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Towards a personalized approach in exercise-based cardiovascular rehabilitation: How can translational research help?

A call to action from the Section on Secondary Prevention and Cardiac Rehabilitation of the European Association of Preventive Cardiology

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Running head: Personalized medicine in cardiac rehabilitation

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Abstract

The benefit of regular physical activity and exercise training for the prevention of cardiovascular and metabolic diseases is undisputed. Many molecular mechanisms mediating exercise effects have been deciphered. Personalized exercise prescription can help patients in achieving their individual greatest benefit from an exercise-based cardiac rehabilitation programme. Yet, we still struggle to provide truly personalized exercise prescriptions to our patients.

In this position paper, we address novel basic and translational research concepts that can help us understand the principles underlying the inter-individual differences in the response to exercise, and identify early on who would most likely benefit from which exercise intervention. This includes hereditary, non-hereditary and sex-specific concepts. Recent insights have helped us to take on a more holistic view, integrating exercise-mediated molecular mechanisms with those influenced by metabolism and immunity. Unfortunately, while the outline is recognizable, many details are still lacking to turn the understanding of a concept into a roadmap ready to be used in clinical routine. This position paper therefore also investigates perspectives on how the advent of ‘big data’ and the use of animal models could help unravel inter-individual responses to exercise parameters and thus influence hypothesis building for translational research in exercise-based cardiac rehabilitation.

1. Introduction

Epidemiological and interventional studies have demonstrated a benefit of regular physical activity and exercise for the prevention of cardiovascular and metabolic diseases.¹⁻⁴ Exercise acts in a pleiotropic manner, addressing cardiac contractile and diastolic properties, muscle anabolic and catabolic pathways, substrate metabolism, and regulatory processes governing tissue perfusion and energy storage.^{5,6}

While physiological research of the past decades allowed us to understand these principal interactions, crucial questions remain on how to effectively implement exercise interventions in clinical therapy. Access and compliance to CR programmes remains a critical factor in the success of an exercise intervention, which requires a highly motivated multi-disciplinary team.⁷ But basic and translational research can also help, addressing questions regarding the personalization of exercise prescription, in order to improve efficacy of exercise interventions throughout the cardio/vascular/metabolic continuum. Why do some patients not respond to exercise-based cardiac rehabilitation (CR), and how can we identify them early on? What drives the difference in response to CR in men and women? How is the response to exercise influenced by metabolism, immunity and their interaction?

In addition to that, research methodology is rapidly advancing, bringing different views on translation of biochemical findings into the clinics. How will the advent of ‘big data’ influence hypothesis building for translational research in CR? What is the sense and nonsense of using animal models in modern CR research?

In this position paper, we aim to address these future challenges for basic and translational research in exercise-based CR. We critically review recent studies dealing with the most important yet unanswered questions in the field, both in preclinical and clinical research. Finally, we pinpoint gaps in current evidence that deserve intensified attention in future research.

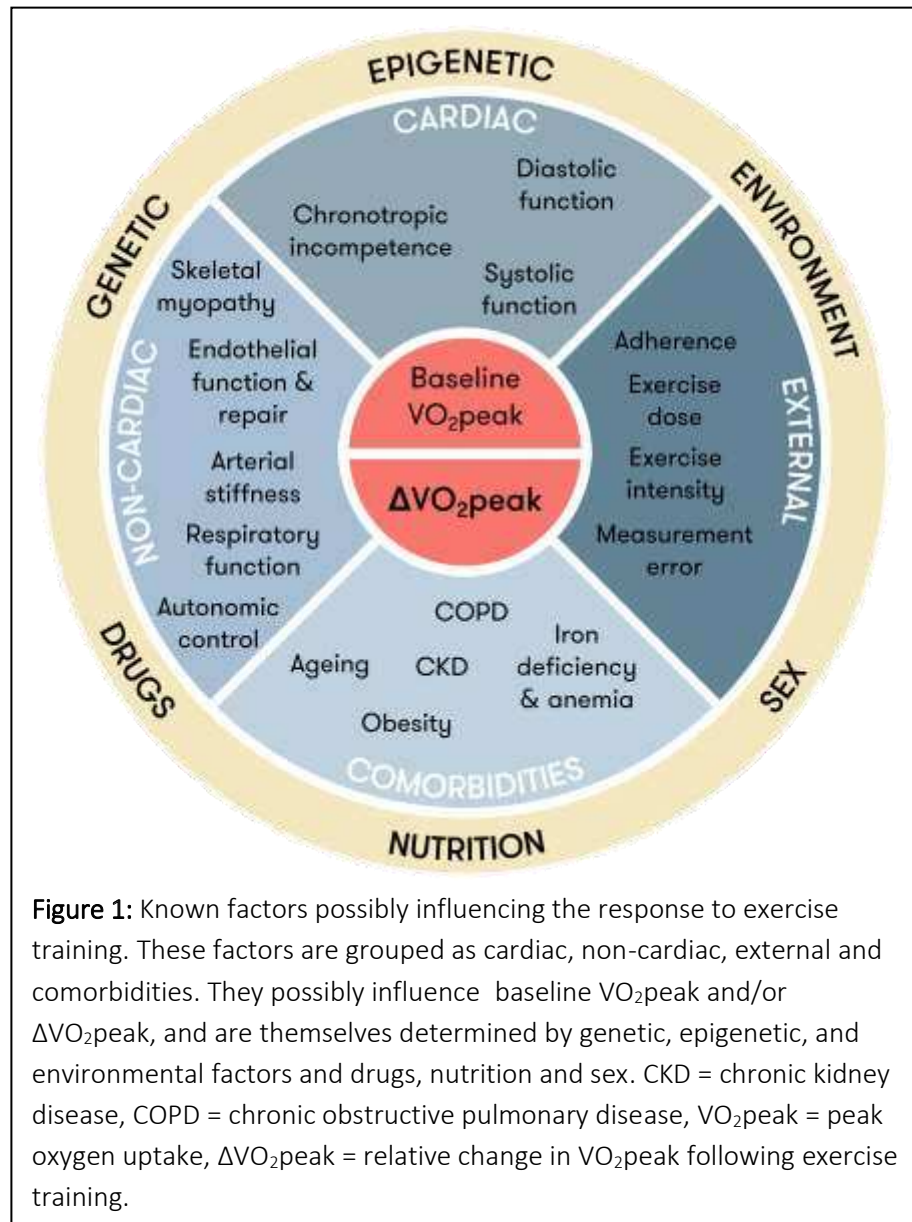
2. Future targets and open questions in translational cardiac rehabilitation research

