REPEATABILITY OF MEASURES OF ARTERIAL FUNCTION

DETERMINING THE REPEATABILITY OF LOW FLOW MEDIATED CONSTRICTION AND TOTAL VESSEL REACTIVITY IN THE BRACHIAL ARTERY OF HUMANS

By: VANESSA RIZZUTO, B.Sc.

A Thesis Submitted to the School of Graduate Studies in Partial Fulfillment of the Requirements for the Degree Master of Science

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TITLE: Determining the Repeatability of Low Flow Mediated Constriction and Total Vessel Reactivity in the Brachial Artery of Humans

AUTHOR: Vanessa Ivana Rizzuto, B.Sc. (McMaster University)

SUPERVISOR: Dr. Maureen MacDonald, Ph.D.

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LAY ABSTRACT

Endothelial function is the ability of arteries to expand and contract. Endothelial dysfunction has been linked to an increased risk for cardiovascular disease (CVD). The most widely used test to assess endothelial function is the flow mediated dilation test (FMD). Two novel measures of endothelial function, low flow mediated constriction (L-FMC) and total vessel reactivity (TVR) have been introduced as supplements to FMD, however little is known about the repeatability of these measurements. Additionally, it is unknown whether L-FMC and TVR are influenced by age, sex, CVD or CVD risk factors. We investigated the day-to-day repeatability of FMD, L-FMC and TVR, and their relationships with age and the influence of sex and CVD and elevated CVD risk. We found that FMD and TVR, but not L-FMC, were repeatable and associated with age. We also found that sex or CVD did not alter the relationship between age and our measures.

ABSTRACT

Endothelial function is the ability of an artery to vasodilate and can be assessed using a flow mediated dilation (FMD) test. While FMD is a useful tool for assessing endothelial function, it has been argued that it does not capture overall vascular function. Two novel measures, low flow mediated constriction (L-FMC) and total vessel reactivity (TVR) have been introduced to compensate for the potential limitations of FMD. Unfortunately, little is known about the repeatability of brachial artery L-FMC and TVR. Additionally, it is unclear how L-FMC and TVR might be influenced by age, sex and the presence of cardiovascular disease (CVD) or CVD risk. Therefore, the main purpose of this investigation was to assess the day-to-day repeatability of FMD, L-FMC and TVR in the brachial artery. The secondary purpose was to assess if FMD, L-FMC and TVR were associated with age and if this relationship was influenced by sex or the presence of CVD or CVD risk factors. 375 participants (age:37±22) were included in the study, 98 participants (age:34±19) underwent two FMD tests and were included in the repeatability analysis. For all participants brachial artery endothelial function was assessed using a FMD test. The day-to-day repeatability of FMD was substantial (ICC=0.68), L-FMC was slight (ICC=0.01) and TVR was moderate (ICC=0.50). Age was associated with FMD and TVR (ρ =-0.24, ρ =-0.19, p <0.005), however there was no relationship between age and L-FMC. The relationships between age and FMD and TVR persisted in individuals with CVD and CVD risk factors, and sex did not moderate the relationship between age and any of our vascular outcomes. These results indicate that brachial artery FMD and TVR are relatively repeatable, however L-FMC is not repeatable. As well, it appears that age is associated with a decrease in FMD and TVR, but not related to L-FMC.

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TABLE OF CONTENTS

LIST OF TABLES

Chapter 2

- Table 1. List of Studies
- Table 2: Participant Characteristics
- Table 3: Hemodynamics, Repeatability Cohort
- Table 4: Hemodynamics, Observational Cohort
- Table 5: Vascular Variables, Repeatability Cohort
- Table 6: Nitroglycerin Challenge Test, Repeatability Cohort
- Table 7: Vascular Variables, Observational Cohort

LIST OF FIGURES

Chapter 1

Figure 1: The mechanism of endothelial dependent vasodilation.

Figure 2: The mechanism of endothelial dependent vasoconstriction.

Chapter 2

Figure 1: Associations between age and [A] flow mediated dilation (FMD), [B] low flow mediated constriction (L-FMC) and [C] total vessel reactivity (TVR).

Figure 2: Associations between age and [A] flow mediated dilation (FMD), [B] low flow mediated constriction (L-FMC) and [C] total vessel reactivity (TVR) in individuals with cardiovascular disease or elevated cardiovascular disease risk.

Figure 3: Individual participant responses across the two visits for [A] flow mediated dilation (FMD), [B] low flow mediated constriction (L-FMC) and [C] total vessel reactivity (TVR).

Figure 4: Correlation between low flow mediated constriction (L-FMC) and flow mediated dilation (FMD).

LIST OF ACRONYMS

SCI spinal cord injury

- SFA superficial femoral artery
- TVR total vessel reactivity

LIST OF EQUATIONS

Chapter 1:

(1) *TVR* % =
$$
\frac{maximal \ diameter - occlusion \ diameter}{occlusion \ diameter} \ X \ 100
$$

(2) $TVR \% = |FMD% + L - FMC%|$

Chapter 2:

(1) FMD (mm) = maximum diameter – baseline diameter
\n(2) FMD (%) =
$$
\frac{maximum diameter - baseline diameter}{baseline diameter} \times 100
$$
\n(3) L – FMC (mm) = occlusion diameter – baseline diameter
\n(4) L – FMC % =
$$
\frac{occlusion diameter - baseline diameter}{baseline diameter} \times 100
$$
\n(5) TVR % =
$$
\frac{maximum diameter - occlusion diameter}{occlusion diameter} \times 100
$$
\n(6) Absolute NTG (mm) = peak NTG – baseline NTG
\n(7) Relative NTG (%) =
$$
\frac{peak NTG - baseline NTG}{baseline NTG} \times 100
$$
\n(8) Blood flow
$$
\left(\frac{mL}{min}\right) = (\pi r^2 \times MBV) \times 60 \text{ where } r = \text{arterial diameter}/2
$$

$$
\binom{1}{\text{min}} = \binom{n}{\text{min}} \times \frac{1}{\text{max}} \times \frac{1
$$

(9) Shear rate
$$
(s^{-1}) = \frac{MBV X B}{\text{arterial diameter}}
$$

DECLARATION OF ACADEMIC ACHEIVEMENT

VIR and MJM conceived the study. VIR led the study development, completed the data collection and data analysis of the prospective cohort, as well as analyzed some of the occlusion images from the retrospective data. VIR was responsible for data interpretation. MJM provided the retrospective dataset from studies previously conducted under her supervision, assisted with study development, data interpretation and provided funding for the project. Christopher Gupta assisted with study development and data collection. Kajeetha Sarvananthan and Jennifer Williams assisted with data collection.

CHAPTER 1: LITERATURE REVIEW

INTRODUCTION 1.1

Cardiovascular disease (CVD) is the second leading cause of death in Canada, claiming over 53 000 lives in 2017 (101). Evidence of early signs of atherosclerosis are present in children and progress with age (82). Results from the Framingham study, a longitudinal study assessing CVD, indicate that there are a variety of risk factors that predispose an individual to develop cardiovascular disease (45). These risk factors include inactivity, obesity, hypertension, cigarette smoking, diabetes and hypercholesterolemia (41, 44, 45). While these risk factors play a large role in the development of CVD, they are unable to predict 100% of CVD risk (18, 32). As a result, researchers have begun to focus on novel risk factors for CVD, such as endothelial function, which is a measure of the function of the arterial wall (32). Endothelial dysfunction refers to altered arterial wall function and is thought to be the first step in the development of atherosclerosis (21, 71).

1.1.1 Arterial Anatomy

Arteries consist of three main tissue layers; the tunica externa, the tunica media and the tunica intima (67, 94). The tunica externa is a layer of connective tissue, mainly comprised of collagen that surrounds the artery and helps maintain the relative position of the artery (67). The tunica media is the thickest arterial layer and consists primarily of smooth muscle that encircles the artery in a circular pattern (67, 94). The tunica media regulates arterial diameter through vasoconstriction and vasodilation (67). The tunica intima is comprised of specialized cells called endothelial cells that directly contact blood flowing through the lumen of the artery (67). It was once thought that endothelial cells were a passive barrier between blood and the other arterial tissue layers, however research has now determined that these cells play an important physiological role in modulating arterial diameter (67).

1.1.2 Endothelial Function

The endothelium is a monolayer of cells which regulate vasomotion through the production of various vasoactive substances, as well as vessel wall inflammation, smooth muscle cell proliferation and cellular adhesion (21). The ability of the endothelial cells to influence arterial diameter is fundamental to ensuring tissue oxygen and metabolic demands are met (21).

1.1.2.1 Endothelial Dependent Vasodilation

Endothelial dependent vasodilation refers to the ability of endothelial cells to promote vasodilation (86). This function can be activated through a variety of pathways, one of which is triggered when blood flowing through the artery imposes a shear stress on the endothelial cells (17, 84, 86). The shear stress promotes the opening of calciumactivated potassium channels, which hyperpolarizes the endothelial cell, leading to calcium influx (17). Calcium influx activates endothelial nitric oxide synthase (eNOS) which converts L-arginine to nitric oxide (NO) (17, 84). From here, nitric oxide diffuses to the vascular smooth muscle where it stimulates soluble guanylate cyclase, an enzyme that converts guanosine triphosphate to cyclic guanosine monophosphate (GMP) (60). The increase in cyclic GMP causes relaxation of the smooth muscle cell layer, which ultimately results in vasodilation (60). Lower levels of endothelial function (also known as endothelial dysfunction) have been shown to be predictive of future cardiovascular events in both symptomatic and asymptomatic individuals (32, 86). Endothelial function has been suggested to be a marker of both traditional and novel CVD risk factors and endothelial dysfunction is thought to be the first step in the progression of atherosclerosis (21, 32).

Figure 1. The mechanism of endothelial dependent vasodilation. Potassium (K), endothelial nitric oxide synthase (eNOS), nitric oxide (NO), soluble guanylate cyclase (sGC), guanosine triphosphate (GTP), guanosine monophosphate (GMP).

