Continuous and intermittent exercise responses in individuals with chronic obstructive pulmonary disease

S Sabapathy, R A Kingsley, D A Schneider, L Adams, N R Morris

Background: While the acute physiological responses to continuous exercise have been well documented in individuals with chronic obstructive pulmonary disease (COPD), no previous study has examined the response to intermittent exercise in these patients.

Methods: We examined the physiological responses of 10 individuals with moderate COPD (forced expiratory volume in 1 second 52 (15)% predicted) who performed both an intermittent (1 min exercise and 1 min rest) and a continuous cycle ergometer test on separate days. Both intermittent and continuous exercise tests were performed at the same power output, calculated as 70% of the peak power attained during an incremental exercise test.

Results: Intermittent exercise was associated with significantly lower values for oxygen uptake, carbon dioxide output, expired ventilation, heart rate, plasma lactate concentration, and ratings of breathlessness than continuous exercise. Subjects were able to complete a significantly greater total amount of work during intermittent exercise (71 (32) kJ) than during continuous exercise (31 (24) kJ). The degree of dynamic lung hyperinflation (change in end expiratory lung volume) was significantly lower during intermittent exercise (0.23 (0.07) l) than in continuous exercise (0.52 (0.13) l).

Conclusions: The greater amount of work performed and lower measured physiological responses achieved with intermittent exercise may allow for greater peripheral training adaptations in individuals with more limited lung function. The results suggest that intermittent exercise may be superior to continuous exercise as a mode of training for patients with COPD.
absolute power output in a group of COPD patients with moderate airflow obstruction. Performing IE and CE at the same absolute intensity will normalise the metabolic demand and allow for a comparison of the physiological responses between the two exercise modes. It is hypothesised that (1) exercise tolerance (total work performed) will be greater during IE than during CE, (2) IE will be associated with a lower degree of physiological perturbation (VO$_2$, VE, blood lactate concentration, dyspnoea), (3) the degree of dynamic hyperinflation will be lower in IE than in CE, and (4) dynamic hyperinflation will be positively correlated with breathlessness.

**METHODS**

**Subjects and experimental design**

Five men and five women with COPD of mean (SD) age 68 (8) years participated in this study. Inclusion criteria for the study were (1) patients classified as having moderate COPD, (2) shortness of breath on exertion, and (3) no documented history of substantial co-morbidity. Subjects visited the laboratory on four separate occasions with each visit separated by at least 48 hours. During the first visit the subjects performed pulmonary function tests, were familiarised with the exercise testing procedures, and provided written informed consent. The second visit was used to determine each subject’s maximal exercise capacity. During the subsequent two visits the subjects performed CE and IE on a cycle ergometer. The order of the CE and IE tests was randomised, and the subjects performed only a single bout of exercise on either test day. The experimental protocol was approved by the Griffith University Human Research ethics committee.

**Experimental procedures**

**Pulmonary function assessment**

Spirometry, static lung volumes, lung transfer factor (TLC), and inspiratory capacity (IC) during exercise were measured using a closed circuit pulmonary function testing system (Collins GS Modular PFT, Braintree, MA, USA). Total lung capacity (TLC) was measured using the helium dilution method while TLC was assessed with the single breath carbon monoxide test.

**Determination of peak VO$_2$ for cycling**

The incremental exercise test used to measure peak VO$_2$ was performed on a Lode cycle ergometer (Excalibur Sport, Groningen, The Netherlands). Subjects commenced unloaded cycling for 3 minutes and then the power output was increased by 4 W/30 s for men and by 3 W/30 s for women until volitional termination of the test.

During the incremental cycling test subjects breathed through a mouthpiece and wore a nose clip. VO$_2$, carbon dioxide output (VCO$_2$) and VE were measured by breath and averaged over 30 second intervals using a metabolic measuring system (MedGraphics CPX/D, St Paul, MN, USA). A 12-lead electrocardiograph (ECG) configuration was used to monitor cardiac rhythm and to determine heart rate (MedGraphics CardiO$_2$, St Paul, MN, USA). Peak exercise values for incremental cycling were calculated as the average of the two highest consecutive 30 second values obtained before termination of exercise.

