Muscle Tensing During Standing
Effects on Cerebral Tissue Oxygenation and Cerebral Artery Blood Velocity

Johannes J. van Lieshout, MD, PhD; Frank Pott, MD; Per Lav Madsen, MD; Jeroen van Goudoever, MSc, PhD; Niels H. Secher, MD, PhD

Background and Purpose—When standing up causes dizziness, tensing of the leg muscles may alleviate the symptoms. We tested the hypothesis that leg tensing improves orthostatic tolerance via enhanced cerebral perfusion and oxygenation.

Methods—In 10 healthy young adults, the effects of leg tensing on transcranial Doppler–determined middle cerebral artery (MCA) mean blood velocity (V\text{mean}) and the near-infrared spectroscopy–determined frontal oxygenation (O\text{2 Hb}) were assessed together with central circulatory variables and an arterial pressure low-frequency (LF) (0.07 to 0.15 Hz) domain evaluation of sympathetic activity.

Results—Standing up reduced central venous pressure by (mean±SEM) 4.3±2.6 mm Hg, stroke volume by 49±7 mL, cardiac output by 1.9±0.4 L/min, and mean arterial pressure at MCA level by 9±4 mm Hg, whereas it increased heart rate by 30±4 beats per minute (P<0.05). MCA V\text{mean} declined from 67±4 to 56±3 cm/s, O\text{2 Hb} decreased by 7±2.8%, and LF spectral power increased (P<0.05). Leg tensing increased central venous pressure by 1.4±2.7 mm Hg and cardiac output by 1.8±0.4 L/min with no significant effect on blood pressure, whereas heart rate decreased by 11±3 beats per minute (P<0.05). MCA V\text{mean} increased to 63±3 cm/s and O\text{2 Hb} increased by 2.1±2.6%, whereas LF power declined (P<0.05). Within 2 minutes after leg tensing, these effects had disappeared.

Conclusions—During standing, tensing of the leg muscles attenuates a reduction in cerebral perfusion and oxygenation as it stabilizes central circulatory variables and reduces sympathetic activity. (Stroke. 2001;32:1546-1551.)

Key Words: Fourier analysis • orthostatic • spectroscopy, near-infrared • syncope • ultrasonography, Doppler, transcranial

A ssumption of the upright position is associated with a reduction in venous return and cardiac output (CO),\textsuperscript{1} and blood pressure is maintained with a sympathetically mediated increase in vascular resistance. In the upright position, the cerebral arteries are positioned ~30 cm above the heart, and their perfusion pressure is reduced.\textsuperscript{2} Both the position of the cerebral circulation and the reduction in CO challenge cerebral blood flow, and although the postural reduction in cerebral perfusion\textsuperscript{3–4} and oxygenation\textsuperscript{7–9} is kept limited via cerebral autoregulatory mechanisms, orthostatic intolerance is not uncommon in healthy subjects.\textsuperscript{10} Leg tensing may relieve orthostatic symptoms,\textsuperscript{11} and we considered that when leg tensing alleviates the dizziness developed during standing, this occurs through the modulation of brain perfusion.

In the present study, we addressed the hypothesis that in the upright position, leg tensing enhances cerebral perfusion and oxygenation. To evaluate rapid changes in cerebral perfusion, we studied the transcranial Doppler ultrasonographically determined middle cerebral artery (MCA) mean blood velocity (V\text{mean},) and near-infrared spectroscopy (NIRS)-indicated cerebral oxygenation (O\text{2 Hb}). In addition, we determined central circulatory variables and an arterial pressure low-frequency (LF) domain evaluation of sympathetic activity.

Subjects and Methods

Subjects
After informed consent was obtained, 11 healthy subjects (4 women, median age 27 years, age range 21 to 38 years, median weight 76 kg, weight range 50 to 85 kg, median height 180 cm, height range 162 to 191 cm) participated in the study as approved by the Ethics Committee of Copenhagen (KF 01-120/96).
Standing and Leg Tensing Protocol

Instrumentation occurred at 9 AM in a room at 22°C and was followed by a test run and baseline recordings after 30 minutes. The subjects then stood up, and after 5 minutes, they tensed their muscles by crossing the legs and pressing them against each other for 2 minutes, followed by 2 minutes of free standing. After 10 minutes of supine rest, the protocol was repeated.

