Single-beat estimation of end-diastolic pressure-volume relationship: a novel method with potential for noninvasive application

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Klotz, Stefan, Ilan Hay, Marc L. Dickstein, Geng-Hua Yi, Jie Wang, Mathew S. Maurer, David A. Kass, and Daniel Burkhoff. Single-beat estimation of end-diastolic pressure-volume relationship: a novel method with potential for noninvasive application. Am J Physiol Heart Circ Physiol 291: H403–H412, 2006. First published January 20, 2006; doi:10.1152/ajpheart.01240.2005.—Whereas end-systolic and end-diastolic pressure-volume relations (ESPV, ED-PVR) characterize left ventricular (LV) pump properties, clinical utility of these relations has been hampered by the need for invasive measurements over a range of pressure and volumes. We propose a single-beat approach to estimate the whole ED-PVR from one measured volume-pressure (Vm and Pm) point. Ex vivo ED-PVRs were measured from 80 human hearts of different etiologies (normal, congestive heart failure, left ventricular assist device support). Indepen-dent of etiology, when ED-PVRs were normalized (EDPVRn) by appropriate scaling of LV volumes, EDPVRns were nearly identical and were optimally described by the relation EDP = A0n·EDV85n/85 with A0n = 28.2 mmHg and B85n = 2.79. V0 (the volume at the pressure of ~0 mmHg) was predicted by using the relation V0 = Vm,n·(0.6 – 0.006·Pm,n) and V30 by V30 = V0 + (Vm,n – V0)/(Pm,n/A0n)1/85n. The entire ED-PVR of an individual heart was then predicted by forcing the curve through Vm, Pm, and the predicted V0 and V30. This technique was applied prospectively to the ex vivo human ED-PVRs not used in determining optimal Am,n and B85n values and to 36 in vivo human, 12 acute and 14 chronic canine, and 80 in vivo and ex vivo rat studies. The root-mean-square error (RMSE) in pressure between measured and predicted ED-PVRs over the range of 0–40 mmHg was <3 mmHg of measured ED-PVR in all settings, indicating a good predictive value of this approach. Volume-normalized ED-PVRs have a common shape, despite different etiology and species. This allows the entire curve to be predicted by a new method with a potential for noninvasive application. The results are most accurate when applied to groups of hearts rather than to individual hearts.

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METHODS

Human Heart Harvest and Ex Vivo Pressure-Volume Relationships

Eighty freshly harvested human hearts were obtained for the study. Hearts were from five normal subjects not suitable for transplantation, 23 transplant patients with ischemic cardiomyopathy, 30 transplant patients with idiopathic cardiomyopathy, and 22 patients with end-stage cardiomyopathy supported with an LV assist device (LVAD, TCI HeartMate, Thoratec, Pleasanton, CA, average length of support, 114 ± 86 days). All hearts were perfused with cold hypocalcemic, hyperkalemic cardioplegic solution at the explant. The passive LV pressure-volume relationship of each arrested heart was measured as described previously with an intraventricular balloon (4).

In Vivo Human Experiments

Single-beat estimation of EDPVR was tested by using in vivo human data from 10 healthy old and 13 healthy young controls and from 13 patients with heart failure and a normal ejection fraction (HFNEF). The in vivo EDPVRs were constructed by conductance catheter technique using transient inferior vena caval occlusion as described in detail previously (7, 20, 24).

In Vivo Canine Experiments

Data were also obtained from 12 open chest dogs and from 14 chronically instrumented awake dogs. In the chronically instrumented dogs, data were available from each dog under normal conditions and following induction of heart failure by repeated coronary embolization (23).

For acute experiments, LV pressure (LVP) was measured by a catheter tip micromanometer (Millar, Houston, TX) placed inside the LV from the right or left carotid artery. A plastic balloon occluder was placed around the inferior vena cava for temporary occlusion (IVCO). LV from the right or left carotid artery. A plastic balloon occluder was placed around the inferior vena cava for temporary occlusion (IVCO).

