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Physiological responses to a five-day adventure race: Continuous blood glucose, hemodynamics and metabolites the 2012 GODZone field-study

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Abstract

Background/Objective: Adventure racing is an ultra-endurance activity that imposes a unique multifaceted stress on the human body. The purpose of this field study was to examine the physiological responses to a 5-day adventure race.

Methods: Eight competitors, two teams (1 female each) in the 2012 GODZone adventure race volunteered. Competitors trekked, cycled and paddled ~326 km in ~116 hours. Continuous glucose was measured the day before and throughout. Body mass, urinary solutes, and blood pressure and heart rate during resting, standing, and repeated squat-stand conditions, were assessed pre and post.

Results: Despite no changes in mean blood glucose levels, there was increased glycemic variability (Standard deviation glucose; Pre: 0.5 ± 0.1 vs Race: 1.0 ± 0.2 mmol/L, p = 0.02) and periods of hypoglycemia (i.e., Min glucose Pre: 4.1 ± 0.3 vs Race: 3.6 ± 0.5 mmol/L, p = 0.05) during the race. After the race, the blood pressure during resting, standing and squat-stand conditions was significantly lower, by 14 ± 14 mmHg, 16 ± 15 mmHg and 18 ± 15 mmHg (all p < 0.05), respectively, with no change in heart rate. During five-days of adventure racing there is increased glycemic variability and more frequent periods of low blood glucose levels. Additionally, following the race pronounced hypotension is observed in competitors.

Conclusion: We observed more frequent glucose fluctuations, lower glucose levels and significant perturbations in blood pressure control. Further research is warranted to examine the long-term impact of adventure racing on metabolic and cardiovascular function.
teams in 2017. Of interest, more than 60% of the competitors in 2017 had never done an expedition length adventure race before. However, despite growing interest and participation in adventure racing there is a paucity of field-based studies investigating the physiological responses to adventure races. Simulated adventure races lack external validity and field studies are often limited to pre- and post-race measurements. Accordingly, the aim of this field study was to examine the blood glucose responses during, and the hemodynamic and autonomic changes after, a multiday expedition-style adventure race. Using continuous glucose monitoring, we explored the impact of adventure racing on the daily variability of blood glucose. This is the first non-simulated field study to examine continuous blood glucose across the entire race, and to study the effects of a multiday adventure race on orthostatic tolerance.

Methods

The race. The 2012 GODZone adventure race was a ~500 km unsupported expedition-style adventure race with eight stages and four disciplines (kayak, canoe, mountain bike and trekking) lasting 4–7 days. In brief, Day 1 involved kayaking, cycling and canoeing, Day 2 trekking, Day 3 cycling, Day 4 trekking and Day 5 a long kayak leg. Teams (four competitors) were provided with the course map just hours before the start of the race.

Participants. Ethical approval was obtained from the University of Otago Ethics Committee. Two teams (eight participants; one female per team) provided informed written consent. One competitor withdrew from the race due to injury, thus not included in analyses. Baseline characteristics are presented in Table 1.

Data Collection. Before the race, body composition was assessed via the sum of eight skinfolds. Body mass was measured before and after the race using portable electronic scales wearing light, dry clothing only. During the race, competitors were monitored and recorded via a GPS satellite-tracking device. The morning after the race (within 24-h), all baseline measures (except skinfolds) were repeated.

Metabolic Measures. A continuous glucose monitor (CGM) was positioned in the subcutaneous layer of the abdomen to measure glucose the day before, and throughout the race (Fig. 1). Data are validated against capillary samples obtained during the race (Carelink, iPro Medtronic). Glycemic variability variables were analysed via spreadsheet (EasyGV, Oxford, UK). Urine samples were collected and measured for hydration (USG), electrolytes (Na⁺, K⁺) using the Ion Selective Electrode technique, and urine glucose, protein, leukocytes and ketones (Combur10 Test®, Roche Diagnostics).