Measurements

The proximal segment of the right MCA was ionized (Multidop X; DWL Sipplingen) through the posterior temporal “window.”13 Once the optimal signal-to-noise ratio was obtained, the probe was covered with an adhesive ultrasonic gel (Tensive; Parker Laboratories Inc) and secured with a headband. MCA Vmean was the integral of the maximal frequency shifts over 1 heartbeat.

Cerebral oxygenation was monitored by NIRS, and changes in absorption of mainly oxyhemoglobin (O2Hb) and deoxyhemoglobin (Hb) were recorded with the light source and the sensing optode positioned on the forehead below the hairline (INVOS 3100 cerebral oximeter; Somanetics [with light at 808.75 and 732.50 nm]).14 With continuous light, the chromophore content is not determined because the path length of light is unknown but the NIRS-determined oxygenation changes in parallel with cerebral blood flow. Changes in O2Hb are given relative to supine rest.

Mean arterial pressure (MAP) was measured with a Finapres (model 5; Netherlands Organization for Applied Scientific Research, Biomedical Instrumentation, TNO-BMI).16 The cuff was applied to the midphalanx of the middle finger of the dominant arm placed at heart level. Central venous pressure (CVP) was measured with a catheter (1.7 mm ID, 16 gauge) introduced percutaneously through the basilic vein of the nondominant arm and advanced to the superior cavaal vein under continuous ECG recording. Correct catheter positioning was confirmed by monitoring of the pressure waveform. CVP was recorded from a transducer (Bentley) referenced to the midaxillary line at the level of the right atrium and connected to a monitor (8041; Simonsen & Weel). A catheter (1.0 mm ID, 19 gauge) was placed at a similar distance in the left midaxillary line at 5 cm behind the right sternocleidomastoid muscle, and another pair of electrodes (Blue Sensor; Medicotest) with 10 mA at 100 kHz were introduced as a ground electrode. Blood pressure and MCA Vmean were obtained from a Zirconia oxygen analyzer (accuracy ±0.03% O2) and a nondispersive infrared sensor for CO2 (accuracy ±0.05% CO2) that delivered VO2 and end-tidal CO2 tension (PETCO2). Arterial and venous blood was sampled (QS50; Radiometer) for blood gas variables and analyzed immediately (ABL-4 and OSM-3 apparatus; Radiometer). PaCO2 was measured at 2 and 1 minute before standing up, at 2 minutes, and at the end of standing, after 1 minute of leg tensing and 1 minute after uncrossing of the legs.

Data Processing and Analysis

Blood pressure and MCA Vmean, values were analog-to-digital converted at 100 Hz and stored on a hard disk. O2Hb and TI were recorded every 15 seconds. MAP and CVP were the integral over 1 beat. MAP at the level of the MCA (MAPmca) took into account the finger-to-Doppler probe distance. The inverse of the interbeat pressure interval was HR, and systemic vascular resistance was calculated from MAP, CO, and CVP. The influence of tensing on the MCA Vmean-PaCO2 relationship was analyzed in 8 subjects in whom satisfying simultaneous recordings of PaCO2 and MCA Vmean were made. Sequences of consecutive MCA Vmean values for ∼15 cardiac cycles at 5 minutes of standing and 1 minute of leg tensing were taken, and their averages were related to the corresponding PaCO2 values. The steady-state CO2 reactivity was calculated from the change in MCA Vmean and corresponding PaCO2 from standing to tensing and expressed as their ratio. The LF component of oscillations of arterial pressure was taken to reflect changes in sympathetic activity.24 During standing and leg tensing, oscillations in arterial pressure were analyzed by fast Fourier transformation, and spectral power was expressed as the integrated area in the LF (0.07 to 0.15 Hz) range.24,25

Statistical Analysis

Data were transformed to equidistantly resampled data at 2 Hz (PetCO2 data at 0.25 Hz accounting for respiratory rate) by polynomial interpolation. Data that fit a normal distribution are expressed as mean and SEM and otherwise as median with range. Changes over time were examined by repeated measures ANOVA, and differences were determined by the Student-Newman-Keuls test. Differences in responses between body positions were examined by t test or Wilcoxon signed rank test. P<0.05 was considered to indicate a statistically significant difference.