While exercise-based intervention programmes are recommended in primary and secondary cardiovascular prevention,^{8,9} it has also become clear that exercise parameters – type, intensity, duration, frequency – differentially address cardio-vascular and metabolic endpoints, and that the quality and quantity of the response differs significantly between participants. In addition to improving implementation, it is the personalization of exercise interventions that is an important focus of current and future research.

2.1 Why do some patients not respond?

The improvement in

maximal aerobic capacity (peak oxygen uptake, $VO_2\text{peak}$) following exercise-based CR is related to survival in a wide range of cardiovascular diseases, independent of other important risk factors.^{10–12} Even small increments in $VO_2\text{peak}$ result in substantially lower risk for all-cause and cause-specific mortality.³ Although trials that investigated the effects of exercise-based CR on exercise capacity have consistently shown favourable and clinically significant changes,^{13,14} a large variability is seen in the individual training response (relative change in $VO_2\text{peak}$ following training, $\Delta VO_2\text{peak}$). This variability exists both in healthy subjects and in patients with established cardiovascular disease, when exposed to similar exercise programs.^{12,15,16} Recent studies have shown that up to 33% of patients fail to demonstrate a meaningful increase in $VO_2\text{peak}$ in response to CR, despite adequate compliance to training. These ‘non-responders’ show a decrease in $VO_2\text{peak}$, or an increase within the test-retest variability of $VO_2\text{peak}$ measurement (generally accepted to be $\pm 6\%$).^{16–18} The mechanisms driving this variability in $\Delta VO_2\text{peak}$ are not well understood, nor do we have good predictors for the response to exercise intervention. Possible contributing factors are summarized in **Figure 1**. As we are moving into an era of personalized medicine, and exercise therapy needs to be individually tailored in order to



generate the best response within the greatest safety margin, this is a field of research that requires urgent attention.

One way of addressing this line of research is by performing 'secondary' responder analyses on existing datasets of original publications. This can be accomplished by quantifying the number of non-responders and responders to different types of exercise interventions. For example, Williams et al. combined data from different laboratories that had compared training volumes ranging between high and moderate intensities, in populations of both healthy subjects and patients with established cardiovascular disease.¹⁹ When exercise was performed with great amounts and high intensities, the likelihood of subjects increasing their exercise capacity was significantly greater. Similarly, Montero et al. showed that healthy non-responders to an exercise training intervention did increase their VO_2peak when subjected to greater training volumes.²⁰ Yet, the evidence regarding the additional beneficial effects of higher exercise intensities is still conflicting.²¹ One could argue that the main determinant for improvements in exercise capacity is the total energy expenditure rather than the exercise intensity in these subjects. More comparative exercise intervention studies are needed to determine the inter-individual variability in exercise capacity caused by different types of exercise programs.

It still remains to be elucidated which phenotypic and genotypic characteristics predict the response of a patient to these specific exercise interventions. Previous studies already suggested that in addition to exercise training characteristics (e.g. intensity, volume, type), common personal characteristics like age, sex, body mass index, and baseline physical fitness predict between 15-21% of variability in $\Delta\text{VO}_2\text{peak}$.^{13,15,17,19} Moreover, an additional physiological factor that may influence $\Delta\text{VO}_2\text{peak}$ in patients with chronic heart failure (HF) is the circulatory response to acute exercise.^{22,23} Considering the relatively low predictability of these factors, other more important factors that affect $\Delta\text{VO}_2\text{peak}$ likely still need to be discovered.

Heritability explains more than 50% of the inter-individual differences in cross-sectionally measured VO_2peak .^{24,25} In addition, the Heritage Family study demonstrated that the change in VO_2peak to exercise training intervention is also largely (47%) determined by heritable factors (i.e. genetic, epigenetic or familial environmental factors).²⁶ Heritability of training-induced changes in haemodynamic response and skeletal muscle characteristics are also relatively high.^{27,28} Most importantly, the heritability of $\Delta\text{VO}_2\text{peak}$ was independent of baseline VO_2peak .²⁹ This implies that even subjects with a low aerobic capacity may still substantially benefit from exercise training during CR.

