Effect of exercise on upper respiratory tract infection in sedentary subjects

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Objective: To determine if exercise training affects the severity and duration of a naturally acquired upper respiratory tract infection (URTI) in sedentary subjects.

Methods: Subjects were sedentary volunteers (two or fewer days a week of exercise for less than 30 minutes a day for the previous three months), 18–29 years of age, with a naturally acquired URTI (three to four days of onset). All subjects were screened—for example, asthma, hay fever—by a doctor and were afebrile. Volunteers were alternately assigned to an exercise (EX) group (four men, seven women) or a non-exercise (NEX) group (three men, eight women). Subjects in the EX group completed 30 minutes of supervised exercise at 70% of target heart rate range for five days of a seven day period. The initial screening, and every 12 hours, all subjects completed a 13 item symptom severity checklist and a physical activity log. Cold symptom scores were obtained until the subjects were asymptomatic. Significance was set at p<0.05.

Results: There were no significant differences between EX and NEX group mean symptom scores for the morning and evening reporting periods. There were also no differences between the groups for the mean number of days from the baseline symptom score to when the subjects were asymptomatic. There were no differences between physical activity levels, other than what was assigned in the EX group.

Conclusion: Moderate exercise in sedentary subjects with naturally acquired URTI probably does not alter the overall severity and duration of the illness. Previously sedentary people who have acquired a URTI and have just initiated an exercise programme may continue to exercise.
part-time jobs. Repeated verbal encouragement was given to persuade the NEX group to remain sedentary and the EX group to refrain from any additional physical activity other than what was assigned. All subjects reported to the laboratory every 12 hours (0700 and 1900) for seven consecutive days, beginning on the evening of the day on which they were selected into the study. All completed the 13 item symptom severity checklist at each reporting period. They all also completed an activity log during each evening reporting period to monitor their physical activity levels. After the seventh day of the study, subjects reported to the laboratory once a day until they were asymptomatic.

Clinical evaluation of URTIs
Subjects completed a previously validated symptom checklist. They rated the severity of 13 common cold symptoms (0 = not present, 1 = mild, 2 = moderate, 3 = severe). A cold with a total score of less than 7 was considered mild, one with a total score of 7–11 was moderate, and one with a total score of 12 or greater was severe. The rise and fall of clinical symptoms and signs using this checklist are clearly associated with virus shedding and served as a valid determination of a URTI. Oral temperatures were taken to ensure that the subjects remained afebrile. These activities continued until the subjects were asymptomatic. The screening and monitoring processes used in this study safeguarded the likelihood that the subject continued to have a URTI and did not develop symptoms indicative of other illnesses—for example, flu, lower respiratory tract illness, allergies, bacterial infection.

Physical activity profile
All subjects were required to complete a physical activity log at each evening reporting period (1900) beginning on the first day of the study. The activity log was simply intended to recognise if or when a subject engaged in activity beyond what was assigned for the EX group. collection of the baseline data. An independent groups t test was used to compare the number of days from baseline until the study subjects were symptom free. The analysis of variance was performed on scores obtained by: (a) subtracting baseline symptom values from values obtained during the study; (b) ranking the resulting difference values; and (c) obtaining normalised z scores for the ranks. A set of polynomial contrasts was specified in the SPSS MANOVA program (SPSS, Inc, Chicago, Illinois, USA) for the day factor. Statistical tests were conducted for the linear relation component of elapsed time from baseline scores and for the relations of the other components combined with the scores. The latter statistical test identified if systematic variation among the score means existed beyond that identified by the linear component—that is, deviation from linearity. The statistical power for evaluating the relation of the day factor with the scores and for the difference between the EX and NEX groups over the days (p<0.05) was 0.89 for Cohen’s large effect size and 0.45 for his medium effect size (x). One way analysis of variance for differences between the measures on the physical activity logs for the EX and NEX groups was also completed. An α level of p≤0.05 was considered significant in this investigation.

