Exercise-associated collapse: an evidence-based review and primer for clinicians

Chad A Asplund,1 Francis G O’Connor,2 Timothy D Noakes3,4

ABSTRACT
Exercise-associated collapse (EAC) commonly occurs after the completion of endurance running events. EAC is a collapse in conscious athletes who are unable to stand or walk unaided as a result of light headedness, faintness and dizziness or syncope causing a collapse that occurs after completion of an exertional event. Although EAC is perhaps the most common aetiology confronted by the medical provider attending to collapsed athletes in a finish-line tent, providers must first maintain vigilance for other potential life-threatening aetiologies that cause collapse, such as cardiac arrest, exertional heat stroke or exercise-associated hyponatraemia. Previously, it has been believed that dehydration and hyperthermia were primary causes of EAC. On review of the evidence, EAC is now believed to be principally the result of transient postural hypotension caused by lower extremity pooling of blood once the athlete stops running and the resultant impairment of cardiac baroreflexes. Once life-threatening aetiologies are ruled out, treatment of EAC is symptomatic and involves oral hydration and a Trendelenburg position – total body cooling, intravenous hydration or advanced therapies is generally not needed.

INTRODUCTION
Endurance sports are increasingly popular with over 500 000 participants in marathon running events in 2010.1 After marathon running events, one study demonstrated that an estimated 25 of every 1000 finishers seek medical attention; however, this number can be highly dependent on environmental conditions.2,3 Of those runners seeking medical attention, exercise-associated collapse (EAC) is the most common condition seen in the medical tent, comprising 59–85% of all visits after marathons and ultramarathons.2,4 The mechanism of EAC is multifactorial and has previously been attributed to hyperthermia or dehydration.5–7 Currently, however, EAC is believed to be principally the result of transient postural hypotension caused by lower extremity pooling of blood once the athlete stops running and the resultant impairment of cardiac baroreflexes.8,9 The purpose of this article is to review the available evidence to better elucidate the mechanisms of EAC to ensure the best treatment modalities and to provide clinicians with an evidence-based algorithm to guide race day management.

METHODS
Medline, limited to human subjects and English language, was searched using the following terms: ‘exercise-associated collapse’, ‘exercise-associated postural hypotension’, ‘postexercise collapse’ and ‘exercise and orthostatic intolerance’, which resulted in 86 articles, of which 26 were review articles. The abstracts of the articles were reviewed, and the references from the review articles were also reviewed, and a total of 34 studies deemed appropriate. Evidence was graded using the Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence.10

DEFINITIONS
Exercise-associated collapse
Collapse in conscious athletes who are unable to stand or walk unaided as a result of light headedness, faintness and dizziness or syncope causing a collapse that occurs after completion of an exertional event or stopping exercise.11

Exercise-associated postural hypotension
Postexercise symptoms caused by a decline in systolic blood pressure by at least 20 mm Hg below supine values on assuming the upright posture.4

Orthostatic intolerance
Symptoms caused by orthostatic hypotension, which is a sustained reduction of systolic blood pressure of at least 20 mm Hg or diastolic blood pressure of 10 mm Hg within 5 min of standing.12

Although EAC, exercise-associated postural hypotension (EAPH) and orthostatic intolerance (OI) all describe potential causes of syncope or presyncope, EAC and EAPH are specific to exercise. EAPH is differentiated from EAC in that blood pressures have been measured and found to be different in a supine and standing position. However, both EAPH and EAC describe collapse in athletes after exertion.

HEAT STROKE AND HYponatraEMIA
Exertional heat stroke (EHS) is characterised by central nervous system dysfunction, which may manifest as collapse or syncope, associated with an increased core body temperature (>40°C), which is induced by exercise.13,14 Exercise-associated hyponatraemia (EAH) is a potentially life-threatening condition characterised by a decrease in serum sodium (<135 mmol/L) and mental status changes. Athletes with EAH may have true syncope, confusion or disorientation but will have alteration in serum sodium.15

Although EHS and EAH can be causes of collapse in endurance sporting activities, they are associated with abnormal vital signs and symptoms and should be considered and ruled out before considering a diagnosis of EAC. The focus of this review is EAC, its mechanism and treatment; therefore, EHS and EAH will not be discussed further in this review.
MECHANISM OF EAC
Endurance training is associated with an increased cardiac output and volume load on the left and right ventricles, causing the endurance-trained heart to a dilatation of the left ventricle combined with a mild-to-moderate increase in left ventricular wall thickness. This training-induced increase in cardiac output allows trained athletes to have a lower resting heart rate compared with the non-trained athletes. Furthermore, during exercise, the active muscles of the lower extremities require increased blood flow, and therefore, peripheral vascular resistance decreases to accommodate this need. To generate this large cardiac output, and to counter the resting decrease in heart rate secondary to training effect, athletes must increase their stroke volume and vascular resistance. Working skeletal muscle functions as a ‘second heart’, ensuring cardiac return to the heart from the dilated lower extremity vasculature. On cessation of activity, the second heart effect no longer assists venous return, and large volumes of blood may pool in the lower extremities and contribute to EAC. Therefore, the very adaptations that contribute to successful completion of endurance activities are also a large factor in the increased OI found in endurance athletes.

