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

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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 rest intervals) 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 ($71 (32) \text{ kJ}$) than during continuous exercise ($31 (24) \text{ kJ}$). The degree of dynamic lung hyperinflation (change in end expiratory lung volume) was significantly lower during intermittent exercise ($0.23 (0.07) \text{ l}$) than in continuous exercise ($0.52 (0.13) \text{ l}$).

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.

E ndurance training has been shown to reduce ventilatory demand during exercise and improve peripheral muscle function in patients with chronic obstructive pulmonary disease (COPD). While these results are encouraging, individuals with moderate to severe COPD are often unable to sustain prolonged periods of exercise at intensities that could maximise peripheral muscle and central cardiovascular adaptations. Consequently, intermittent exercise (IE) has been suggested as an alternative training modality that may be better tolerated in patients with COPD. Intermittent exercise is characterised by repeated short bouts of exercise separated by periods of rest and may be more suited to COPD patients whose daily activities typically require short bursts of exertion interspersed with periods of recovery.

In healthy individuals IE is associated with lower values for heart rate, oxygen uptake ($\text{VO}_2$), expired ventilation ($\text{VE}$), and blood lactate concentration than continuous exercise (CE). An important functional outcome is that total work performed is greatly increased during IE compared with CE when performed at the same absolute intensity. Moreover, Morris and colleagues showed that the lower $\text{VO}_2$ response associated with IE compared with CE at 70% of peak power was primarily due to the exponential $\text{VO}_2$ kinetic response typical of a step change in activity level (on-transient $\text{VO}_2$ kinetics). At the onset of constant load exercise a transient exponential increase in $\text{VO}_2$ is observed, attaining a new steady state level within 120–180 seconds during light to moderate intensity exercise. Even during higher intensity exercise that engenders a slow component of increasing $\text{VO}_2$, the on-transient kinetic response remains exponential. Thus, for exercise intervals greater than 120 seconds, the $\text{VO}_2$ attained at the end of each exercise interval approaches that reached during CE at the same exercise intensity. This suggests that the duration of the exercise period is an important factor in determining the IE response, with longer exercise intervals reducing the differences observed between CE and IE.

To date there have been no studies examining the acute response to IE in individuals with COPD. However, Vogiatzis et al reported that the perception of dyspnoea was systematically lower during IE training than during CE training in patients with moderate to severe COPD, despite IE being performed at a greater relative intensity than CE. A reduced ventilatory demand and lower degree of dynamic lung hyperinflation during IE could contribute to a reduction in dyspnoea and an improvement in exercise tolerance, independent of the metabolic demand for this mode of exercise. Studies in patients with COPD have also demonstrated slowed on-transient $\text{VO}_2$ kinetics (measured as the time constant or time taken to attain 63% of the asymptotic amplitude) compared with healthy control subjects during submaximal exercise. Slower kinetics may in turn result in a relatively lower $\text{VO}_2$ amplitude during IE.

Severe deconditioning and dyspnoea with exertion are major deterrents to physical activity in COPD patients and could reduce compliance with exercise rehabilitation programmes. If total work performed and/or time to exhaustion are increased and perceived intensity of breathlessness reduced during IE compared with CE, then IE may be a useful training mode in the pulmonary rehabilitation setting. The purpose of the present study was therefore to compare the physiological responses to IE using 1 minute exercise and 1 minute rest intervals, and CE performed at the same intensity.

**Abbreviations:** CE, continuous exercise; EELV, end expiratory lung volume; FEV₁, forced expiratory volume in 1 second; FVC, forced vital capacity; FRC, functional residual capacity; HRpeak, peak exercise heart rate; IC, inspiratory capacity; IE, intermittent exercise; $\text{ICO}_2$, carbon monoxide transfer factor; TLC, total lung capacity; $\text{V}O_2$peak, peak $\text{O}_2$ uptake; $\text{VE}_{\text{peak}}$, peak expired ventilation
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 (VO2, 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,19 (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 (TLCO), and inspiratory capacity (IC) during exercise were measured using a closed circuit pulmonary function testing system (Collins G5 Modular PFT, Braintree, MA, USA). Total lung capacity (TLC) was measured using the helium dilution method while TLCO was assessed with the single breath carbon monoxide test.

Determination of peak VO2 for cycling

The incremental exercise test used to measure peak VO2 was performed on a Lode cycle ergometer (Excelfit, 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. VO2, carbon dioxide output (VCO2) and VE were measured breath 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 CardiO2, 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 VO2. 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:s. Total work completed was calculated as the product of exercise time and external power output.

