Enhancing the efficacy of the 20 m multistage shuttle run test

A D Flouris, G S Metsios, Y Koutedakis

Objective: Maximal oxygen uptake (Vo2max) of 44 ml kg\(^{-1}\) min\(^{-1}\) is an accepted criterion (Vo2CR) below which health and fitness for young male adults may be compromised. New algorithms validated for Vo2CR screening using the 20 m multistage shuttle run test (20MST) were developed.

Methods: Vo2max was assessed in 110 males using a stationary gas analyser in a treadmill test (TT) and in 40 of these subjects using a portable gas analyser in the 20MST. Vo2max predicted from the 20MST in 70 subjects was used for cross validation. Two equations predicting Vo2max during 20MST (EQMST) and TT (EQTT) were developed.

Results: Significant energy cost variance (ECv) was detected between TT and 20MST (p<0.001), correlated significantly with subject height, and was a significant predictor of Vo2max differences between TT and 20MST. The \( r^2 \) of EQMST was 0.92 (p<0.001). Predicted Vo2max values from EQMST correlated with directly measured 20MST Vo2max at \( r = 0.96 \) (p<0.001). ANOVA detected no mean difference (p>0.05) between predicted and measured values. Prevalence of low fitness based on Vo2CR was 0.37. McNemar \( \chi^2 \) indicated significant differences in sensitivity (p<0.001) and specificity (p<0.05) between the original 20MST equation (EQLEG) and EQTT, regarding Vo2CR screening. Cohen’s \( k \) demonstrated higher agreement with TT Vo2max for EQTT (p<0.001) than EQLEG (p<0.05). TT Vo2max correlated with the end result of both EQLEG and EQTT at \( r = 0.75 \) (p<0.001). Unlike EQTT (p<0.05), mean predicted Vo2max from EQLEG was significantly higher compared to TT Vo2max (p<0.001).

Conclusion: These algorithms increase the efficacy of 20MST to accurately evaluate aspects of health and fitness.

Despite the vast amounts of research focusing on various cardiorespiratory fitness (CF) assessments and the acceptance of specific CF cut-offs in national health guidelines,\(^1\)\(^2\) statistical screening methodology such as calculating receiver operating characteristics (ROC) curves has not been employed hitherto. The ROC curve analysis is extensively used in epidemiology to provide a graphic means for assessing the accuracy of a diagnostic instrument.\(^3\) The difficulty in adopting ROC curves in sports medicine is mainly attributed to the fact that most outcome measures are in continuous format. However, these biomarkers can be dichotomised using dummy variables according to clinically accepted critical values Q and defined positive or negative if the test outcome measure is greater or lesser than Q. For instance, a maximal oxygen uptake (Vo2max) of 44 ml kg\(^{-1}\) min\(^{-1}\) for young male adults (18–29 years of age) has been generally accepted as a criterion (Vo2CR) below which both health and fitness may be compromised.\(^4\)\(^5\)

The 20 m multistage shuttle run test (20MST)\(^6\) represents an acceptable field assessment tool for CF, and has been repeatedly employed in different health\(^7\)\(^8\) and fitness\(^9\) settings. However, the popularity of the 20MST is mainly attributed to its practical use for simultaneous measurement of large groups of individuals. Studies evaluating its accuracy in predicting laboratory Vo2max have reported contradictory results.\(^10\)\(^11\) More importantly, the efficacy (that is, the extent to which a specific procedure produces a valid classification of data in relation to established criteria) of the original 20MST model in screening for CF remains unknown.

From a statistical standpoint, the limited accuracy of the 20MST may be attributed to the repeated measures design used in the original study.\(^1\) It is well known that the inherent dependency of within-subject observations can reduce the power of prediction models.\(^12\) Concurrently, it seems tenable that the theoretical basis of the original 20MST model may be further compromised by the use of generally large and heterogeneous samples in the validation procedures.\(^7\) It has been established that severely biased linear relationships can occur owing to sample heterogeneity.\(^13\)

From a physiological viewpoint, it could be argued that the curtailed ability of the original 20MST model to predict treadmill Vo2max values might be attributed to differences in the exercise modes utilised in the validation procedures (that is, shuttle running vs forward running). Findings from recent investigations suggested that Vo2max during the 20MST is significantly higher compared to a treadmill test.\(^14\)\(^15\) Ergo, a prediction model controlling for differences in energy cost (EC) between the reference standard laboratory assessment and the proxy 20MST may result in more accurate prediction of Vo2max and increased efficacy in screening for Vo2CR. The objective of the present investigation was to develop a new Vo2max prediction algorithm for the 20MST using data collected via portable indirect calorimetry and statistical procedures which accounted for within-subject observation dependency. Thereafter, the efficacy of both the original and the novel models was assessed in predicting standard treadmill Vo2max and screening for Vo2CR.

