absolute BSA		
LAEDV (mL)	70±13 (52–92)	25.7±5.6 (24.6–34)	78±12 (54–101)	26.6±3.5 (18–32)	72±21 (43–117)	25.5±6.8 (22.6–35.3)	0.567	1.000
LVEDV (mL)	182±28 (142–232)	66.8±11.3 (52–81)	143±18 (100–170)	52.8±6.6 (36–65)	211±35 (162–272)	74.7±9.6 (57–88)	<0.001	0.018
LVESV (mL)	63±16 (42–90)	23±6.4 (16–35)	42±9 (25–61)	15.5±3.4 (19–23)	76±18 (47–111)	26.8±5.6 (16–39)	<0.001	0.049
IVSd (mm)	11±1 (9–13)	7.8±0.9 (6.6–9.5)	10±2 (7–13)	6.9±1.0 (5.1–9.4)	10±1 (9–12)	7.4±0.5 (6.6–8.5)	0.049	1.000
PWd (mm)	10±1 (8–11)	6.9±0.9 (5.8–8.2)	8±1 (7–10)	5.9±0.6 (7–7)	10±1 (9–12)	7.3±0.5 (6.5–8.5)	<0.001	0.113
LV length (mm)	88±6 (78–97)	63±4.5 (56.8–70)	93±6 (84–102)	96.0±5.8 (85–104)	97±7 (89–112)	69.1±3.1 (62.4–73.9)	0.088	<0.001
LV mass (g)	148±16 (120–167)	54.6±6.7 (45–66)	147±23 (108–180)	54.2±7.1 (44–71)	151±23 (119–210)	53.3±5.2 (43–64)	1.000	1.000
RVEDV (mL)	181±24 (150–227)	66.6±9.4 (56–88)	146±19 (113–187)	54.2±7.2 (41–66)	215±37 (143–276)	72.1±21.5 (58–92)	0.003	0.008
RVESV (mL)	63±15 (45–96)	23±6.4 (18–37)	42±13 (25–69)	15.8±4.7 (8–25)	82±22 (41–114)	26.8±5.6 (18–42)	0.005	0.011
LVSV (mL)	119±18 (101–163)	43.8±6.9 (36–56)	101±11 (75–1115)	37.3±4.1 (27–46)	136±21 (104–183)	47.9±5.4 (36–55)	0.014	0.036
RVSV (mL)	119±16 (102–174)	43.7±6.4 (36–54)	104±12 (77–124)	38.4±4.0 (28–48)	133±21 (97–154)	44.5±12.6 (36–45)	0.047	0.093
LVEF (%)	66±5 (55–71)	–	71±4 (64–78)	–	65±4 (56–74)	–	0.008	1.000
RVEF (%)	66±5 (58–75)	–	72±6 (63–82)	–	62±6 (53–73)	–	0.03	0.22

Values are expressed as mean±SD and (range).

Data from ref. 9.

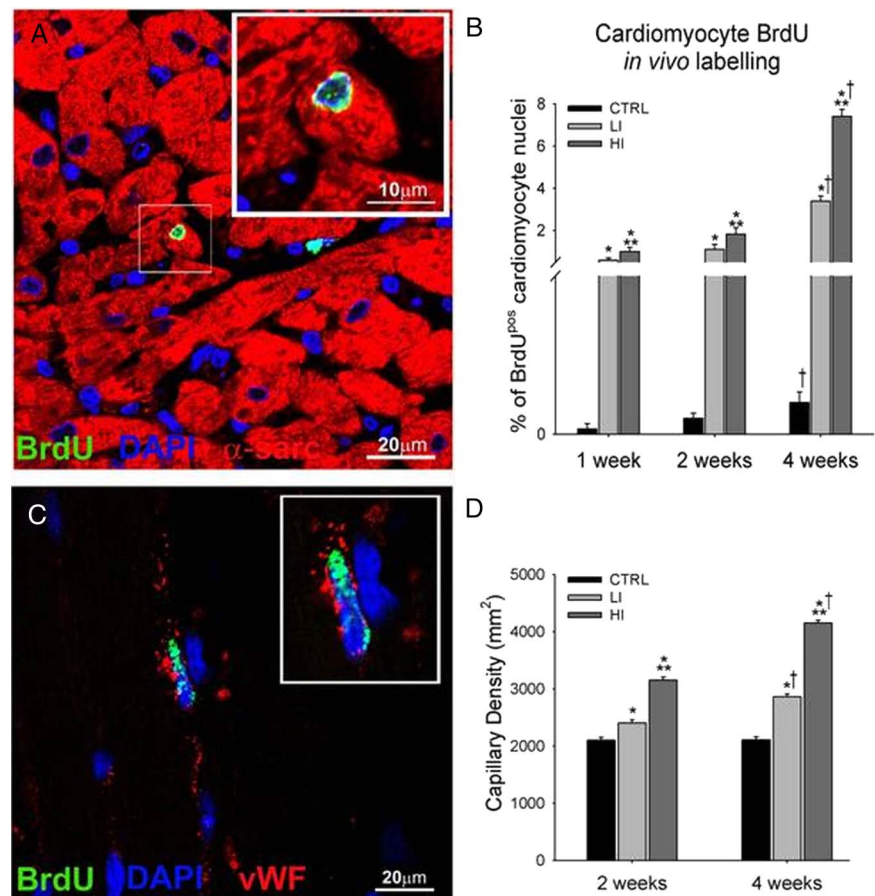
BSA, body surface area; CMR, cardiac MR; IVSd, intraventricular septum during diastole; LAEDV, left atrium end diastolic volume; LVEDV, LV end-diastolic volume; LVESV, LV end-systolic volume; LVSV, LV stroke volume; PWd, posterior wall thickness during diastole; RVEDV, RV end-diastolic volume; RVESV, RV end-systolic volume; RVSV, RV stroke volume.