For chronic experiments, animals were instrumented with an indwelling pressure gauge (Konigsberg), sonomicrometer crystals, and an balloon occluder around the inferior vena cava as described previously (28). LVP was obtained the same way as in acute experiments. Measurements of EDPVRs were obtained in a conscious state of the animal by transient IVCO at baseline and 4 wk after induction of heart failure by repeated, daily intracoronary microsphere embolization.

Ex Vivo and In Vivo Rat Experiments

Data were also obtained from Sprague-Dawley rats in heart failure 6 and 12 wk after coronary artery ligation (n = 58) and in 22 normal control rats. For in vivo assessment of the LV passive pressure-volume characteristics, the rats were intubated after induction of anesthesia with isoflurane, and the right carotid artery was cannulated with a Millar conductance catheter (Millar Instruments, Houston, TX). LV EDPVRs were performed by temporary IVCO. For ex vivo assessment of the LV passive pressure-volume characteristics, the heart was arrested in diastole and excised quickly. The left atrium was opened, and a thin latex balloon was attached to the end of a 10-cm length of stiff polyethylene tubing with fenestrations at the distal 3 mm of its tip. LVP was measured using a 5-Fr Millar micromanometer as volume was infused into the balloon at 0.025-ml increments.

All procedures involving human hearts were approved by the Institutional Review Board of Columbia University and the John Hopkins Medical Institutions. All animals involved in these studies received humane care in compliance with the Guide for the Care and Use of Laboratory Animals published by the National Institutes of Health (NIH Publication No. 85-23, Revised 1996). These studies were approved by the Institutional Animal Care and Use Committee of Columbia University.

Theoretical Considerations

EDPVR analysis. Although human, canine, and rat hearts in different states (normal, failing, and post-LVAD) have very different sizes, earlier studies have shown that EDPVRs from such hearts can all generally be described by one of several nonlinear analytical expressions (e.g., EDP = α × EDV^β or EDP = α × e^(β×EDV)) with different coefficient values (17). This suggests that EDPVRs share a common underlying shape and that, if appropriately scaled using a single descriptive equation, the curves may converge. To test this hypothesis, ex vivo EDPVRs from humans were normalized (EDPVRn) in the volume dimension to account for the unstressed volume (V0, volume at which EDP is ~0 mmHg) and V30, the volume at which EDP equals 30 mmHg, according to the following equation:

\[ EDP_n = (EDV - V_0)/(V_30 - V_0) \]

The resulting EDPVRn obtained from the experiments outlined above were superimposed to visually determine their degree of similarity. After having established qualitatively that indeed a relatively high degree of similarity exists among these normalized curves, we proposed that the ex vivo EDPVRn from different groups (human, canine, and rat hearts) could be described by a function with a single universal set of parameter values (A_n, B_n) for the function:

\[ EDP = A_n \times EDV_n \]

which optimally describe the data (least-square method using commercially available software; IgorPro 4.1, WaveMatrics, Lake Oswego, OR).

Single-beat approach to predicting EDPVR. As will be shown, data indicate that EDPVRn are similar from ex vivo human, dog, and rat hearts, and curve fitting yielded essentially the same values for A_n and B_n in the different species, indicating a common underlying shape of the EDPVR. From this observation, it is possible to predict the entire EDPVR from a single point on the curve as detailed forthwith.

The procedure starts with measurement of EDP and EDV on a single beat (P_m, V_m, respectively). Based on Eq. 1, normalized measured volume (V_m,n) is defined as follows:

\[ V_{m,n} = (V_m - V_0)/(V_{30} - V_0) \]

The resulting V_m,n-P_m point would fall on the curve:

\[ P_m = A_n \times V_{m,n} \]

Solving Eq. 4 for V_m,n, substituting the result into Eq. 3, and solving for V_{30} yields:

\[ V_{30} = V_0 + (V_{m,n} - V_0)(P_{m,A_n})^{1/B_n} \]