Results

Standing Up

One subject developed syncopal symptoms during free standing with a 22% fall in O2Hb accompanied by a 25% reduction in MCA Vmean, and the experiment was terminated. In the other subjects, CVP decreased by 4.3±2.5 mm Hg and TI increased from 45.3±3.2 to 48.9±4.0 Ω after 1 minute and to 49.9±3.8 Ω after 5 minutes. After 1 minute of standing, HR had increased by 30±4 beats per minute, whereas SV was reduced by 49±7 mL and CO was reduced by 1.9±0.4 L/min.

At 2 and 1 minute before the subjects stood up, PaCO2 was 5.2±0.13 and 5.34±0.18 kPa, respectively (P=0.145). After the subjects stood up, ventilation increased (Table 1) and PaCO2 fell to 4.68±0.13 kPa at 2 minutes and then remained stable until the end of standing (4.64±0.17 kPa). The SaO2 did not change, but the Svo2 continued to decrease. After 8 seconds of standing, a reduction in MAPmca coincided with a fall in MCA Vmean by 20±3 cm/s, followed by a recovery and an overshoot with a peak after 15 seconds and similar changes in blood pressure (Figure 1). After ∼3 minutes, MAPmca had decreased by 9±4 mm Hg, Vmean stabilized at 84±5% of the level established during rest, and cerebral oxygenation decreased by 7.2±2.6% (Figures 2 and 3). LF variability in MAP increased from 3.4±3.5 to 16.9±1.8 mm Hg2/Hz.
After 2 seconds, CVP increased by 1.4 ± 2.7 mm Hg, whereas TI did not change significantly. The MAP response was biphasic with a 7 ± 4 mm Hg increase after 2.5 seconds, a nadir at −6 ± 4 mm Hg after 8 seconds, and then a recovery after 14 seconds (Figures 2 and 3). Apart from these initial changes, MAPmca was not significantly different from the values during free standing.

After 9 seconds, CO was elevated by 1.8 ± 0.4 L/min, followed by a decline as HR decreased 11 ± 4 beats per minute. MCA Vmean increased to ~62 cm/s during the first 70 seconds and to ~59 cm/s until muscle tensing was terminated (Figures 2 and 3). O2Hb increased by 2.1 ± 2.5% after 2 minutes. The TI was maintained at 49.8 ± 3.8 Ω during tensing. With muscle tensing, PACO2 increased to 4.90 ± 0.13 kPa, although ventilation did not change significantly and the “CO2 reactivity” of the Vmean was elevated (Table 2). Leg tensing reduced the LF variability from 16.9 ± 7.8 to 9.8 ± 5.7 mm Hg/Hz (P<0.01) (Figure 4).

During the first 2 minutes after the cessation of muscle tensing, CVP, CO, MCA Vmean, PACO2, and O2Hb fell to the level of 5 minutes of free standing.

**Discussion**

When humans stand up, the gravitational displacement of blood from the chest to lower parts of the body reduces venous return within seconds, resulting in a fall in cardiac filling volume1 and a reduction in cerebral perfusion1–6 and oxygenation.7–9 The new finding of the present study is that tensing of the leg muscles attenuates the orthostatic reduction in MCA Vmean and in cerebral oxygenation.

We did not evaluate how leg tensing enhances cerebral perfusion or oxygenation during standing, but pressing the legs against each other modified central circulatory variables.

