

# THE IMPACT OF AGE ON VASCULAR SMOOTH MUSCLE FUNCTION IN HUMANS

Short title: Age and vascular smooth muscle function

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## Conflicts of Interest

The authors report no conflicts of interest.

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**Aim:** Advanced age is associated with vascular endothelial dysfunction, characterized by reductions in endothelium-dependent vasodilation of conduit and resistance arteries, in part from decreased nitric oxide (NO) bioavailability. Although vascular smooth muscle function (SMF), assessed by responsiveness to an exogenous NO donor, is typically reported to be intact, many of these studies are limited by small sample size. Therefore, the purpose of this meta-analysis is to systematically review and determine whether vascular SMF is different between older *versus* young healthy subjects.

**Design:** We conducted a systematic search of MEDLINE, Cochrane and Scopus, since their inception until January 2014 for articles evaluating SMF in the brachial artery and/or resistance arteries (BAsMF and RAsMF, respectively), as assessed by the endothelium-independent vasodilator response to exogenous NO donors in older ( $\geq 60$  years) and young ( $< 30$  years) groups of healthy subjects. Meta-analyses were performed to compare the mean difference (MD) in BAsMF and the standardized mean difference (SMD) in RAsMF between older and young groups. Subgroup analyses were performed to identify sources of heterogeneity.

**Results:** Fifteen studies assessing BAsMF and 20 studies assessing RAsMF were included, comprising 550 older and 516 young healthy subjects. After data pooling, BAsMF and RAsMF were lower in older compared with young groups (MD=-1.89 %,  $P=0.04$ ; SMD=-0.46,  $P=0.0008$ , respectively). Significant heterogeneity was observed in the BAsMF ( $I^2=74$  %;  $P<0.00001$ ) and RAsMF ( $I^2=57$  %;  $P=0.0008$ ) meta-analyses. Subgroup analyses revealed that studies with (predominantly) males showed similar SMF responses between older and young groups.

**Conclusions:** Based on current published studies, vascular SMF is reduced in conduit and resistance arteries of otherwise healthy older subjects, particularly in women.

**Keywords:** advanced age; vascular smooth muscle function; conduit artery; resistance arteries.

## 1 INTRODUCTION

2 Older age is a primary risk factor for the development of cardiovascular diseases [1, 2].

3 The influence of advanced age on increased cardiovascular risk is, at least partly,

4 mediated through its effects on the arterial vasculature [1]. In this regard, ageing is

5 associated with vascular endothelial dysfunction in humans, characterized by reduced

6 endothelium-dependent vasodilator function in conduit [3-13] and resistance [6, 9, 14-

7 24] arteries. Alterations in the nitric oxide (NO) signaling pathway and/or decreased

8 NO bioavailability have been proposed to contribute to the age-related decrease in

9 endothelium-dependent vasodilator function [25, 26].

10

11 The ability of vessels to dilate is dependent on the function of the endothelium, but is

12 also subordinated to vascular smooth muscle (vasodilator) function (SMF). Smooth

13 muscle responsiveness represents the final, and frequently underappreciated, step of

14 endothelium-dependent vasodilation. However, relatively little is known about the

15 impact of advanced age on SMF. Some reports from animal studies indicate that

16 advanced age is associated with reduced vascular SMF [27-29]; nonetheless, this finding

17 is not universal [25]. In humans, studies assessing vascular SMF in healthy older and

18 young subjects have reported variable results, possibly as a result of small sample sizes

19 [3-6, 8-10, 12, 14-24, 30-43].

20

21 Therefore, the primary aim of this study was to perform a systematic review and meta-

22 analyses of available studies comparing vascular SMF in older and young healthy

23 subjects. We hypothesized that SMF would be reduced in conduit and resistance

24 arteries of older compared with young healthy adults. We selected studies that

25 assessed SMF, determined by the endothelium-independent vasodilator response to

26 exogenous NO donors, in the brachial artery (BASMF) and in resistance arteries  
27 (RASMF) of healthy young and healthy older subjects.

28

## 29 METHODS

30 The review is reported according to the Meta-analysis Of Observational Studies in  
31 Epidemiology (MOOSE) Group guidelines [44].