**Continuous and intermittent exercise tests**

The power output for the continuous and intermittent exercise tests was calculated as 70% of the power output achieved at peak VO$_2$. Each of the CE and IE tests was preceded by 3 minutes of unloaded cycling. The IE test consisted of 1 minute of exercise interspersed with 1 minute of rest—that is, an exercise to rest ratio of 1:1. Subjects were encouraged to cycle until the limit of tolerance during both exercise tests. The tests were terminated if subjects were able to complete 30 minutes of CE and/or 60 minutes of IE. Gas exchange indices were measured as described for the incremental exercise test. The breath by breath data were smoothed using a middle five of seven breath averaging procedure. Heart rate and rhythm (Lohmeier M607, Munich, Germany) were monitored during the tests with the ECG electrodes placed in a CM5 configuration. Gas exchange and heart rate values are reported as the peak value attained within a 10 second bin at the end of every minute of exercise. For example, the value at the end of the first minute of exercise for both modes would represent the peak value attained between 0:50 and 1:00 min. Total work completed was calculated as the product of exercise time and external power output.

**Effect of VO$_2$ kinetics on intermittent exercise response**

In order to determine if any differences in VO$_2$ between the exercise modes were related to the on-transient kinetics of VO$_2$, the time constant ($\tau$) of the initial rise in VO$_2$ (the phase II or primary component) during the CE bout was calculated (see online data supplement at www.thoraxjnl.com supplementary). The phase II $\tau$ (\(\tau = 82 (8)\) seconds, \(N = 7\)) was then used to predict the VO$_2$ amplitude at 1 minute of exercise and compared with the mean measured VO$_2$ obtained during the exercise intervals of the IE bout. To demonstrate the effect of the speed of the on-transient component on the VO$_2$ amplitude for IE, a $\tau$ value of 42 seconds was also used to predict the IE response. This $\tau$ value was previously determined for healthy older subjects performing constant load exercise at a similar relative intensity to that used in the present study.

**Determination of plasma lactate concentration**

Before commencement of the CE and IE tests an indwelling cannula was inserted into an antecubital vein of each subject. The plasma lactate concentration was determined (Ciba-Corning Blood Gas Analyser, Medfield, MA, USA) from blood samples obtained at rest, at the end of 3 minutes of unloaded cycling, after 3 and 6 minutes of CE and IE, and at the end of the exercise bouts.

| Table 1 Subject characteristics, pulmonary function, and peak exercise values obtained during incremental exercise |
|-----------------|-----------------|-----------------|-----------------|-----------------|
| Age (years)     | 68 (8)          | % predicted     |                 |
| Height (cm)     | 165 (12)        |                 |                 |
| Body mass (kg)  | 68.7 (14.0)     |                 |                 |
| Pulmonary function |
| FEV$_1$ (l)     | 1.35 (0.50)     | 52 (15)         |                 |
| FVC (l)         | 2.86 (1.15)     | 87 (8)          |                 |
| FEV$_1$/FVC (%) | 48 (7)          |                 |                 |
| TLC (l)         | 6.64 (1.87)     | 126 (18)        |                 |
| FRC (l)         | 4.40 (1.21)     | 144 (20)        |                 |
| TCO$_2$ (mmol/min/mlHg) | 9.32 (0.76) | 46 (13)         |                 |
| Incremental exercise test |
| VCO$_2$peak (ml/kg/min) | 14.8 (2.3) | 61.3 (14.5)    |                 |
| Peak power (W)  | 57 (25)         |                 |                 |
| VTpeak (l/min)  | 3.84 (15.3)     | 82.0 (8.4)      |                 |
| HR peak (beats/min) | 126 (13)    | 82.6 (9.6)      |                 |

Values presented are mean (SD). FEV$_1$, forced expiratory volume in 1 second; FVC, forced vital capacity; TLC, total lung capacity; FRC, functional residual capacity; TCO$_2$, carbon monoxide transfer factor; VCO$_2$peak, peak CO$_2$ uptake; VTpeak, peak expired ventilation; HRpeak, peak exercise heart rate.
Measurement of inspiratory capacity and end expiratory lung volume

End expiratory lung volume (EELV) was calculated by subtracting IC from the TLC. Inspiratory capacity was measured at rest (while seated on the cycle ergometer), following 7 minutes of exercise, and at the end of CE and IE. The IC manoeuvre was demonstrated before each test by one of the investigators. At each measurement point the subjects were prompted and encouraged to inspire maximally to TLC. The sampling lines to the pulmonary function system and the pneumotachograph and gas sampling lines to the metabolic cart were interfaced through a single mouthpiece worn throughout the duration of the CE and IE tests.