1.1.2.2 Endothelial Dependent Vasoconstriction

Endothelial cells also have the ability to induce vasoconstriction (21). The main vasoconstrictor substance that is produced by the endothelial cells is endothelin-1 (ET-1) (93). ET-1 was first described in 1988, and since then two other isoforms, endothelin-2 and endothelin-3 have been discovered, however only ET-1 is produced by the endothelium in humans (72, 93, 99). The release of ET-1 is mediated by a variety of factors, including shear stress (46). Specifically, low levels of shear stress have been shown to increase the release of ET-1, intermediate levels of shear stress have been shown to result in initial increases then decreases in ET-1 release, and high levels of shear suppress the release of ET-1 (49). When ET-1 is produced it binds to endothelin receptors ET_A and ET_B (4). ET_A and ET_B receptors are located on the vascular smooth muscle and ET_B receptors are located on the endothelium (10). Binding of ET-1 to the endothelin receptors on the vascular smooth muscle produces vasoconstriction, however binding of ET-1 to the endothelium has been shown to increase NO and prostacyclin production (10). ET-1 imposes its vasoconstrictor effects on vascular smooth muscle through a complicated signaling process that involves many pathways (46). In the classical signaling pathway, ET-1 binds to ET_A on the vascular smooth muscle, which activates phospholipase C (46, 93). Phospholipase C produces inositol triphosphate and diacylglycerol from phosphatidylinositol (46). Inositol triphosphate then binds to receptors on the endoplasmic reticulum, causing in an increase in intracellular calcium, which results in vasoconstriction (46). It has been suggested that elevated plasma levels of ET-1 are involved in certain pathological states, such as hypertension (93).

Figure 2. The mechanism of endothelial dependent vasoconstriction. Endothelin-1 (ET-1), endothelin receptor A (ETA), phospholipase C (PLC), inositol triphosphate (IP3), phosphatidylinositol (PPI), endoplasmic reticulum (ER), calcium (Ca2+).

1.1.2.3 Measures of Endothelial Function

As endothelial function has been implicated as a marker of cardiovascular health, there have been a variety of techniques introduced to assess both the vasodilatory and vasoconstrictor capacity of endothelial cells.

Infusion Methods

The most direct method of assessing endothelial function is through angiography accompanied by the infusion of vasoactive substances, and this technique has been primarily applied to investigations of coronary arteries (92). Specifically, a guide wire along with a catheter is placed into the coronary artery of interest (53). Acetylcholine is then infused through the catheter in increasing concentrations; acetylcholine has been shown to promote vasodilation in arteries with healthy endothelial cells and

vasoconstriction in arteries with endothelial dysfunction and atherosclerosis, due to direct interaction between acetylcholine and the tunica media (53, 64, 100). Images are collected at baseline and each increment and a dose response curve is then created (53, 92). Arteries with a dose dependent increase in vasodilation are deemed healthy (92). While this method is considered the gold standard for evaluating coronary endothelial function, it is invasive, expensive and the procedure comes with potential risks for the patient (92). As a result, researchers began using a similar infusion method in the brachial artery, which is associated with fewer risks. Instead of a dose response curve however, the forearm blood flow during the acetylcholine infusion is measured using venous occlusion plethysmography and blood flow during each infusion is compared to rest to determine the level of endothelial dependent dilation that occurs (73, 92). While this infusion method is reliable and repeatable, it is still invasive and poses potential risks to participants (92).

Flow Mediated Dilation (FMD)

Flow mediated dilation (FMD), first introduced by Celermajer and colleagues in 1992, is a non-invasive measure that is used to assess the ability of endothelial cells to promote vasodilation in response to an increase in shear stress (11). FMD is performed using Duplex ultrasound to capture both the arterial diameter and blood flow of the target artery, often the brachial artery, however other arterial segments such as the radial artery, superficial femoral artery and popliteal artery can be imaged (87). Images of the artery are acquired at rest, and then a pneumatic is cuff placed around the participant's limb that is inflated to a suprasystolic level (11). The cuff can be placed either distal to the

ultrasound probe or proximal to the ultrasound probe (86). The cuff remains inflated for 5 minutes and then is released, which results in a dramatic increase in blood flow, referred to as reactive hyperemia (11, 86). An additional image of the target artery is obtained to allow determination of the maximal diameter resulting from the reactive hyperemia stimulus (11). Percent dilation is calculated relative to baseline, to assess the relative change in diameter (11). Importantly, it has been shown that endothelial function in the brachial artery measured by FMD is correlated to endothelial function of the coronary arteries as measured by acetylcholine infusion (7). Additional studies determined that FMD was largely mediated by the release of NO (86). FMD is currently the most commonly used technique to assess endothelial function and it has been suggested that a 1% increase FMD results in a 13% decrease risk of future cardiovascular events (32, 36). *Low Flow Mediated Constriction (L-FMC)*

While infusion techniques and FMD have provided valuable information about endothelial function, some have argued these measures do not capture overall vascular function (29). Gori and colleagues argued that FMD only measures the "recruitability" of endothelial cells, but fails to capture basal arterial tone (29). As a result, a relatively newer measure, low flow mediated constriction (L-FMC) has been introduced to account for the limitations of FMD (28). L-FMC is a measure of the change in arterial diameter that occurs during a period of low blood flow and can be determined from data obtained during the occlusion phase of a traditional FMD test (28, 31). Unlike FMD, L-FMC is not thought to be mediated by NO, and instead is mediated through an increase of ET-1 and an inhibition of vasodilators, specifically endothelial derived hyperpolarizing factor (EDHF) and prostaglandins (28, 80). While there has been an increased interest in L-FMC in the last decade, it was first described by Levenson and colleagues in 1987, who observed a marked decrease in mean blood flow and mean blood velocity as well as an increase in vascular resistance after 60 seconds of wrist cuff occlusion (42, 51). In 1989, Anderson and colleagues extended these findings when they performed 10 minutes of forearm occlusion while using Doppler ultrasound to image the brachial artery (6, 42). The group observed a marked decrease in blood flow during 10 minutes of forearm occlusion that was associated with a decrease in brachial artery diameter (6). In 2008, Gori and colleagues revisited the technique and since then there has been a substantial increase in L-FMC research (28). Gori *et al.* observed the presence vasoconstriction during low flow in the radial artery in a number of studies (28, 29, 31) and additional studies have also reported similar findings (20, 96). However, responses during low flow in the brachial artery appear to be variable with multiple studies reporting individual responses that range from vasodilation to vasoconstriction or no change in diameter during the low flow period (5, 34, 38, 48).

Total Vessel Reactivity (TVR)

Some studies assessing both FMD and L-FMC have reported a relationship between the two variables. Harbin *et al.*, Harrison *et al.,* and Aizawa *et al.* found a significant positive correlation between brachial artery L-FMC and FMD, while Kranen *et al.* found no such relationship (5, 34, 38, 48). Spiro and colleagues found that there was a relationship between brachial artery L-FMC and FMD in healthy individuals, but not individuals with atherosclerosis (81). Aizawa *et al.* found that the low flow response

independently predicted FMD (5). Similarly, studies assessing radial artery L-FMC and FMD have reported conflicting findings with some reporting the two measures are related (30, 96) and others not (28, 29). Total vessel reactivity (TVR, also referred to as modified FMD, vasoactive range etc.) is a composite score of FMD and L-FMC and is thought to provide a more comprehensive assessment of overall vascular function as it takes into consideration both the vasodilatory and vasoconstrictor functions of the endothelium (38, 42). However, there has been limited investigation into this novel measure, and there is no general consensus on how best to evaluate overall vascular range, as a variety of equations have been used previously (5, 9, 20, 38, 48, 69, 70). Two commonly used equations to calculate TVR are:

(1) *TVR* % =
$$
\frac{maximal \ diameter - occlusion \ diameter}{occlusion \ diameter} \ X \ 100
$$

$$
(2) \ TVR \ % = |FMD\% + L - FMC\%|
$$

1.1.3 Endothelial Independent Vasodilation

While the previously mentioned techniques focus on assessing endothelial dependent dilation and constriction, there are also tests used to evaluate vascular smooth muscle function, independent from the endothelium. A nitroglycerin challenge test (NTG) is often used to assess endothelial independent dilation (17). This challenge test can be performed along with either the infusion technique or FMD technique for assessing endothelial dependent dilation (11, 92). For the less invasive FMD test, sublingual nitroglycerin is administered to the participant (11). Nitroglycerin is a nitric oxide donor, and has been shown to promote vasodilation by directly operating on the vascular smooth muscle (11, 17). The percent change in diameter resulting from the administration of nitroglycerine is then calculated to determine endothelial independent vasodilation (11).

1.2 REPEATABILITY OF MEASURES OF ENDOTHELIAL FUNCTION

1.2.1 Overview

In recent years there has been a general scientific focus on ensuring study results are reproducible or repeatable. In preclinical research it is estimated that 75-90% of study findings are not reproducible (8). Groups in both physiology and psychology have attempted to address these reproducibility issues. In 2014, the National Institute of Health put forward a plan to improve reproducibility that included improved training for researchers, ensuring a more systematic approached is used for assessing grant applications and introducing a data bank where researchers could access unpublished data (15). Similarly, peer reviewed scientific journals such as *Nature* have removed restrictions on the length of methods sections to improve reporting of procedural details (15). In psychology, the Open Science Collaboration created the Reproducibility Project, which sought to understand the level of reproducibility in psychological science (66).

While improving reproducibility across studies is important, researchers can also work to ensure the methods they use are repeatable. In this case, the aim is to determine how precise or variable the measurement is from a research test (26). This type of repeatability is referred to as test-retest reliability, and is determined by performing a test multiple times on the same individual, under the same conditions (26). There are a variety of statistical methods used to assess test-retest reliability, two of which are intraclass correlation coefficients (ICC) and Cohen's Kappa. ICCs provide a measure of both the correlation and agreement between two or more measurements (47). In general, ICCs are a ratio of the variance over the sum of the variance plus error (47, 77). ICC calculations produce a coefficient between 0-1, with 1 meaning perfect repeatability and 0 meaning poor repeatability (47). There are various forms of ICCs however, it is recommended that a two-way mixed effects model with absolute agreement be used for test-retest studies (47). Cohen's Kappa (κ) is similar to ICC in that it measures the degree of agreement or consistency between two different measurements (54). Cohen's κ can be performed on data that consists of at least two mutually exclusive categories (54). The calculation of Cohen's κ quantifies the agreement or consistency present in the measurement that is beyond the level of agreement that is expected by pure chance (54). Values of κ range from -1 to 1, a κ = -1 indicates a level of a agreement poorer than what is expected by chance, $\kappa = 0$ signifies that the level of agreement is no greater than what is expected by chance and a $\kappa = 1$ signifies perfect agreement (54).