Figure 1 Cellular cardiac adaptations with physiological and pathological remodelling. The question mark after irreversible signifies whether by identifying cellular and molecular mechanisms new therapeutic targets could be devised to reverse pathological remodelling. These cellular and molecular mechanisms could be identified from what occurs with physiological remodelling and as a result of exercise training. eCSC, endogenous cardiac stem and progenitor cells.



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Figure 2 Intensity-controlled treadmill running exercise in rats induces cardiac myogenesis and angiogenesis. (A) A small newly formed BrdU^{pos} (green) cardiomyocyte (α -sarcomeric actin; red) in LV of a high-intensity exercising animal. (Inset is $\times 2$ zoom of boxed area.) Nuclei detected by 4',6-diamidino-2-phenylindole, dihydrochloride (DAPI) in blue. (B) The % number of BrdU^{pos} cardiomyocytes formed was dependent on exercise duration and intensity. (C) A newly formed BrdU^{pos} (green) capillary (vWF; red) from LV of a high-intensity exercising animal. (Inset is $\times 2$ zoom.) (D) Capillary density in LV of exercising animals was dependent on exercise intensity. (Data are mean \pm SEM, * $p < 0.05$ vs control (CTRL), ** $p < 0.05$ vs LI, † $p < 0.05$ vs 1 (B) and 2 (B and D) weeks; $n = 6$ for all). Adapted from Waring *et al.*¹⁵



phosphorylation were increased in the hearts of IGF-1R transgenic mice.²⁹ On the other hand, mice lacking the p85 subunit of PI3K showed attenuation of exercise-induced cardiac hypertrophy³⁰ and in mice with ablation of the IGF-1R gene in cardiomyocytes, the hypertrophic response to swim exercise training was blunted.³¹ Importantly, PI3K (p110 α) is critical for physiological exercise-induced growth of the heart but not for pathological growth. dn-PI3K mice showed significant hypertrophy in response to pressure overload, but a blunted hypertrophic response to swim training, compared with non-transgenic mice.³² Additionally, hearts of double transgenic mice overexpressing both IGF-1R and dnPI3K were not significantly different in size to those from dnPI3K mice alone.²⁹

Akt, a serine/threonine kinase (also known as protein kinase B), is a well-characterised target of PI3K activity. Recent studies on Akt knockout mice suggest that Akt1 is required for physiological rather than pathological heart growth. Akt1 knockout mice (showing normal cardiac phenotype under basal conditions) showed a blunted hypertrophic response to swim training but not to pressure overload.³³ On the other hand, overexpression of nuclear-targeted Akt does not directly induce cardiac hypertrophy; however, transgenic hearts are protected from ischaemia-reperfusion injury.³⁴

We have identified the upregulation of the growth factors, neuroregulin, bone morphogenetic protein-10 (BMP-10), IGF-1 and transforming growth factor beta (TGF- β 1), in the