Previous research has used several approaches to improve our understanding of the genetics underlying the variability in VO_2peak and $\Delta\text{VO}_2\text{peak}$. In the late 1990s Montgomery et al. assessed left-ventricular wall thickness as a proxy for the response to exercise intervention in 140 army recruits.³⁰ Subjects with a specific mutation in the gene for the angiotensin converting enzyme showed no improvement in left ventricular mass, while in subjects without this mutation left ventricular mass increased by 22-26%. After this publication, 'The human gene map for performance and health-related fitness phenotypes' was created.³¹ Even though more than 200 autosomal gene variants and quantitative trait loci have been identified from this study, the authors noted that data was mainly derived from underpowered sample sizes. Therefore this study did not provide compelling evidence that DNA sequence variants in a given gene are associated with human variation in fitness and

performance traits.³¹ Interaction between gene variants and disease modifying factors add to the complexity. For example, a single nucleotide polymorphism (SNP) in the *FTO* gene is associated with higher risk for adiposity, but this interaction term was weaker in physically active people.³²

A means to overcome the focus on a single gene or locus could be transcriptome wide RNA expression profiling studies. Timmons et al. identified 11 SNPs in skeletal muscle, which were responsible for nearly 50% of the heritability of $\Delta\text{VO}_2\text{peak}$ in healthy subjects.³³ Genome-wide association studies could also provide unbiased insight into the genetics underlying baseline VO_2peak as well as $\Delta\text{VO}_2\text{peak}$. Bouchard et al. discovered a total of 39 SNPs significantly associated with $\Delta\text{VO}_2\text{peak}$.³⁴ Unfortunately, there was no overlap between the genes identified by Timmons et al. and those reported by Bouchard et al.³⁵ Another large genome-wide association study compared SNPs in 1520 elite athletes with SNPs in 2760 non-athletes, and identified only a single SNP (in the *GALNTL6* gene) that was more common in athletes.³⁶ Hence, while previous studies have started to use hypothesis-free methods to improve our understanding of the genetics underlying VO_2peak and $\Delta\text{VO}_2\text{peak}$, there is still a long way to go.

Post-translational modifications may also influence protein function. Indeed, several non-coding RNA species have been linked to VO_2peak or $\Delta\text{VO}_2\text{peak}$. In healthy subjects, microRNAs are released into the circulation even after acute exercise, and exercise training induces long-term changes in their expression.^{37,38} In a rat model of HF, Souza et al. identified a set of 14 cardiac microRNAs of which expression was influenced by exercise training.³⁹ Other studies have identified additional exercise-responsive microRNAs in animal models of different cardiovascular diseases.³⁸ To date, only two small studies have assessed the effect of exercise training on microRNA expression in human patients with established cardiovascular disease.^{40,41} Taurino et al. showed that *miR-92a* and *miR-92b* were upregulated after exercise-based CR in patients with coronary artery disease, coinciding with a downregulation of their gene targets.⁴⁰ Xu et al. identified 3 miRNA dysregulated by acute exercise in HF patients, but a clear correlation with VO_2peak was not found.⁴¹ More extensive studies, including larger numbers of patients and screening for more miRNA, are still needed before reliable conclusions can be drawn.

Personalization of therapy also means that target parameters need to be chosen according to the clinical need of the patient, based on their underlying morbidities and risk profile. This is not necessarily always VO_2peak , but can be improved submaximal exercise parameters, increased cardiac function, better glucose handling, reduced inflammation, or improved vascular stiffness.⁴²⁻⁴⁶ Of note, target parameters of the exercise intervention might even change over time in each patient.

- *To summarize, the change in VO_2peak to exercise training shows large inter-individual variability. Understanding how such inter-individual differences emerge is important, as a lower response is linked to poorer outcomes. $\Delta\text{VO}_2\text{peak}$ seems to be regulated by the interaction between heritable factors and lifestyle – including exercise parameters, SNPs, and non-coding RNAs – but individual targets have yet to be confirmed. We need controlled randomized studies using multi-omics techniques (transcriptomics, genomics, proteomics and metabolomics) to identify potential pathways in a ‘systems biology’ approach. The complex interaction between lifestyle and heritable factors likely explains a large part of the individual*

response to exercise training, and future studies should aim to improve our understanding of this interaction.

2.2 The potential role of sex differences in response to CR

In general, VO_2 peak is ~15% lower in women compared to men.⁴⁷ Intriguingly, however, women seem to experience better clinical outcomes following exercise training, despite similar improvements in exercise capacity.^{48,49} While sex-specific effects thus likely play a key role in the clinical benefits associated with exercise interventions, the mechanisms responsible for these benefits remain poorly understood.