Cardiovascular Measures. Beat-to-beat heart rate (HR; 3-lead ECG) and BP (Finapres Medical Systems, Netherlands) were assessed for five min in a supine position following 20 min of rest. Following this, orthostatic tolerance and baroreflex sensitivity were assessed via: 1) a single supine-to-stand maneuver (stood rapidly

<table>
<thead>
<tr>
<th>Table 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline characteristics and race data collected from the two participating teams that completed the GODZone adventure race.</td>
</tr>
<tr>
<td>Age (y)</td>
</tr>
<tr>
<td>Team 1 (3 M:1F)</td>
</tr>
<tr>
<td>Team 2 (3 M:1F)</td>
</tr>
<tr>
<td>Kayak/Canoe:</td>
</tr>
<tr>
<td>Kayak/Canoe:</td>
</tr>
</tbody>
</table>

**Fig. 1.** Schematic of the different stages in the 2012 GODZone adventure race, and the timing of physiological outcomes before, during and after the race.

**Table 2**

Continuous glucose data (n = 5) before (Pre) and for each day during the adventure race.

<table>
<thead>
<tr>
<th>Glucose mean (mmol/L)</th>
<th>Glucose Min (mmol/L)</th>
<th>SD Glucose (mmol/L)</th>
<th>Glucose Max (mmol/L)</th>
<th>LBGI</th>
<th>MAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-race</td>
<td>Day 1</td>
<td>Day 2</td>
<td>Day 3</td>
<td>Day 4</td>
<td>Day 5</td>
</tr>
<tr>
<td>4.9 ± 0.3</td>
<td>5.0 ± 0.5</td>
<td>4.8 ± 0.5</td>
<td>5.1 ± 0.7</td>
<td>4.7 ± 0.3</td>
<td>4.8 ± 0.6</td>
</tr>
<tr>
<td>4.1 ± 0.3</td>
<td>3.6 ± 0.6</td>
<td>3.6 ± 0.5</td>
<td>3.6 ± 0.7</td>
<td>3.5 ± 0.4</td>
<td>3.7 ± 0.2*</td>
</tr>
<tr>
<td>0.5 ± 0.1</td>
<td>0.7 ± 0.1</td>
<td>0.8 ± 0.1*</td>
<td>1.2 ± 0.5*</td>
<td>0.6 ± 0.0</td>
<td>0.7 ± 0.3*</td>
</tr>
<tr>
<td>6.3 ± 0.1</td>
<td>6.7 ± 0.7</td>
<td>6.7 ± 0.5</td>
<td>8.8 ± 1.4</td>
<td>6.4 ± 0.6</td>
<td>6.4 ± 1.1</td>
</tr>
<tr>
<td>2.3 ± 0.3</td>
<td>2.9 ± 1.2</td>
<td>3.8 ± 2.4</td>
<td>4.4 ± 3.6</td>
<td>3.5 ± 1.0</td>
<td>4.4 ± 1.4*</td>
</tr>
<tr>
<td>0.7 ± 0.2</td>
<td>0.8 ± 0.1</td>
<td>1.1 ± 0.1*</td>
<td>1.1 ± 0.3*</td>
<td>0.9 ± 0.1</td>
<td>0.9 ± 0.4</td>
</tr>
</tbody>
</table>

LBGI = low blood glucose index, MAG = mean absolute glucose change per hour.

* p < 0.05 vs Pre-race.
and remained standing still for 1 min), followed by 2) repeated squat-stand for 2 min (5-s cycles at each posture; i.e., 5-s in a half squat position followed by 5-s of upright standing), synchronized to a metronome. Mean HR and BP, power spectrum analysis of heart rate variability (HRV) and cardiac baroreflex sensitivity (BRS) were calculated for each block using LabChart 7.1 and the HRV2.0 and BRS macros (v7.1, ADInstruments, NZ). Beat-to-beat BP was calibrated by a manual sphygmonanometer.

Statistical Analyses. Statistical analyses and normality were assessed using SPSS (IBM, IL, USA), with results reported as means ± standard deviations and/or 95% confidence intervals. Glucose data (Table 2) were analysed using one-way repeated measures ANOVA, whereas paired t-tests compared the glucose data during the race (average of 5 race days) compared to pre-race, and pre-post changes in body mass, BP, HR, HRV and BRS. Effect sizes and magnitude-based inferences (MBI) for the true effect are reported based on the methods by Hopkins and Batterham. MBI give the probability that an outcome effect is positive, trivial or negative based on whether the change is clinically, practically or mechanistically meaningful and are reported as a % beneficial/trivial/adverse. For blood glucose, −1.1 mmol/L (based <3.9 mmol/L ADA criteria11) was deemed a meaningful change. An increase in the Low Blood Glucose Index (LBGI), of 2.5 increments was used based on hypoglycemia and hospitalization. For MAP, a change >13 mmHg upon standing based on the criteria for orthostatic hypotension.15 For other variables, the default value of 0.20 Cohen units was used.