Effect of VO2 kinetics on intermittent exercise response

In order to determine if any differences in VO2 between the exercise modes were related to the on-transient kinetics of VO2, the time constant (τ) of the initial rise in VO2 (the phase II or primary component) during the CE bout was calculated (see online data supplement at www.thoraxjnl.com/ supplemental). The phase II τ (τ = 82 (8) seconds, N = 7) was then used to predict the VO2 amplitude at 1 minute of exercise and compared with the mean measured VO2 obtained during the exercise intervals of the IE bout.20 To demonstrate the effect of the speed of the on-transient component on the VO2 amplitude for IE, a τ value of 42 seconds was also used to predict the IE response. This τ value was previously determined for healthy older subjects performing constant load exercise at a similar relative intensity to that used in the present study.21

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

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Mean (SD)</th>
<th>% Predicted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>68 (8)</td>
<td></td>
</tr>
<tr>
<td>Height (cm)</td>
<td>165 (12)</td>
<td></td>
</tr>
<tr>
<td>Body mass (kg)</td>
<td>68.7 (14.0)</td>
<td></td>
</tr>
<tr>
<td>Pulmonary function</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FEV1 (l)</td>
<td>1.35 (0.50)</td>
<td>52 (15)</td>
</tr>
<tr>
<td>FVC (l)</td>
<td>2.86 (1.15)</td>
<td>87 (8)</td>
</tr>
<tr>
<td>FEV1/FVC (%)</td>
<td>48 (7)</td>
<td></td>
</tr>
<tr>
<td>TLC (l)</td>
<td>6.64 (1.87)</td>
<td>126 (18)</td>
</tr>
<tr>
<td>FRC (l)</td>
<td>4.40 (1.21)</td>
<td>144 (20)</td>
</tr>
<tr>
<td>TLCO (ml/min/mmHg)</td>
<td>9.32 (0.76)</td>
<td>46 (13)</td>
</tr>
<tr>
<td>Incremental exercise test</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VO2peak (ml/kg/min)</td>
<td>14.8 (2.3)</td>
<td>61.3 (14.5)</td>
</tr>
<tr>
<td>Peak power (W)</td>
<td>57 (25)</td>
<td></td>
</tr>
<tr>
<td>Vpeak (l/min)</td>
<td>38.4 (15.3)</td>
<td>82.0 (8.4)</td>
</tr>
<tr>
<td>HR peak (beats/min)</td>
<td>126 (13)</td>
<td>82.6 (9.6)</td>
</tr>
</tbody>
</table>

Values presented are mean (SD). FEV1, forced expiratory volume in 1 second; FVC, forced vital capacity; TLC, total lung capacity; FRC, functional residual capacity; TLCO, carbon monoxide transfer factor; VO2peak, peak VO2 uptake; Vpeak, 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.
Intermittent exercise in COPD

Figure 3 Change from rest to end of exercise in ratings of perceived breathlessness and end expiratory lung volume (EELV) during continuous (closed bars) and intermittent exercise (open bars). Error bars denote SE. *p<0.05, continuous exercise v intermittent exercise.

Figure 4 Oxygen uptake responses to a single bout of continuous (closed circles) and intermittent exercise (open circles) in a representative subject. The data represent the middle five of seven breath average responses. Each exercise bout was preceded by 3 minutes of unloaded cycling, but only the final minute of unloaded cycling is shown. The vertical dotted line indicates application of the predetermined workload. For clarity, only transitions early and late in the intermittent bout are depicted. A line of best fit (dashed line) was applied to the continuous exercise data, projecting to its asymptotic value and extrapolated through to the end of the intermittent bout.