32

### 33 *Data sources and searches*

34 Our systematic search included MEDLINE, Cochrane and Scopus, since their  
35 inception until January 2014. We used combinations of the subject headings “older”,  
36 “vascular smooth muscle”, “endothelium independent”, “nitroglycerin”, “sodium  
37 nitroprusside”, “vascular function”, “vasodilation” and “vascular reactivity”; the search  
38 strategy for MEDLINE is shown in Supplemental Figure S<sub>1</sub>. We also performed hand  
39 searching in reference citations of articles included in meta-analysis and related  
40 citations in MEDLINE.

41

### 42 *Study selection*

43 To be included in the analysis, an observational report had to assess BASMF and/or  
44 RASMF in an older group (mean age  $\geq 60$  years) and a young group (mean age  $< 30$   
45 years) of healthy subjects. In the event of multiple publications pertaining to the same  
46 research, the first published or most comprehensive study was included. Inclusion of  
47 studies was not limited by publication status or language.

48

### 49 *Data extraction and quality assessment*

50 The following variables were extracted into a pre-formatted spreadsheet: authors, year  
51 of publication, characteristics of study participants ( $n$ , gender, age, height, weight, body  
52 mass index (BMI), systolic blood pressure (SBP), diastolic blood pressure (DBP),  
53 physical activity, maximal oxygen consumption ( $VO_{2max}$ ), morbidities, risk factors to  
54 health, medication) and vascular variables (vascular region, vasodilation parameter,  
55 baseline vascular tone, NO donor, dosage, time of analysis after NO donor  
56 administration, wall-tracking system, BASMF, RASMF, endothelial function). A  
57 systematic appraisal of quality for observational research (SAQOR) [45] previously  
58 applied in meta-analysis of observational studies evaluating arterial function [46] was  
59 performed to provide assessment of study quality. The SAQOR was adjusted to assess  
60 1) the older sample group, 2) the young sample group, 3) quality of vascular SMF  
61 measurement, 4) confounding variables and 5) data. Overall, the SAQOR was scored  
62 out of 16, quality deemed better with a greater score (Table S<sub>1</sub> and S<sub>2</sub>).

63

#### 64 *Data synthesis and analysis*

65 The meta-analyses and subgroup analyses were performed using Review Manager  
66 software (RevMan 5.2, Cochrane Collaboration, Oxford, UK). The primary outcomes  
67 were the mean difference (MD) in BASMF and the standardized mean difference (SMD)  
68 in RASMF between older and young groups. SMD summary statistic allowed us to  
69 standardize RASMF values expressed in different units into a uniform scale to complete  
70 this meta-analysis. Each MD and SMD was weighted according to the inverse variance  
71 method [47] and they were pooled with a random-effects model [48]. SMD of 0.2, 0.5,  
72 and 0.8 represents small, medium, and large effect sizes, respectively [49].  
73 Heterogeneity between studies was assessed using the chi-squared test for  
74 heterogeneity and  $I^2$  statistics. Potential moderating factors were evaluated by

75 subgroup analysis comparing studies grouped by dichotomous or continuous variables  
76 potentially influencing vascular SMF. Median values of continuous variables were used  
77 as cut-off values for grouping studies. Publication bias was evaluated by estimating the  
78 asymmetry of the Begg and Mazumdar's funnel plot [50]. A *P* value of less than 0.05  
79 was considered statistically significant.

80

## 81 RESULTS

### 82 *Study selection and characteristics*

83 The flow diagram of the process of study selection is shown in Figure 1, which resulted  
84 in the inclusion of 33 articles. Thirteen of these articles assessed BASMF, 19 assessed  
85 RASMF and 1 assessed both BASMF and RASMF. One of the articles assessing BASMF  
86 presented two groups of older subjects, each of which had been independently  
87 compared with a location-matched young group [43]. Therefore, these data were  
88 evaluated as two individual studies. Table 1 shows the main clinical characteristics of  
89 the 15 BASMF studies and 20 RASMF studies, comprising a total of 550 subjects in the  
90 older group and 516 subjects in the young group. Older and young groups were  
91 gender-matched in all studies (omitting 1 study in which gender-related data was not  
92 available [22]). All subjects were free from co-morbidities and risk factors according to  
93 cut-off values, non-smokers (except for 1 study allowing < 5 cigarettes per day [23])  
94 and not taking medications (other than oral contraceptives reported in 1 study [31]).  
95 The quality of the studies was moderate-to-high according to a previously validated  
96 scale [45, 51]. The mean score was  $13.9 \pm 1.2$  for studies assessing BASMF and  $11.8 \pm 1.2$   
97 for studies assessing RASMF, out of a possible 16 points (Table S<sub>1</sub> and S<sub>2</sub>). As for the  
98 evaluation of potential bias, the Begg and Mazumdar's funnel plot for the MD in BASMF  
99 was moderately asymmetric, suggesting the presence of publication bias and/or other