Evidence supports this increased susceptibility to OI in exercise-trained athletes. Studies support the concept of increase in calf and lower extremity compliance and increased diastolic chamber compliance and distensibility as contributors to OI in athletes. Endurance athletes have larger increases in left ventricular end-diastolic volume compared with non-athletes, which allow them to generate the necessary larger stroke volume. Trained athletes also demonstrated a decreased ventricular untwisting rate compared with non-trained athletes, demonstrating the trained heart’s ability to adapt to maintain cardiac output. Training-related expansion of vascular volume is associated with decreased heart rate response to baroreceptor stimulation. In addition, this exercise-induced change in cardiac filling volume and output may lead to a resetting of the cardiopulmonary baroreflex. Because of this reset baroreflex, trained individuals may depend more on maintenance of venous return to maintain upright body position after exercise. Finally, a critical review supports the exercise-induced increase

Table 1  Mechanism

<table>
<thead>
<tr>
<th>Ref</th>
<th>Author/journal</th>
<th>Year</th>
<th>Study type</th>
<th>Patients</th>
<th>Outcome</th>
<th>LOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>Morikawa et al Med Sci Sports Exerc</td>
<td>2001</td>
<td>Controlled trial</td>
<td>26 female runners, 23 age-matched controls</td>
<td>Exercise-trained females have a high level of orthostatic intolerance during LBNP. Increase in leg compliance may play an important role.</td>
<td>2</td>
</tr>
<tr>
<td>17</td>
<td>Levine et al Circulation</td>
<td>1991</td>
<td>Controlled trial</td>
<td>7 athletes and 6 controls</td>
<td>Endurance athletes have greater diastolic chamber compliance and distensibility than non-athletes</td>
<td>2</td>
</tr>
<tr>
<td>18</td>
<td>Levine et al J Appl Physiol</td>
<td>1991</td>
<td>Controlled trial</td>
<td>8 high fit, 8 mid fit and 8 low-fit athletes</td>
<td>Calf compliance and carotid baroreflex response contributed to individualised response to LBNP</td>
<td>2</td>
</tr>
<tr>
<td>19</td>
<td>Esch et al Am J Physiol Heart Circ Physiol</td>
<td>2007</td>
<td>Controlled trial</td>
<td>8 athletes and 8 controls</td>
<td>Endurance athletes had larger increases in left ventricular end-diastolic volume compared with non-athletes despite similar right ventricular cavity area</td>
<td>2</td>
</tr>
<tr>
<td>20</td>
<td>Esch et al J Appl Physiol</td>
<td>2010</td>
<td>Controlled trial</td>
<td>8 athletes and 8 controls</td>
<td>Endurance athletes demonstrated a decreased left ventricular untwisting rate compared with non-athletes</td>
<td>2</td>
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<tr>
<td>21</td>
<td>Convertino Med Sci Sports Exerc</td>
<td>2003</td>
<td>Controlled trial</td>
<td>8 men</td>
<td>Expansion of vascular volume after exercise is associated with reduced heart rate response to baroreceptor stimulation</td>
<td>2</td>
</tr>
<tr>
<td>22</td>
<td>Ogoh et al J Appl Physiol</td>
<td>2006</td>
<td>Clinical trial</td>
<td>8 men</td>
<td>Cardiopulmonary baroreflex may be reset during exercise to a new operating point associated with exercise-induced change in cardiac filling volume</td>
<td>2</td>
</tr>
<tr>
<td>23</td>
<td>Ogoh et al J Physiol</td>
<td>2003</td>
<td>Clinical trial</td>
<td>14 men</td>
<td>Highly fit individuals depend more on maintenance of venous return to maintain upright body position</td>
<td>2</td>
</tr>
<tr>
<td>24</td>
<td>Convertino Med Sci Sports Exerc</td>
<td>1993</td>
<td>Critical review</td>
<td>NA</td>
<td>Increased stroke volume is the main mechanism of compensation in aerobic trained individuals</td>
<td>3</td>
</tr>
</tbody>
</table>

LBNP, lower body negative pressure; LOE, level of evidence.

