Sodium ingestion and the prevention of hyponatraemia during exercise

The study of TwenEBold et al.4 is important for a number of reasons, not all of which may have been emphasised sufficiently by the authors. Firstly, it confirms that a rate of fluid intake of 1000 ml h⁻¹ is too high for a group of female runners running at 10 km/h and who would therefore complete a 42 km marathon in about 4.25 hours. As the athletes drank 4 litres and gained 2 kg during the trial, their average rate of weight loss (as opposed to sweat rate) was about 500 ml h⁻¹. As not all of the weight lost during exercise is sweat and as much as 1–3 kg of this weight loss may result from fuel and water losses that do not contribute to dehydration,4,5 the absolute maximum rate at which these athletes should have ingested fluid during exercise was probably even less than 500 ml h⁻¹.

As not all of the weight lost during exercise is sweat and as much as 1–3 kg of this weight loss may result from fuel and water losses that do not contribute to dehydration,4,5 the absolute maximum rate at which these athletes should have ingested fluid during exercise was probably even less than 500 ml h⁻¹. This is substantially less than the drinking guidelines of the American College of Sports Medicine11,12 and the Gatorade Sports Science Institute13 who both have promoted rates of fluid ingestion of up to 1200–1800 ml/h. As there is no evidence that gaining weight during exercise improves performance9 whereas there is good evidence that athletes who either lose no weight or who gain weight during exercise are increasingly likely to (a) have an impaired performance,14 (b) develop troubling gastrointestinal symptoms,15,16 or (c) finish the race with serum sodium concentrations below about 130 mmol//l causing hyponatraemic encephalopathy,17–19 it is not immediately clear why the authors chose such high rates of fluid intake in these athletes. Except, perhaps, if they wished to "prove" the value of sodium ingestion during exercise. I note, for example, that the study was funded by a commercial company that, I am informed, markets a sports drink containing sodium chloride.

For it seems highly probable that if athletes overdrink so that they retain fluid and gain weight, then the extent to which their serum sodium concentration falls will be influenced, albeit to a quite limited extent, by the sodium content of the ingested fluids. This indeed was shown by the results of this study. But whether that finding has relevance to the sodium requirements of athletes who are specifically advised not to overdrink during exercise to ensure they do not develop hyponatraemic encephalopathy20 is an entirely different question, which cannot be answered with the study design chosen by these authors.

For example, the presence of a control group who drank according to the dictates of thirst ("ad libitum") and not according to the guidelines of influential sports medical4,12 and commercial organisations, so that they may be less prone to overdrink and so to gain weight during exercise, would have established that athletes who lose more than 1–3 kg during exercise do not develop symptomatic hyponatraemic encephalopathy20 even though they are both dehydrated and sodium deficient. Rather, they are more likely to finish such races with raised serum sodium concentrations.

I would rather argue that a fundamental feature of all prospective trials that aim to evaluate a novel intervention such as the role of sodium ingestion in the prevention of hyponatraemia during exercise should be to compare the new intervention with the currently established 'best practice'.

As the currently established best practice is not to ingest fluid at such high rates that weight is gained during exercise, because this practice can produce a fatal outcome,9 so this study design should, in retrospect, not have been sanctioned. Rather, the control group in the study should have ingested fluid according to guidelines based on the strongest body of current information. It is, for obvious reasons, my biased opinion that the guidelines that come closest to a defendable evidence base are those that have been recently accepted by the United States Track and Field and the International Marathon Medical Interest Group.21