100 biases (Figure S<sub>2</sub>). The Begg and Mazumdar's funnel plot for the SMD in RVSMF was  
101 relatively symmetrical (Figure S<sub>3</sub>).

102

### 103 *Brachial artery smooth muscle function (BASMF)*

104 All studies assessing BASMF evaluated the vasodilator response to 0.4 mg of  
105 nitroglycerin by means of high-resolution ultrasound (Table 2). Resting brachial  
106 diameter ranged from 3.0 to 4.4 mm, with older groups commonly presenting a larger  
107 resting brachial diameter than young groups. After data pooling, the meta-analysis  
108 revealed that BASMF was lower in older compared with young groups (15 studies,  
109 MD=-1.89%; P=0.04) (Figure 2). Significant heterogeneity was detected ( $I^2=74%$ ;  
110  $P<0.00001$ ). In subgroup analyses, studies above the median in presence of females in  
111 the study group showed lower BASMF in older compared with young groups (8  
112 studies, MD=-3.38%; P=0.01). In contrast, studies below the median in presence of  
113 females had similar BASMF in older and young groups (7 studies, MD=0.19%; P=0.80).  
114 Both sex subgroups were significantly different when compared with each other  
115 (P=0.02) (Table S<sub>3</sub>). In addition, lower brachial artery endothelial function in older  
116 compared with young groups was related to lower BASMF (P=0.03, Table S<sub>3</sub>). No  
117 other potential moderating factor (n, age, height, weight, BMI, SBP, DBP,  $VO_{2max}$ ,  
118 vascular assessment, methodological quality, year of publication) significantly influenced  
119 the MD in BASMF between older and young groups in subgroup analyses (Table S<sub>3</sub>).

120

### 121 *Resistance artery smooth muscle function (RASMF)*

122 RASMF was determined by evaluating the absolute peak [6, 14, 15, 18, 23, 24, 30-33,  
123 35], percent increase from baseline [8, 9, 16, 17, 19-21, 34] or slope [22] in  
124 vasodilation in response to sodium nitroprusside (Table 3). After data pooling, the

125 RASMF was lower in older compared with young groups (20 studies, SMD=-0.46;  
126 P=0.0008) (Figure 3). Significant heterogeneity was detected ( $I^2=57\%$ ; P=0.0008). In  
127 subgroup analyses, studies above the median in presence of females showed lower  
128 RASMF in older compared with young groups (10 studies, SMD=-0.77; P=0.001). In  
129 contrast, studies below the median in presence of females presented similar RASMF in  
130 older and young groups (9 studies, SMD=-0.17; P=0.20). Both sex subgroups were  
131 significantly different when compared with each other (P=0.02) (Table S<sub>3</sub>). No other  
132 potential moderating factor (n, age, height, weight, BMI, SBP, DBP, VO<sub>2max</sub>, vascular  
133 assessment, methodological quality, year of publication) significantly influenced the  
134 SMD in RASMF between older and young groups (Table S<sub>3</sub>).

135

## 136 DISCUSSION

137 In this systematic review and meta-analysis, we pooled and analyzed data from 33  
138 articles comparing vascular SMF, determined by the vasodilator response to exogenous  
139 NO donors, in 550 older and 516 young healthy subjects. The main finding of this  
140 meta-analysis is that vascular SMF is significantly lower in older compared to young  
141 individuals, a finding that is similarly present in conduit and resistance arteries (Figure 2  
142 and 3). In subgroup analyses, we found that sex altered the impact of age on vascular  
143 SMF. More specifically, studies including females only or a higher ratio of females to  
144 males displayed a significant and marked impact of age on conduit and resistance artery  
145 SMF, whilst studies involving males only or a lower ratio of females to males reported  
146 no effect of age on SMF (Table S<sub>3</sub>).

