Influence of sex and active muscle mass on renal vascular responses during static exercise

Afsana Momen,1 Brian Handly,1 Allen Kunselman,2 Urs A. Leuenberger,1 and Lawrence I. Sinoway1

1Division of Cardiology, Department of Medicine, and 2Department of Health Evaluation Sciences, Pennsylvania State University College of Medicine, Milton S. Hershey Medical Center, Hershey, Pennsylvania

Submitted 31 August 2005; accepted in final form 23 January 2006

Momen, Afsana, Brian Handly, Allen Kunselman, Urs A. Leuenberger, and Lawrence I. Sinoway. Influence of sex and active muscle mass on renal vascular responses during static exercise. Am J Physiol Heart Circ Physiol 291: H121–H126, 2006. First published February 3, 2006; doi:10.1152/ajpheart.00931.2005.—During exercise, reflex renal vasoconstriction helps maintain blood pressure and redistributes blood flow to the contracting muscle. Sex and muscle mass have been shown to influence certain cardiovascular responses to exercise. Whether sex and/or muscle mass influence renal vasoconstrictor responses to exercise is unknown. We studied healthy men (n = 10) and women (n = 10) matched for age and body mass index during handgrip (HG, small muscle mass) and quadriceps contraction (QC, large muscle mass) as beat-to-beat changes in renal blood flow velocity (RBV; duplex ultrasound), mean arterial pressure (MAP; Finapres), and heart rate (ECG) were monitored. Renal vascular resistance (RVR) index was calculated as MAP/ RBV. Responses to HG vs. QC were compared in 13 subjects. We found that 1) RVR responses to short (15-s) bouts and fatigue HG were similar in men and women (change in RVR during 15-s HG at 70% of maximum voluntary contraction = 23 ± 4 and 31 ± 4% in men and women, respectively, P = not significant); 2) post-HG circulatory responses were similar in men and women; and 3) HG and QC were similar during short (15-s) bouts (change in RVR during HG at 50% of maximum voluntary contraction = 19 ± 3 and 18 ± 5% for arm and leg, respectively, P = not significant). Our findings suggest that muscle reflex-mediated renal vasoconstriction is similar in men and women during static exercise. Moreover, muscle mass does not contribute to the magnitude of the reflex renal vasoconstrictor response seen with muscle contraction.

EXERCISE CAUSES ACTIVATION of the sympathetic nervous system, which leads to increases in heart rate (HR), blood pressure, and peripheral vasoconstriction. As part of these processes, renal vasoconstriction helps maintain blood pressure and redistribute blood flow to the active skeletal muscle. Two important neural mechanisms are believed to be involved in the sympathoexcitatory responses during exercise: 1) central command, a feedback system that stems from the higher brain center and causes parallel activation of motor and cardiovascular control centers (37), and 2) the exercise pressor reflex, a feedback system from exercising muscle. This reflex mechanism is activated when mechanosensitive and metabosensitive afferent nerve endings within the contracting skeletal muscle are stimulated (1, 14). Activation of these neural mechanisms results in efferent sympathetic outflow to different effector organs. Studies have shown that different neural mechanisms have different onset latencies for increases in muscle sympathetic nerve activity (MSNA), an important index of sympathetic drive directed to skeletal muscle blood flow. Specifically, increases in MSNA during the initial several seconds of exercise are due to central command (36) and/or the muscle mechanoreflex (10, 11), whereas metabosensitive muscle afferent nerves activate the sympathetic system >60 s after initiation of muscle contraction (19, 32–35).

Prior reports examining the effects of sex on sympathoexcitatory responses to exercise have yielded conflicting results. Some reports showed no effect of sex on cardiovascular responses during exercise (13, 27), whereas others showed reduced exercise-induced pressor responses in women compared with men (4–6). Ettinger et al. (6) postulated that the muscle metaboreflex contribution to sympathetic outflow of exercise was reduced in women compared with men. It was also suggested that the sex-related differences in sympathetic outflow are not due to differences in muscle mass.

There has been considerable debate regarding the effects of exercising muscle mass on sympathoexcitatory responses during exercise. A number of reports in healthy human subjects have suggested that the magnitude of the pressor response during static exercise is dependent on the size of the active muscle mass (3, 12, 16, 23, 31). Other studies have suggested that increases in cardiovascular responses are dependent on the relative tension generated by the contracting muscle and not on the size of the active muscle mass (9, 17, 21, 38).