To predict the EDPVR, a reasonable estimate of V_0 is required. The relative constancy of the shape of the normalized EDPVR further suggested a relatively consistent relationship between the volume at a certain pressure and V_0. To test this, we determined the volumes from each human ex vivo heart that provided pressures of 10, 15, 20, and 25 mmHg. These volumes designated V_{10}, V_{15}, V_{20}, and V_{25}, respectively, were each separately plotted versus the V_0 determined from each measured EDPVR (Fig. 1). For each plot, we determined the linear regression equation forced through the origin:

\[ V_0 = k \times V_m \]
EDPVR PREDICTION FROM SINGLE BEAT

**Statistical Methods**

Results are expressed as means ± SD. Root-mean-square error (RMSE) between measured and predicted pressures over the entire EDPVR was calculated for each heart as \( \left[ \sum (P_m - P_p)^2 \right]^{1/2} \) with the summation performed over each measured pressure-volume point. One-way ANOVA was used to detect significant differences in RMSE values among the different groups of hearts (ex vivo and in vivo human hearts, acute dog experiments, chronic dog experiments, and ex vivo and in vivo rat hearts). Dunn’s test was used for post hoc multiple comparison. Analyses were performed using commercially available software (SPSS 11.5, Chicago, IL).

**RESULTS**

**Ex Vivo Human Heart Results**

Representative examples of EDPVRs measured from ex vivo human hearts are shown in Fig. 2A. As shown in these examples, EDPVRs from different types of hearts (normal, idiopathic dilated cardiomyopathy, ischemic cardiomyopathy, post-LVAD) spanned very wide ranges of volumes. Some hearts reached filling pressures of 30 mmHg at as little as ~80 ml, and others reached this same pressure at more than 300 ml. These same EDPVRs are shown in Fig. 2B after volume was normalized according to Eq. 3. These curves reveal a high degree of concordance between hearts in these different states.

Figure 3 shows data from all 80 human EDPVRs superimposed on each other. As shown, there is relatively little deviation of these normalized data around a common curve. Optimal \( A_n \) and \( B_n \) values (±SD) obtained from the group as a whole were 27.8 ± 0.3 and 2.76 ± 0.05, respectively. Furthermore, although the amount of data available from normal hearts is fairly limited, \( A_n \) and \( B_n \) were similar between normal and cardiomyopathic hearts (\( P > 0.7 \)).

Optimal \( A_n \) and \( B_n \) from a randomly selected subset of 40 of the ex vivo human hearts (designated as group 1) were 28.2 and 2.79 mmHg, respectively, which were very similar to those obtained from the group as a whole. These parameter values were used prospectively to predict the EDPVRs in the remaining ex vivo human data (designated as group 2). Representative examples of EDPVR prediction from single beat.
EDPVR prediction from single beat

The raw data using a nonlinear analytic expression (EDPVR predictive capability of the approach. Note in these two examples of end-diastolic pressure-volume relations (EDPVRs) measured from ex vivo human hearts. These EDPVRs spanned very wide ranges of volumes from as little as ~80 ml to >300 ml at filling pressures of 30 mmHg. B: EDPVRs from A normalized to volume and superimposed on each other. Despite different diseases, the volume-normalized shape of the curves is the same. ICM, ischemic cardiomyopathy; DCM, idiopathic dilated cardiomyopathy; LVAD, hearts supported with a left ventricular assist device.

Fig. 2. A: examples of end-diastolic pressure-volume relations (EDPVRs) measured from ex vivo human hearts. These EDPVRs spanned very wide ranges of volumes from as little as ~80 ml to >300 ml at filling pressures of 30 mmHg. B: EDPVRs from A normalized to volume and superimposed on each other. Despite different diseases, the volume-normalized shape of the curves is the same. ICM, ischemic cardiomyopathy; DCM, idiopathic dilated cardiomyopathy; LVAD, hearts supported with a left ventricular assist device.

square shows an end-diastolic pressure-volume point at an EDP of ~15 mmHg selected for the test (i.e., these are P_m and V_m for Eqs. 9 and 10). The dotted line shows the curve fit from the raw data using a nonlinear analytic expression (EDP = P_0 + \alpha \cdot \text{EDV}^\beta). The solid line shows the EDPVR predicted from Eqs. 9, 10, and 11. The average RMSE between measured and predicted EDPVRs from the 40 hearts used for the test was 1.74 ± 1.2 mmHg. Figure 4, A and B, shows examples for which the RMSE between measured and predicted EDPVRs was close to the average for the overall group; these results, which are indicative of the average results, reveal a good predictive capability of the approach. Note in these two examples that the predicted V_{30} point is very close to the measured value. Figure 4C shows an example with a very low RMSE value (0.51 mmHg, among the best predictions), whereas Fig. 4D shows an example with one of the highest RMSE values (5.70 mmHg, among the worst predictions). Interestingly, we did not find any differences in the predictive capability of this approach among the different types of hearts studied (i.e., chronic heart failure, post-LVAD, or normal control hearts).