147

148 The impact of age on vascular SMF had not been explored in detail in most previous  
149 individual studies (Table 2 and 3), possibly because of low statistical power and

150 presence of confounding factors inherent in cross-sectional comparisons. Results from  
151 this meta-analysis indicate that, in addition to endothelial dysfunction, older age is  
152 associated with smooth muscle dysfunction in conduit and resistance arteries, as  
153 represented by reduced smooth muscle sensitivity to a NO donor. Consistent with  
154 this finding, studies performed in older rats demonstrated reduced vasodilator  
155 response to NO [27-29] and decreased vascular smooth muscle expression of soluble  
156 guanylyl cyclase (sGC) [27, 52] (i.e., the principal intracellular receptor of NO and  
157 mediates vasodilation via formation of cyclic guanosine monophosphate (cGMP) [53]).  
158 In humans, decreased expression and activity of sGC in brain tissue have been related  
159 to advanced age and Alzheimer's disease, respectively, although no specific vascular  
160 measures were provided [54, 55]. Whether an age-related reduction in expression and  
161 activity of sGC in vascular smooth muscle contributes to a blunted vascular  
162 responsiveness to NO needs further investigation.

163

164 A consistent finding from previous studies is that brachial artery flow-mediated  
165 dilation, as well as resistance artery responses to acetylcholine, are impaired in older  
166 healthy humans. As most of these previous studies found no difference in the  
167 endothelium-independent vasodilation to exogenous NO donors, the general  
168 consensus was that the lower flow-mediated dilation and resistance artery responses  
169 to acetylcholine supported the presence of a dysfunctional endothelium. Our results,  
170 however, suggest the presence of a small-to-moderate but significant age-related  
171 impairment in SMF that is present across the vascular tree. Moreover, our finding also  
172 suggests that a portion of the impaired NO-dependent responses in conduit and  
173 resistance arteries in older healthy subjects may be in part due to reduced smooth  
174 muscle sensitivity to NO. This important observation should be taken into

175 consideration when interpreting the lower NO-dependent responses in healthy older  
176 humans.

177

178 Another important finding of this meta-analysis was the influence of sex on the  
179 difference in vascular SMF between young and older humans. Studies that involved  
180 (predominantly) males, which is a common observation in studies in the field of  
181 cardiovascular physiology, found similar BASMF and RASMF between older and young  
182 groups. However, studies with females only or studies with a relatively high ratio of  
183 females to males reported a significantly lower BASMF and RASMF in the older group  
184 compared with the young group. One potential explanation for this finding may be  
185 related to menopausal status in women. Indeed, reduced vasodilation to exogenous  
186 NO donors has been reported in conduit and resistance arteries of healthy older  
187 women but not in those on hormonal replacement therapy. This suggests that  
188 hormone replacement therapy in postmenopausal women may preserve the sensitivity  
189 of vascular smooth muscle to NO [56-58]. In this regard, it is important to emphasize  
190 that none of the studies included in our meta-analyses involved women on hormonal  
191 therapy. Consequently, based on the assumption that the majority of older women  
192 were post-menopausal, the lower vascular SMF in older groups could be a result of the  
193 loss of vascular protection from circulating estrogens associated with post-menopause.  
194 Nevertheless, removal of estrogen with ovariectomy in rodents does not appear to  
195 alter vasodilator responses to sodium nitroprusside [59, 60], suggesting that loss of  
196 estrogen after menopause may not be the sole factor contributing to reduced vascular  
197 SMF in older women. [Alternatively, estrogen-independent alterations in the NO](#)  
198 [signaling pathway could underlie the altered vascular SMF in older women in view of](#)  
199 [the decreased NO-stimulated vascular cGMP formation in middle-aged and older](#)

200 women (with no report of menopause) compared with men [61]. Whilst speculative,  
201 the sex-related reduced vascular sensitivity to NO might partly explain why women  
202 remain more symptomatic and present lower cardiovascular status compared with  
203 men after long-term nitrate therapy for heart failure [62].