Fortunately, the data of TwenEBold et al.4 do allow some calculations to estimate the likely value of the extra sodium that was ingested by two of their groups. Thus, the athletes in their study had a mean weight of 54 kg. According to the formula of Montain et al.15,16 their predicted extracellular fluid (ECF) volume would be about 14.5 litres (25% of body weight). As the starting serum (and ECF) sodium concentration ([Na⁺]) in the three groups of runners was 137 mmol/l (table 3 of their article), the average total ECF Na⁺ content of the three experimental groups was 1909–1993 mmol at the start of the race. As weights increased by 1.8–2.1 kg in the three groups during exercise (table 3 of their article), the increases in ECF volume would have been 450–525 ml in the respective groups, assuming that the ECF increased in proportion to the increase in total body water (TBW). Multiplying this new ECF volume by the serum [Na⁺] after the race gives the new total ECF Na⁺ content after the race. As shown in table 1, the total ECF Na⁺ content increased by 3 mmol in the group that ingested the high salt drink (H) during the race, but fell by 23 mmol in the group drinking water (W). As all groups ran for about four hours, according to these calculations the new total ECF Na⁺ content after exercise was likely to be ignored by those15,22,23,25 who argue incorrectly that it is the Na⁺ deficit that determines the extent to which the serum [Na⁺] falls in those who develop hyponatraemia during exercise. This calculation elegantly shows why small changes in ECF volume determine whether or not hyponatraemic
encephalopathy will develop in those who overdrink, regardless of whether or not they also incur a Na⁺ deficit either during exercise or at rest. A recent paper confirms these predictions by showing that mathematical modelling supports the argument that changes in TBW exert a much greater effect on serum [Na⁺] than does whole body Na⁺ content in those who overdrink and hence gain weight during exercise. Perhaps the point of these calculations is to show that it is not possible to calculate the state of Na⁺ balance in athletes during exercise and so to determine whether or not athletes have developed a Na⁺ "deficit" or have gained Na⁺ simply by measuring serum [Na⁺]. This is because the ECF volume will not be the same before, during, and after exercise and will change depending on the nature of the fluid ingested and the extent of any fluid deficit or excess that develops during exercise. But more importantly, these calculations clearly show why the regulation of the TBW and the ECF volume will have a much greater influence on serum [Na⁺] than will either the expected Na⁺ losses in sweat or the amount of Na⁺ ingested from sodium-containing sports drinks.

For example, a 1 litre (7%) reduction in the ECF volume would "release" 140 mmol Na⁺ into the contracted ECF volume. This means that it is possible to lose 140 mmol Na⁺ in sweat and urine without any change in serum [Na⁺] provided that the ECF volume were to contract by only 7%. If sweat [Na⁺] is about 40 mmol/l, as appears to have been the case in this study of Twerenbold et al., then this 140 mmol is the equivalent of about 3.5 litres of sweat.

As athletes in this study sweated at a maximum rate of only 500 ml/h when running at 10 km/h, this means that simply by reducing their ECF volume by 1 litre, those athletes could have maintained their pre-race serum [Na⁺] while running for seven hours and drinking just sufficient water to allow for a 1 litre reduction in ECF volume and without requiring any Na⁺ replacement whatever. This simple calculation explains why those endurance athletes who, before about 1969, were advised either not to drink at all, or only sparingly during exercise, always finished the races with raised serum [Na⁺] despite having incurred what might have been quite sizeable Na⁺ deficits.

In contrast, athletes in this study who believed the incorrect advice that ingesting Na⁺ at high rates is essential to maintain a normal serum [Na⁺] during exercise, so they overdrank sufficiently to increase their ECF volume by 1 litre, would need to ingest and retain at least an additional 140 mmol Na⁺ in addition to the ~80 mmol lost in sweat (table 1). This is equivalent to the Na⁺ content of 1.2 litres of the low and 7.5 litres of the high sodium drinks respectively in this trial. To maintain fluid balance in this four hour trial when drinking at those high rates and sweating at about 500 ml/h, they would then need to urinate at rates of 1375–2600 ml/h. Both of these rates exceed the maximum at which human kidneys are able to produce urine at rest," let alone during and after prolonged exercise. Drinking at such rates would therefore only lead to progressive fluid accumulation and ultimately death from hyponatraemic encephalopathy.

In summary, these calculations explain (a) why contraction of the ECF in athletes who lose body weight during exercise will maintain the serum [Na⁺] even in the face of quite large and unreplaced Na⁺ loss in sweat, and (b) why the ingestion of sodium-containing sports drinks in the vain hope of matching the rates of Na⁺ loss in sweat can only lead to fluid retention and progressive hyponatraemic encephalopathy, which, as these calculations and this study again show, cannot occur without the presence of distinct fluid overload.

