To the Editor: Ross makes a powerful argument for the measurement of cardiorespiratory fitness (CRF) in clinical care and challenges us to take action. Cardiorespiratory fitness is potentially a stronger predictor of mortality than are established risk factors such as smoking, hypertension, high cholesterol, and type 2 diabetes mellitus, and its routine measurement would certainly improve patient care.

The routine measurement of CRF, however, is not feasible in most clinical settings because of logistics, cost, and time. The use of nonexercise estimates of CRF has been advocated as an alternative to CRF measurement. These CRF estimates are based on complex sex-specific formulas that are negatively affected by age, body mass index, and resting heart rate and positively affected by a physical activity score/index obtained from self-reported exercise intensity, duration, and frequency.

The exercise vital sign (EVS) has been proposed to help health care systems and providers prioritize physical activity assessment, advice, and promotion during clinical encounters. The EVS is the product of the answer to 2 questions: “On average, how many days per week do you engage in moderate to strenuous exercise like a brisk walk?” and “On average how many minutes do you engage in exercise at this level?” The result can determine whether an individual is meeting current physical activity guidelines. The EVS includes 2 of the self-reported physical activity components (frequency and duration) that formulas use to estimate CRF. The EVS is easily obtained and calculated and is already included in many electronic medical records.

Until CRF can be more easily measured or estimated in clinical practice, health care providers should focus on promoting physical activity and CRF by routinely obtaining the EVS.

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Importance of assessing cardiorespiratory fitness in clinical practice: a case for fitness as a clinical vital sign

To the Editor: In his letter, Langland acknowledges the importance of including cardiorespiratory fitness (CRF) as a routine measure in clinical practice, as CRF is a stronger predictor of mortality than are established risk factors, and consequently its routine measure would improve patient care. Langland agrees that direct measures of CRF in most clinical settings is not feasible because of logistics and cost. However, he posits that the alternative recommendation—to use nonexercise estimates of CRF—presents a challenge, as they are based on complex sex-specific formulas that incorporate age, body mass index, resting heart rate, and self-reported measures of physical activity to derive the CRF estimate. Alternatively, health care professionals are encouraged to assess physical activity levels using the exercise vital sign approach that determines physical activity on the basis of a response to 2 straightforward questions.

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