Recently, studies from this laboratory have used Doppler ultrasound technology (duplex ultrasound) to measure renal blood flow in humans during exercise. The excellent time resolution of this method has afforded the opportunity to observe renal vascular responses within the first few seconds after the initiation of exercise. Using this method, we have found that activation and sensitization of mechanosensitive muscle nerve afferents play a crucial role in evoking renal vasoconstriction during static exercise in healthy humans (25) as well as in those with heart failure (24).

However, it is not known whether sex and/or muscle mass influences renal vascular responses to exercise in humans.

Therefore, in this report, we examined renal vasoconstrictor responses to static exercise in age- and body mass index (BMI)-matched healthy young men and women to address the following questions: 1) Do men and women exhibit different renal vasoconstrictor responses during fatiguing handgrip (HG) and post-HG circulatory arrest (PHG-CA)? 2) Do men and women exhibit differences in renal vascular responses to short

Address for reprint requests and other correspondence: L. I. Sinoway, Cardiology, H047, Pennsylvania State Univ. College of Medicine, PO Box 850, Hershey, PA 17033 (e-mail: l.sinoway@psu.edu).

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(15-s) bouts of static exercise? 3) Does the size of the active muscle mass affect renal vascular responses to static exercise during short (15-s) bouts of exercise?

Our studies suggest that renal vasoconstrictor responses are similar in men and women during HG. Our results also reveal that the size of the active muscle mass does not influence the renal vasoconstrictor response during short bouts of exercise.

METHODS

Study Population

A total of 10 healthy young men (age 28 ± 2 yr, mean BMI 24 ± 1 kg/m²) and 10 healthy young women (age 25 ± 2 yr, mean BMI 22 ± 1 kg/m²) were recruited for protocols 1–3 (see below). The same nine men and the same eight women participated in protocols 1 and 2; some of these individuals participated in protocol 3. Each subject signed an informed written consent and had a physical examination before participating in the study protocols, which had been approved by the Institutional Review Board. Volunteers were nonsmokers and nonobese and were taking no medication.

Renal Blood Flow Velocity

All subjects were studied in the postabsorptive state. Duplex ultrasound (model HDI 5000, ATLUltrasound, Bothell, WA) was used to determine renal blood flow dynamics. The renal artery was scanned using the anterior abdominal approach while the subject was supine. A curved-array transducer (2–5 MHz) with a 2.5-MHz pulsed Doppler frequency was used. The probe insolation angle to the renal artery was <60°. The focal zone was set at the depth of the renal artery. To obtain optimum velocity traces, the transducer was held in a constant position; thus the data were obtained in the same phase of the respiratory cycle. Care was taken to ensure that the subject did not make QC reflex responses” impossible to quantify during a bout of fatiguing QC. Therefore, we performed only short bouts of QC in the subjects.

Protocol 2: static HG exercise at graded intensity. After protocols 1 and 2 were completed, protocol 3 was performed on a separate day in 15 subjects (8 men and 7 women). This protocol was designed to compare the renal vasoconstrictor responses during muscle contraction trials of a small muscle with those of a large muscle mass. HG was used as the small muscle mass paradigm and QC as the large muscle mass paradigm. A custom-made device for quadriiceps exercise was utilized for this paradigm. Subjects were placed in a supine position. The thigh was supported at an angle of 45° by an adjustable, padded, triangular wooden support. A recalibrated, universal, flat load cell (Strainert, West Conshohocken, PA) was mounted directly beneath and attached to the left ankle with nylon strapping. The device was calibrated before each study with 22.7- and 45.5-kg weights.

Before the studies were initiated, the MVC was determined for quadriiceps muscle contractions.

Baseline HR, MAP, and RBV data were collected for 5 min. Each subject completed 15-s bouts of static QC at 10, 30, 50, and 70% of the respective subject’s MVC. The subjects received visual feedback, via an analog meter, of the amount of tension generated. The same sequence was maintained in all subjects. Each bout of exercise was preceded by ~1 min of rest.

Data Analysis and Statistics

Beat-by-beat sequential analysis of HR, MAP, RBV, and RVR was performed for all subjects. Baseline values for each parameter were considered the average values obtained during the 5-min rest period before the beginning of each paradigm.

In the fatigue static HG protocol, each variable was measured around the time that represented 10, 20, 40, 60, 80, and 100% (peak) of the respective subject’s time to exhaustion. Data from the last 15-s period during circulatory arrest were used in the statistical analysis.

In protocols 2 and 3, data were analyzed in 5-s time periods. Statistical analyses were performed separately on each 5-s period (i.e., 1–5, 6–10, and 11–15 s).