The overall accuracy of this approach to predict V_0 (Eq. 8) and V_{30} (Eq. 5) is summarized in Fig. 5 and Table 1 for group 2 ex vivo human hearts (Fig. 5A) and for hearts of other settings (Fig. 5B). As shown, the measured versus predicted V_0 and V_{30} points fall nearly on the line of identity over the large range of volumes tested (V_0, R^2 = 0.84; P < 0.001; V_{30}, R^2 = 0.99; P < 0.001). Overall, predicted V_0 average 5.7 ± 13.7 ml (2.7 ± 20.6%) smaller than measured V_0. Overall, predicted V_{30} averaged 5.6 ± 12.7 ml smaller than measured V_{30}.

Examination of this difference in the four groups of Fig. 5B (and expressing the difference as a percent to account for the different value ranges) revealed measured V_{30} exceeded predicted V_{30} by 13.5 ± 11.2% in in vivo human hearts, 7.6 ± 6.2% in in vivo chronic dog hearts, and 0.7 ± 3.6% in ex vivo human hearts, whereas for in vivo acute dog hearts average predicted V_{30} was greater the measured V_{30} by 10.4 ± 12.7%. However, multiple linear regression (with group coded as a dummy variable) analysis indicated that the relationship between measured and predicted V_{30} values did not differ significantly between these groups.

We next explored whether the accuracy of the EDPVR prediction depended on the range within which the measured end-diastolic pressure point falls. RMSE between measured and predicted EDPVRs were obtained from all ex vivo EDPVRs at different pressure points (~10, ~15, and ~20 mmHg). Figure 6 shows that when a measured pressure-volume point having an EDP above 15 mmHg is used to predict the EDPVR, the prediction is better than when it is predicted by a point having an EDP of 10 mmHg or less (P < 0.05 10 mmHg vs. 15 and 20 mmHg).

In Vivo Human Hearts

EDPVRs were measured from 36 human hearts in vivo by using the conductance catheter technique of volume measurement and transient IVCO to reduce preload. The EDP-EDV from the starting loop (i.e., before IVCO) were the designated P_m and V_m values for EDPVR prediction. Overall, the average RMSE obtained from the 36 EDPVRs was 2.99 ± 1.72 mmHg. Four examples (two average, one above average, and one of the worst examples) are shown in Fig. 7, A–D, respectively. The example showing the worst predictive value (Fig. 7D) was from a patient with heart failure with normal ejection fraction (HFNEF) in which the EDPVR did not have an asymptote with the x-axis, which was considered to be because of high right-sided filling pressures and pericardial mediate interventricular interactions. Another means of assessing the accuracy of the prediction was to compare measured and predicted pressures at an intermediate volume, e.g., at a volume yielding 15 or 20 mmHg, V_{15} and V_{20}, respectively. For these in vivo human hearts, measured versus predicted V_{15} was 113 ± 27 vs. 110 ±
27 ml, and for $V_{20}$ these numbers were $120 \pm 28$ vs. $115 \pm 29$, differences of only 3–5 ml or less than a 5% error.

Other Species

To explore the overall general applicability of this approach, data from acute and chronic in vivo dog hearts and in vivo and ex vivo rat hearts were also explored. Plots comparable to those of Fig. 3 revealed similar behavior in each of these settings and, remarkably, the parameter values for $A_n$ and $B_n$ were nearly identical to those identified in the ex vivo human hearts (Table 1). Also shown in Table 1, the means ± SD RMSE values between measured and predicted EDPVRs and the regression coefficients for the relationship between measured and predicted $V_{30}$ values for all groups were also, in general, comparable among these different settings so that prospective EDPVR predictions (Fig. 8) were generally excellent. The RMSE values for in vivo human and chronic dog hearts were slightly higher than those attained in the other settings, but the values were still relatively small, indicating good prospective predictive capability of this approach.