1.2.2 Flow Mediated Dilation

There has been extensive research assessing the repeatability of FMD since its inception. In 1995, Sorensen *et al*. assessed the repeatability of brachial artery FMD in 40 adults (20 males, 20 females) aged 22-51 (79). The group measured FMD at 4 time points to assess between-day, between-week and between-month repeatability (79). The overall coefficient of variation (CV), a measure of variability, was 1.8%, indicating FMD was repeatable (79). Importantly, it appeared variation was not higher for the between-week and between-month analysis when compared to between-day variation, and variation between the sexes was similar (79). In contrast, Hardie and colleagues found that FMD

was poorly repeatable in a sample of 19 (6M, 13F) healthy adults (35). The group assessed FMD at two time points, separated by an average of 90 days, and found the mean between day difference in FMD was 0.57% with a standard deviation of 6.83% (35). Additionally, there appeared to be more variability in women when compared to men (35). However, neither of these studies controlled for the time of day the test was performed or the caffeine and food intake of the participants prior to testing (35, 79). Liang *et al.* assessed FMD in 30 (10M, 20F) healthy adults at two time points separated by an average of 2.5 weeks (52). Participants in this study were instructed to refrain from ingesting caffeine 8 hours prior to testing and ask to maintain their typical lifestyle for diet, physical activity and alcohol ingestion (52). The group reported a CV of 10.8% and concluded that FMD had satisfactory repeatability (52). Malik *et al.* assessed FMD in a group of 20 healthy men twice within a 10 day period (55). Their results indicated poor repeatability of FMD with a CV of 41% and an ICC=0.10 (55). Onkelinx and colleagues assessed the within-day and between-day repeatability of FMD in a cohort of 18 men with coronary artery disease (CAD) (65). They reported that FMD had excellent within-day (ICC=0.94) and between-day (ICC=0.99) repeatability (65). Charakida *et al.* assessed short (48 hours apart), medium (3 months apart) and long term (9 months apart) FMD repeatability in a group of 67 patients with coronary heart disease participating in a multisite trial (14). They found that short and medium term repeatability of FMD was similar $(ICC=0.80, ICC=0.74)$, but long term repeatability was poorer $(ICC=0.58)$ (14).

As there appears to be lack of consensus on the repeatability of FMD within and between studies, three guideline papers have been released in 2002, 2011 and 2019 outlining recommendations for researchers to improve FMD repeatability and standardized protocols (17, 86, 87). One major recommendation centered around the pneumatic cuff placement during FMD, as some groups place the cuff distal to the ultrasound probe and others place the cuff proximal (86). It was determined that FMD assessed with the cuff placement distal to the probe was largely mediated by NO, whereas FMD with the cuff placed proximal is mediated by NO and other factors (86, 87). Therefore, it was recommended that the cuff be placed distal to the probe to ensure the FMD measured is largely endothelial NO dependent (86, 87). Some recommendations have centered on participant preparation, as more is understood about factors that influence FMD. It is recommended that participants are fasted, avoid exercise, caffeine, medication and supplements prior to testing, as these are all known to influence FMD (17, 86, 87). As well, testing should be performed in a quiet temperature controlled room at approximately the same time of day if measures are repeated (17, 86). For premenopausal women it has also been recommended that testing occur at the same time point during the menstrual cycle, optimally between day 1-7 of the menstrual cycle when estrogen levels are low (86). Guidelines for image acquisition and analysis, protocols and sonographer training have also been introduced (17, 86, 87). Importantly, Greyling and colleagues performed a systematic review of studies assessing FMD repeatability and found that greater adherence to the 2011 guidelines was associated with less variation and improved repeatability of FMD (33).

1.2.3 Low Flow Mediated Constriction

Relatively few studies have investigated the repeatability of L-FMC, and there appear to be important differences between arteries in this measure. Gori and colleagues assessed the repeatability of L-FMC in the radial artery of 25 young healthy participants (28). They found that radial artery L-FMC had substantial repeatability, reporting an ICC of 0.80 (28). Similarly, Weissgerber and colleagues investigated the repeatability of radial artery L-FMC in a cohort of 23 pregnant and 27 non-pregnant women (96). They found that L-FMC had moderate and substantial repeatability within the two groups (ICC=0.56 non pregnant women, ICC=0.86 pregnant women) (96). In contrast, studies assessing the repeatability of brachial artery L-FMC have reported conflicting findings, with some reporting low levels of repeatability and others reporting high levels of repeatability. Harbin and colleagues assessed the repeatability of brachial artery L-FMC in a cohort of 26 young adults and reported that L-FMC diameters had weak intra- and interday repeatability (34). Similarly, Kranen *et al.* assessed the day-to-day repeatability of brachial artery L-FMC in 27 adolescents using both ICCs and Cohen's κ (48). The group found there was poor agreement for L-FMC between days ($\kappa = 0.04$) as well as poor repeatability between days (ICC=0.17) (48). In contrast, Bell and colleagues assessed the day-to-day repeatability of brachial artery L-FMC in a sample of 5 healthy young men and found almost perfect repeatability (ICC=0.87). Spiro *et al.* found that in a cohort of 10 healthy young adults, L-FMC was repeatable across a two hour time period (81). Unfortunately, there are currently no guidelines for L-FMC measurement and differences

in methods used exist between groups. Therefore, more work needs to be done to comprehensively understand the repeatability of L-FMC.

1.2.4 Total Vessel Reactivity

Only two studies have assessed the repeatability of TVR. Inaba and colleagues assessed TVR (calculated as the absolute value of FMD+L-FMC) in a cohort of 25 healthy men and found the measure had excellent repeatability (ICC = 0.93) (43). In contrast, Kranen *et al.* found that TVR (calculated as the difference between peak diameter and occlusion diameter relative to baseline diameter) had only moderate repeatability (ICC=0.52) in a group of 27 adolescents (48). Due to the relative lack of information regarding the repeatability of TVR, more research is required.

1.3 FACTORS INFLUENCING VASCULAR FUNCTION

1.3.1 Biological Sex

It is well known that differences in the cardiovascular system exist between males and females, and in the past few decades some research has focused on identifying and understanding these biological differences. Differences in baseline diameter between boys and girls have been documented in children as young as 6 years old, where as differences in FMD between the sexes have been shown to appear around age 17 (40). One main difference between the sexes is that unlike males, natural cycling females experience fluctuations in sex hormones (mainly estrogen and progesterone) across their menstrual cycle (1, 16). The menstrual cycle is comprised of three phases: the menstrual phase, the follicular phase and the luteal phase (25, 94). During the menstrual phase of the cycle both estrogen and progesterone levels are low (25). In the follicular phase estrogen

increases, with peak levels occurring just prior to ovulation (1, 25). Finally, during the luteal phase estrogen levels fall and progesterone levels increase (1, 94). Importantly, estrogen has been shown to influence endothelial function through two main pathways; the genomic and non genomic pathways (13). Endothelial cells express estrogen receptors, mainly estrogen receptor alpha (ERα) and estrogen receptor beta (ERβ). In the genomic pathway, estrogen diffuses through the endothelial cell plasma membrane and binds to either ERα or ERβ, which causes the receptors to dimerize into homo- or heterodimers (13). These dimers then enter the nucleus and initiate gene transcription, which leads to an increase of eNOS expression (13). In the non-genomic pathway, estrogen binds to cell surface ERα which results in the phosphorylation of eNOS, increasing the capacity of eNOS to produce NO (13). There is also limited evidence that fluctuations in estrogen may lead to fluctuations in ET-1 expression (68). Polderman and colleagues found that ET-1 was highest during the menstrual phase of the cycle and lowest during the follicular phase, when estrogen is elevated (68). Therefore, it has been suggested that fluctuations in estrogen that occur throughout the menstrual cycle may lead to fluctuations in vascular function.

In 1995, Hashimoto and colleagues were the first to investigate if fluctuations in endothelial function occurred across the menstrual cycle in healthy young naturally cycling females (39). The group assessed FMD in 17 males and 17 females, testing females in the menstrual phase, follicular phase and luteal phase (39). Their results indicated that females had similar levels of FMD when compared to males during the menstrual phase, but that in females FMD increased during both the follicular and luteal phases of the cycle (39). Since this landmark paper, many groups have assessed endothelial function across the menstrual cycle and have reported conflicting findings. Some group have found similar results (3, 37) whereas others have found no change in FMD across the menstrual cycle (19, 76, 98). However, there has been limited investigation of how L-FMC or TVR may fluctuate across the hormonal cycle. Rakobowchuk *et al.* found that neither L-FMC nor TVR fluctuated across the menstrual cycle (70). Additionally, there has been limited research evaluating potential sex differences in L-FMC or TVR. A study performed in in adults with varying levels of coronary artery disease found that radial artery L-FMC was lower in males when compared to females (31). In contrast, Norioka *et al*. found that male sex was an independent predictor of the presence of brachial artery L-FMC in a group of smokers (63). Therefore more research is warranted to understand if sex differences exist in L-FMC and TVR.

In addition to fluctuations of endogenous sex hormones, millions of females take oral contraceptive pills (OCP) that create a different pattern of hormonal fluctuation (78). There are two main OCP dosing patterns: monophasic dosing and tricyclic dosing; in monophasic dosing active pills with a stable concentration of ethinyl estradiol (EE) and progestin (synthetic form of progesterone) are taken for 21 days, with a 7 day placebo phase (78). In contrast, tricyclic dosing has a constant EE dose with an incremental increase in progestin every 7 days across the 21-day active pill phase, followed by a 7-day placebo phase (78). Researchers have assessed whether fluctuations of sex hormones that occur across an OCP cycle also influence vascular function. Similar to the lack of consensus in findings in natural cycling females, some groups have found increases in FMD in the active phase compared to the placebo phase (59, 89), while others have found no differences (76, 89, 90) or decreases in FMD (90). To our knowledge, no study to date has assessed L-FMC or TVR in females using OCPs.