Table 2  Dehydration/heat

<table>
<thead>
<tr>
<th>Ref</th>
<th>Author/journal</th>
<th>Year</th>
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<th>Patients</th>
<th>Outcome</th>
<th>LOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td>Ogoh et al J Physiol</td>
<td>2003</td>
<td>Clinical trial</td>
<td>14 men</td>
<td>Baroreflex response to progressive depletion of central blood volume is attenuated in endurance training</td>
<td>2</td>
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<tr>
<td>26</td>
<td>Crandall Am J Physiol Heart Circ Physiol</td>
<td>2000</td>
<td>Controlled trial</td>
<td>12 subjects</td>
<td>Reduced baroreflex response coupled with a reduction in ability to increase heart rate may contribute to increased susceptibility to OI</td>
<td>2</td>
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<tr>
<td>27</td>
<td>Cheuvront et al J Appl Physiol</td>
<td>2010</td>
<td>Critical review</td>
<td>NA</td>
<td>Dehydration augments hyperthermia and reduced plasma volume, which accentuates cardiovascular strain</td>
<td>3</td>
</tr>
<tr>
<td>28</td>
<td>Wilson et al Am J Physiol Regul Integr Com Physiol</td>
<td>2006</td>
<td>Controlled trial</td>
<td>15 men</td>
<td>Heat stress decreases cerebral blood velocity and increases cerebral vascular resistance</td>
<td>2</td>
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<tr>
<td>29</td>
<td>Charkoudian et al J Physiol</td>
<td>2003</td>
<td>Controlled trial</td>
<td>13 healthy subjects</td>
<td>Exercise-induced dehydration leads to changes in baroreflex control of blood pressure</td>
<td>2</td>
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<tr>
<td>30</td>
<td>Holtzhausen et al Med Sci Sports Exerc</td>
<td>1995</td>
<td>Clinical trial</td>
<td>31 runners</td>
<td>All runners were volume depleted (average of 4.6% deficit), 68% developed asymptomatic EAPH, dehydration did not compromise cardiovascular status</td>
<td>2</td>
</tr>
</tbody>
</table>

EAPH, exercise-associated postural hypotension; LOE, level of evidence; OI, orthostatic intolerance.
in stroke volume as a compensatory mechanism against OI.24 (table 1).

THE ROLES OF HEAT AND DEHYDRATION

Although dehydration leading to hyperthermia has been postulated as a primary factor for EAC,5–7 there is no evidence to support its overall responsibility for OI or EAC in endurance athletes.25 Evidence, however, supports both heat stress and increased skin temperature as contributing factors in OI. Heat stress results in the reduction of baroreflex control in response to an orthostatic challenge.26 Heat stress has also been postulated to impair aerobic exercise performance, primarily through increased cardiovascular strain.27 In addition, increasing body temperature may increase cerebral vascular resistance, reducing the cerebral threshold for neurogenic collapse.28

Two small studies found that laboratory-induced hypovolemia may lead to changes in baroreflex control of blood pressure in certain individuals, which may increase susceptibility to EAC.22,29 However, a larger clinical trial following the body composition of 31 runners completing an ultramarathon event found that the collapsed runners did not have a higher body temperature than those who did not collapse, and all the runners were dehydrated, but this level of dehydration was unrelated to the degree of postural hypotension after the event30 (table 2). Therefore, although heat and dehydration have not been found to be true causes of EAC or OI in endurance running events, they may possibly be risk factors for EAC or contribute by impairing peripheral vasconstriction leading to the orthostatic state.

BAROREFLEX MODULATION

Pooling of blood in the lower extremities at the cessation of exercise has been implicated as a mechanism of EAC; if the systemic vascular resistance, which is reduced during exercise, is not triggered by an intact baroreflex to increase after stopping exercise, a lower body negative pressure (LBNP) situation develops and postural hypotension may occur. LBNP is a widely used technique to study the cardiovascular response to this orthostatic stress. Many studies on the effect of LBNP have shown this altered baroreflex to be a primary mechanism of OI after exercise.

Reduction in baroreflex control has been implicated in the diminished orthostatic response after exercise.31 A controlled trial of exercising men found that baroreflex control is altered after dynamic exercise.32 Furthermore, in a clinical trial of 51 finishers of a mountain marathon, it was found that a diminished orthostatic response of resistance vessels was the likely aetiology in the OI in these runners after exercise.33

In a clinical trial of experienced male runners, systolic blood pressure decreases after exercise secondary to a reduction in peripheral vascular resistance leading to a decreased filling volume.34 Women, however, may respond differently to exercise than do men. A controlled clinical trial of both women and men showed that the mechanism of OI in women is likely caused by reduced cardiac filling rather than impaired baroreflex35 (table 3).