204

205 A potential explanation for a lower NO-mediated dilation of the brachial artery in  
206 older subjects may relate to the larger baseline diameter. As demonstrated in several  
207 previous studies, the brachial artery dilator response to ischemia or glyceryl trinitrate  
208 is inversely related to the baseline diameter [63-67]. Nonetheless, in the present study,  
209 the difference in baseline brachial diameter between older and young groups did not  
210 modify the MD in BASMF according to subgroup analysis (Table S<sub>3</sub>). Moreover, the  
211 magnitude of the difference in baseline brachial diameter between older men and  
212 young men (4 studies) was not different than the difference between older women and  
213 young women (3 studies) ( $P=0.24$ ). Furthermore, the impact of sex on BASMF is not  
214 explained by artery diameter [68]. Taken together, we believe differences in brachial  
215 artery diameter between older and young groups do not entirely explain the age-  
216 related decline in BASMF observed in the present meta-analysis.

217

218 As for the prognostic value of vascular SMF, adverse cardiovascular events were  
219 associated with reduced smooth muscle sensitivity to NO in high-risk populations  
220 when assessed in conduit [69] and resistance arteries [70] by means of ultrasound and  
221 plethysmography, respectively. It should be noted that blood flow responses in the  
222 microcirculation assessed via plethysmography and laser Doppler techniques—such as  
223 those used in the studies included in the RASMF meta-analysis— may be, to a certain  
224 degree, dependent on microvascular structure, which in turn is strongly associated

225 with cardiovascular events [71]. Conversely, NO-dependent responses determined by  
226 micromyography did not predict cardiovascular events in high-risk patients, suggesting  
227 that resistance artery function per se has low clinical relevance [72]. Similarly, it cannot  
228 be discarded that the age-related reduction in RASMF is an observation dependent on  
229 differences in microvascular structure. Further research is warranted to determine the  
230 extent to which vascular structural changes with ageing influence the non-invasive  
231 estimates of smooth muscle responsiveness to NO and their clinical significance.

232

233 There are some limitations in this meta-analysis. First, cross-sectional comparisons may  
234 be misleading when addressing the question of the impact of advanced age [73].  
235 Second, we were unable to accurately determine the level of physical activity or fitness  
236 in the included studies. Since physical activity or exercise training has well-established  
237 effects on endothelial function [74], we were unable to identify the potential impact of  
238 this factor on our results. Likewise, body composition, fat distribution and blood lipids  
239 could be suggested as potential moderating factors, albeit not investigated in this meta-  
240 analysis. Third, although single-dose (0.4 mg of nitroglycerin) is the common procedure  
241 to evaluate BASMF (Table 2), there are physiological and methodological variables that  
242 may affect the reproducibility of BASMF [75, 76]. In addition, the administration of 0.4  
243 mg of nitroglycerin is considered to induce a maximal NO-mediated vasodilator  
244 response [75], which could be dissociated from vascular smooth muscle submaximal  
245 responses to lower or step-wise doses of NO. In this respect, dose-response studies  
246 might have higher sensitivity to detect small differences in BASMF between older and  
247 young groups [75].

248

249 In conclusion, the current meta-analysis provides evidence that advanced age is  
250 associated with a relatively small, but significant impairment in conduit and resistance  
251 artery SMF in healthy humans. The magnitude of vascular smooth muscle dysfunction  
252 seems more prevalent in women than in men, potentially related to the loss of  
253 circulating estrogens in women after menopause. A potential implication of our finding  
254 is that the impairment in conduit and resistance artery endothelial function with  
255 advanced age may, at least in part, be attributed to changes in vascular SMF in healthy  
256 adults. Further studies are needed to determine sex-related mechanisms that may  
257 influence the ageing-associated alterations in vascular SMF in humans.