1.3.2 Aging

It is well known that the risk for CVD increases with age (74). While endothelial dysfunction is often seen in association with CVD, evidence suggests that endothelial dysfunction occurs as a result of aging in the absence of CVD or CVD risk factors (74). It is thought that this dysfunction is mainly due to decreases in bioavailability of NO and increases in oxidative stress and inflammation (75). NO bioavailability is impacted by the availability of tetrahydrobiopterin (BH4), an important cofactor necessary for the production of NO $(75, 95)$ and BH₄ availability is lower in older adults $(74, 95)$. As we age, there is also an increase in superoxide production without an concomitant increase in antioxidant production, leading to more oxidative stress overall (74). Donato and colleagues assessed brachial artery FMD and the level of oxidation present in the endothelial cells of both younger and older men (23). They found that brachial artery FMD was 50% lower in older men when compared younger men, and that decreases in FMD were associated with higher levels oxidative stress (23). Additionally, inflammatory markers such as interleukin-6 and C-reactive protein appear to be higher in older adults (22). Donato *et al.* assessed markers of inflammation and endothelial dependent vasodilation in older and younger adults and found higher levels of some inflammatory factors (interleukin-6, tumor necrosis factor- α and monocyte chemoattractant protein-1) and a transcription factor that increases inflammation (nuclear factor κ B) in older adults compared to younger adults (22). They also found lower levels of endothelial dependent dilation in the older adults when compared to the younger adults (22). It has also been suggested that an increase production of ET-1 might be responsible for lower levels of endothelial dependent vasodilation in older adults. Donato *et al.* found that the expression of ET-1 in vascular endothelial cells was greater in older men when compared to young men, and that ET-1 expression was inversely related to FMD (24). Wenner *et al.* found that ET_B receptor blockade increased vasodilation in response to local heating in postmenopausal women, whereas ET_B receptor blockade decreased vasodilation in young women (97). The group concluded these result indicate that ET_B receptor function is altered in women with aging (97).

Importantly, the impacts of aging on endothelial function appear to differ between men and women. Celermajer *et al.* was the first to report the presence of sex based differences in the age associated decline of endothelial function in 1994 (12). The group assessed FMD in 238 healthy individuals aged 15-72 and found that FMD begins to decline in men at approximately age 40, whereas women experience a decline in FMD around age 50 (12). Additionally, the rate of decline in FMD was greater in women when compared to men (12). The group concluded that the loss of estrogen that occurs during menopause was likely the reason for the different pattern of decline seen in women (12). In 2012, Moreau *et al.* evaluated FMD across the phases of the menopause transition in 132 healthy women (61). They observed a stepwise decrease in FMD from premenopause to postmenopause and found that lower FMD was associated with lower levels of estrogen (61). Gavin and colleagues assessed if changes in estrogen status from pre- to postmenopause altered endothelial ERα expression, and whether not this influenced FMD (27). They noted that ERα was lower in postmenopausal women when compared to premenopausal women in the late follicular phase, but the same as premenopausal women in the menstrual phase (27). Additionally, FMD was approximately 30% lower in postmenopausal women and was positively related to ERα expression in the overall group and in postmenopausal women (27). In contrast, it is unclear if aging influences L-FMC and TVR. One study found that brachial artery occlusion diameters were different between children and adults when compared to older adults (85).

1.3.3 Cardiovascular Disease

Both CVD and the presence of CVD risk factors have been shown to influence vascular function. Kuvin *et al.* found that individuals with coronary artery disease (CAD) had a significantly lower FMD when compared to those without CAD (50). Additionally, the group found that individuals with more CVD risk factors had a lower FMD than those with fewer risk factors (50). Celemajer *et* al. found children with familial hypercholesterolemia had lower levels of FMD compared to healthy children (11). Adachi *et al.* assessed FMD in 75 individuals with and without stroke and found that individuals with stroke caused by either large artery atherosclerosis or cardioembolism, but not small vessel occlusion had a significantly lower FMD when compared to those without stroke (2). The impact of CVD and CVD risk factors on L-FMC and TVR is less clear. L-FMC and TVR in the radial artery appears to be lower in individuals with CAD compared to those without CAD (28, 29). Importantly, Gori *et al.* found that L-FMC
progressively declines with worsening CAD severity (31). Dawson *et al.* found that radial artery L-FMC and TVR were reduced in individuals after radial artery catheterization (20). Gori *et* al. found that the addition of FMD and L-FMC to a model including CAD risk factors improved the model's ability to predict the presence of CAD (31). In the brachial artery, Spiro and colleagues found that L-FMC was greater in patients with unstable CAD compared to those with stable CAD (81). Aizawa and colleagues found that the presence of CVD risk factors did not influence L-FMC (5). Harrison *et al.* investigated FMD, L-FMC and TVR in a cohort of 46 adults with varying CVD risk factors and found that while there were no differences in FMD and L-FMC in the group with multiple risk factors when compared to healthy individuals, TVR was significantly lower in those with multiple risk factors (38).

1.3.4 Elevated Cardiovascular Disease Risk – Spinal Cord Injury and Cerebral Palsy

There are various populations that are thought to be at elevated risk for cardiovascular disease, two of which are individuals with spinal cord injury (SCI) and cerebral palsy (CP). Individuals with SCI appear to have a greater prevalence of CVD, as well as higher mortality from CVD when compared to ambulatory individuals (62). CVD risk factors, such as metabolic syndrome, dyslipidemia, obesity and physical inactivity, are also more common in individuals with SCI (62). These risk factors, along with autonomic dysfunction that often accompanies SCI, contribute to the development of CVD in this population (62). Our lab, along with others have assessed FMD in this population to determine how endothelial function may be altered by SCI (83, 88, 91).

Thijssen *et al.* assessed FMD in the superficial femoral artery (SFA) of 14 men, including 6 men with SCI (88). The group found greater SFA FMD in SCI individuals when compared to controls, however this difference was no longer apparent after correction for shear rate area under the curve (88). Our group assessed both brachial artery and SFA FMD in 8 individuals with SCI and 8 ambulatory individuals (91). We found that there were no differences in FMD in either of the arterial segments, however when FMD was scaled to baseline diameter, SCI individuals appeared to have lower SFA FMD than ambulatory individuals (91). It is unclear if L-FMC or TVR might be altered in SCI individuals.

Cerebral palsy (CP) is a disorder that results in motor impairments that impact an individual's physical activity levels (58). It has been show that physical activity levels of individuals with CP decline with age and worsening disease status (57, 58). Low levels of physical activity in this population have been associated with increased risk for cardiovascular disease (57). Researchers from our lab have worked to understand if endothelial function of adolescents and adults with CP is altered (56, 58). Martin *et al.* assessed brachial artery FMD in adolescents with and without CP and found children with CP participated in less vigorous physical activity, however there were no differences in FMD between adolescents with CP and those without (56). Similarly, McPhee and colleagues assessed FMD in ambulatory and non-ambulatory individuals with CP and found that there were no differences in FMD, even though individuals who were nonambulatory participated in fewer minutes of moderate-vigorous physical activity (58). To our knowledge, no study has evaluated L-FMC or TVR in this population.

1.4 STUDY OBJECTIVES AND HYPOTHESES

The main purpose of this study was to assess FMD, L-FMC and TVR in a diverse population of individuals to determine:

(1) The repeatability of brachial artery FMD, L-FMC and TVR. We hypothesized that the repeatability of FMD, L-FMC and TVR would be moderate.

(2) How brachial artery FMD, L-FMC and TVR are influenced by age and how this relationship is moderated by sex, elevated cardiovascular disease risk and the presence of overt CVD. We predicted that FMD, L-FMC and TVR would decrease with aging, and that differences between the sexes would be evident. We hypothesized that the presence of CVD and elevated CVD risk would lead to a reduction in FMD, L-FMC and TVR.

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CHAPTER 2: MANUSCRIPT

Determining the Repeatability of Low Flow Mediated Constriction and Total Vessel Reactivity in the Brachial Artery of Humans

By: Vanessa I. Rizzuto, Katherine D. Currie, Ninette Shenouda, Natalie T. D'Isabella,

Patrick G. McPhee, Julia O. Totosy de Zepetnek, Joey P. Bacauanu, Audra A. Martin,

Lisa M. Cotie, Jem L. Cheng, Austin J. Cameron, Greg M. McGill, Jelmer H. van

Puffelen, Jason S. Au, Ada Tang, Brian Timmons, Jan Willem Gorter, Maureen J.

MacDonald

2.1 ABSTRACT

Endothelial function is the ability of an artery to vasodilate that is often assessed in the peripheral vasculature using a flow mediated dilation (FMD) test. While FMD has been shown to be a valuable tool, it may not ideally capture overall vascular function. Two novel measures, low flow mediated constriction (L-FMC) and total vessel reactivity (TVR) have been introduced to provide a complementary vascular assessment to FMD, however little is known about the repeatability of L-FMC and TVR, particularly in the brachial artery. Additionally, it is unclear how L-FMC and TVR might be influenced by aging or the presence of cardiovascular disease (CVD) or elevated CVD risk and if these measures differ between the sexes. Therefore the main purpose of this investigation was to assess the day-to-day repeatability of FMD, L-FMC and TVR in the brachial artery of humans. The secondary purpose was to assess how FMD, L-FMC and TVR change with aging and if this relationship was influenced by sex or the presence of CVD or elevated CVD risk. 375 participants (age: 37 ± 22) were included in the overall study, which included both retrospective and prospective data. 98 participants (age: 34 ± 19) underwent two FMD tests; as such they were included in the repeatability analysis. For all participants brachial artery endothelial function was assessed using a FMD test. A 30 second image was taken at 4 minutes of cuff occlusion to capture the low flow response. The between day repeatability of FMD was substantial (ICC = 0.68), TVR was moderate (ICC = 0.50) and L-FMC was slight (ICC = 0.01). FMD and TVR ($p=$ -0.24, $p=$ -0.19, p<0.005) were associated with age, however there was no relationship between age and L-FMC. These relationships persisted in individuals with CVD and elevated CVD risk,

and sex did not moderate the relationship between age and any of our vascular outcomes. These results indicate that brachial artery FMD and TVR are relatively repeatable, however L-FMC is not repeatable. As well, it appears that while age is associated with a decrease in FMD and TVR, there is no such relationship between age and L-FMC.