Sensitivity Analysis

It is pertinent to ask about the sensitivity of the predicted curves to potential inaccuracies in measurement of pressures and volumes, particularly for the clinical scenario when both parameters may be measured noninvasively. Of course, any technique for measuring the EDPVR is equally sensitive to the methods used to measure both pressure and volume. Such an analysis is relatively straightforward because of the simple analytical nature of the prediction algorithm, therefore, for the sake of brevity, only two important examples involving errors in $P_m$ variation are considered in this section; a similar analysis of error in $V_m$ yields similar findings. Figure 9 shows EDPVRs predicted from a common $V_m$ of 100 ml and $P_m$ values of 16 mmHg along with $P_m$ values of 14 and 18 mmHg and 13 and 19 mmHg (i.e., $16 \pm 2$ and $16 \pm 3$ mmHg). As seen, the impact is relatively minor if one were interested in determining...
ventricular capacitance. For example, consider an arbitrary clinical application in which one desired to define capacitance as the volume at a pressure of either 10, 15, or 20 mmHg ($V_{10}$, $V_{15}$, $V_{20}$, respectively). In this example, the 6-mmHg range of possible errors of specifying $P_m$ would result in only an ~6 ml range of predicted $V_{10}$, $V_{15}$, or $V_{20}$, which amounts to a range of approximately ±3%.

Next consider the potentially more difficult example in which data from groups of normal and heart failure patients may be compared. In such a case, $P_m$ may be in the range of 12 mmHg and $V_m$ in the range of 100 ml in the normal group and 24 mmHg and 225 ml, respectively, in a group of patients with heart failure due to systolic dysfunction. Figure 9B shows predicted EDPVRs at these values of $V_m$ and $P_m$ along with those obtained with $P_m$ values ±3 mmHg. The graphs show that even with errors of this magnitude and despite performing estimates from different pressure ranges, information regarding the EDPVR is relatively consistent. More specifically, in the heart failure state, the value of capacitance (volume at a given pressure) is influenced similarly in the simulated failing and normal states (except in the low pressure range). However, the shape of the EDPVR (which would relate more directly to an estimate of chamber compliance and stiffness) is more significantly influenced in the heart failure state, especially in the low pressure range.

Another important aspect of the prediction algorithm is the estimation of $V_0$ using Eq. 8, which can be associated with significant uncertainty and inaccuracy especially as the volume of the heart increase as in systolic heart failure. Figure 9C shows a hypothetical example with an assumed $V_m$ of 200 ml at a $P_m$ of 10 mmHg. Equation 9 predicts a $V_0$ of 108, but based on Fig. 1, $V_0$ could exhibit considerable variability. The three graphs of Fig. 9C show EDPVR predictions with $V_0$ values of 75, 100, and 125 ml. Despite this rather large variation in the assumed $V_0$ value, the impact on predicted EDPVR is relatively mild.

**DISCUSSION**

We developed and tested a novel method for estimating the EDPVR from a single end-diastolic pressure-volume point. From the availability of Doppler-echocardiography (6, 18), radionuclide ventriculography (3, 27), and magnetic resonance (9) imaging methods to estimate ventricular pressures and volumes, this approach to EDPVR estimation has the possibility of being utilized noninvasively. Interestingly, though developed primarily based on data from human hearts, the approach appears to be generally applicable to normal and diseased hearts of different species. Values of RMSE ranging between 0.5 and 6 mmHg among all these hearts (Table 1) indicate that, on average, the predicted EDPVR falls within 1.8 mmHg of the actual EDPVR over a range of conditions.

The proposed single-beat EDPVR estimation method is based on the premise that the end-diastolic pressure-volume relation can generally be described by common nonlinear analytical expressions with coefficient values that are reasonably well linked with the size of the heart (17). This suggests that overall these EDPVRs share a common underlying shape.

The present results are intended to facilitate the use of the EDPVR in clinical and research settings where assessment of changes in passive ventricular properties are important, such as in certain disease states and following therapeutic interventions. The prospective prediction of EDPVRs measured in vivo using the conductance catheter technique combined with transient inferior vena caval occlusion serve as important validation of the approach.