METHODS

Subjects and procedures

A total of 110 healthy males (age: 21.6 (SD 2.5); BMI: 23.6 (2.2)) volunteered. Exclusion criteria included smoking and any muscular or skeletal injuries. Written informed consent was obtained from all participants after full explanation of the procedures involved. The cohort was arbitrarily divided into two 55-subject groups. The first 55 subjects (group A) undertook all procedures in the laboratory. The second 55 subjects (group B) undertook all procedures in the laboratory.

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Abbreviations: ANOVA, analysis of variance; CF, cardiorespiratory fitness; CI, confidence interval; CV, coefficient of variation; EC, energy cost; GEE, generalised estimating equations; GLM, general linear model; LR, likelihood ratio; MST, multistage shuttle run test; MST, multistage shuttle run test; O2, oxygen; Q, threshold; SD, standard deviation; TT, treadmill test; 20MST, 20 m multistage shuttle run test; VO2, oxygen uptake; VO2CR, cardiorespiratory fitness cut-off; Vo2max, maximal oxygen uptake; Vo2min, minimal oxygen uptake; Vo2Qmax, maximal oxygen uptake for a given energy cost (EC) cut-off.
7–10 min. The treadmill inclination was increased by 2.5° accordingly in order to bring the subject to exhaustion in

**Data collection**

Ethics Board of the University of Wolverhampton.

Each subject either between 9:00 and 12:00 h or between order, by the same investigators, and at the same time for data collection visits. Tests were conducted in a random order, the same investigators, and at the same time for data collection visits. Prior to data collection visits, subjects were familiarised with all assessment protocols. They were also advised to avoid stressful activities 36–48 h prior to the testing, while subjects inspired room air through a facemask. Maximal oxygen uptake was the main parameter determined using the open circuit method. Prior to measurement, the gas analyser was calibrated with standard gases. Exhaustion was confirmed when at least two of the following criteria were met: (i) maximal heart rate greater than 185 bpm, (ii) respiratory exchange ratio greater than 1.1, and/or (iii) detection of plateau in VO2 curve. EC in kcal was calculated for each individual minute/stage as the product of mean VO2 (1 min⁻¹) by the corresponding caloric equivalent.7

**Field assessment of VO2max (20mMST)**

This test was conducted according to established procedures.6 In the model group a portable gas analyser (K4b², Cosmed, Rome, Italy) was used to record respiratory parameters every 20 s during testing, while subjects inspired room air through a facemask. Maximal oxygen uptake was the main parameter determined using the open circuit method. Prior to measurement, the gas analyser was calibrated with standard gases. Exhaustion was confirmed when at least two of the following criteria were met: (i) maximal heart rate greater than 185 bpm, (ii) respiratory exchange ratio greater than 1.1, and/or (iii) detection of plateau in VO2 curve. The EC in kcal was calculated for each individual minute/step as the product of mean VO2 (1 min⁻¹) by the corresponding caloric equivalent.7 In the validation group, VO2max was predicted from the 20mMST performance according to established procedures.6

The K4b² gas analyser weighed 475 g and was not expected to significantly alter the subjects’ energy demands. A pilot study using five subjects (age: 21.6 (SD 1.3); BMI: 24.3 (1.5)) was conducted in order to investigate additional energy demands and ensure that significant agreement existed between the two gas analysers employed. The subjects, who did not partake in the main part of the investigation, performed the previously described TT twice using both gas analysers. Results showed no significant difference (p>0.05) between the mean VO2max value recorded by the stationary (Vmax 29, SensorMedics) and the portable (K4b², Cosmed) gas analyser (48.7 (SD 3.1) v 49.1 (3.5) ml kg⁻¹ min⁻¹, respectively), with an average absolute error of 0.51 (SD 0.18) ml kg⁻¹ min⁻¹.