Values are means ± SE. Resting values were compared using paired t-tests. Repeated-measures two-way ANOVA was applied to the data for each response variable (changes from the respective baseline) to assess the two main effects: sex (male vs. female) and
**RESULTS**

At rest, the average of all baseline hemodynamic variables was similar in the two sex groups. No significant group differences were found with respect to age and BMI. HG and quadriceps muscle MVC were greater in the male than in the female subjects ($P < 0.0001$).

### Fatiguing Static Exercise Followed by PHG-CA

The time to fatigue was not significantly different in male and female subjects: $128 \pm 21$ and $90 \pm 19$ s, respectively ($P = 0.19$). Comparable changes in RVR and RBV from baseline to fatigue were noted in male and female subjects: RVR was $1.79 \pm 0.09$ and $1.67 \pm 0.13$ units, respectively, at baseline and $2.73 \pm 0.26$ and $2.48 \pm 0.21$ units, respectively, at fatigue. RBV was $55.7 \pm 3.8$ and $55.4 \pm 4.8$ cm/s, respectively, at baseline and $50.5 \pm 5.8$ and $45.8 \pm 3.7$ cm/s, respectively, at fatigue. No sex effect was seen during PHG-CA (Fig. 1, Tables 1 and 2).

### Static HG Exercise at Graded Intensity

RVR responses were similar in men and women (Fig. 2). RBV, HR, and MAP were also similar in men and women during this protocol (not shown).

### Static QC at Graded Intensity

RVR rose with static QC (Fig. 3), and the pattern of rise in RVR, RBV, and HR was similar in the two groups. However, MAP rose more in men than in women during 11–15 s of quadriceps exercise ($P < 0.05$; Table 3).
Smaller (Forearm) vs. Larger (Quadriceps) Muscle Mass Contractions

HR, MAP, RBV, and RVR responses were similar during short bouts of quadriceps and HG contractions in 13 subjects (Table 4).

During 11–15 s of static contraction at 70% MVC for HG and QC, HR was 76 ± 4 and 79 ± 4 beats/min, respectively, MAP was 103 ± 7 and 101 ± 7 mmHg, respectively, RBV was 52.2 ± 3.6 and 52.2 ± 3.0 cm/s, respectively, and RVR was 2.03 ± 0.13 and 1.97 ± 0.14 units, respectively.

DISCUSSION

The objectives of this report were to evaluate the effects of sex and muscle mass on renal vascular responses to muscle contraction. The major new findings in this report are as follows: 1) Renal vasoconstrictor responses to HG are similar in men and women. 2) Renal vasoconstrictor responses during short bouts of exercise do not depend on the size of the contracting muscle mass.

Baseline RBV and RVR were similar in men and women. These findings are consistent with several previous animal and human studies (8, 22, 29). Resting MAP and HR were also not different in the groups. Some previous reports have suggested that MAP may be higher in men than in women (13, 22), whereas other reports have noted similar resting blood pressure in men and women (6, 8, 28). The exact reason for this inconsistency in resting blood pressure among men and women is not clear. However, fitness level, family history, or environmental factors could play a role (15, 18, 26, 30).

Fatiguing Static HG Followed by PHG-CA

In this study, no sex differences for RVR were observed during fatiguing HG. Ettinger et al. (6) observed reduced MSNA responses in women compared with men during the 2nd min of HG. In addition, they noted an attenuated rise in MAP in women, suggesting attenuated engagement of the muscle metaboreflex in women (6). Jones et al. (13) also observed reduced responses in blood pressure and MSNA during HG in women compared with men when absolute values were examined. However, percent increases from baseline were similar in the two groups (13).

The RVR responses in women and men were similar during fatiguing HG, even though the rise in blood pressure tended to be less in women than in men (Table 1). This suggests that sympathetic drive to the kidney during static exercise is similar in men and women. Moreover, similar RVR responses were also found between the groups during PHG-CA (which isolates the muscle metaboreflex), despite a tendency to reduced blood pressure responses in women. These findings suggest that muscle metaboreflex-mediated renal vasoconstriction was similar in men and women.