The low RMSE values between measured and predicted EDPVRs indicate good predictive accuracy of the approach. The accuracy was greatest when the pressure of the single measured end-diastolic pressure-volume point existed within a pressure range over 15 mmHg. Specifically with regard to the clinical situation, this single-beat approach provided a predicted EDPVR that was on average within ~3 mmHg of that measured in humans using the conductance technique.

Taken to the extreme, the underlying assumption that the EDPVR of all hearts share a common underlying shape regardless of species or disease state would lead to the conclusions that passive myocardial properties and chamber geometry change in only one way and that any two hearts that have a single common end-diastolic pressure-volume point would have identical EDPVRs. However, consider even the extreme case shown in Fig. 4D. In this example, measured and predicted values of $\alpha$ and $\beta$ are considerably different. Despite such deviations, which reflect expected variations in material properties and geometry, the differences between the actual

**Table 1. $A_n$ and $B_n$ values derived from each experimental setting along with RMSE values and correlation coefficient between measured and predicted $V_{00}$**

<table>
<thead>
<tr>
<th></th>
<th>$A_n$</th>
<th>$B_n$</th>
<th>RMSE</th>
<th>$R^2$</th>
<th>$V_{00}$</th>
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</thead>
<tbody>
<tr>
<td>Ex vivo</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human</td>
<td>27.8</td>
<td>2.76</td>
<td>1.74±1.19*</td>
<td>0.99546</td>
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</tr>
<tr>
<td>Rat</td>
<td>28.3</td>
<td>2.67</td>
<td>1.76±0.79*</td>
<td>0.99786</td>
<td></td>
</tr>
<tr>
<td>In vivo</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human</td>
<td>2.99±1.72</td>
<td>0.89058</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic dog</td>
<td>3.02±1.44</td>
<td>0.97833</td>
<td></td>
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</tr>
<tr>
<td>Acute dog</td>
<td>1.07±0.65*</td>
<td>0.88961</td>
<td></td>
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</tr>
<tr>
<td>Rat</td>
<td>1.02±0.66*</td>
<td>0.96741</td>
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</tbody>
</table>

All values are means ± SD. RMSE, root-mean-square error in estimate of pressures. $R^2$, correlation coefficient; $A_n$ and $B_n$, parameter values. *P < 0.05 vs. in vivo human and chronic dog.
and predicted EDPVRs are relatively small. The average results indicate that the expected deviation between predicted and measured EDPVR curves is typically <3 mmHg. Nevertheless, this means that results obtained using the proposed approach would be most accurate when applied to groups of hearts (where such deviations would average out), rather than to individual hearts.

To illustrate this point, consider the example shown in Fig. 10. Little et al. (16) provided group-average end-diastolic pressure-volume data in Table 1 of their publication. These data were obtained in an experimental canine preparation in which volumes were measured by sonomicrometry and pressure measured by a solid-state transducer over a range of conditions achieved by phenylephrine administration. These data, which are rarely provided in published papers, were plotted and the EDPVR predicted using the proposed approach. This completely independent data suggest that the proposed approach is reasonable. We propose that one potentially important use of this approach is in a research setting in which group-averaged EDPVRs from different groups are to be estimated and compared.

Several prior studies have reported methods for single-beat estimation of the end-systolic pressure-volume relationship (ESPVR) with good predictions of end-systolic elastance (7, 24, 26). The linearity of the ESPVR simplifies in some ways its prediction. The inherent nonlinearity of the EDPVR makes its prediction with a single beat approach more difficult. However, the common shape of this curve and uniformity following...
The correlation between predicted and measured points was excellent in all ex vivo setups and in vivo acute dogs and rats, measured with sonomicrometry and conductance techniques, respectively. These experimental settings offer ideal conditions in which confounding factors (e.g., controlling respiration) are minimized, and the ability to vary volumes and pressures over a broad range is possible. The good, but slightly lower, correlation obtained from in vivo chronic conscious dog and human data may reflect the effects of respiration and possibly effects of interventricular interactions and pericardial constraints, which may result in an EDPVR that does not have an asymptote with the volume axis (as in Fig. 7D). However, these factors did not impair the ability of the overall approach to provide good predictions in a majority of cases. Such factors could become more important in disease states where right ventricular overload is more prominent and thus limit the utility of the present approach.