258

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261

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## FIGURE LEGENDS

**FIGURE 1** Flow diagram of the process of study selection

**FIGURE 2** Forest plot of the mean difference (MD) in brachial artery smooth muscle function (BAsMF) between older and young groups. BAsMF was expressed as the percentage increase in brachial artery diameter from baseline to maximal vasodilation. Squares represent the MD in BAsMF for each study. The diamond represents the pooled MD in BAsMF across studies. CI, confidence interval; IV, inverse variance; SD, standard deviation

**Figure 3.** Forest plot of the standardized mean difference (SMD) in resistance artery smooth muscle function (RASMF) between older and young groups. Squares represent the SMD in RASMF for each study. The diamond represents the pooled SMD in RASMF across studies. CI, confidence interval; IV, inverse variance; SD, standard deviation

**TABLE I.** Main clinical characteristics of studies included in the meta-analyses

Study, year of publication	n		Females (%)		Age (years)		BMI (m <sup>2</sup> /kg)		SBP (mm Hg)		DBP (mm Hg)		Morbidities
	YNG	OLD	YNG	OLD	YNG	OLD	YNG	OLD	YNG	OLD	YNG	OLD	
<i>Studies assessing brachial artery SMF</i>													
DeVan et al [4], 2013	21	25	12	17	24±5	62±6*	23±5	26±6*	111±11	121±12*	60±5	75±6*	none
Pierce et al [42], 2011	16	18	0	0	25±4	63±5*	26±4	27±3	118±13	124±11	69±9	78±5*	none
Black et al [3], 2009	9	8	100	100	26±3	60±6*	23±3	31±6*	101±12	122±14*	56±9	67±8*	none
Donato et al [6], 2009	27	23	0	0	22±5	62±5*	25±5	26±5*	117±11	124±10*	63±11	78±10*	none
Walker et al [12], 2009	26	15	0	0	23±10	66±4*	24±5	26±4	116±10	124±12*	61±5	74±8*	none
Donato et al [5], 2007	51	44	0	0	23±7	63±7*	24±7	26±7*	114±7	121±13*	62±7	75±7*	none
Gates et al [39], 2007	10	12	50	50	21±3	60±7*	22±3	25±3*	105±6	114±17	60±6	70±10*	none
Parker et al [41], 2006	8	8	100	100	22±4	70±7*	22±3	25±3*	109±15	131±11*	68±7	78±11*	none
Eskurza et al [36], 2006	9	9	11	11	26±3	64±6*	24±4	26±2	110±6	108±9	60±9	71±9*	none
Eskurza et al [38], 2005	10	9	0	0	22±3	62±6*	23±3	26±3	110±9	111±12	58±6	69±3*	none
Heiss et al [40], 2005	20	20	50	65	25±4	61±9*	22±4	24±4	117±9	122±13	77±9	81±9	none
Eskurza et al [37], 2004	11	9	0	0	25±3	64±6*	24±3	26±3	113±7	116±12	63±7	73±12*	none
McCohon et al [10], 2000	10	10	100	100	28±5	61±3*	23±2	24±2	106±13	124±9*	75±10	79±12	none
Woo et al A [43], 1997	19	19	68	68	29±5	63±5*	24±8	23±4	115±11	129±14*	76±10	83±8	none
Woo et al B [43], 1997	19	19	68	68	28±6	63±4*	23±3	25±3	108±9	127±13*	75±7	79±11	none
<b>Mean</b>	<b>18</b>	<b>17</b>	<b>37</b>	<b>39</b>	<b>25</b>	<b>63</b>	<b>23</b>	<b>26</b>	<b>111</b>	<b>121</b>	<b>66</b>	<b>75</b>	—
<i>Studies assessing resistance artery SMF</i>													