Cardiac physiology as well as pathophysiology are markedly different between men and women. The main differences are summarized in **Table 1**. For a more extensive overview, we refer the reader to existing reviews.^{50–52}

Table 1: Selected sex differences in cardiac physiology and pathophysiology

Subject	Sex difference	Ref.
Epidemiology: risk factors	Premenopausal women have lower blood pressure compared to men, which is lost after menopause	53
	When present, risk factors (hypertension, cholesterol levels, diabetes) are more often uncontrolled in women	54–57
Epidemiology: cardiac disease	Epicardial coronary artery disease is less common in women	58
	Heart failure: higher prevalence of preserved EF in women and of reduced EF in men	59
	Acute coronary syndromes: in women more often due to spontaneous coronary artery dissection, Takotsubo syndrome, and microvascular angina	60,61
Cardiovascular structure and function	LV volumes are smaller in women, even after adjustment for body size	62
	LV EF is higher in women and the increase in EF with age is larger in women	63
	Reduction in LV systolic long axis contraction with age is larger in women	64
	Increased vascular and LV stiffness in women	62
Cardiomyocyte function	Ion handling and rhythmicity differs in women, leading to higher rest heart rate, shorter PR and longer QT segments	65,66
	Altered calcium handling in female cardiomyocytes, myofibrils require more time to relax	67
	Female cardiac mitochondria suffer less oxidative damage under stress	68
	Cardiomyocytes have higher protein kinase A activity in women	69
	Cardiomyocyte loss with ageing is higher in women	70
Response to treatment	Women show higher mortality after coronary revascularization and cardiac surgery	71,72
	Response to cardiac resynchronization therapy may be better in women	73

Abbreviations: EF = ejection fraction, LV = left ventricular

Sex-specific hormones may explain part of these differences. In pre vs. postmenopausal women of similar age, blood pressure is lower, and left ventricular end-systolic volume, ejection fraction and filling rate are larger.⁷⁴ The vasodilating properties of oestrogen may play a role.⁷⁵ Also, RNA sequencing in cardiomyocytes revealed more than 600 genes with sexually dimorphic expression patterns.⁶⁹ This adds to genetic differences due to male specific Y-chromosomal gene expression and differences in epigenetics (histone and DNA modifications, non-coding RNA expression).⁵² Thus, in addition to the obvious endocrine differences between men and women, a variety of anatomical, genetical and molecular differences exists within the heart. These may influence not just cardiovascular disease progression, but also affect secondary prevention strategies.

While central hemodynamic differences likely explain some of the sex-specific effects in response to CR,⁵⁰ other factors are also involved. It is well established that cardiac disorders induce secondary impairments to the periphery, including endothelial and skeletal muscle dysfunction, which are closely linked to symptoms of exercise intolerance and prognosis.⁷⁶ Surprisingly, it is still largely unclear how sex modulates the crosstalk of mechanisms governing the loss of endothelial, skeletal and cardiac function. A few studies have revealed that in patients with HF, mitochondrial enzymes in skeletal muscle show either no major changes or more pronounced deficits in men compared to women, with a greater shift towards glycolytic enzymes and type IIX fatigable fibres in men.^{77,78} In response to an aerobic endurance training intervention, evidence has revealed minor differences in terms of skeletal muscle biochemistry, with reports suggesting men with HF can increase the content of the slow myosin heavy chain isoform towards similar levels to that observed at baseline in women.⁷⁹ Thus, women may experience a greater preservation of muscle oxidative function compared to men with HF, which could help to explain why women demonstrate greater clinical benefits after CR.⁴⁸ The mechanisms underpinning the sex-specific differences in muscle physiology and effects of exercise intervention remain unclear. Hormonal effects of oestrogen regulation on mitochondrial dynamics and/or a preferential shift towards fatty acid oxidation in women may play a role,^{80,81} but more extensive measures of muscle function and physiology and higher sample sizes are still required to confirm this.

In addition to skeletal muscle alterations, endothelial dysfunction also develops in HF patients, both in men and women.⁸² Yet little data is available to clearly demonstrate whether any sex-specific alterations are present following CR in patients. Recent evidence from animals models of HF have shown that high-intensity interval training can attenuate endothelial dysfunction in both female and male rats, which seems to act via mechanisms specifically lowering oxidative stress in males and increasing endothelial nitric oxide synthase expression in females.^{83,84} Whether these molecular benefits are paralleled in male and female patients with HF remains unclear. Furthermore, sex-specific substrate utilisation could play a key role in the exercise response in women and may fill the above-mentioned gap in the literature with regards to the effectiveness of exercise-based CR. One example is that women rely on carbohydrates to a lesser extent but have a higher content of intramyocellular lipids.⁸⁵

While CR programs clearly reduce the risk of all-cause and cardiac-related mortality and improve quality of life, directly extrapolating these findings from men to women remains fraught with complexities since women have consistently been under-represented in previous trials.⁸⁶ In large meta-analyses and randomized controlled trials, the amount of women recruited was 11-28%.⁵⁰ Given

that women are also ~40 % less likely to enrol in CR and have a significantly lower adherence to the interventions compared to men,^{87,88} the need to better understand sex-specific mechanisms in response to exercise training will first require rapid improvement in CR recruitment and adherence of women. Identification of sex-specific targets is likely to substantially improve outcomes following CR programmes by optimising training regimes.

Nonetheless, women seem to benefit at least as much from exercise-based CR as men.^{48,89,90} The most recent Cochrane reviews which assessed the benefits of exercise-based CR concluded that exercise improves cardiovascular mortality and hospitalization (in patients with coronary artery disease) and improves health-related quality of life (in patients with coronary artery disease or HF).^{91,92} The authors also clearly state that evidence for benefits of exercise-based CR in women is currently insufficient. Given the above mentioned physiological and pathophysiological differences between men and women, we cannot assume that exercise regimes which worked for men will also be effective for women.