The values of $A_n$ and $B_n$ were obtained from normal and dilated cardiomyopathic hearts, which may limit the applicability of the approach to other disease states. Nevertheless, the approach appeared to apply well in vivo to patients even with heart failure and normal ejection fraction due to hypertensive and/or idiopathic hypertrophic cardiomyopathies. This again speaks to the general applicability of the underlying observation that the EDPVR generally has a common shape.

The mathematical form of the equation used to describe the EDPVR ($P = \alpha V^3$) was chosen because it was the only one of the commonly used equations that lends itself to the analytical solution permitting the current prediction. However, it is cur-

![Fig. 9. Examples of sensitivity to of EDPVR predictions to errors in measurement of end-diastolic pressure. A: EDPVRs predicted at $V_m$ of 100 ml and $P_m$ of 16 mmHg showing impact of $\pm 2$ and $\pm 3$ mmHg errors. Dashed lines, pressure levels at which volumes at pressures of 10, 15, and 20 mmHg would be identified. B: hypothetical EDPVRs predicted in normal hearts (with $V_m$ 100 ml and $P_m$ 12 mmHg) and from a patient with systolic heart failure (with $V_m$ 225 ml and $P_m$ 24 mmHg) along with impact of $\pm 3$ mmHg errors in pressure estimates. C: impact of errors in $V_0$ estimation on EDPVR prediction. See text for details.]

![Fig. 10. Group-averaged canine end-diastolic pressure-volume data from Littl et al. (circles) (16) were replotted and EDPVR predicted using the proposed method. Prediction (line) matches this group-averaged data (from a completely independent source) quite satisfactorily.]
rently more common that an exponential equation be used to describe the EDPVR (e.g., \( P = \alpha e^{\beta V} \)). Thus the values of \( \alpha \) and \( \beta \) generated using the present approach will differ from those now commonly appearing in the literature. For example, typical values for \( \alpha \) and \( \beta \) obtained with the present approach would be \( 1.6 \times 10^{-11} \text{mmHg and } 6.0 \), respectively, for normal human hearts and \( 4.1 \times 10^{-15} \text{mmHg and } 5.8 \), respectively, for normal dog hearts.

From an analytical perspective, the prediction also depends on a degree of difference between the \( P_m \) and 30 mmHg. Thus, for \( P_m \) between \( \sim 27 \) and 32 mmHg, the current predictions break down. Future efforts could also resolve this limitation.

Finally, further consideration should be given to the effects of right-sided filling pressures, pericardial pressures, and ventricular interdependence. This is especially important in the data generated by caval occlusion in which these pressures are changing and can influence the resulting EDPVR. Whereas such effects can be eliminated in studies performed ex vivo (i.e., by completely unloading the RV), these effects are difficult (sometimes impossible) to discern in vivo without the use of special instrumentation (e.g., pericardial pressure measurements). Thus, even when measured invasively with a conductance catheter or by sonomicrometry, interpretation of an EDPVR measured in vivo during caval occlusion is subject to these same limitations.

In addition to potentially addressing these limitations, future efforts could possibly improve the proposed approach. The cornerstone of such efforts should be aimed at obtaining a larger amount of invasive data from human and animal hearts over a range of normal and pathophysiological states. Such data could be used to refine the parameters employed in the prediction method. Among the parameters that could possibly be refined would be those used in the prediction of \( V_0 \) in different settings and an attempt to understand the degree to which actually allowing disease-specific differences in the shape of the EDPVR could improve predictive accuracy.

In conclusion, the LV end-diastolic pressure-volume relationship can be reasonably estimated from a single pressure-volume point, and the predicted relationships are generally well correlated with directly measured data. The results obtained are most accurate when applied to groups of hearts rather than to individual hearts. The potential for noninvasive applications is particularly appealing and is complementary to the recently proposed approach to single beat estimation of the ESPVR.

REFERENCES