Figure 3 Activation and proliferation of c-kit^{pos} endogenous cardiac stem and progenitor cells (eCSCs) in hearts of exercising animals. (A) c-kit^{pos} eCSC number in LV of control (CTRL) and following 2 or 4 weeks of high-intensity exercise training. (B) c-kit^{pos} (green), Ki67^{pos} (white) eCSCs from LV (α -sarcomeric actin; red) of a high-intensity exercise-trained animal. Nuclei detected by 4',6-diamidino-2-phenylindole, dihydrochloride (DAPI) in blue. (Data are mean \pm SEM, * $p < 0.05$ vs CTRL; $n = 6$ for all). Panel (A) is adapted from Waring *et al.*¹⁵

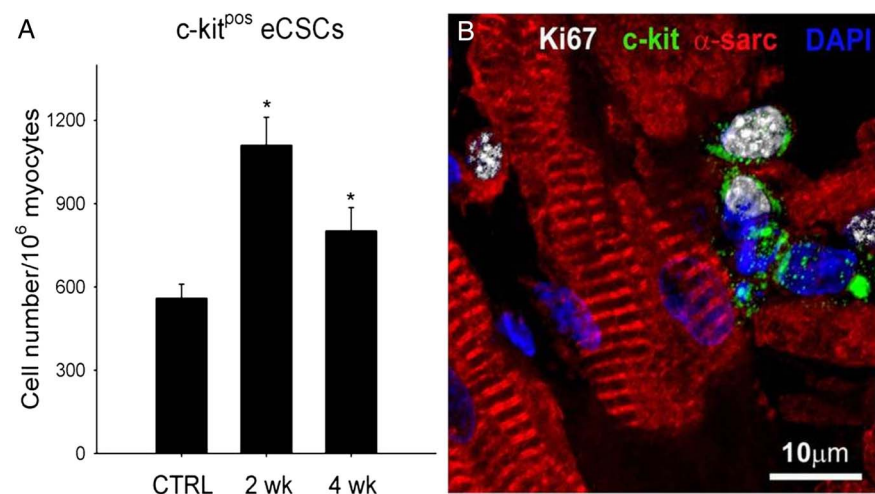


Table 3 Molecular features of physiological and pathological cardiac remodelling

Physiological	Pathological
<p>↑ Autocrine and paracrine humoral factors such as IGF-1, neuroregulin, periostin, BMP-10, TGF-β, cardiotrophin 1 (CT-1)</p> <p>↑ Heat shock proteins 20, 27 and 70</p> <p>↑ S6K1, eNOS</p> <p>↑ Rates of fatty acid and glucose oxidation</p> <p>Microarray—cell survival, fatty acid oxidation, insulin signalling, EGF signalling and HSF1 gene clusters</p> <p>miRNA-1, miRNA-133, miRNA-29c</p> <p>Signalling pathways</p> <p>IGF-1-PI3K(p110α)-Akt pathway</p> <p>Gp130/JAK/STAT pathway</p> <p>Thyroid hormone signalling</p> <p>HSF1 pathway</p>	<p>↑ Autocrine and paracrine humoral factors (AngII, ET-1, noradrenaline, TGF-β, TNF-α, serum response factor)</p> <p>↑ expression of fetal genes (ANP, BNP, β-MHC, α-actin)</p> <p>↑ Ca²⁺ handling proteins (SERCA2A)</p> <p>↑ S6K1, RhoA,</p> <p>Microarray—inflammation, apoptotic, cardiac fetal gene and oxidative stress gene clusters</p> <p>miRNA-1, miRNA-133</p> <p>Signalling pathways</p> <p>GPCR-Gαq signalling</p> <p>PI3K (110γ)</p> <p>MAPKs (ERKs, JNKs, p38-MAPKs)</p> <p>Protein kinases C (PKC) and D (PKD)</p> <p>Calcineurin and calmodulin (CAMKII)</p> <p>GTPases—Ras and Rho</p>

Italics—not directly shown to be activated by exercise but have been shown to have a protective role in the heart and with physiological heart growth. Data taken from Bernardo *et al*⁶⁵ and Waring *et al*.¹⁵

ANP, atrial natriuretic peptide; BMP-10, bone morphogenetic protein-10; BNP, brain natriuretic peptide; CAMKII, Ca²⁺/calmodulin-dependent protein kinase II; EGF, epidermal growth factor; ERKs, extracellular signal-regulated kinases; ET-1, endothelin-1; HSF1, heat shock transcription factor 1; IGF-1, insulin-like growth factor-1; JNKs, c-Jun N-terminal kinases; MAPKs, mitogen-activated protein kinases; S6K1, ribosomal S6 kinase 1; SERCA2A, sarcoplasmic reticulum Ca²⁺ ATPase; TGF- β , transforming growth factor beta; TNF- α , tumour necrosis factor alpha; β -MHC, beta-myosin heavy chain.