- *To summarize, important differences exist in the response to CR in men and women. Besides obvious differences in cardiovascular and skeletal muscle structure, function and physiology, the underlying hormonal and molecular mechanisms are still understudied. Identification of sex-specific targets might further improve outcomes after CR.*

2.3 Immune-metabolism interactions and inflammation

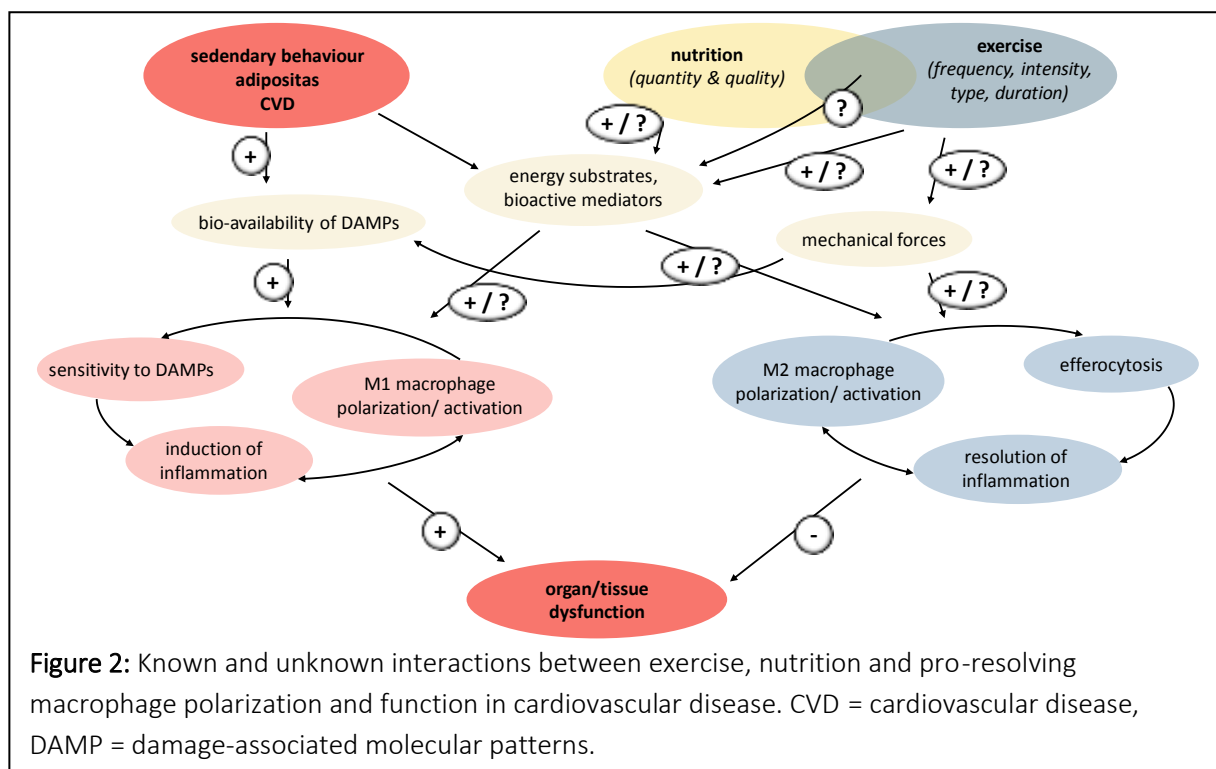
Both enhanced activation and impaired resolution of inflammation are major underlying principles of cardiovascular and metabolic pathologies.⁹³ Regular exercise training has been shown to lower systemic and vascular inflammatory load within a few weeks of intervention.⁴⁶ This has been partly attributed to active secretion of anti-inflammatory myokines from skeletal muscle.⁹⁴ While biochemical interactions of some myokines have been deciphered, it remains a major task to chart the network of biochemical interactions between energy demand by skeletal muscle contractile activity (affected by exercise parameters, such as duration, type and frequency) and the fine-tuning of inflammatory mechanisms. The recent years have brought a refinement in our understanding of inflammation in atherosclerosis, including the appreciation of resolution of inflammation as an active process, distinct from inhibition of inflammation, as well as the tight interactions between immune cell activation and their energy metabolism. Only a fraction of these newly understood mechanisms has been exploited in the context of the cardiovascular effects of regular exercise training.

Resolution of inflammation versus anti-inflammation: The inability to resolve an ongoing inflammatory process is a hallmark of inflammatory degenerative processes, including atherosclerosis. On the one hand, innate immune-activating signals - ligands of pattern-recognition receptors, such as modified lipids - do not disappear in atherosclerosis, as it would happen in a 'normal' injury. On the other hand, the production of pro-resolving mediators appears to be dysregulated. Anti-inflammatory therapies have been employed more or less successfully in secondary cardiovascular prevention. However, therapeutic success appears to depend on the inflammatory signalling mechanism targeted, likely interleukin-1 β and interleukin-6 signalling, and may be flawed by increased incidence of lethal infections.^{95,96} In addition, blocking inflammation also appears to block resolving mechanisms, the removal of apoptotic particles and cell debris as well as the induction of regenerative processes.⁹⁷ The termination of an acute inflammatory response is normally governed by both the decay of pro-inflammatory signals, as well as the active production of pro-resolving factors.⁹⁸ A number of studies

support the ability of exercise - ranging from a single session of high-intensity interval exercise to a 3-month multicomponent exercise programme – to reduce cellular responsiveness to toll-like receptor-mediated signalling, induced by damage-associated molecular patterns.^{99–101}