2.2 INTRODUCTION

Arterial endothelial function refers to the ability of endothelial cells to produce vasodilation (4, 43). Endothelial function is commonly assessed in the peripheral vasculature using the non-invasive flow mediated dilation (FMD) dilation test (44). Importantly, FMD has been shown to be predictive of future cardiovascular events in both symptomatic and asymptomatic individuals (43). While FMD has been shown to be a valuable tool for assessing endothelial function, some have argued that it does not capture overall endothelial function, particularly the full expression of vascular range including vasoconstriction and vasodilation (17, 25). As a result, two novel measures of endothelial function, low flow mediated constriction (L-FMC) and total vessel reactivity (TVR) have been introduced to address some of the apparent limitations of FMD (16). L-FMC is a measure of arterial diameter during a low blood flow state that is meant to provide information on resting vascular tone and vasoconstriction capacity (16, 17, 19). The information required to determine L-FMC can be acquired during the occlusion phase of a traditional FMD test (16). It is thought that L-FMC is mediated by an increased production of endothelin-1 (ET-1) and a decreased production of certain vasodilators (endothelial derived hyperpolarizing factor, prostaglandins) (16). TVR is a composite score of both FMD and L-FMC and is thought to provide a more comprehensive assessment of vascular function in comparison to either index alone (23, 25). While these two novel measures of vascular function can potentially improve our understanding of endothelial function, little is known about their repeatability, particularly when assessed in the brachial artery. Previous studies assessing the repeatability of brachial artery L-FMC have reported conflicting findings, with some reporting that L-FMC has good within and between day repeatability, while others reporting that L-FMC has poor repeatability in adolescents and young adults (3, 21, 27, 42). The very limited research available that assessed the repeatability of brachial artery TVR has found either almost perfect (26) or moderate repeatability (27) in adolescents and healthy young adults.

It is well known that aging influences endothelial function and it is thought that a combination of a decrease in nitric oxide (NO) bioavailability, an increase in inflammatory factors and reactive oxygen species are responsible for the age related decline in vascular function (38). As such, studies have reported higher levels of reactive oxygen species and inflammation along with lower FMD (11, 12). While decreases in FMD with age have been well documented, little is known about how aging influences L-FMC and TVR. A study by Gori *et al.* found that older age (>65 years) was associated with lower L-FMC (19). To our knowledge, no study has comprehensively the effects of aging of L-FMC and TVR.

Endothelial function has been shown to vary between the sexes. Hashimoto *et al.* were the first to show that natural cycling women have higher levels of FMD during the follicular and luteal phase when compared to men, however in their study FMD during the menstrual phase was similar between men and women (24). Since that early report, a variety of studies have assessed FMD across the menstrual cycle and have either reported increases or no change in FMD across the menstrual cycle (1, 10, 22). Recent work from our lab found there were no changes in FMD across both a natural menstrual cycle or oral contraceptive pill cycle, however once scaled to baseline diameter, women had lower levels of FMD when compared to men (40). Important sex differences are also present with aging, as women appear to show a decline in FMD later in life compared to men, and the rate of decline in FMD with aging is greater in women compared to men (5). Additionally, Moreau *et al.* found FMD progressively decreased across the phases of the menopause transition (34). Until now, very little work has assessed potential sex differences in L-FMC and TVR. One study found that L-FMC did not change across the menstrual cycle (37). A study by Gori *et al.* found that male sex was associated with lower radial artery L-FMC and Norioka *et al.* found that male sex was associated with the presence of brachial artery L-FMC (19, 35).

Endothelial function has been shown to be reduced in individuals with CVD and elevated CVD risk. Kuvin *et al.* found individuals with coronary artery disease (CAD) had lower levels of FMD and that the number of cardiovascular disease (CVD) risk factors was associated with FMD (28). Little is known about the influence of CVD and CVD risk factors on L-FMC. Gori *et al* found that both radial artery L-FMC and TVR were lower in individuals with CAD and that L-FMC was negatively correlated with CAD severity (16, 17, 19). Aizawa *et al.* found the presence of CVD risk factors did not influence L-FMC (2). In agreement with this finding, Harrison *et al* found no differences in FMD and L-FMC between individuals with and without CVD risk factors, however TVR appeared lower in those individuals with CVD risk factors when compared to those without CVD risk factors. (23).

Given the work to date, the main purposes of this study were to assess FMD, L-FMC and TVR in a diverse population of individuals to determine: (1) the repeatability of brachial artery FMD, L-FMC and TVR and (2) how brachial artery FMD, L-FMC and TVR are influenced by age, sex, elevated cardiovascular disease risk and the presence of overt CVD. We hypothesized that the repeatability of FMD, L-FMC and TVR would be moderate and that FMD, L-FMC and TVR would decrease with aging. Furthermore, we hypothesized that differences between the sexes would be evident, such that men would show a decline in both FMD and L-FMC earlier in life than women and that the presence of CVD or elevated CVD risk would lead to a reduction in FMD, L-FMC and TVR.

2.3 METHODS

2.3.1 Participants

Retrospective data along with prospective data were used for the present investigation. Our retrospective data set included 355 participants that previously underwent at least one FMD test in our laboratory. This data set consisted of individuals ranging from six to eighty-one years of age, including healthy young adults, individuals with spinal cord injury, individuals with cerebral palsy, individuals with stroke, individuals with coronary artery disease and healthy older adults. The FMD results from many of these studies have been published elsewhere (6–9, 32, 33, 39–41, 45). All of the data was collected using a similar FMD protocol as described below. This cohort also consists of data from forty participants (age <18 years old) taking part in the SKIP

(School-age Kids" health from early Investment in Physical activity) study (data not yet published).

80 participants from the retrospective cohort had undergone repeated testing; therefore, the data from these individuals were used for the day-to-day repeatability analysis. We controlled for hormonal fluctuations in both natural cycling women and women taking oral contraceptive pills. For natural cycling women we used data from two visits that occurred during the menstrual phase of the menstrual cycle. For women on oral contraceptive pills we used two visits that occurred during the active phase of a pill cycle, as repeat data was not available during the placebo phase. As some studies were intervention studies that had randomized baseline visits, we used the first two visits based on chronological order. Additionally, we only utilized baseline (or pre-intervention) data from any study that had an intervention component.

For our observational analysis, we utilized the first visit for any participants that underwent multiple testing visits. Additionally, the SKIP study is a longitudinal study assessing various measures within school-aged children across a three-year period. As such, we only utilized data from the first year of the study.

In addition to our retrospective data set, we collected prospective data from 20 individuals (14 women, 6 men) who were recruited from McMaster University using poster advertisements as well as advertisements in a local newspaper. Individuals were required to be 35-80 years of age to address the age ranges where our retrospective data was most sparse. Postmenopausal women were included if they had not experienced menses for >1 year and were not currently taking hormone replacement therapy. No premenopausal women were recruited in the prospective cohort. Participants needed to be free of active cardiovascular or cerebrovascular disease to be included in the prospective portion of the study. The study was approved by the Hamilton Integrated Research Ethics Board (HiREB #5291).

47

RAM – Repeatability of Arterial Measures, SFCP – Stay Fit Cerebral Palsy: Cardiovascular Health, CAMO – Cardiovascular Health and Mobility in community older adults, SKIP – school-age kids health from early investment in physical activity, SCI – Cardiovascular and metabolic health in spinal cord injury, CAD – Vascular adaptations to low-volume HIIT in coronary artery disease, TR – Endothelial adaptations to SIT vs END vs Control, TVR – Total Vessel Reactivity, NESTLE – Step reduction in older adults, CAMS – Cardiovascular Health and Mobility after stroke, AC – Sex-differences in response to a single bout of SIT, AM – Arterial Measures, ASPEN – Artery Function Responses to Changes in Blood Flow, SPEC – Speckle Tracking Study, AB – SCI – Cardiovascular and metabolic health in able bodied individuals, ACUTE ENDO – acute endothelial function, EDS – exercise dilation study, COS - CHOICES: Cardiovascular/Health Outcomes in spinal cord injury.

2.3.2 Study Design

All study visits for prospective data collection took place in the Vascular Dynamics Lab at McMaster University. All participants attended one familiarization visit. At the familiarization visit participants were screened to ensure they were eligible to take part in the study. Participants provided informed consent and were given a demonstration of the FMD technique, however no data was acquired at this visit.

Prior to the testing visits, participants were instructed to refrain from vigorous physical activity for 24 hours, as well to have fasted overnight for at least 10 hours. Testing visits took place in the morning between the hours of 7:00am-12:00pm to control for diurnal variation. At the start of the first testing visit anthropometric measurements including body weight and height were collected.

For postmenopausal women and men, data was collected during two study visits

scheduled at the same time of day on two different days separate by at least 24 hours. For postmenopausal women a blood sample was collected at the start of all visits. For men, one blood sample was collected at the start of one of the two visits, of which was randomized for each participant. Immediately following the blood draw, participants were fitted with three electrocardiography electrodes (AD Instruments, Colorado Springs, CO) that were used to record heart rate throughout the duration of the protocol. Participants had ten minutes of supine rest, after which blood pressure was assessed using an automated, oscillometric blood pressure device (Dinamap ProSeries, Batesville, IN). Blood pressure was assessed once every minute, for at least three minutes. The first measure of blood pressure was discarded, and the second and third measures were averaged. However, if the second and third measures were greater than 5mmHg apart, one additional measurement was collected. The two closest measures of blood pressure were then averaged.

2.3.3 Outcome Measures

2.3.3.2 Venous Blood Draw

A 16.0mL venous blood sample was collected at the start of each visit for women and at the start of one visit for men. Blood was collected in four 4.0mL serum blood collection tubes (BD Vacutainer Plus, Red BD Hemogard Closure, Franklin Lakes, NJ) and set aside to clot for at least 45 minutes. Following coagulation, the tubes were spun at 4000rpm for ten minutes in a centrifuge set to 4°C (Sorvall Legend XTR Centrifuge, Thermo Fisher Scientific, Waltham, MA). Serum was aliquoted into three 1.5mL eppendorfs and frozen at -20°C. Frozen serum samples were brought to the Core Laboratory at the McMaster University Medical Centre for analysis of endogenous estradiol (Architect Estradiol Chemiluminescent Microparticle Immunoassay, Abbott Laboratories, Abbott Park, IL), progesterone (Architect Progesterone Chemiluminescent Microparticle Immunoassay, Abbott Laboratories, Abbott Park, IL), and testosterone (Immulite 2000 Total Testosterone Chemiluminescent Enzyme Immunoassay, Siemens Healthcare Diagnostics, Tarrytown, NY).