cardiomyocytes following high-intensity treadmill exercise training. IGF-1 and neuroregulin increase eCSC proliferation, with the activation of their respective receptors and physiological molecular signalling targets, Akt and STAT-3, respectively.¹⁵ Furthermore, overexpression of myocardial IGF-1 increases the survival and number of eCSCs and prevents myocyte attrition during ageing fostering myocyte renewal, which is governed by the PI3K–Akt signalling pathway.³⁵ Intriguingly, cardiac-specific expression of nuclear-targeted Akt in transgenic mice prolongs postnatal cardiomyocyte cycling and promotes the expansion of the c-kitpos-Nkx-2.5pos cardiac progenitor cell population. However, cardiac progenitor cells genetically modified to overexpress nuclear-localised Akt exhibit increased proliferation but have inhibited capacity for cardiomyocyte lineage commitment.³⁶ On the other hand, BMP-10 and TGF- β 1 stimulated differentiation of eCSCs into the three main cardiac lineages: cardiomyocytes, vascular smooth muscle and endothelial cells.¹⁵

Using the cellular and molecular mechanisms of exercise to identify new therapeutic targets

By identifying the cellular and molecular mechanisms associated with physiological cardiac remodelling, we can identify new therapeutic targets that could prevent or reverse pathological remodelling and heart failure. Exercise increases the production and secretion of key growth factors, for example, IGF-1, hepatocyte growth factor (HGF), neuregulin1, vascular endothelial growth factor, BMP-10, nitric oxide (NO), periostin, TGF- β 1, platelet-derived growth factor and their associated signalling pathways.^{28 37–41} Intracoronary injections of IGF-1 and HGF, following myocardial infarction in a pig heart, promote cardiomyocyte survival and contractility, and induce eCSC migration, proliferation and cardiomyogenic differentiation, leading to physiologically significant myocardial repair and regeneration.⁴² Moreover, Santini *et al*⁴³ found that in postinfarcted mice, which express the transgene of the locally acting IGF-1 in the myocardium (mIGF-1), had improved myocardial repair and function, attributable in part to an increase in the number of newly formed cardiomyocytes. The origin of these replenished

myocytes was not determined, but in light of recent findings it is likely they are the product of eCSC myogenic differentiation.

Finally, by identifying the specific profile of cardiac upregulated and downregulated miRNAs in exercise-trained physiological hypertrophic hearts, as opposed to pathological hypertrophy, it will be possible to test the relative miRNA mimics and/or miRNA antagonists/inhibitors as a specific therapy for CV disorders. This work is currently ongoing.

Vascular structure and functional adaptations in response to exercise

Exercise, the endothelium and NO

The endothelium is a single layer of cells that lines the entire CV system and plays a key role in the vascular adaptations seen with exercise training. The endothelium produces a number of vasoactive hormones that alter the tone of conduit and resistance vessels. Principal among these is NO, which, in addition to causing smooth muscle cell relaxation and vasodilation, has anti-atherogenic and antithrombotic properties.⁴⁴ Indeed, the endothelium and the release of NO has been postulated as the vehicle for exercise-induced improvement in CV risk profile, given that modification of traditional risk factors explain only 50% of risk reduction in patients performing exercise.⁴⁵

In response to an increase in blood flow and shear rate, endothelial NO is released and over time (and exercise stimulus) repeated episodic increases in shear stress provoke vascular adaptation and remodelling of the artery. The integrity of blood vessels function can be assessed using the technique of flow-mediated dilatation (FMD), which uses an ischaemic challenge to induce changes in shear stress that stimulates vasodilation that is NO dependent.⁴⁶ Acute exercise causes a biphasic FMD response. Immediately postexercise (5–30 min) FMD is reduced, with enhanced FMD 1–24 h postexercise and a normalisation back to baseline between 24 and 48 h. The postexercise reduction in FMD is dependent on exercise intensity and mode, with higher intensities causing a greater reduction in FMD. The mechanisms responsible for reduced FMD relate to an increase in oxidative stress⁴⁷ and/or a decline in endothelial (arginine)

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substrate use to cleave NO.⁴⁸ Additionally, high-intensity exercise may cause more oscillatory or retrograde flow patterns that inhibit the NO production pathways than the more laminar antegrade flow patterns promoted at lower intensities.⁴⁹