Ratings of breathlessness

During the CE and IE tests subjects were asked to provide ratings of their perceived shortness of breath using a word labelled visual analogue scale. Following a clear explanation of the scale, the subjects were asked to rate their breathlessness at rest, following 7 minutes of exercise, and at the end of exercise.

Statistical analysis

All results are presented as mean (SE) unless otherwise stated. A two way analysis of variance was performed to detect changes in the dependent variables across the two within subject factors (time and exercise mode). Post hoc tests with Bonferroni adjustments were used when a significant interaction or main effect was identified. The differences in time to exhaustion, total work completed, EELV, and subjects’ rating of breathlessness between the two exercise modes were compared using dependent samples t tests. The relationship between EELV and perceived intensity of breathlessness was assessed using Pearson’s correlation coefficient. Statistical significance was accepted at p<0.05. Data were analysed using SPSS Version 11.5 (Chicago, IL, USA).

RESULTS

The physical characteristics of the subjects, pulmonary function test results, and peak exercise values obtained during incremental cycling are shown in table 1. The pulmonary function results showed that the subjects had moderate COPD. Peak VO₂ was reduced by about 40% relative to normal age predicted values.

Figure 1  (A) Oxygen uptake, (B) CO₂ output, (C) expired ventilation and (D) heart rate responses during continuous (closed circles) and intermittent exercise (open circles). Error bars denote SE. The rest intervals were eliminated from the IE trend to equalise the timeline between exercise modes. UL: unloaded cycling; EE: end exercise. *p<0.05, continuous exercise v intermittent exercise.

Figure 2  Plasma lactate response during continuous (closed circles) and intermittent exercise (open circles). Error bars denote SE. UL, unloaded cycling; EE, end exercise. The rest intervals were eliminated from the IE trend to equalise the time line between exercise modes. *p<0.05, continuous exercise v intermittent exercise.
Figure 1 shows the cardiopulmonary responses measured during CE and IE. A significant mode by time interaction was observed for \( \dot{V}O_2 \) (F = 41.87, p < 0.001), \( \dot{V}CO_2 \) (F = 55.30, p < 0.001), \( \dot{V}E \) (F = 21.57, p < 0.001) and heart rate (F = 24.43, p < 0.001). For both modes of exercise \( \dot{V}O_2 \), \( \dot{V}CO_2 \) and \( \dot{V}E \) increased significantly from the unloaded to loaded exercise transition (measured 1 minute after the workload was applied). These variables then remained relatively unchanged throughout the duration of IE, but continued to increase significantly up to 6 minutes of CE. During CE the end exercise values for \( \dot{V}O_2 \), \( \dot{V}CO_2 \) and \( \dot{V}E \) were not significantly different from the 6 minute values. There was a significant increase in heart rate from unloaded cycling to the end of exercise in both CE and IE (fig 1D). However, the increase in heart rate between consecutive time points was only significant from 3 minutes of CE onwards and between 6 minutes and the end of exercise during IE.

Continuous exercise resulted in significantly higher values for \( \dot{V}O_2 \), \( \dot{V}CO_2 \), \( \dot{V}E \) and heart rate from 3 minutes of exercise onwards in comparison to IE. At the end of exercise the mean differences between CE and IE were: \( \dot{V}O_2 \) 0.25 l/min (95% CI 0.10 to 0.34); \( \dot{V}CO_2 \) 0.34 l/min (95% CI 0.23 to 0.45); \( \dot{V}E \) 9.14 l/min (95% CI 4.94 to 13.30); heart rate 15 beats/min (95% CI 7.01 to 21.99). The predicted \( \dot{V}O_2 \) (0.85 (0.09) l/min) using \( \tau \) values calculated from the individual CE tests was not significantly different from the values measured during IE (0.82 (0.07) l/min). However, experimentally “speeding” on-transient kinetics through the use of a \( \tau \) value derived from healthy older individuals resulted in predicted \( \dot{V}O_2 \) values (0.97 (0.10) l/min) that were significantly greater than the values measured in our subjects.