Dietary interventions targeting synthesis of specialized resolving mediators (SPM) have been tested for some time now and it becomes evident that both, the dosage and the formulation might be relevant to their success in cardiovascular prevention.¹⁰² In contrast, only few studies have systematically addressed the effects of exercise intervention on the release of SPMs – resolvins, lipoxins, protectins and maresins – but the existing literature indicates an increase in SPM release by regular exercise.^{103–105} This might be attributed to acute and chronic effects: strain and acute release of pro-inflammatory mediators are associated with SPM release in acute high-intensity exertion, while chronic effects of exercise intervention might be connected to the exercise-mediated shift in macrophage polarization towards the M2-like phenotype.^{103,105,106} M2-like macrophages are better suited to perform efferocytosis than the M1-like phenotype and it is during efferocytosis that SPMs are released.¹⁰⁷ Thus, we know that regular exercise is associated with a shift towards the more pro-resolving macrophage spectrum, as well as higher levels of pro-resolving mediators, but we do not know which exercise parameters (e.g. intensity, volume, type) could be used to boost this effect, nor whether a combination with dietary approaches to supplement SPMs could potentiate the effects of exercise intervention on cardiovascular inflammation (**Figure 2**).

Energy metabolism and inflammation: From tumour biology, we know that increased glycolysis and glutaminolysis provide energy flexibility to the cell and generate intermediates that feed into anabolic processes - probably the reason why glycolysis is preferred over oxidative phosphorylation by proliferating tumour cells.^{108–110} In a similar manner, glycolysis is preferred by activated and proliferating myeloid and lymphoid cells¹¹¹ and stimulating glycolysis can activate macrophages.¹¹² In addition, M1-type macrophages feature a ‘broken’ Krebs cycle, with increased output of intermediates that serve as substrates in the synthesis of pro-inflammatory mediators, or are pro-inflammatory



mediators in themselves.^{113 114,115} In contrast, 'alternative' M2-like macrophages favour oxidative phosphorylation and fatty acid oxidation.^{116,117} Indeed, oxidative phosphorylation was a prerequisite of M2-type phenotypic macrophage polarization.¹¹⁷

Of note, the complex spectrum of M2-like macrophage phenotypes recognized with their diverse roles in atherosclerosis, have not been charted in detail for their inflammation-resolving and energy metabolism phenotype yet, nor regarding the effect of exercise in their polarization. Similarly, NK cells and various T lymphocyte populations react to acute and chronic exercise and contribute to both, polarization of innate immune cells and functionality of various tissues and organs, including distinct fat depots (perivascular, subcutaneous, visceral).¹¹⁸

Both the amount and type of energy substrates provided and physical exercise can affect the phenotype of monocytes and macrophages.^{112,119–122} Energy sensors, such as AMP-dependent kinase, can be targeted by both diet and exercise. On the way to personalized lifestyle-based therapies, we need to learn more about the integration of exercise parameters (e.g. type, intensity, frequency, volume) with diet (e.g. macronutrient composition, amount and timing of eating/fasting) and pharmacological means to modulate energy metabolism and (thereby) activation state of inflammatory cells.^{123–127} Of note, activation of the relevant mechanisms might shift between individuals, being influenced by a number of factors such as hormonal status/sex, age, pharmacotherapy and co-morbidities as well as genetic background.^{128–130}

- *To summarize, macrophage phenotype shift, leading to reduced release of pro-inflammatory mediators and an increased release of pro-resolving mediators, might well be a nexus of exercise-mediated anti-inflammatory and metabolic cardio-protective effects. The available seminal data, however, requires a better resolution: continuously improved techniques of single-cell immunophenotyping¹³¹ and assessment of cellular metabolism¹³² allow for the fine-mapping of immune-inflammatory interactions and can be used to develop diagnostic tools, assessing individual response to exercise and personalizing exercise parameters. In addition, better understanding of the cellular and molecular nodes of the immuno-metabolic network might help to optimize exercise parameters on an individual level to improve cardio-vascular and metabolic benefit, potentially in combination with pharmacological and diet-based approaches.*

3. Challenges and opportunities in translational CR research methodology

The advent of high-throughput molecular techniques, single-cell diagnostics and organs-on-a-chip have opened countless opportunities in exercise research, but some important challenges have surfaced simultaneously. How can we successfully pinpoint important findings within these vast datasets? And if computers can handle increasingly complex tasks, what is the use of animal models in the future?