Exercise-induced adaptations of the endothelium and the blood vessels have been reviewed extensively.⁵⁰ Briefly, studies undertaken in patients with symptomatic coronary heart disease report that exercise enhances endothelial function both locally (in the popliteal artery following leg exercise) and systemically (in the brachial artery following leg exercise).⁵¹ This pattern of response is less clearly evident in healthy asymptomatic individuals and may be intensity related, with low-to-moderate-intensity exercise enhancing endothelial function whereas high intensities do not.⁵² Tinken *et al*⁵³ qualified this by measuring FMD every two weeks across 8 weeks of training and observed that following an initial upregulation FMD returned to baseline after 4 weeks, suggesting that studies that measure FMD merely pre and post would likely miss training-induced changes.

Longitudinal training studies report enlarged diameter of conduit arteries, and indeed, when assessed by peak vasodilator capacity, Tinken *et al*⁵³ reported the same change from week 4 to 8 of training. Taken together, FMD and vasodilator capacity data signify that with training endothelial function improves prior to a structural modification of the vessel and that the latter occurs to normalise shear rate and thereby return FMD to baseline levels. These observations may also help explain the paradox that in athletic population's endothelial function is similar to sedentary individuals. Rowley *et al*⁵⁴ reported larger vessel diameters in the dominant versus non-dominant arms of squash players, and that both diameters were larger than sedentary controls. In addition, wall thickness was less in squash players, and consequently, wall to lumen ratios was reduced in athletes. Therefore, the structural modification that enhances lumen size in the athlete operates to normalise shear rate and explains the observed 'normal' FMD in elite athletes.

The mechanisms responsible for the upregulation of endothelial function and the structural diameter changes appear to relate to shear stress during exercise. Tinken *et al*⁵⁵ repeated the 8-week exercise training study reported previously, with the exception that blood flow and shear rate were reduced by the inflation of a pneumatic cuff in one arm during each training session. In the uncuffed arm, the usual pattern of increased FMD followed by structural modification was observed, whereas in the cuffed arm these adaptations were abolished (figure 4). These data strongly suggest that shear stress is obligatory for training-induced changes in vascular structure and function. The changes in wall thickness were independent of shear rate modification, suggesting that a systemic rather than localised mechanism exists, with the most likely candidate being changes in transmural pressure.⁵⁶

The vasculature is the target for both functional and structural changes in response to exercise. The degree of change detected is dependent on the individual's health and fitness status, as well as exercise intensity. What is clear is that the phenotype for an athlete's artery is different from sedentary individuals (figure 5). The athlete's artery is characterised by a large lumen with a thin wall and relatively normal endothelial function. Such structural modification conveys performance and health benefits, although the exact mechanism responsible for these modifications requires further investigation.

Optimising the CV benefits of exercise

How much exercise?

In 2008, the US Department of Health and Human Services released 'physical activity guidelines for Americans';⁵⁷ being

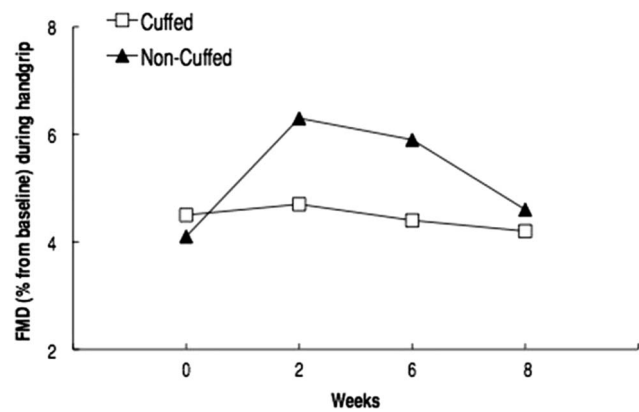


Figure 4 Relative change in brachial artery flow-mediated dilation (FMD) from baseline (FMD%) across the 8-week handgrip exercise training in healthy young men. FMD (an index of endothelial function) adapts rapidly to training and then returns towards baseline levels. These adaptations may be superseded by other functional changes or structural arterial remodelling. When the shear stress response to each bout of exercise was ameliorated by inflation of a proximal pressure cuff, functional adaptations were not apparent. These studies suggest that repeated increases in shear stress are obligatory for adaptation of conduit arterial function in response to exercise training. Adapted from ref. 50.