2.3.3.3 Flow Mediated Dilation (FMD)

A Duplex ultrasound (Vivid Q, GE Medical Systems, Horten, Norway) along with a 12 MHz linear array probe was used to simultaneously assess brachial artery diameter and mean blood velocity. A single lead ECG was connected to the ultrasound to simultaneously collect heart rate. At the start of the test, a pneumatic cuff was placed on the participant's right forearm and a baseline image of the right brachial artery was taken for thirty seconds. The cuff was then rapidly inflated to 200 mmHg and remained inflated for five minutes. An additional Duplex image of the brachial artery was acquired at four minutes of occlusion for thirty seconds. The cuff was then rapidly deflated at five minutes, and a cineloop was taken in Duplex mode for three minutes to capture the reactive hyperemia response. Ultrasound images were then prepared for offline analysis using a software program (Sante DICOM Editor). First raw images were transferred from the ultrasound to a computer. Individual frames were then extracted at or before every R spike of the cardiac cycle. The extracted frames were then merged into a single loop for all baseline, four-minute and reactive hyperemia images. For analysis, a semi-automated edge tracking software (Arterial Measurement System II Image and Data Analysis,

Gothenburg; Sweden) was used to determine brachial artery diameter at all three time points.

Flow mediated dilation was calculated by subtracting the mean baseline diameter from the maximum diameter reached during reactive hyperemia using the following equations to determine absolute and relative FMD:

 (1) FMD (mm) = maximum diameter-baseline diameter

(2) FMD (
$$
\%
$$
) = $\frac{\text{maximum diameter-basedine diameter}}{\text{baseline diameter}}$ X 100

Low flow mediated constriction was calculated by subtracting the mean baseline diameter from the mean occlusion diameter using the following equations to determine absolute and relative L-FMC:

 (3) L-FMC (mm) = occlusion diameter-baseline diameter

(4) L-FMC
$$
\% = \frac{\text{occlusion diameter-basedine diameter}}{\text{baseline diameter}} \times 100
$$

Total vessel reactivity was calculated by subtracting the occlusion diameter from the maximum diameter using the following equation:

5) TVR $\% = \frac{\text{maximum diameter-occlusion diameter}}{\text{occlusion diameter}}$ X 100

2.3.3.4 Nitroglycerin Challenge Test (NTG)

For 194 of 375 participants, a nitroglycerin challenge test (NTG) was used to assess smooth muscle function. After the FMD test participants were given 10 minutes of supine rest. Following the rest period, a thirty-second baseline image of the brachial artery was taken. A 0.4 mg dose of nitroglycerin (NTG) was then administered sublingually to the participant. Following NTG administration, a thirty-second image was obtained every minute for ten minutes. Images were then prepared for offline analysis and analyzed as described above. The absolute and relative diameter change after NTG administration was calculated using the following equations:

 (6) Absolute NTG (mm) = peak NTG-baseline NTG

7) Relative NTG (%) = $\frac{\text{peak} \text{NTG-basedine} \text{NTG}}{\text{baseline} \text{NTG}}$ X 100

2.3.3.5 Mean Blood Velocity & Shear Rate

Mean blood velocity signals were collected during the baseline, occlusion and reactive hyperemia phases of the test while the ultrasound was in Duplex mode. A spectral analysis system (Neurovision 500M TCD, Multigon Instruments, Yonkers, NY, USA) was used to perform a Fast Fourier transformation function on the acquired audio signals from the ultrasound to generate intensity weighted mean blood velocity (MBV) signals. A Powerlab system (Powerlab model ML870, AD Instruments, Colorado Springs, CO, USA) was then used to sample the MBV signal and convert the analog signals to digital which were then analyzed offline using LabChart software (LabChart 8, AD Instruments, Colorado Springs, CO, USA). For reactive hyperemia MBV and arterial diameters were then averaged into 5-cycle rolling average bins and used to calculate blood flow and shear rate using the following equations:

(8) Blood flow
$$
\left(\frac{mL}{min}\right) = (\pi r^2 x MBV) x 60
$$
 where $r =$ arterial diameter/2
(9) Shear rate $(s^{-1}) = \frac{MBV x 8}{\text{arterial diameter}}$

Differences in the retrospective cohort

While our FMD acquisition and analysis has remained relatively consistent over

the years of the studies included in this analysis, there are some differences between studies in the retrospective cohort. Some studies included a familiarization visit (where participants were given a demonstration of the FMD technique, but no data was acquired), while others did not. The fasting period for studies included in the retrospective dataset ranged from 4-12 hours (8, 9, 32, 33, 39–41, 45). Similarly, the period of time the participant was instructed to refrain from exercise ranged from 12-24 hours. The rest period prior to vascular testing ranged from 10-20 minutes. A majority of studies utilized a GE Vivid Q ultrasound with a 12 MHz linear array probe (6–8, 33, 39– 41, 45), while one study utilized the GE System FiVe with a 10 MHz linear array probe (32). Studies also utilized a slightly different cuff placement, ranging from 3-10cm away from the antecubital fossa, however all cuff placement was distal to the brachial artery assessment site. One study had a different protocol for acquiring the ultrasound images during the FMD test; they acquired a baseline image 3 heart cycles in duration, after cuff deflation they collected blood velocity signals for 30 seconds, after which they collected an image 3 heart cycles in duration every 15 seconds until 3 minutes after cuff deflation (32). The nitroglycerin challenge test protocol also varied between studies. One study gave participants 15 minutes of rest before NTG and acquired ultrasound images of the brachial artery at every two minutes after nitroglycerin administration (45). Another study acquired images that were 10 heart cycles in duration at baseline and every minute after nitroglycerin administration (8).

2.3.4 Statistical Analysis

Statistical Package for the Social Sciences (SPSS Inc., Version 25.0, Chicago IL)

was used for all analyses. We utilized intraclass correlation coefficients (ICCs, two way mixed, absolute agreement) to determine the repeatability of FMD, L-FMC and TVR. ICC cut off values are as follows: poor ≤ 0 , slight 0 - 0.2, fair 0.21-0.4, moderate 0.41 -0.60, substantial $0.61 - 0.80$, almost perfect 0.81-1 (29). Sample size calculations were based on previous research assessing the repeatability of L-FMC using ICC,Sample.Size in Rstudio (Version 1.1.423) to estimate a sample size if the ICC value is between 0.2- 0.3. The sample size required to detect an ICC in this range with $\alpha = 0.05$ and $\beta = 0.80$ fell between 83 – 192 participants. As a secondary measure of repeatability for L-FMC, we utilized Cohen's Kappa to measure the level of agreement between the two repeat visits. Relative L-FMC at each visit was assigned a label as follows: > 0 was labeled "dilate", $= 0$ was labeled "no change" and ≤ 0 was labeled "constriction". To determine if a relationship existed between age and our vascular measures we utilized Spearmen's correlation coefficients as our data were non-parametric upon visual inspection. To determine if sex moderated the relationship between age and our vascular measures, we utilized a moderated multiple regression with sex as the dichotomous moderator variable and also assessed potential between day differences in hemodynamic variables using a signed rank test. Potential differences in between day endothelial independent dilation were assessed using paired-sample t-tests.

2.4 RESULTS

FMD data was available in 375 participants for the observational study and repeat data was available in 98 participants for the repeatability analysis. From the 20 participants that were recruited, all 20 were included in the observational study analysis

and 18 were included in the repeatability investigation as one participant only completed one visit and another did not follow pretesting instructions at one visit. Participant characteristics are outlined in Table 2, while hemodynamic variables are outlined in Table 3 for the repeatability cohort and Table 4 for the observational cohort.

Observational Cohort		
Sex	253M, 122F	
Age (years)	37 ± 22	
BMI	24.4 ± 5.8	
Repeatability Cohort		
Sex	53M, 45F	
Age (years)	34 ± 19	
RMI	25.2 ± 5	

Table 2. Participant Characteristics

Data are presented as mean \pm standard deviation. M – males, F - females.

Repeatability Study

There were differences in systolic blood pressure $(p<0.005)$, diastolic blood pressure ($p=0.010$) and mean arterial pressure ($p=0.002$) between the two visits, however there were no differences in heart rate $(p=0.826)$. Data on FMD variables can be found in Table 5. We found that FMD had substantial repeatability (ICC=0.68), L-FMC had poor repeatability (ICC= 0.01) and TVR had moderate repeatability (ICC= 0.50) in our cohort. At Visit 1 40.8% of individuals presented with constriction during low flow and 59.2% presented with dilation. Similarly, at Visit 2, 39.8% of individuals presented with constriction during low flow, 59.2% presented with dilation and 1% showed no change. 19 participants consistently presented with constriction, 37 consistently presented with dilation and 41 participants presented with dilation at one visit and constriction at the other visit. In contrast, baseline, occlusion and peak arterial diameters all had almost perfect repeatability (Table 5). Additionally, we found that there was poor agreement of L-FMC between the visits ($\kappa = 0.12$). We found that there were no differences in endothelial independent function between the two visits (Table 6). Blood analysis in the 20 prospective participants revealed all females were within normative values for postmenopausal women for estrogen and testosterone at both visits, however one female had slightly elevated progesterone at Visit 2. Males were within normative values for estrogen, progesterone and testosterone.

Tuble of Hemoa Analines, Repeatablity Conore				
	Visit 1	Visit 2	p	
HR(bpm)	62(15)	62(15)	.862	
SBP (mmHg)	116(20)	113(17)	< 0.005	
DBP (mmHg)	69(9)	67(7)	0.010	
MAP (mmHg)	87(8)	85(7)	0.002	

Table 3. Hemodynamics, Repeatability Cohort

Data are presented as medians with interquartile range. HR – heart rate, SBP – systolic blood pressure, DBP $-$ diastolic blood pressure, MAP – mean arterial pressure. Results are from a sign rank test. n=87.