OTHER

There is strong evidence to support an attenuated baroreflex response as a responsible mechanism of OI and EAC. It has been seen that heat may contribute to this response. However,
Table 5  Treatment

<table>
<thead>
<tr>
<th>Ref</th>
<th>Author/journal</th>
<th>Year</th>
<th>Study type</th>
<th>Patients</th>
<th>Outcome</th>
<th>LOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>42</td>
<td>Journeay et al  Aviat Space Environ Med</td>
<td>2004</td>
<td>Randomised controlled trial</td>
<td>6 subjects</td>
<td>Lower body positive pressure promoted restoration of haemodynamics</td>
<td>1</td>
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<tr>
<td>43</td>
<td>Anley et al  Br J Sports Med</td>
<td>2010</td>
<td>Randomised controlled trial</td>
<td>28 athletes</td>
<td>EAPH was effectively treated with Trendelenburg positions and oral hydration</td>
<td>1</td>
</tr>
<tr>
<td>44</td>
<td>Davis and Fortney  Int J Sports Med</td>
<td>1997</td>
<td>Controlled trial</td>
<td>5 men</td>
<td>Fluid ingestion is an effective treatment for orthostatic intolerance</td>
<td>2</td>
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<tr>
<td>45</td>
<td>Durand et al  Am J Physiol Regul Integr Comp Physiol</td>
<td>2004</td>
<td>Randomised controlled trial</td>
<td>8 subjects</td>
<td>Skin surface cooling is effective in improving orthostatic tolerance in otherwise normothermic individuals</td>
<td>1</td>
</tr>
<tr>
<td>46</td>
<td>Wilson et al  J Appl Physiol</td>
<td>2002</td>
<td>Clinical trial</td>
<td>9 subjects</td>
<td>Skin surface cooling may protect against orthostatic intolerance in heat stressed humans</td>
<td>3</td>
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<tr>
<td>47</td>
<td>Cui et al  Am J Physiol Heart Circ Physiol</td>
<td>2005</td>
<td>Controlled trial</td>
<td>9 subjects</td>
<td>Skin surface cooling induced an upward shift in central venous pressure</td>
<td>2</td>
</tr>
<tr>
<td>48</td>
<td>Privett et al  Clin J Sport Med</td>
<td>2010</td>
<td>Controlled trial</td>
<td>6 subjects</td>
<td>Runners who are prone to OI after exercise may reduce this risk by wearing compression stockings while running</td>
<td>2</td>
</tr>
</tbody>
</table>

EAPH, exercise-associated postural hypotension; OI, orthostatic intolerance.

Figure 1  Exertional collapse algorithm.
TREATMENT
The evidence points towards a lower extremity pooling of blood with an attenuated baroreflex response as the primary mechanism of EAC; therefore, treatment options should be directed primarily at correcting these deficits. Because there is no good evidence to support hyperthermia or dehydration as the primary aetiologies of EAC, total body cooling and intravenous fluids should not have a role in the initial treatment of EAC.

In a randomised controlled trial, it has been shown that lower body positive pressure, such as what occurs in the Trendelenburg positions, promoted restoration of normal haemodynamics. Studies also suggest that oral hydration may be preventive against EAC and may also be used as an effective treatment for EAC. A randomised controlled trial and two smaller trials suggest that skin surface cooling may act towards directing peripheral blood flow centrally and decreasing cardiovascular strain, thus treating EAC. Finally, the results of a study of compression stockings in runners suggest that runners who are prone to OH after exercise may benefit from wearing compression hose while running. Those prone to EAC may also potentially benefit from taking H1 or H2 blocking medications, skin surface cooling along the course and ensuring adequate glucose levels during participation (table 5).

ALGORITHM
Using the evidence for aetiology, mechanism and treatment, we propose an algorithm, which is currently used at the Marine Corps Marathon, as a clinical framework for the treatment of EAC in endurance athletes (figure 1). The key to using the EAC algorithm is to approach a collapsed athlete with a wide differential that includes potential life-threatening causes such as EAH or EHS and ruling those out with a concise physical examination evaluating mental status and body temperature before proceeding down the EAC algorithm.

CONCLUSION
EAC is a common occurrence in medical tents after endurance sporting activities, which is typically characterised by collapse after completion of the event in the absence of neurological, biochemical or thermal abnormalities. Although EAC is perhaps the most common aetiology confronted by the medical provider attending to collapsed athletes in a finish-line tent, the provider needs to be reminded that EAC is a diagnosis of exclusion and that he or she needs to be vigilant for other aetiologies that cause collapse. There is no evidence to support the previous idea that EAC is caused primarily by dehydration or heat stroke. These factors, however, along with medications, hypoglycaemia and hypoglycaemia, may be contributory to EAC. Evidence currently supports that postural hypotension caused by pooling of blood in the lower extremities, secondary to decreased vascular resistance in the face of an attenuated baroreflex response, as the principal mechanism of EAC. Women may sustain EAC more from decreased cardiac filling than from altered baroreflex. Treatment of EAC is usually symptomatic and involves oral hydration and a Trendelenburg position – total body cooling, intravenous hydration or advanced therapies are generally not needed.

REFERENCES