150–300 min per week of moderate intensity aerobic exercise or 75 min per week of vigorous intensity exercise. While all exercise programmes must consider intensity, duration and frequency, it is the total volume of exercise that appears to be the most consistently related to the size of reduction in CV disease or functional improvement.⁵⁸ While no optimal exercise volume or 'dose' has been established, low doses of casual lifelong exercise (2–3 sessions per week) do not prevent the decreased cardiac compliance and distensibility observed in healthy yet sedentary ageing. Bhella *et al*⁵⁹ observed stiffer ventricles in casual exercisers (2–3 sessions per week) than committed (4–5 exercise sessions per week), with LV distensibility similar between casual exercisers and sedentary individuals. Since LV stiffening is associated with the pathophysiology of many CV conditions, the 'dose' of exercise is clearly an important consideration in the prevention of CV disease.

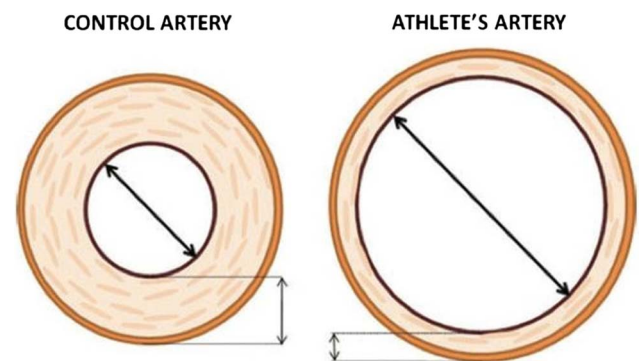


Figure 5 An athlete's artery relative to an artery from a healthy non-athletic control subject. A figure representing an 'athlete's artery' comprising a larger lumen dimension with a decreased wall thickness, relative to an artery from a healthy non-athletic control individual. Two key points to consider: (1) this conclusion is drawn from endurance athlete data as little is known about the systematic effects of resistance or power athleticism on arterial size or function; and (2) it is not always apparent that athletes' arteries are larger based on resting lumen dimensions; this is due to the possible compensatory increase in basal constrictor tone in larger arteries. Adapted from ref. 64.

How intense should exercise be?

Exercise intensity, specifically vigorous (>6 metabolic equivalents (METs)) or high-intensity interval training (HIIT; >85% $\dot{V}O_{2peak}$ or >90% HR_{peak}, separated by 2–3 min of active recovery), and its impact upon CV health and cardiorespiratory fitness vs moderate-intensity continuous training (MICT) have recently received significant attention. A meta-analysis of patients with cardiometabolic diseases (ie, coronary artery disease, heart failure, hypertension, metabolic syndrome and obesity) observed significantly greater increases in $\dot{V}O_{2peak}$ following HIIT compared with MICT, equivalent to 9%, meaning that HIIT improved cardiorespiratory fitness by almost double.⁶⁰ It appears that HIIT improves cardiorespiratory fitness more than MICT across a broad range of populations, including healthy sedentary⁶¹ and heart failure patients with preserved EFs.⁶² Possessing good aerobic capacity is important as $\dot{V}O_{2max}$ is a prognostic marker of CV disease more so than any other established risk factor.⁶³ It should be noted, however, that 6 METs is often used as a definition of 'vigorous' activity, equating to just 21 mL/kg/min. Thus, MET use for prescribing high-intensity exercise is mediocre at best as it does not consider an individual's exercise capacity. Six METs in relatively fit individuals is likely to be far from >85% $\dot{V}O_{2peak}$ or >90% HR_{peak}.

The vast majority of evidence suggests that regular (≥4 times per week), sustained (≥45 min) and intensive exercise throughout life is the most advantageous to optimise CV health. However, considering that physical activity rates in adolescents and adults are reducing year on year, a balance must be struck considering (1) there is no lower exercise threshold for CV benefits to be seen and (2) CV disease risk reduction is greatest in the unfittest individuals who start exercising, signifying that 'some exercise is better than none'.

CONCLUSION

In conclusion, exercise is a potent stimulator activating numerous downstream cascades at a molecular and cellular level, that if sustained and intensive enough enables gross anatomical remodelling capable of enhancing functional capacity in both healthy and diseased populations. Since aerobic capacity is a prognostic marker of CV disease and mortality more than any other established risk factor, clinicians should promote the expansive benefits of exercise in all spectrums of society, be it the casual exerciser, the sedentary individual or those with established CV disease.

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Mathew G Wilson, Georgina M Ellison and N Tim Cable

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