A significant mode by time interaction was also observed for plasma lactate concentrations (F = 8.31, p < 0.001). Plasma lactate increased from rest through to the end of exercise during both CE and IE (fig 2). While plasma lactate concentrations during CE were systematically greater than during IE, the differences between exercise modes were only significant at 6 minutes and onwards. The increase in plasma lactate concentrations from rest to the end of exercise was significantly greater during CE (3.1 (0.7) mmol/L) than during IE (1.8 (0.4) mmol/L). The mean difference between exercise modes for plasma lactate concentration at end exercise was 1.7 mmol/L (95% CI 0.8 to 2.5).

The subjects were able to exercise longer and to complete a greater amount of work during IE (29.2 (0.8) min; 70.5 (10.2) kJ) than during CE (11.1 (2.4) min; 30.5 (7.4) kJ). While eight of the 10 subjects were able to perform 60 minutes of IE (which amounts to 30 minutes of exercise), none was able to complete 30 minutes of CE.

Figure 3 shows the change from baseline to the end of exercise in EELV and breathlessness during IE and CE. The change in the degree of breathlessness from rest to the end of exercise was 1.7 mmol/L (95% CI 0.8 to 2.5).

The results of the present study indicate that IE is better tolerated than CE in patients with COPD because of improved ventilatory mechanics as well as reduced metabolic and cardiovascular perturbations. As previously discussed, the amplitude of the \( \dot{V}O_2 \) response at a given exercise intensity during IE is determined primarily by the duration of the exercise period. The 1 minute intervals used during IE in the present study would therefore result in lower \( \dot{V}O_2 \) as well as \( \dot{V}CO_2 \), \( \dot{V}E \) and heart rate values, given that these variables are tightly coupled to metabolism within the active muscle during exercise. When exponential models were applied to the \( \dot{V}O_2 \) data measured during the CE bouts, the predicted \( \dot{V}O_2 \) values at the end of 1 minute of exercise were not significantly different from the \( \dot{V}O_2 \) values obtained during the exercise intervals of the IE bouts (see online data supplement at www.thoraxjnl.com/supplemental). Moreover, the measured \( \dot{V}O_2 \) values were not significantly different between exercise modes during the first minute of exercise following the application of the predetermined workload.
The results suggest that IE may be superior to CE as a mode of training for patients with COPD. Further details are given in the online supplement available at www.thoraxjnl.com/supplemental.

**Authors’ affiliations**

S Sabapathy, R A Kingsley, D A Schneider, L Adams, N R Morris, School of Physiotherapy and Exercise Science, Gold Coast Campus, Griffith University, Queensland, Australia

Supported by the Breathlessness Research Charitable Trust, UK

**REFERENCES**


LUNG ALERT

Adjuvant prednisolone therapy does not improve survival in HIV-associated tuberculous pleurisy

Glucocorticoids reduce excessive inflammation in pleural tuberculosis and have been shown to hasten resolution in HIV negative patients. Active tuberculosis can speed progression of HIV infection since HIV replicates more rapidly in activated lymphocytes. Given that prednisolone therapy is associated with reduced immune activation in HIV positive patients with pleural tuberculosis would decrease viral replication and improve survival.

In this study, 197 Ugandan HIV infected patients with pleural tuberculosis were randomised to receive treatment for 8 weeks with either a reducing dose of prednisolone or placebo, together with 6 months of treatment with a four-drug antituberculosis regime. The median follow up periods were 1.65 and 1.48 years in the prednisolone and placebo groups, respectively. Prednisolone had no effect on either survival or HIV viral load. The mortality rate ratio for prednisolone compared with placebo, after adjusting for confounding factors, was 0.99 (95% CI 0.62 to 1.56, p = 0.95). Use of prednisolone was associated with significantly more rapid improvements in anorexia, weight loss, cough, and radiological resolution of pleural effusion. However, use of prednisolone was also associated with a significantly increased risk of adverse effects (9%) compared with placebo (2%; p = 0.03), and a significantly higher incidence of Kaposis’s sarcoma (prednisolone 4.2 cases/100 person-years; placebo 0 cases/100 person-years, p = 0.02).

In light of the lack of survival benefit and the increased risk of Kaposis’s sarcoma, the authors recommend that prednisolone should not be used in HIV associated tuberculous pleurisy.

R Johns
MRC Clinical Research Fellow, University College London, UK; r.johns@ucl.ac.uk