DISCUSSION

In this study patients with COPD were able to complete a greater total amount of work during IE than during CE. Since the majority of the subjects attained the 60 minute time limit during IE but none achieved the 30 minute CE limit, there was potential for an even greater amount of work to be completed during IE. Intermittent exercise was associated with a lower measured physiological response, with VO₂, VCO₂, VE, heart rate, and plasma lactate concentrations all systematically lower than in CE. Moreover, subjects had a lower level of dynamic hyperinflation during IE than during CE, as assessed by the change in EELV, and this may in turn have contributed to their lower sensation of breathlessness. 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 VO₂ 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 VO₂ as well as VCO₂, VE 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 VO₂ data measured during the CE bouts, the predicted VO₂ values at the end of 1 minute of exercise were not significantly different from the VO₂ values obtained during the exercise intervals of the IE bouts (see online data supplement at www.thoraxjnl.com supplemental). Moreover, the measured VO₂ values were not significantly different between exercise modes during the first minute of exercise following the application of the predetermined workload.
that the lower \( V\dot{O}_2 \) values observed during IE compared with CE resulted in systematically lower plasma lactate values during IE. The greater plasma lactate response associated with CE than with IE may also have contributed, in part, to the higher \( V_E \) observed during CE. The buffering of hydrogen ions linked with lactic acid production ultimately results in the formation of “non-metabolic” \( CO_2 \). Both an increase in hydrogen ion concentration and excess non-metabolic \( CO_2 \) production act to stimulate ventilation.

Since exertional dyspnoea can be a major contributing factor to exercise limitation in patients with COPD, we decided to examine ventilatory mechanics during CE and IE. In many individuals with COPD the increasing ventilatory demand during exercise results in the progressive trapping of air due to incomplete lung emptying. The accompanying increase in EELV is termed dynamic hyperinflation. This increase in EELV during exercise, compounded by an already increased resting functional residual capacity (table 1), curtails the ability of the COPD patient to expand tidal volume in line with the greater ventilatory demand. An increase in \( V_E \) must then be mediated primarily by an increase in breathing frequency, which reduces expiratory flow time and further exacerbates the degree of dynamic hyperinflation. Dynamic hyperinflation has been associated with an increase in dyspnoea and may play an important role in the observed exercise intolerance in patients with COPD. The increase of dynamic hyperinflation on \( V_E \) is primarily a function of the lower \( V_i \) during this mode of exercise. In addition, the rest intervals may have provided the subjects with the opportunity to “deflate” their lungs, allowing the lung volume to return to or approach passive FRC before the start of the next exercise bout. This would reduce the degree of dynamic hyperinflation achieved in the subsequent exercise bout.

The findings of the present study suggest that further examination of training intensity and volume, as well as exercise mode, could improve exercise prescription practices in pulmonary rehabilitation programmes. In particular, the use of IE training at intensities comparable to those used in CE protocols may result in similar levels of functional improvement. Recently, Morris et al. and Vogiatzis et al. compared CE and IE training in healthy older individuals and in patients with COPD, respectively. These studies showed that, when total work performed was equalised between the exercise modes, the benefits gained were independent of exercise mode as well as intensity. Furthermore, it is our opinion that IE training could possibly benefit individuals ranging in disease severity. For those individuals with severe airflow limitation, breathlessness can be a major psychological deterrent to the pursuit of an active lifestyle. The decreased perception of breathlessness associated with IE may improve adherence to training programmes and encourage individuals with lung disease to reverse the debilitating effects of a sedentary lifestyle. The greater options associated with IE protocol design (exercise to rest ratios as well as a greater range of tolerated intensities) could benefit those with mild disease. Even if lung mechanics were not a limiting factor, there is evidence that metabolic and morphological changes in the skeletal muscles of patients with COPD may result in a reduced exercise tolerance. In the present study the lower measured levels of plasma lactate during IE compared with CE suggest either a lower degree of metabolic perturbation during IE or greater lactate clearance (during the rest intervals) with better maintenance of intramuscular as well as blood homeostasis. This would be of benefit to individuals whose exercise tolerance is limited by peripheral factors.

In summary, we have shown that individuals with moderate COPD were able to complete a greater amount of work during IE than during CE performed at 70% of peak power. Measures of gas exchange, plasma lactate, dynamic hyperinflation, and perceived breathlessness were significantly lower during IE than during CE. The greater amount of work performed and lower measured physiological responses achieved with IE may allow for greater peripheral training adaptations in individuals with more limited lung function. 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.thoraxjournal.comsupplemental

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Supported by the Breathlessness Research Charitable Trust, UK

REFERENCES


LUNG ALERT

Adjunct prednisolone therapy does not improve survival in HIV-associated tuberculosis 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 subjects, the authors hypothesised that adjunct therapy with prednisolone 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 1.6, 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 Kaposi’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 Kaposi’s sarcoma, the authors recommend that prednisolone should not be used in HIV associated tuberculous pleurisy.

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Thorax 2004 59: 1026-1031
doi: 10.1136/thx.2004.026617

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