Finally, it is important to note that, even though Na⁺ ingestion marginally increased serum [Na⁺] in the group that ingested the most concentrated Na⁺ drink, this practice was without benefit as running performances were unaltered by Na⁺ ingestion, and the incidence of symptoms was no different between the groups as no athletes reportedly developed symptoms. However, the symptoms of mild hyponatraemic encephalopathy are mild and may not have been sought with sufficient diligence. For example, all subjects, myself included, in our study in which mild hyponatraemia was induced by fluid overload at rest," developed quite disabling symptoms at serum [Na⁺] of ~136 mmol/l or lower. Indeed it would have been most interesting to determine whether the presence of subtle mental symptoms was different in the three groups in this study, as all had similar degrees of fluid overload despite different serum [Na⁺]. If the symptoms in this condition are due purely to fluid overload, then the incidence of symptoms should have been the same in all groups despite different serum [Na⁺]. Alternatively, if the symptoms are related to the degree of hyponatraemia, then they should have been most obvious in the W group, who finished with the lowest post-race serum [Na⁺]. My bias would be to expect that the extent of any symptoms are more likely related to the degree of fluid overload, and hence the increase in the ICF, than to the level to which the serum [Na⁺] has been reduced.

| Table 1 Sodium balance calculations for three groups of runners running at ~10 km/h for four hours while ingesting solutions with different [Na⁺] |
|-------------------------------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Pre-race ECF volume (litres) (A) | Pre-race ECF Na⁺ content (mmol) (A-B) | Post-race ECF volume (litres) (B) | Post-race ECF Na⁺ content (mmol) (C-D) | Post-race ECF Na⁺ balance (mmol/l) (E) | Amount of Na⁺ ingested (mmol/l) (F) | Apparent amount of Na⁺ loss during exercise (mmol/l) (G) |
| H | 137.3 | 14.50* | 1991 | 134.8 | 15.02 | 2025 | +34 | 118t | 84/21 |
| L | 137.2 | 14.50 | 1989 | 132.8 | 14.95 | 1985 | -4 | 71 | 76/19 |
| W | 137.5 | 14.50 | 1992 | 131.8 | 14.95 | 1970 | -23 | 0 | 24/6 |

H, High sodium intake; L, low sodium intake; W, water during exercise. *Based on 25% of mean body weight of 57.7 kg for the total group of runners. Weights for different groups were not reported.

†From table 2 of Twerenbold et al. to convert mg sodium (table 2) into mmol sodium, divide by the molecular weight of sodium (22.99).

**References**


Tennis


It is widely recognised that each sport has its own unique demands and injuries. In particular, the IOC, ITF, ATP, WTA, and Society for Tennis Medicine and Science should be congratulated on producing, in this publication, a comprehensive overview of tennis sport medicine. Together they have assembled an impressive array of experts in this field to write succinct and relevant chapters.

Every aspect of tennis is covered to cater to a broad range of readers, including players themselves. Some areas are covered in a high level of technical detail toplease the biomechanists, in particular. However, some of the sports medicine is basic in concept and lacking significant evidence based validity.

Nevertheless, I would highly recommend this book to any health professional who treats a large number of tennis players. Most chapters provide a link between common sport medicine problems and their occurrence in tennis, including conditions that are unique to this sport. At times, some authors are somewhat optimistic with their view of recovery time from surgery—for example, three weeks for arthroscopic debridement of the infrapatellar fat pad.

Overall it is well presented with relevant and useful graphs and diagrams to aid the reader, and each chapter gives a list of further recommended reading. Unfortunately, the book does not provide an answer to where 14 million tennis balls go, imported each year into Australia, as discussed by the editor recently!

BOOK REVIEWS

Dying to win


Dying to win gives an eye opening account of the extent to which drugs play a major role in sport. Doping is not new and has been used in sport since ancient Olympic times; it is just that drug use in modern times is at such a level of sophistication, it is now an industry in its own right. The book describes the

privileged position sport holds in society, having appeal for both the participant and the spectator. This has led to the massive media interest, commercialism, professionalism, and governmental regulation and manipulation. Economic pressure in the industrialised world and governmental propaganda in the former East Germany, and more recently China, have added to the increasing pharmaceutical intervention in sport. With the fall of the GDR, the world saw for the first time what it had long suspected, the extent of systematic doping on a State run basis, and the most interesting fact is that the East Germans had better records! Further, the book takes a look at the next big issue surrounding drugs in sport—genetic engineering.