**Statistical analyses**

ANOVA was used to compare mean EC between TT and 20mMST. The effect of energy-cost variance between TT and 20mMST (ECV) on the original 20mMST prediction model (EQMAX (E)) was assessed via a simultaneous general linear model (GLM). This model aimed to predict VO2max differences/errors between TT and EQMAX using mean ECV as an independent variable. In addition, Pearson’s correlation coefficients were used to detect linearity between ECV and various anthropometrical characteristics.

For the calculation of the novel prediction model, the generalised estimating equations (GEE)14 approach was employed to account for subject specific dependency between the repeated observations. The GEE is a powerful approach in fitting generalised linear models to non-normally but dependently distributed response variables.19 A GLM framework analysis when at least two of the following criteria were met: (i) maximal heart rate greater than 185 bpm, (ii) respiratory exchange ratio greater than 1.1, and/or (iii) detection of plateau in VO2 curve. EC in kcal was calculated for each individual minute/stage as the product of mean VO2 (1 min⁻¹) by the corresponding caloric equivalent.7

### Table 1

Univariate statistics (mean (SD)) and generalised estimated equations analyses for predicting VO2max during the 20mMST and the TT in the model group (n = 40)

<table>
<thead>
<tr>
<th>Model</th>
<th>Independent</th>
<th>Dependent</th>
<th>r2</th>
<th>χ²</th>
<th>SEE</th>
<th>yVO2max</th>
<th>ΔVO2max</th>
<th>r</th>
</tr>
</thead>
<tbody>
<tr>
<td>EQMAS</td>
<td>MAS</td>
<td>VO2max</td>
<td>0.79</td>
<td>236.4*</td>
<td>2.72</td>
<td>48.3 (5.9)</td>
<td>46.9 (5.7)</td>
<td>0.91*</td>
</tr>
<tr>
<td>EQMST</td>
<td>MAS</td>
<td>VO2max</td>
<td>0.92</td>
<td>456.2*</td>
<td>1.70</td>
<td>49.2 (5.9)</td>
<td>49.2 (5.9)</td>
<td>0.96*</td>
</tr>
<tr>
<td>EQtt</td>
<td>EQMST</td>
<td>VO2max</td>
<td>0.89</td>
<td>317.3*</td>
<td>1.94</td>
<td>47.0 (0.8)</td>
<td>46.9 (5.7)</td>
<td>0.94*</td>
</tr>
</tbody>
</table>

Values in parentheses are standard deviations (SD). Significant ANOVA between yVO2max and ΔVO2max values: tp<0.001. χ² significant at tp<0.001. ΔVO2max, actual values measured during testing; EQMAS, EQMST, calculated regression models to predict TT; Eq_MAX, calculated regression model to predict 20MST VO2max, Dependent variable; yVariable, independent variable; kVariable, measured during the 20MST using the K4b² portable analyser; MAS, maximal attained speed (km h⁻¹); χVariable, predicted values using the calculated models; r, correlation coefficient between actual and predicted values; χ², coefficient of determination; SEE, standard error of the estimate; yVO2max, VO2max measured during the TT; χ², chi-square.
with GEE estimation was introduced to generate an equation (EQMST) predicting \( V_{O2max} \) measured during the 20mMST using the model group data \((n=40)\). For the latter model, the maximal attained speed (MAS) during the 20mMST was set as the independent variable. Thereafter, a second GLM with GEE estimation was performed generating the EQTT model which aimed to predict the reference standard TT \( V_{O2max} \) as an independent variable. This procedure was employed to produce a 20mMST \( V_{O2max} \) model that accounts for ECV. In order to ensure that the procedures followed in the calculation of the EQTT model were indeed superior to the traditional approach, a GLM was calculated using TT \( V_{O2max} \) (dependent variable) and MAS (independent variable). ANOVA and Pearson’s correlation coefficients were used to detect possible bias between the mean actual and predicted \( V_{O2max} \) values for the three models.