3.1 Impact of 'big data' and artificial intelligence on translational research in CR

As analytical techniques evolve, new challenges arise with regards to handling the enormous amount of data they generate. This is especially true in the area of genomics, epigenomics, proteomics and metabolomics, but also applies to datasets obtained from large clinical trials or registries, and epidemiological research.¹³³ These datasets cannot be readily viewed on any computer, which complicates human pattern recognition. Moreover, the analysis of 'big data' requires additional

statistical precaution, taking into account the increased 'noise' of high-throughput techniques.¹³⁴ Novel 'data mining' techniques have been developed to derive relationships and statistical inference from these datasets, often relying on some form of artificial intelligence. These techniques, grouped under the term 'machine learning', can be either supervised (the user determines the relation between subjects) such as traditional regression analysis, or unsupervised (the computer determines the relation between subjects), such as clustering analysis.^{135,136}

Some of these novel techniques have already been applied to translational exercise research. In 2009, Goud et al. set up a cluster-randomized trial in 21 CR centres, comparing effects of a computerized decision support system to standard care.¹³⁷ In centres implementing the decision support system, concordance with CR guideline recommendations were modestly increased, reducing both over- and under-treatment. Further efforts have been made with regard to artificial intelligence-based exercise prescription.¹³⁸⁻¹⁴² Most of these studies describe a framework to automate exercise prescription based on patient demographics, comorbidities, test results and reason for referral. Randomized clinical trials evaluating these fully computerized exercise prescription are still lacking. Finally, the vast amount of data obtained from wearable devices opens up possibilities for data-driven personalization strategies. For example, one study succeeded in predicting active energy expenditure (a predictor of $\Delta\text{VO}_2\text{peak}$) from photo-plethysmographic heart rate measurements, even in patients under beta blocker therapy.¹⁴³

But many more possibilities of 'big data' and machine learning exist in the field of CR, which we will demonstrate at the hand of two examples from other areas within cardiovascular research: imaging and phenotyping.

Imaging is especially suited for the application of machine learning because images contain a rich amount of data both within the image itself and through extraction of quantitative features.¹³⁵ Furthermore, powerful computational approaches to handle image data have undergone extensive development within academic clinical research and non-medical fields such as facial recognition and image searching.¹⁴⁴ Combined with recent availability of large imaging datasets,¹⁴⁵ this has meant artificial intelligence approaches to identify images, automatically quantify image features and predict disease from the patterns in the image have developed rapidly within cardiology and radiology.¹³⁵ As a result, automated quantification is now entering clinical use, but broader diagnostic application will require robust clinical validation before adoption.¹⁴⁶ Of particular interest in CR will be to understand whether imaging after cardiac events (e.g. echocardiography) contains information of value for prediction of outcome, risk of HF and likelihood of response to exercise interventions.

Another approach of unsupervised machine learning is to find clusters of similar data items: subjects in the same cluster are similar to each other, and dissimilar to subjects in other clusters. This can aid in discovering subtypes of patients with a certain disease. For example, machine learning has been able to identify clusters of patients with HF based on their baseline characteristics and test results (including cardiopulmonary exercise tests).¹⁴⁷⁻¹⁵⁰ Phenotyping through machine learning predicted the prognosis of HF patients, and performed better compared to traditional predictors such as ejection fraction.¹⁴⁹

A major concern of artificial intelligence is the 'black box' phenomenon. More complex machine learning processes, such as neural networks, build layer upon layer of automated decisions up to a

point where it is impossible to retrace the individual steps.¹⁵¹ Thus, while some neural networks have been proven to outperform humans (for example in image recognition¹⁵²), it is often hard to assess *how* the computer reached its decision or classification. One technique to overcome the ‘black box’ is to ask the computer to simultaneously create a simpler ‘surrogate’ model to gain insight in the reasoning process.¹⁵³

Also, while the decision process can be fully automated and intelligent, large datasets still need to be imputed to train machine learning models. Availability of enough training data is currently still an issue, but the increased promotion of open science and data sharing will hopefully provide an answer to this problem soon.

Finally, a major challenge will be to convert artificial intelligence-derived predictions and recommendations into effective action. Better phenotyping and improved risk stratification do not automatically lead to improve health. To truly achieve a health care transformation, behavioural changes are needed at both patient and physician level.¹⁵⁴ For example, artificial intelligence may improve exercise prescription, but a patient’s health will only improve if his or her physician implements this improved prescription in practice, and he or she adheres to the prescribed training.

- *To summarize, early applications in CR research and advanced examples from imaging and phenotyping studies show that the advent of ‘big data’ and machine learning will likely change current practice. Major challenges include picking up useful signals between increased noise in big datasets, the ‘black box’ phenomenon, and implementing behavioural changes based on computerized recommendations. We suggest some future research areas in **Table 2**.*

Table 2: Suggested research areas for application of data mining and machine learning in exercise-based CR

Data Source	Suggested Application	Examples
Cardiopulmonary exercise test raw data	Improve risk stratification	Discover novel prognostic variables
	Detection of subliminal patterns	Exercise oscillatory ventilation Autonomic dysfunction
Baseline data (including imaging) of large exercise studies	Discover novel subtypes / phenogroups	Different phenotypes of heart failure ^{147–150}
	Improve diagnostic process	AI-driven diagnosis of left ventricular dysfunction
Outcome data of large exercise studies	Improve prescription of CR	AI-driven exercise prescription, similar to human-driven Expert tool ^{141,142}
Omics (genomics, epigenomics, proteomics, metabolomics)	Prediction of low or high response to CR	Presence of certain SNP indicates better response ^{33,34}
	Improve prescription of CR	Presence of certain SNP indicates better response to certain training modality