RESULTS
Symptom severity/duration
There was no overall difference (days 2–7 combined) between the cold symptom score mean values in the NEX and EX groups. The combined EX and NEX group cold symptom score means decreased linearly for the combined AM and PM times of days 2–7. The average AM symptom mean was higher than the average PM for both the EX and NEX groups, which is consistent with the general trend of the symptom means decreasing during the study. However, the average decrease in the means from AM to PM for the days was larger for the EX group than for the NEX group. There was no difference between the EX and NEX groups in the mean number of days from baseline before the subjects were asymptomatic (8.36 and 8.45 respectively).

Physical activity
Log measures of total minutes of walking and cycling (transportation purposes), hours of work, and participation in recreational activity were determined from reviewing physical activity measurement instruments required daily physical activity reports.

Exercise training
By the second day of the study, subjects in the EX group began the supervised exercise training sessions. They were scheduled for either a morning or an evening exercise session, and were expected to exercise at the same time for all five days of the study. Exercise sessions lasted 30 minutes at 70% of target heart rate with the mode of exercise chosen by the subject from the following list of choices: the Air-Dyne bicycle (Schwinn Bicycle Co, Chicago, Illinois, USA); the Cybex MET 100 cycle (Cybex Metabolic Systems, Ronkonkoma, New York, USA); walking or jogging on a treadmill (Trotter, Millis, Massachusetts) or on an indoor track; or stair climbing on the StairMill (StairMaster Sports and Medical Products, Kirkland, Washington, USA). All subjects performed the same mode for each training session. Heart rate was monitored continuously via Polar heart rate telemetry units.

Statistical analysis
Symptom severity scores from the cold symptom checklist were summed. Two statistical analyses were performed. A two group (EX and NEX) by two factor repeated measures analysis of variance was used to compare the mean symptom questionnaire values of study subjects for mornings and evenings (AM/PM) of six time periods (DAY) after collection of the baseline symptom data (2 × 2 × 6). The analyses included data obtained for only days 2–7 of the study because some study subjects were unable to participate on the first day after

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seems plausible that, as the hormonal and psychological stress of initiating an exercise programme during a URTI did not increase symptom severity and duration, then continuing in an exercise programme that has already begun may be permissible. This warrants further research.

Significant findings with respect to time (AM/PM) were observed in symptom severity among and between groups. Illness severity was higher in the morning for both the EX and NEX groups. This is considered normal for people with colds. Interestingly, the difference in the AM and PM symptom severity scores in the EX group was less than that reported by the NEX group. Perhaps exercise induced psychological and/or hormonal responses account for this decline. Weidner et al found that symptom severity scores (acute response) had not changed significantly after exercise. This study may indicate that there is a more chronic effect of exercise on symptoms that is beneficial in decreasing their severity over the course of a day. However, the overall symptom severity and duration of the URTI is not altered.

This study is the first attempt to examine the influence of exercise training on the symptom severity and duration of a naturally acquired URTI in sedentary subjects. Alternative forms of exercise such as weight training, particularly that resembling heavy physical labour, would help to determine if, and to what extent, these patterns influence symptom severity and duration. The course of cold symptom severity and duration during exercise among an older (>50 years) and younger (<18 years) population also warrants further investigation. In addition, there is a need to investigate this response in highly fit athletes with a URTI.

The results from this investigation suggest that moderate exercise training in sedentary people during a naturally acquired URTI will not affect illness symptom severity or duration. This finding adds to a trend that moderate exercise during a URTI does not affect symptom severity or duration. Further, moderate exercise during a URTI does not affect pulmonary function test and exercise responses, running gait, or physical performance. Similar studies with other forms of exercise (for example, weight training), other populations (for example, young and old, labourers), and fitness levels (for example, highly fit) warrant further investigation.

**Take home message**

This study affirms the recommendation that people can exercise moderately during a naturally acquired URTI.

**REFERENCES**