Millet et al [30], 2012	20	42	85	86	24±3	69±7*	22±3	23±4	116±8	128±10*	67±7	71±7*	none
Donato et al [8], 2011	16	22	25	32	25±4	64±5*	24±3	28±5*	111±12	126±14*	71±8	78±9*	none
Westby et al [24], 2011	14	14	0	0	25±4	61±7*	24±2	26±2*	114±11	125±11*	66±7	78±7*	none
Kirby et al [16], 2010	13	13	38	38	21±4	66±11*	22±2	24±3*	N/A	N/A	N/A	N/A	none
Tew et al [19], 2010	15	14	20	29	27±2	65±6*	25	27	119±12	124±12	75±9	79±7	none
Donato et al [6], 2009	15	18	0	0	21±4	62±4*	25±4	26±4*	117±8	124±8*	63±8	78±8*	none
Nicholson et al [31], 2009	10	10	40	40	29±9	68±4*	24±3	25±2	116±16	122±13	62±8	69±12	none
Kirby et al [17], 2009	14	14	36	36	22±4	65±7*	25±3	24±3	N/A	N/A	N/A	N/A	none
Donato et al [32], 2008	11	14	18	29	23±7	64±4*	24±2	26±3	110±10	123±11*	71±7	78±7*	none
Galetta et al [9], 2006	16	16	50	31	27±2	65±4*	23±2	24±2	118±7	122±6	75±3	80±2*	none
Al-Shaer et al [21], 2006	15	17	47	24	22±4	62±12*	25±4	28±4*	116±12	126±12*	67±12	78±8*	none
Newcomer et al [33], 2005	8	8	0	0	24±6	67±6*	25±3	26±3	113±11	129±8*	74±11	81±8	none
Weverling-Rijnsburger et al [34], 2004	7	8	0	0	22	80*	N/A	N/A	N/A	N/A	N/A	N/A	none
Ahlers et al [14], 2004	14	10	0	0	23±3	62±7*	N/A	N/A	118±11	120±19	74±11	72±13	none
Smith et al [35], 2003	10	20	0	0	28±3	62±4*	25±5	29±3	115±9	124±9	64±9	81±9*	none
Minson et al [18], 2002	10	10	50	50	22±6	77±16*	24±3	24±3	120±13	137±19*	71±9	79±13	none
DeSouza et al [15], 2002	22	41	0	0	28±5	61±6*	23±6	27±4*	114±14	122±13*	65±9	76±13*	none
Wang et al [20], 2002	12	10	0	0	24±3	67±3*	22±5	23±4	127±17	139±22	77±10	73±16	none
Taddei et al [23], 2000	12	12	33	33	27±2	63±6*	23±4	24±4	119±5	119±6	77±3	78±3	none
Gerhard et al [22], 1996	11	7	N/A	N/A	20-29	60-69*	N/A	N/A	N/A	N/A	N/A	N/A	none
<b>Mean</b>	<b>13</b>	<b>16</b>	<b>23</b>	<b>23</b>	<b>24</b>	<b>66</b>	<b>24</b>	<b>26</b>	<b>116</b>	<b>126</b>	<b>70</b>	<b>77</b>	—

Data are *n*, % of females, mean or mean  $\pm$  SD. One study presented two groups of older subjects, each of which had been independently compared with a young group [43], thus they were evaluated as individual studies (distinguished by A and B). \* significantly different from young group at  $P < 0.05$   
BMI, body mass index; DBP, diastolic blood pressure; OLD, older group; SBP, systolic blood pressure; SMF, smooth muscle function; YNG, young group



**TABLE 2.** Brachial artery smooth muscle function (SMF) assessment of studies included in the meta-analysis

Study, year of publication	Artery	Wall-tracking system	Resting diameter (mm)		SMF			EF
			YNG	OLD	Stimulus	Dose (mg)	OLD vs. YNG	OLD vs. YNG
DeVan et al [4], 2013	brachial	computerized	4.0±0.4	4.0±0.5	NTG sublingual	0.4	↔	↓
Pierce et al [42], 2011	brachial	computerized	4.0±0.4	4.1±0.5	NTG sublingual	0.4	↔	↓
Black et al [3], 2009	brachial	computerized	3.3±0.1	3.6±0.6	NTG sublingual	0.4	↔	↓
Donato et al [6], 2009	brachial	computerized	N/A	N/A	NTG sublingual	0.4	↔	↓
Walker et al [12], 2009	brachial	computerized	4.1±0.4	4.4±0.5*	NTG sublingual	0.4	↔	↓
Donato et al [5], 2007	brachial	computerized	N/A	N/A	NTG sublingual	0.4	↔	↓
Gates et al [39], 2007	brachial	computerized	3.7±0.4	4.0±0.8	NTG sublingual	0.4	↔	↓
Parker et al [41], 2006	brachial	computerized	3.0±0.5	3.1±0.4	NTG sublingual	0.4	↓	↓
Eskurza et al [36], 2006	brachial	computerized	4.0±0.6	4.3±0.7	NTG sublingual	0.4	↔	↓
Eskurza et al [38], 2005	brachial	computerized	4.1±0.4	4.4±0.5	NTG sublingual	0.4	↔	↓
Heiss et al [40], 2005	brachial	computerized	3.7±0.9	4.2±0.5*	NTG sublingual	0.4	↔	↓
Eskurza et al [37], 2004	brachial	manual	4.1±0.3	4.3±0.3	NTG sublingual	0.4	↔	↓
McCrohon et al [10], 2000	brachial	manual	3.1±0.3	3.6±0.4*	NTG sublingual	0.4	↓	↓
Woo et al A [43], 1997	brachial	manual	3.5±0.5	3.6±0.6	NTG sublingual	0.4	↔	↔
Woo et al B [43], 1997	brachial	manual	3.4±0.6	3.7±0.5	NTG sublingual	0.4	↔	↓