AI = artificial intelligence, CR = cardiac rehabilitation, SNP = single nucleotide polymorphism

3.2 Sense and nonsense of animal models

Appropriate animal models are important to unravel the molecular mechanisms for how exercise-based CR mediates its beneficial effects. Small rodents in particular are attractive models for cardiovascular research, possessing unique properties such as easy handling, short gestation time and low costs. Perhaps most important is the availability of transgenic mice and rats, which allow the possibility to study the involvement of specific molecules in transmitting the positive effect of exercise training, which otherwise would not be possible in humans. Nevertheless, a certain scepticism is warranted based on whether animal models appropriately translate to humans, which has resulted (and rightly so) in the value of such research being questioned.^{155–157}

An ideal disease model should mimic the human condition genetically, experimentally and physiologically. Therefore, using inbred mouse strains may not reflect the response generated in a genetically polymorphic human population, which may be one reason for the failure of many promising preclinical drugs when translated into human clinical trials. In support, a recently published comment stated that >80% of potential therapeutics fail when tested in humans, even after animal studies have provided evidence that the treatment is safe and effective.¹⁵⁸ One future avenue to circumvent such translational problems may reside in the use of humanized models, whereby mice expressing human transgenes or engrafted human cells/tissue are used in preclinical research.¹⁵⁹ Obviously, generating diseased animal models due to genetic defects is much easier than trying to mimic a more complex disease pattern, where several comorbidities contribute to the final clinical phenotype. One contemporary example of such a complex disease is heart failure with preserved ejection fraction (HFpEF). Since the development of HFpEF is driven by several comorbidities, which include hypertension, diabetes, obesity and ageing,^{160–162} it remains difficult to define an animal model that appropriately mimics the HFpEF phenotype. As of yet, the animal models used to probe molecular changes occurring in HFpEF and in response to exercise training have been predominantly based on a single risk factor such as aging or hypertension.^{83,163,164} More recently this line of research included a more clinically relevant animal model, in a way that HFpEF develops due to the onset of multiple comorbidities that mirror a metabolic syndrome.^{84,165–167} Another problem with appropriate animal models may be that most models develop over a short time period, whereas in humans sometimes several years or decades pass before a clear phenotype is established.

Animals used for cardiovascular exercise studies most commonly range from small rodents (e.g. mice, rats) to large animals (e.g. rabbits, canine, goats, sheep, pigs, horses).^{168–173} In these animal models exercise can either be voluntary (e.g., animal cage is equipped with a running wheel) or forced (e.g., animal is placed onto a treadmill for a specific period). Many exercise training studies have been employed using a variety of animal models of diseases that include HF,^{165,174,175} diabetes,^{176,177} and neurodegenerative diseases.¹⁷⁸ Beside the classical animal models (mouse and rat) used to analyse the effect of exercise training on molecular and physiological parameters, more recently other species have been used such as drosophila and zebrafish.^{179–182} Exercise training in drosophila results in improvements of physiological and molecular measures, which include enhanced climbing speed, flight performance, aconitase levels, and cardiac contractility. Clearly, while the main advantage of using flies as an animal model is that you can train several thousand flies simultaneously, the question of whether and to what extent these findings translate to humans looms large. We also have to keep in mind that it is even more difficult in animal models to control for activity levels. In human studies

most of the patients recruited into an exercise study exhibit a very low exercise level, which is difficult to control for in animals.

- *To summarize, the 'sense' to use animal models to investigate the benefits associated with exercise in disease is difficult to refute: animal studies have often provided the initial clues to help elucidate how exercise exerts its benefits for treating disease. However, animal research can also provide much 'nonsense' when translated to humans. Future studies should therefore continue focusing on developing more complex and robust animal models of disease that closely reflect the human condition.*

4. Conclusion and Outlook

Exercise-based CR has consistently shown positive effects on the course of cardiovascular disease. However, recent studies showed that there is a large variation in training effects at the individual level, with up to one third of patients failing to demonstrate a significant increase in exercise capacity despite adequate compliance. Therefore, in order to improve the effects of exercise-based CR it is crucial to (1) gain more in-depth knowledge on the determinants and mechanisms governing the response to exercise in the organs - beyond the skeletal muscle, heart and vascular system - and (2) to acknowledge their interaction at a systemic level.

Heritable and non-heritable factors each determine approximately 50% of inter-individual heterogeneity in $\Delta\text{VO}_2\text{peak}$. High-throughput technologies in combination with improved bio-informatics and bio-statistical approaches can help identify major regulatory nodes among large datasets that cannot be readily interpreted otherwise.

Sex-specific differences in the response to exercise in cardiovascular therapy are severely understudied. Although endocrine, anatomical and molecular differences between men and women are assumed to play a role, the exact mechanisms remain largely unknown. Future research therefore needs to include sufficient numbers of female patients to address these issues.

Based on these studies, a concise, easy-to-use panel of markers that could help personalize exercise parameters could be developed. This panel could include regulatory nodes identified in clusters of patients through their classical risk profile, but also inflammatory and metabolic status, and genetic traits identified through advanced bio-statistics. Finally, while animal models have inherent limitations complicating translation to humans, complex and robust animal models closely reflecting human cardiovascular diseases will be needed to test the hypotheses mentioned and to gain further insight in the complex physiology of exercise-based CR.

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