Static HG and Quadriceps Exercise at Graded Intensities

The data in the present report also suggest that differences in muscle mass do not contribute to RVR responses, because the curves for RVR vs. percent MVC for HG and QC were superimposable. Sympathoexcitatory responses during 15 s of exercise could be due to central command (36) and/or the muscle mechanoreflex (10). Engagement of muscle metaboreflexes is very unlikely, because accumulation of metabolites is not sufficient in the contracting skeletal muscle during 15 s of exercise. An earlier report from this laboratory using involuntary biceps contractions suggested that central volitional influences are not necessary to evoke renal vasoconstriction (25). Thus we would argue that the similar renal vasoconstriction response for HG and QC in the present report suggests that the muscle mechanoreflex control of the renal bed is not influenced by 10.220.33.3 on July 13, 2017 http://ajpheart.physiology.org/ Downloaded from http://ajpheart.physiology.org/ by 10.220.33.3 on July 13, 2017

Fig. 2. Percent change from baseline RVR index during 15-s bouts of static handgrip at 10, 30, 50, and 70% of MVC in male and female subjects. Values are means ± SE. Data were examined separately for 0–5, 6–10, and 11–15 s. P value reflects statistical significance (by 2-way ANOVA) of difference between male (n = 9) and female (n = 8) subjects.

Fig. 3. Percent change from baseline RVR index during 15-s bouts of static quadriceps (Quad) exercise at 10, 30, 50, and 70% of MVC in male and female subjects. Values are means ± SE. Data were examined separately for 0–5, 6–10, and 11–15 s. P value reflects statistical significance (by 2-way ANOVA) of difference between male (n = 8) and female (n = 7) subjects.
Table 3. Cardiovascular, including renal hemodynamic changes during short bouts of static QC (larger muscle mass): protocol 3

<table>
<thead>
<tr>
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<th>Men (n = 8)</th>
<th>Women (n = 7)</th>
<th>Statistics (P)</th>
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<tr>
<td></td>
<td>10% MVC</td>
<td>30% MVC</td>
<td>50% MVC</td>
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<tr>
<td>HR</td>
<td>3.4 ± 2.5</td>
<td>9.3 ± 2.6</td>
<td>13.6 ± 3.0</td>
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<tr>
<td>MAP</td>
<td>3.4 ± 2.0</td>
<td>7.7 ± 3.9</td>
<td>17.2 ± 2.7</td>
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<tr>
<td>RBV</td>
<td>-1.1 ± 4.4</td>
<td>-1.5 ± 4.4</td>
<td>2.9 ± 4.0</td>
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|                  |            |               |               |               |                  | 6–10 s       |            |               |               |
| HR               | 3.2 ± 2.5  | 5.4 ± 2.5     | 15.6 ± 3.0    | 25.0 ± 3.9    | 9.2 ± 4.3       | 4.6 ± 3.6   | 10.6 ± 2.9 | 20.3 ± 4.6 | NS          | 0.001 | NS          |
| MAP              | -3.3 ± 1.1 | 5.8 ± 2.4     | 12.8 ± 3.2    | 19.6 ± 4.9    | -2.5 ± 1.8      | 3.8 ± 2.4   | 8.0 ± 2.7  | 15.7 ± 2.1 | NS          | 0.001 | NS          |
| RBV              | -4.6 ± 4.4 | -4.4 ± 5.0    | -2.5 ± 4.7    | -8.6 ± 8.1    | -6.8 ± 1.3      | -5.2 ± 2.3  | -8.3 ± 2.2 | -14.6 ± 5.3| NS          | NS    | NS          |

|                  |            |               |               |               |                  | 11–15 s      |            |               |               |
| HR               | 7.2 ± 2.0  | 14.7 ± 2.6    | 25.0 ± 3.5    | 37.6 ± 4.7    | 8.7 ± 2.6       | 12.3 ± 4.4  | 17.8 ± 3.7 | 27.5 ± 5.5 | NS          | 0.001 | NS          |
| MAP              | -0.8 ± 1.8 | 6.2 ± 2.2     | 15.4 ± 2.9    | 17.2 ± 4.8    | -2.2 ± 1.5      | -0.4 ± 3.1  | 5.4 ± 1.6  | 10.0 ± 2.2 | 0.051       | 0.001 | NS          |
| RBV              | -3.9 ± 4.3 | -7.3 ± 4.4    | -3.2 ± 5.4    | -4.2 ± 6.4    | -6.1 ± 1.5      | -3.7 ± 2.3  | -5.5 ± 2.3 | -13.6 ± 5.5| NS          | NS    | NS          |

Values are means ± SE expressed as percent change from baseline. QC, quadriceps contraction. P values were determined by 2-way ANOVA.