Data from the remaining 70 subjects (referred to as the validation group) were used to cross validate EQTT and the original EQMST model. Correlation coefficients, ANOVA, 95% limits of agreement analyses (LIMAG), and percent coefficients of variation (CVk) were adopted to validate the two models according to established procedures. Ninety-five percent confidence intervals (CI95%) and ROC curve analysis were calculated using statistical software incorporated in SAS/Macro/IML. The latter software is designed specifically to fit ROC curves using dummy variables for data obtained from repeated measures designs. The area under the ROC curve was estimated using the Wilcoxon non-parametric method. The demarcation point for \( V_{O2CR} \) was set at 44 ml kg\(^{-1}\) min\(^{-1}\) according to available guidelines. Calculated sensitivity and specificity with corresponding CI95% were used to determine the efficacy of the two equations in screening for \( V_{O2CR} \). Sensitivity (SE) was defined as the proportion of subjects below the \( V_{O2CR} \) who demonstrated a 20mMST predicted value below 44 ml kg\(^{-1}\) min\(^{-1}\). Specificity (SP) was defined as the proportion of subjects above the \( V_{O2CR} \) who revealed a 20mMST predicted value above or equal to 44 ml kg\(^{-1}\) min\(^{-1}\). McNemar \( \chi^2 \) analysis examined the differences between calculated sensitivity and specificity at the cut off point for both equations. Cohen’s \( \kappa \) statistic was used to evaluate the agreement between the prediction models and the reference standard test. Finally, ANOVA and Pearson’s correlation coefficients were used to detect possible bias between the mean actual and predicted values. All statistical analyses were carried out with SPSS (version 11.5; SPSS, Chicago, IL) and SAS (version 8.2; SAS Institute, Cary, NC, USA) statistical software packages. The level of significance was set at \( p<0.05 \).

**RESULTS**

**Effect of energy-cost variance on EQLEG**

ANOVA detected significant differences in EC and \( V_{O2max} \) between TT and EQLEG \((p<0.001; \text{fig 1})\). Further, GLM results indicated that mean ECV was a significant predictor of \( V_{O2max} \) differences between TT and EQLEG \( r^2 = 0.25, F_{1,38} = 28.89, p<0.001 \). A significant linearity was also detected between ECV and subject height \((r = 0.94, p<0.001)\).

**Prediction of \( V_{O2max} \) achieved via 20mMST and TT**

Table 1 shows relevant statistics for the calculated models (that is, EQMST, EQTT, and EQLEG). Routine pre-analysis screening procedures were used to assess whether the data conformed to the assumptions of GLM. Although normally distributed, the variables used in these analyses were not independent of one another. Examination of residuals scatterplots detected no violation of normality, linearity, and homoscedasticity between predicted \( V_{O2max} \) scores and errors of prediction. Mahalanobis distance of each case to the centroid of all cases detected no multivariate outliers for \( \chi^2=0.001 \). As expected the values in the variables utilised were multicollinear, being similar measures of the same parameter (that is, \( V_{O2max} \)). As significant linearity was detected between ECV and subject height (see previous section), initial calculations for EQMST and EQTT included height as a covariate. Nevertheless, the latter variable was not a significant predictor \((p>0.05)\) for either model.

\[
\text{EQLEG: } V_{O2max} = \text{MAS} \times 6.87 - 39.54 \\
\text{EQMST: } V_{O2max} = \text{MAS} \times 6.65 - 35.8 \\
\text{EQTT: } V_{O2max} = \text{EQMST} \times 0.95 + 0.182
\]

Thus,

\[
\text{EQTT: } V_{O2max} = (\text{MAS} \times 6.65 - 35.8) \times 0.95 + 0.182
\]

**Figure 2**

ROC curve for EQLEG and EQTT regression models. The ROC curve is defined as the curve of the results from validation-group variance and EQLEG or EQTT regression models, respectively. Asterisks indicate the designated cutoff point of 44 ml kg\(^{-1}\) min\(^{-1}\).
Model cross validation
Means (SD) and comparisons of various performance indices from the TT and the 20mMST, as well as results for LIM\(_{XG}\) and CV\(_{\text{E}}\) appear in table 2. Preliminary analyses for LIM\(_{XG}\) revealed no positive relationship between the differences/errors (either (EQ\(_{\text{LEG}}\)-TT) or (EQ\(_{\text{TT}}\)-TT)) and the size of measurements (given by either (the mean of EQ\(_{\text{LEG}}\) and TT) or (mean of EQ\(_{\text{TT}}\) and TT)), respectively. Thus, the LIM\(_{XG}\) can be reported as absolute measurements.\(^{21}\) Finally, unlike EQ\(_{\text{LEG}}\) and TT (\(t = 1.46, p > 0.05\)), the mean difference (error) between estimates from EQ\(_{\text{LEG}}\) and TT (\(t = -8.86, p < 0.001\)) was biased.