Observational Study

Vascular variables for the observational analysis can be found in Table 7. In our cohort 190 individuals experienced vasoconstriction during the low flow period (50.7%) while 185 presented with vasodilation (49.3%). Individuals who experienced vasoconstriction during low flow appeared to be slightly older than those who presented with vasodilation (38 vs. 35 years) and the percentage of men and women who experienced vasodilation and vasoconstriction were similar. Analysis revealed that there was a negative correlation between age and FMD ($p=$ -0.24) as well as age and TVR ($p=$ -0.19) however there was no correlation between age and L-FMC. To assess whether the presence of CVD or elevated CVD risk would alter this relationship, we reran the correlations excluding healthy individuals ($n = 124$). Similarly to the overall observation cohort, we found that FMD and L-FMC were correlated with age (ρ = -0.41 p<0.005, ρ = -0.43 p<0.005), however L-FMC was not correlated with age in the cohort with CVD and elevated CVD risk. Additionally we found that there was a positive correlation between FMD and L-FMC ($p= 0.27$, $p<0.005$). Our moderator analysis revealed sex did not moderate the relationship between age and any of our vascular measures.

Table 4. Hemodynamics, Observational Cohort

	$Mean \pm Standard Deviation$
$HR (bpm) (n=322)$	65 ± 12
SBP (mmHg) $(n=362)$	116 ± 17
DBP (mmHg) $(n=362)$	67 ± 10
$MAP (n=305)$	86 ± 11

Data are presented as mean ± standard deviation. HR – heart rate, SBP – systolic blood pressure, DBP – diastolic blood pressure, MAP – mean arterial pressure.
	Visit 1	Visit 2	$CV(\%)$	ICC
Baseline Diameter	3.87 ± 0.76	3.89 ± 0.74	2.4	0.97
Occlusion Diameter	3.88 ± 0.78	3.92 ± 0.74	2.6	0.97
Peak Diameter	4.09 ± 0.76	4.12 ± 0.74	2.4	0.96
Absolute FMD	0.22 ± 0.10	0.23 ± 0.10	13.1	0.63
FMD%	5.90 ± 3.10	6.15 ± 3.09	14.4	0.68
Absolute L-FMC	0.01 ± 0.07	0.03 ± 0.10		0.01
L -FMC%	0.33 ± 1.89	0.90 ± 2.92		0.01
TVR%	5.56 ± 2.80	5.25 ± 3.19	36.3	0.50

Table 5. Vascular Variables, Repeatability Cohort

Data are presented as mean ± standard deviation. FMD – flow mediated dilation, L-FMC – low flow mediated constriction, TVR – total vascular reactivity, CV – coefficient of variation, ICC – intraclass correlation coefficient.

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	Visit 1	Visit 2	p		
Baseline Diameter (mm)	3.71 ± 0.71	3.71 ± 0.70	0.80		
Peak Diameter (mm)	4.50 ± 0.75	4.48 ± 0.75	0.37		
Absolute NTG (mm)	0.79 ± 0.19	0.77 ± 0.20	0.35		
NTG%	21.92 ± 6.26	21.46 ± 6.44	0.36		
TTP (minutes)	7 ± 2	7 ± 2	0.47		

Table 6. Nitroglycerin Challenge Test, Repeatability Cohort

Data are presented as mean \pm standard deviation. NTG – nitroglycerin challenge test, TTP – time to peak. Results are from a paired sample t-test. N=78 for all variables except TTP V2 where n=77.

	$Mean \pm Standard Deviation$
Baseline Diameter	3.79 ± 0.82
Occlusion Diameter	3.79 ± 0.82
Peak Diameter	4.03 ± 0.84
Absolute FMD	0.24 ± 0.13
FMD%	6.55 ± 3.91
Baseline Blood Flow (n = 215)	50.61 ± 33.98
Peak Blood Flow $(n = 215)$	358.25±166.33
Peak Shear Rate $(n = 223)$	964.42±544.53
Shear Rate AUC ($n = 205$)	23234.50±17603.69
Absolute L-FMC	-0.001 ± 0.12
L-FMC%	0.01 ± 3.31
TVR%	6.61 ± 4.55
Baseline NTG Diameter (n=194)	3.97 ± 0.71
Peak NTG Diameter (n=194)	4.75 ± 0.79
Absolute NTG (n=194)	0.78 ± 0.23
$NTG% (n=194)$	20.09 ± 6.11
NTG TTP $(n=190)$	7 ± 2

Table 7. Vascular Variables, Observation Cohort

Results are presented as mean \pm standard deviation. FMD – flow mediated dilation, L-FMC – low flow mediated constriction, TVR – total vascular reactivity, NTG – nitroglycerin challenge test, TTP – time to peak. n=375 unless otherwise stated.

Figure 1. Associations between age and [A] flow mediated dilation (FMD), [B] low flow mediated constriction (L-FMC) and [C] total vessel reactivity (TVR). A significant association was found between age and FMD and age and TVR but not age and L-FMC.

Figure 2. Associations between age and [A] flow mediated dilation (FMD) [B] low flow mediated constriction (L-FMC) and [C] total vessel reactivity (TVR) in individuals with cardiovascular disease or elevated cardiovascular disease risk. A significant association was found between age and FMD and age and TVR but not age and L-FMC.

Figure 3. Lines depict individual participant responses across the two visits for [A] flow mediated dilation (FMD) [B] low flow mediated constriction (L-FMC) and [C] total vessel reactivity (TVR).

Figure 4. Correlation between low flow mediated constriction (L-FMC) and flow mediated dilation (FMD).

2.5 DISCUSSION

This is the first study to comprehensively assess the repeatability of both brachial artery L-FMC and TVR in a diverse cohort of individuals. Additionally, we are the first to directly investigate the relationship between age and L-FMC or TVR as well as the influence of sex on this relationship.

2.5.1 Repeatability Analysis

In contrast to our hypothesis, our results suggest that FMD is repeatable in the brachial artery, while L-FMC is not repeatable and TVR is only moderately repeatable. Our finding that brachial artery FMD is substantially repeatable is consistent with some, but not all, previous literature. Malik *et al.* assessed the between-day repeatability of brachial artery FMD within a ten day period in a cohort of twenty healthy men and found FMD had poor repeatability (ICC=0.10) (31). In contrast, Onkelinx *et al.* found brachial artery FMD had excellent between-day repeatability in a cohort of 18 patients with CAD (ICC=0.99) (36). Liang *et al.* assessed the repeatability of FMD in 30 adults across an average of 2.5 weeks and found a CV of 10.8% (30). In a recent systematic review, Greyling *et al.* found that greater adherence to current FMD guidelines was associated with less variation in FMD (20). As our lab follows a standard operating procedure for all FMD studies that was developed to follow the current guidelines, this may explain why we found FMD had substantial repeatability in our cohort. However, the data in our repeatability cohort came from multiple studies and was collected and analyzed by different individuals, despite a majority of repeat tests being analyzed by the same individuals within a participant. Additionally, there were some methodological differences between studies, such as different ultrasound equipment and pre-testing instructions. This between-study variation could result in greater variation in FMD and may explain why our level of repeatability was not as high as other studies.

Our study is the largest study to date to assess the repeatability of L-FMC in the brachial artery. Consistent with previous work, we found brachial artery L-FMC is highly variable both within, and between, individuals (2, 21, 23, 27). We also found that L-FMC was not repeatable between days in the brachial artery, however the repeatability of the occlusion diameter was almost perfect. Similar to our findings, Kranen *et al.* found that in a cohort of 27 adolescents L-FMC had poor repeatability (ICC= 0.17 , $\kappa = 0.04$) however the occlusion diameter had almost perfect repeatability (ICC = 0.94) (27). Additionally, Harbin and colleagues found that brachial artery L-FMC was not repeatable within, or between, days (21). In contrast, Sprio *et al.* found that L-FMC in a cohort of 10 healthy adults was repeatable within a day (42). Similarly, Bell and colleagues found brachial artery L-FMC had almost perfect between-day repeatability in a cohort of 5 healthy young men $(ICC=0.87)$ (3). There are a variety of potential reasons why these contradictory findings exist. First, both the studies by Bell *et al.* and Sprio *et al.* used relatively small sample sizes $(n=5 \text{ and } n=10 \text{ respectively})$ when compared to our study as well as those by Kranen *et al.* and Harbin *et al.* (3, 21, 27, 42). Using a sample size calculation we determined a much larger sample than $n=5$ or $n=10$ would be required to detect the presence of poor L-FMC repeatability. Additionally, both our study and the study by Kranen *et al.* utilized retrospective data. For our study this retrospective data included studies in which the data was collected and analyzed by different individuals,

which could have increased the variability in our sample. It is also important to note that in all of the previous studies as well as our study, both the absolute and relative diameter change during low flow reported is quite small (3, 21, 27, 42). Therefore, it is possible that our equipment is not sensitive enough to accurately detect these small changes in diameter, or the error in our measurements is greater than the actual change in diameter. Either of these problems could be responsible for the variability observed in L-FMC present in the brachial artery in the current study, as well as the contradictory findings present in the literature. While guidelines exist for the assessment of FMD, no such guidelines have been developed for L-FMC. Differences in the timing of the low flow measurement and the definition of dilation/constriction exist in the literature, which could also be responsible for the observed differences seen between studies.

Our results indicate that TVR in the brachial artery is moderately repeatable (ICC $= 0.50$). There have been limited previous investigations into TVR, with only two groups previously assessing the repeatability of TVR in the brachial artery. Inaba *et al.* assessed TVR (calculated as the absolute value of FMD+L-FMC) in 25 healthy men and found the measure had almost perfect repeatability (ICC = 0.93) (26). In contrast, Kranen *et al.* assessed TVR (as the difference between peak and occlusion diameter relative to baseline diameter) in 27 adolescents and found brachial artery TVR had moderate repeatability $(ICC = 0.52)$ (27). We calculated TVR as the difference between peak and occlusion diameter relative to occlusion diameter and found similar results to Kranen *et al.* In a follow up analysis, we also calculated TVR as the absolute value of $FMD + L-FMC$. another commonly used equation in the literature. The repeatability of this measure (ICC=0.52) was similar to that observed for our previously calculated TVR measure. Regardless of the equation used, TVR is a composite score of FMD and L-FMC and as such, is influenced by variability present in both of these measures. As we reported poor L-FMC repeatability, the high level of variability in L-FMC likely influenced the repeatability of TVR. Importantly, we found that there were no between day differences in any of the nitroglycerin challenge test variables. These results indicate that smooth muscle function did not differ between the two visits, which is in accordance with previous work that found NTG was relatively repeatable between days (15).