Dying to win does not just describe the evolution of doping. It explains the complex relationship between anti-doping policy, implementation of those policies, and the role of governments, the IOC, and international and national sporting organisations. With the ever increasing involvement of the legal profession, a vicious circle occurs: it becomes too costly for sporting organisations to fight court battles, with their reliance on Government funding depending on results and punishments set in accordance with what will stand up in courts. This all leads to the relative inertia of the governing bodies to be pro-active in the anti-doping campaign.

The inception of the World Anti-Doping Agency (WADA) after the 1998 France drugs fiasco provided a way forward to standardise and implement anti-doping policy across the world by an independent body.

Problems and solutions to anti-doping policy are addressed. The major problem is inadequate definition of doping—to quote Arthur Gold “The definition lies not in words but in integrity of character.”. It is interesting to note that those behind the athlete, namely coaches, administrators, medical profession, and scientists, all seem to lose perspective along with their ethics and “integrity of character” when the race for “gold” is on. Nevertheless, I would highly recommend this book to any health professional who treats a large number of tennis players. Most chapters provide a link between common sport medicine problems and their occurrence in tennis, including conditions that are unique to this sport. At times, some authors are somewhat optimistic with their view of recovery time from surgery—for example, three weeks for arthroscopic debridement of the infrapatellar fat pad.

Overall it is well presented with relevant and useful graphs and diagrams to aid the reader, and each chapter gives a list of further recommended reading. Unfortunately, the book does not provide an answer to where 14 million tennis balls go, imported each year into Australia, as discussed by the editor recently!
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This congress will provide the world’s leading sports medicine experts with an opportunity to present their work to an international audience made up of physicians, therapists, scientists, and coaches. The Congress will present scientific information on sports injury epidemiology, risk factors, injury mechanisms and injury prevention methods with a multidisciplinary perspective. Panel discussions will conclude symposia in key areas providing recommendations to address the prevention issue in relation to particular injuries and sports. Further details: Oslo Sports Trauma Research Centre and Department of Sports Medicine, University of Sport and Physical Education, Sognsvægen 220, 0806 Oslo, Norway. Email: 2005congress@nih.no; website: www.ostrc.no

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15–17 September 2005, Curiohaus, Hamburg Congress-Chairman: Johannes M. Rueger, M.D., Professor and Chair Topics:
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Further details: Email: pyrgos.com@cytanet.com.cy

BASEM Conference 2005
10–12 November 2005, Edinburgh, Scotland
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Corrections
doi: 10.1136/bjsm.2004.03921corr1

doi: 10.1136/bjsm.2004.000044corr1
Dadebo B, White J, George K P. A survey of flexibility training protocols and hamstring strains in professional football clubs in England (Br J Sports Med 2004;38:388–94). The multiple regression equation within the Abstract section of this paper was published incorrectly. The correct equation is:

\[ HSR = 37.79 - (0.335 H1 + 10.055 S + 2.245 TE) \]

We apologise for this error.

doi: 10.1136/bjsm.2004.010876corr1
Sran M M. To treat or not to treat: new evidence for the effectiveness of manual therapy (Br J Sports Med 2004;38:521–5). The volume number for reference 23 (Sran et al) was incorrectly published as 24; the correct volume number is 29.

In Table 2 the results for Giles and Muller should read: Greater short term benefit for back pain with manipulation, but not for neck pain. Acupuncture more effective for neck pain.

In the section “Definitions and search strategy” in the first line of paragraph 2 should read: I searched Medline, Cinahl, and Embase databases for randomised clinical trials comparing manual therapy, including spinal joint mobilisation (with or without manipulation) or manipulation only with other conservative treatments for back or neck pain.

We apologise for these errors.
Sodium ingestion and the prevention of hyponatraemia during exercise

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Br J Sports Med 2004 38: 790-792
doi: 10.1136/bjsm.2004.014191

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