Data are dose or mean ± SD. One study presented two groups of older subjects, each of which had been independently compared with a location-matched young group [43], thus they were evaluated as individual studies (distinguished by A and B). \* significantly different from young group at P<0.05  
 EF, endothelial function; N/A, data not available; NMD, nitrate-mediated dilation; NTG, nitroglycerin; OLD, older group; SMF, smooth muscle function; YNG, young group; ↔, no significant difference between older and young groups; ↓, significant decrease in older compared with young groups

**TABLE 3.** Resistance artery smooth muscle function (SMF) assessment in studies included in the meta-analysis

Study, year of publication	Vascular region	Technique	SMF		EF	
			Stimulus	OLD vs. YNG	Stimulus	OLD vs. YNG
Millet et al [30], 2012	supramedial malleolar (skin)	laser Doppler	SNP iontophoresis	↔	local heating	↔
Donato et al [8], 2011	forearm	plethysmography	SNP infusion	↔	ACh infusion	↓
Westby et al [24], 2011	forearm	plethysmography	SNP infusion	↔	ACh infusion	↓
Kirby et al [16], 2010	forearm	plethysmography	SNP infusion	↔	ACh infusion	↓
Tew et al [19], 2010	forearm (skin)	laser Doppler	SNP iontophoresis	↓	ACh iontophoresis	↓
Donato et al [6], 2009	forearm	plethysmography	SNP infusion	↔	ACh infusion	↓
Nicholson et al [31], 2009	forearm	plethysmography	SNP infusion	↔	N/A	N/A
Kirby et al [17], 2009	forearm	plethysmography	SNP infusion	↓	ACh infusion	↓
Donato et al [32], 2008	forearm	plethysmography	SNP infusion	↔	ACh infusion	↓
Galetta et al [9], 2006	forearm	plethysmography	SNP infusion	↔	ACh infusion	↓
Al-Shaer et al [21], 2006	forearm	plethysmography	SNP infusion	↓	ACh infusion	↓
Newcomer et al [33], 2005	leg <sup>a</sup>	ultrasound	SNP infusion	↔	ACh infusion	↓
Weverling-Rijnsburger et al [34], 2004	forearm	plethysmography	SNP infusion	↔	ACh infusion	↔
Ahlers et al [14], 2004	forearm	plethysmography	SNP infusion	↔	ACh infusion	↓
Smith et al [35], 2003	forearm	plethysmography	SNP infusion	↔	Bk infusion	↔
Minson et al [18], 2002	forearm (skin)	laser Doppler	SNP microdialysis	↓	local heating	↓
DeSouza et al [15], 2002	forearm	plethysmography	SNP infusion	↔	ACh infusion	↓

Wang et al [20], 2002	lower leg (skin)	laser Doppler	SNP iontophoresis	↔	ACh iontophoresis	↓
Taddei et al [23], 2000	forearm	plethysmography	SNP infusion	↓	ACh infusion	↓
Gerhard et al [22], 1996	forearm	plethysmography	SNP infusion	↔	ACh infusion	↓

<sup>a</sup> Leg and forearm resistance artery SMF were reported. Leg resistance artery SMF was used in meta-analysis because of lower (as compared with forearm) coefficient of variation

ACh, acetylcholine; Bk, bradykinin; EF, endothelial function; N/A, data not available; OLD, older group; SMF, smooth muscle function; SNP, sodium nitroprusside; YNG, young group; ↔, no significant difference between older and young groups; ↓, significant decrease in older compared with young groups