Results

Continuous glucose data. CGM data was analysed from 5/8 participants (3 dislodged during the race), with time spent below 3.9 mmol/L is shown in Fig. 2. Mean glucose during the race was not significantly different compared to pre-race (p = 0.56, Cohens d 0.4, Table 2). The variability in 24-h glucose, measured using standard deviation (SD) was significantly higher during the race compared to pre-race (p = 0.02, Table 2). The chance of the true effect being beneficial/trivial/adverse was 1/1/98%, (Cohens d 1.7). Minimum glucose during the race was significantly lower than pre-race (p = 0.05, Table 2). The true effect for the change in minimum glucose was 0/98/2% (Cohens d 1.3). The LBGI was not statistically different, however the true effect was 0/88/12%, (Cohens d 1.2, Table 2).

Autonomic function. The average MAP during resting, standing and repeated squat-stand manoeuvres was significantly lower after the race, −14 mmHg (95% CI: −25 to −3 mmHg, p = 0.02, Cohens d 1.1, Fig. 3), 16 mmHg (95% CI: −27 to −3 mmHg, p = 0.02, Cohens d 1.0) and 18 mm Hg (95% CI: −31 to −4 mmHg, p = 0.02, Cohens d 0.9), respectively. The true effect for the change in MAP on standing was 1/21/79% (Cohens d 1.0). HR, HRV and baroreflex sensitivity were not significantly different after the race (all p > 0.25, Table 3).

Body weight, hydration and urine analysis. Body mass and hydration status (USG) were not significantly different from baseline (Table 4). Dipstick urine analysis showed traces of proteins (7/8 competitors), elevated leukocytes (4/8) and ketones (3/8). Urine glucose remained in the normal range.

Discussion

The major findings of this field study were: a) Competitors experienced higher variability in blood glucose and lower glucose concentrations; and b) Blood pressure was significantly lower after the race, 16–18 ± 5 mmHg during resting, standing and squatting. Although, future research with a larger sample size is required it is possible that the increase in glycemic variability and hypotention observed in the present study may, in part, explain reports of low energy, fatigue and orthostatic intolerance/syncope after prolonged expedition-style adventure races.

Adventure racing poses unique, multifaceted stress on the body. The maintenance of blood glucose levels within the normal range is critical for optimal physiological functioning and exercise performance. Although glucose is not the predominant fuel oxidized
during prolonged low-intensity exercise (typical of adventure racing) glucose is necessary for fatty acid metabolism, high intensity bursts of effort and for arm exercise.\textsuperscript{15–17} We observed a two-fold increase in glycemic variability and periods of hypoglycemia during the race, however the mean glucose levels did not significantly deviate from pre-race levels, highlighting the importance of during race measures. The increase in glycemic variability observed is likely to due to the increased energy requirements and glucose uptake that accompany prolonged ultraendurance exercise.\textsuperscript{7,4} In addition, poor nutrition patterns may in part explain the increased glycemic variability. For example, anecdotally after the race the times throughout the night, and measures were obtained the following morning at their first convenience. Thus, our cardiovascular measures may be confounded by the circadian influence of blood pressure.\textsuperscript{22} Regardless, five days of almost continuous exercise with variable and limited sleep, is likely to disrupt the circadian rhythm.

**Conclusions.** This field study provided a unique opportunity to study physiological responses to one of the most popular, gruelling, and unpredictable ultra-endurance endeavours; the “GODZone” adventure race. We observed more frequent glucose fluctuations, lower glucose levels and significant perturbations in BP control.

**Author contributions**

All authors declare no conflict of interest.


All authors have approved the final version of the paper and agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved. All persons designated as authors qualify for authorship, and all those who qualify for authorship are listed.

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**Appendix A. Supplementary data**

Supplementary data related to this article can be found at https://doi.org/10.1016/j.jesf.2018.07.002.

**References**