Relevant univariate statistics and ROC curve analyses for the designated cut off point (that is, 44 ml kg\(^{-1}\) min\(^{-1}\)) appear in table 3 and fig 2. Twenty six subjects (37.1%; CI 95%: 0.9%) were diagnosed below the V\(O_2\)max during the 20mMST and the TT, rather than relying on statistical inference from a generally large and heterogeneous sample. The cohort consisted entirely of males to avoid the well known phenomenon of severely biased (that is, nonsense or spurious) linear relationships attributed to sample heterogeneity.\(^{15}\) This phenomenon has been demonstrated explicitly by Anderson\(^{23}\) who examined various factors associated with prediction power in the original 20mMST model. Anderson concluded that research utilising large heterogeneous samples in the validation process of predictive tests of aerobic capacity must be suspect. It seems reasonable to suggest that the prediction models developed using these procedures are rather generalised, representing merely vague indicators of the true values. These hypotheses are verified in the present study by the reduced accuracy of the EQ\(_{\text{LEG}}\) prediction model, as compared to EQ\(_{\text{TT}}\).

On another note, the present results are in line with previous studies suggesting increased energy demands during shuttle running compared to treadmill running.\(^{14,15}\) This may well be attributed to differences in factors such as intensity, exercise mode, technique, and musculature employed between the two conditions. These factors should be considered in the design of physical training programmes that incorporate shuttle running elements. This information should also be taken into account when designing the physical training for sports incorporating shuttle running (for example, football, basketball, rugby). In addition, the present results suggest that EC\(V\) is exacerbated with increased body stature. It is tenable that various biomechanical complexities of shuttle running may account for this. The EQ\(_{\text{MST}}\) model developed herein to predict V\(O_2\)\(_{\text{max}}\) during the 20mMST can be used to calculate the oxygen transport demands of shuttle running, when such information is required.

It is important to acknowledge, however, that the 20mMST is a test requiring maximal effort. Therefore, it may not be suitable for populations with specific diseases. In addition, the novel EQ\(_{\text{TT}}\) model represents a strict means of assessing CF. Three subjects with CF above the V\(O_2\)\(_{\text{CR}}\) in our cross validation sample were mis-screened as performing below the V\(O_2\)\(_{\text{CR}}\). Practicing such strict screening techniques may be beneficial in circumstances where adequate levels of CF are crucial (for example, military training). The applications from the present investigation would be further increased by

### Table 3

<table>
<thead>
<tr>
<th></th>
<th>(S_p) (CI(_{95%}))</th>
<th>(S_s) (CI(_{95%}))</th>
<th>(PV) (CI(_{95%}))</th>
<th>(PV) (CI(_{95%}))</th>
<th>LR (CI(_{95%}))</th>
</tr>
</thead>
<tbody>
<tr>
<td>EQ(_{\text{LEG}})</td>
<td>0.23 (0.16)</td>
<td>1.00 (0.00)**</td>
<td>1.00 (0.16)</td>
<td>0.69 (0.10)**</td>
<td>∞</td>
</tr>
<tr>
<td>EQ(_{\text{TT}})</td>
<td>0.81 (0.15)**</td>
<td>0.82 (0.11)</td>
<td>0.72 (0.16)</td>
<td>0.88 (0.10)**</td>
<td>4.44 (0.19)</td>
</tr>
</tbody>
</table>

McNemar \(x^2\) increased at: \(^{**}p<0.05, ^{*}p < 0.001\).

\(S_p\), 95% confidence interval; EQ\(_{\text{LEG}}\), original 20mMST prediction model; EQ\(_{\text{TT}}\), calculated regression model to predict TT V\(O_2\)\(_{\text{max}}\); LR, likelihood ratio; \(PV\), negative predicted value; \(PV\), positive predicted value; \(S_p\), sensitivity; \(S_s\), specificity; ∞, mathematical infinity.
calculating additional prediction models for both males and females of various age groups. In addition, it is worth mentioning that the present results are subject to some variability among different models of metabolic carts. Within the limits of the present investigation, it is concluded that the developed models can be valuable tools that explicitly increase the efficacy of the 20MST to discern subjects according to VO₂CR.

Authors’ affiliations
A D Flouris, Faculty of Applied Health Sciences, Brock University, St Catherine’s, Ontario, Canada L2S 3A1
G S Metsios, School of Sports, University of Wolverhampton, Wolverhampton, UK
Y Koutedakis, Department of Sport and Exercise Science, University of Thessaly, Trikala, Greece

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REFERENCES
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