2.5.2 Observational Analysis

Our study is the first to directly investigate the relationship between age and L-FMC and TVR. In agreement with our hypothesis, we found that both FMD and TVR were negatively associated with age, and in contrast we found that L-FMC was not significantly associated with age. It is thought that the age related decline in FMD is related to a decreases in NO bioavailability and increases in oxidative stress and inflammation (38). Our results are inline with previous studies that have reported a decline in FMD as age increases (5, 34). Additionally, we expected that TVR would show a similar decline with age to FMD, as TVR is a composite score of FMD and L-FMC. We postulated that L-FMC would be attenuated with age, as Gori *et al.* found that being over 65 years old was associated with lower radial artery L-FMC (19). However, our results suggest that there is no relationship between L-FMC and age. It is possible the contrasts in the results of different studies may be due to conflicting alterations in ET-1 and vascular structure that occur with aging. ET-1 has been shown to increase with age, therefore increases in ET-1 could potentially lead to an increase, rather than a decrease in L-FMC (13, 38). However, Harrison *et al*. found that L-FMC was positively correlated with brachial artery pulse wave velocity, suggesting that increases in stiffness are related to an attenuation of L-FMC (23). Therefore, it is possible that the contradictory actions of increased ET-1 and arterial stiffening might counterbalance each other, leading to no change in L-FMC with aging. We expected that CVD and elevated CVD risk would lead to a reduction in FMD, L-FMC and TVR and thus, the relationship between age and our vascular measures would be altered. However, we found that the relationship between age and our vascular measures was maintained in our cohort of individuals with CVD and elevated CVD risk.

Surprisingly, we found that sex did not moderate the relationship between age and any of our vascular measures. Earlier work has found sex differences in FMD in both younger and older adults (5, 14, 24). It is possible that the different patient populations in our sample could have influenced our ability to detect an effect of sex. While we attempted to increase the number of middle aged and older adults through our prospective cohort, a larger portion of our sample included children and younger adults. As there are conflicting findings of sex differences in younger adults, it is possible that the greater number of these individuals in our observational cohort influenced the sex specific moderator analysis of our data. As we saw L-FMC was highly variable in our repeatability analysis, it is possible that any influence of sex on the relationship between age and L-FMC is imperceptible. As both the relationship between age and FMD and L-FMC was not moderated by sex, it was unsurprising that the relationship between TVR and age was also not moderated by sex.

Our results indicate there is a positive relationship between FMD and L-FMC. This suggests that reactivity to low flow influences the subsequent reactive hyperemia response and highlights the importance of assessing L-FMC alongside FMD. These findings are consistent with some $(2, 18, 21, 23)$ but not all $(16, 19, 27)$ studies that have previously assessed FMD and L-FMC. Importantly, it appears there are differences between the brachial artery and radial artery, as a majority of studies performed in the brachial artery have found a relationship between FMD and L-FMC (2, 21, 23), whereas those performed in the radial artery have not (16, 19). These findings highlight the potential for physiological differences between the two arterial beds.

2.5.3 Limitations and Future Directions

One major limitation of the present investigation is that our retrospective data included data from multiple studies that were collected and analyzed by different individuals. It is possible that having multiple sonographers and different individuals analyzing the ultrasound images could have increased the variation seen in our measurements. Additionally, there were slight differences in certain aspects of testing between the studies, such as the ultrasound equipment used and pretesting instructions, which could have influenced our results. While we found similar results to other studies that utilized healthy individuals, the inclusion of individuals with cardiovascular disease and elevated cardiovascular disease risk could have also increased the variability seen in our sample.

Future studies should continue to assess the repeatability of L-FMC and TVR and

guidelines for both of these measures should be developed if they are to be used as supplementary measurements to FMD. More work should be done to understand the mechanisms that are responsible for the low flow response and in particular address the dichotomy of dilatory and constrictor responses both within and between individuals. Additionally, more mechanistic studies should be performed in the brachial artery, as there has been relatively little research in this area and mechanistic studies may provide insight into why large variability exists between and within individuals. Finally, studies should focus on understanding other potential physiological factors that may influence L-FMC and TVR.

2.6 CONCLUSION

Our results indicate that FMD has substantial between day repeatability, while TVR is only moderately repeatable between days and L-FMC is not repeatable between days. Additionally we found that FMD and TVR were negatively associated with age, however L-FMC showed no relationship with age. Sex did not appear to moderate the relationship between age and any of our vascular measures and relationships between age and FMD and TVR persisted in our cohort of individuals with CVD and elevated CVD risk.

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APPENDICES

APPENDIX 1: RAW DATA

Shaded areas indicate missing data.

Repeatability Cohort

Participant Characteristics

Hemodynamics

Blood Analyses

Normative Values Postmenopausal Women: estradiol (<103 pmol/L), progesterone (<0.7 nmol/L), testosterone $(\leq 1.5 \text{ nmol/L})$

Normative Values Men: estradiol (<162 pmol/L), progesterone (<0.7 nmol/L), testosterone (4.5-26.6 nmol/L)

Vascular Variables

Nitroglycerin Challenge Test (NTG) Data

Observational Cohort

Participant Characteristics

Hemodynamics

Vascular Variables

Nitroglycerin Challenge Test Data

Blood flow and Shear Rate

APPENDIX 2: STATISTICS

Hemodynamics - Repeatability **Heart Rate (HR)**

Hypothesis Test Summary

Asymptotic significances are displayed. The significance level is .05.

Median

Systolic Blood Pressure (SBP)

Hypothesis Test Summary

Asymptotic significances are displayed. The significance level is .05.

Median

Diastolic Blood Pressure (DBP)

Asymptotic significances are displayed. The significance level is .05.

Median

Mean Arterial Pressure (MAP)

Hypothesis Test Summary

Asymptotic significances are displayed. The significance level is .05.

Median

FMD Repeatability

Two-way mixed effects model where people effects are random and measures effects are fixed.

a. The estimator is the same, whether the interaction effect is present or not.

b. Type A intraclass correlation coefficients using an absolute agreement definition.

c. This estimate is computed assuming the interaction effect is absent, because it is not estimable otherwise.

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L-FMC Repeatability

TVR Repeatability

Baseline Diameter Repeatability

 $\begin{array}{c} \hline \end{array}$

Peak diameter Repeatability

Four-minute Diameter Repeatability

Absolute FMD Repeatability

Absolute L-FMC Repeatability

Intraclass 95% Confidence Interval F Test with True Value 0

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TVR (absolute value of FMD+L-FMC) Repeatability

 $\begin{array}{c} \hline \end{array}$

Cohen's Kappa for L-FMC

 $\begin{array}{c} \hline \end{array}$

Symmetric Measures

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a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Frequency of Low Flow Response

V1_LOWFLOW_RESPONSE

V2_LOWFLOW_RESPONSE

Nitroglycerin Challenge Test (NTG)

Relative NTG

Paired Samples Test

Absolute NTG

Paired Samples Correlations

Paired Samples Test

Paired Samples Test

Baseline NTG Diameter

Paired Samples Correlations

Paired Samples Test

Paired Samples Test

Time to peak (TTP)

V2PEAK_NTG

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Paired Samples Correlations

Paired Samples Test Paired Differences Mean Deviation Mean Lower Upper t df Std. Std. Error Mean 95% Confidence Interval of the Difference Lower Upper Pair 1 V1TTP - V2TTP -15789 1.91174 $.21929$ -59475 $.27896$ -720 75

Paired Samples Test

OBSERVATIONAL ANALYSIS

Frequency of Low Flow Response

LOWFLOWRESPONSE

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Correlations Age x FMD

**. Correlation is significant at the 0.01 level (2-tailed).

Age x L-FMC

Correlations

Age x TVR

Correlations

. Correlation is significant at the 0.01 level (2-tailed). **Moderator Analysis

Age x FMD, Sex as a moderator variable

Variables Entered/Removed^a

a. Dependent Variable: RelFMD

b. All requested variables entered.

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Model Summary^c

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Model Summary^c

a. Predictors: (Constant), Males, Age

b. Predictors: (Constant), Males, Age, agexmale

c. Dependent Variable: RelFMD

- a. Dependent Variable: RelFMD
- b. Predictors: (Constant), Males, Age
- c. Predictors: (Constant), Males, Age, agexmale

Coefficients^a

a. Dependent Variable: RelFMD

- a. Dependent Variable: RelFMD
- b. Predictors in the Model: (Constant), Males, Age

Age x L-FMC, Sex as a moderator variable

Variables Entered/Removed^a ÷.

- a. Dependent Variable: RelLFMC
- b. All requested variables entered.

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Model Summary^c

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Model Summary^c

a. Predictors: (Constant), Male, Age

b. Predictors: (Constant), Male, Age, agexmale

c. Dependent Variable: RelLFMC

a. Dependent Variable: RelLFMC

b. Predictors: (Constant), Male, Age

c. Predictors: (Constant), Male, Age, agexmale

Coefficients^a

a. Dependent Variable: RelLFMC

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- a. Dependent Variable: RelLFMC
- b. Predictors in the Model: (Constant), Male, Age

Age x TVR with Sex as a moderator variable

Variables Entered/Removed^a

a. Dependent Variable: TVR

b. All requested variables entered.

Model Summary^c

Model Summary^c

Change Statistics

a. Predictors: (Constant), Male, Age

b. Predictors: (Constant), Male, Age, agexmale

c. Dependent Variable: TVR

ANOVA^a

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a. Dependent Variable: TVR

b. Predictors: (Constant), Male, Age

c. Predictors: (Constant), Male, Age, agexmale

Coefficients^a

a. Dependent Variable: TVR

Excluded Variables^a

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- a. Dependent Variable: TVR
- b. Predictors in the Model: (Constant), Male, Age

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Correlation FMD and L-FMC

**. Correlation is significant at the 0.01 level (2-tailed).

Correlation between age and vascular measures – CVD and CVD Cohort only Correlations

Correlations

Correlations