Table 4. Cardiovascular, including renal hemodynamic changes during short bouts of static QC (larger muscle mass) and static HG (smaller muscle mass)

<table>
<thead>
<tr>
<th></th>
<th>QC</th>
<th>HG</th>
<th>Statistics (P)</th>
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<td></td>
<td>10% MVC</td>
<td>30% MVC</td>
<td>50% MVC</td>
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<tr>
<td>HR</td>
<td>4.5 ± 1.9</td>
<td>10.5 ± 2.1</td>
<td>12.6 ± 2.4</td>
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<tr>
<td>MAP</td>
<td>2.3 ± 1.5</td>
<td>7.6 ± 2.5</td>
<td>14.2 ± 2.4</td>
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<tr>
<td>RBV</td>
<td>-3.9 ± 2.9</td>
<td>0.0 ± 3.2</td>
<td>1.7 ± 2.5</td>
</tr>
<tr>
<td>RVR</td>
<td>7.1 ± 2.9</td>
<td>8.8 ± 4.4</td>
<td>13.9 ± 4.8</td>
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|                  |            |               |               |               |                  | 6–10 s       |            |               |               |
| HR               | 4.8 ± 2.7  | 6.1 ± 2.2     | 13.8 ± 2.3    | 22.9 ± 3.1    | 4.0 ± 2.7       | 5.9 ± 2.2   | 13.6 ± 3.0  | 22.8 ± 4.4   | NS          | 0.001  | NS        |
| MAP              | -3.4 ± 1.0 | 4.1 ± 1.8     | 10.6 ± 2.5    | 16.9 ± 3.0    | -0.6 ± 1.9      | 3.5 ± 1.9   | 8.1 ± 1.9   | 17.4 ± 2.7   | NS          | 0.001  | NS        |
| RBV              | -5.7 ± 2.7 | -5.2 ± 3.2    | -3.7 ± 3.0    | -9.0 ± 5.0    | -3.9 ± 2.7      | -3.5 ± 2.6  | -6.3 ± 3.6  | -1.5 ± 5.6   | NS          | NS     | NS        |
| RVR              | 3.2 ± 3.0  | 11.5 ± 5.4   | 16.5 ± 5.4    | 35.1 ± 12.1   | 4.0 ± 3.2       | 8.4 ± 4.0   | 16.8 ± 3.1  | 22.5 ± 4.6   | NS          | 0.001  | NS        |

|                  |            |               |               |               |                  | 11–15 s      |            |               |               |
| HR               | 7.6 ± 1.6  | 15.2 ± 2.4    | 21.2 ± 2.8    | 33.2 ± 4.3    | 5.8 ± 3.0       | 6.1 ± 2.2   | 17.5 ± 3.7  | 28.2 ± 5.3   | 0.083       | NS     | NS        |
| MAP              | -1.3 ± 1.3 | 3.1 ± 2.3     | 11.3 ± 2.4    | 13.1 ± 3.0    | -0.8 ± 1.6      | 3.1 ± 1.6   | 7.8 ± 2.1   | 15.3 ± 2.9   | 0.001       | NS     | NS        |
| RBV              | -4.2 ± 2.6 | -6.2 ± 2.9    | -4.3 ± 3.4    | -6.0 ± 4.1    | -4.6 ± 2.9      | -6.0 ± 2.4  | -8.3 ± 3.5  | -7.2 ± 5.4   | NS          | NS     | NS        |
| RVR              | 3.6 ± 2.7  | 11.3 ± 5.0    | 17.9 ± 5.2    | 23.0 ± 7.5    | 5.2 ± 3.6       | 10.6 ± 3.5  | 18.7 ± 3.2  | 26.9 ± 4.4   | 0.001       | NS     | NS        |

Values are means ± SE expressed as percent change from baseline. QC, renal vascular resistance. P values were determined by 2-way ANOVA.
ute to blood pressure control, but not to renal vascular control, and that muscle mechanoreflex-mediated control of the renal vascular bed is not influenced by muscle mass. The present report does not allow us to draw inferences regarding the effect of muscle mass on central command and metaboreflex-mediated control of the renal vascular bed. We can also conclude that mechanoreflex control of the renal vascular bed is similar in men and women.

ACKNOWLEDGMENTS
The authors are grateful to Jennifer Stoner for expert manuscript preparation, Michael Herr and Kristen Gray for technical assistance, and the staff of the General Clinical Research Center.

GRANTS
This work was supported by National Institutes of Health Grants R01 HL-070222 (L. I. Sinoway), PO1 HL-077670 (L. I. Sinoway), R01 HL-068699 (U. A. Leuenberger), M01 RR-010732, and C06 RR-016499 and by Pennsylvania Tobacco Settlement Funds-Penn State College of Medicine.

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