### Table 1. Ventilatory Responses to Standing Up and Leg Tensing

<table>
<thead>
<tr>
<th></th>
<th>Supine</th>
<th>Standing: 5 min</th>
<th>Leg Tensing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>60 s</td>
</tr>
<tr>
<td>SaO2, %</td>
<td>97 (0.3)</td>
<td>98 (0.2)*</td>
<td>98 (0.2)</td>
</tr>
<tr>
<td>SvO2, %</td>
<td>78 (1)</td>
<td>62 (2)*</td>
<td>64 (1)</td>
</tr>
<tr>
<td>Vc, L/min</td>
<td>7.7 (4.7–9.4)</td>
<td>9.5 (6.5–15.0)*</td>
<td>9.8 (7.2–13.8)</td>
</tr>
<tr>
<td>f, /min</td>
<td>17 (1.2)</td>
<td>16 (1.0)</td>
<td>16 (1.3)</td>
</tr>
<tr>
<td>PETCO2, kPa</td>
<td>5.31 (4.80–5.60)</td>
<td>4.83 (3.67–5.31)*</td>
<td>5.07 (4.05–5.45)</td>
</tr>
<tr>
<td>PacO2, kPa</td>
<td>5.34 (0.18)</td>
<td>4.64 (0.17)*</td>
<td>4.90 (0.13)†</td>
</tr>
</tbody>
</table>

Vc indicates ventilation; f, respiratory frequency. Values given as mean ± SEM; significant difference (P<0.05).

*Standing vs supine.
†Leg tensing vs standing.

Figure 1. MCA blood velocity and mean arterial pressure (MAP) responses to standing. Thin lines indicate individual values; thick line, averaged response (n=10).

Figure 2. Cerebrovascular and cardiovascular responses to leg tensing. For PETCO2/Paco2, line indicates PETCO2 dots, Paco2. SVR indicates systemic vascular resistance; dotted lines, supine reference level.
Leg tensing increased CVP without affecting the central blood volume, as indicated by an unchanged TI, which suggests a reduced central venous compliance. Whether or not the central blood volume was increased, apparently more blood was provided to the heart as CO increased.12 This was the case, although 3 indices suggested a reduced sympathetic activity during leg tensing.

First, during standing, the increase in HR results from an enhanced sympathetic activity rather than from vagal withdrawal.26 Conversely, when leg tensing attenuates the increase in HR elicited by standing up,12 the reduction is likely to be by way of reduced sympathetic outflow. Furthermore, during standing, the integrated area of muscle sympathetic bursts and the spectral power of LF arterial pressure oscillations increase in proportion to the degree of orthostatic stress.27 We found an increased arterial pressure LF spectral power during standing but a reduction during leg tensing. Finally, the leg-tensing maneuver resulted in a reduced systemic vascular resistance with an elevation in CVP. A similar effect was observed by Ray et al28 when they examined muscle sympathetic nerve activity during 1-legged exercise in the upright position. They demonstrated that in the first minute of exercise, CVP became elevated and sympathetic nerve activity decreased.

The MCA $V_{mean}$ was chosen for evaluation of cerebral perfusion because it allows for a time resolution corresponding to 1 heartbeat, with the assumption that changes in MCA $V_{mean}$ are representative of changes in cerebral blood flow.29 During craniotomy, Giller et al30 found that the diameter of the large cerebral vessels did not change with large changes in arterial pressure, and a reduced cerebral perfusion pressure in the upright position31 renders an increase in cerebral vessel diameter unlikely. Orthostatic stress as simulated by lower body negative pressure32 does not alter the MCA diameter as determined with MRI,29 supporting the assumption that under the conditions of this study, the changes in MCA $V_{mean}$ represent changes in cerebral blood flow. The postural reduction in MCA $V_{mean}$ was attenuated for as long as leg tensing was maintained with no significant change in MAP, and an increase in cerebral blood flow was supported by an increase in cerebral oxygenation.9,14,33

Postural stress, either by active standing or mimicked by lower body negative pressure, induces a reduction in cerebral blood flow velocity.3,4,6,34–36 Harms et al9 showed that postural stress reduces cerebral oxygenation and MCA $V_{mean}$ in both healthy subjects and patients with sympathetic failure, although the decline in these variables was more profound in the patients. There also is evidence for the notion that cerebral vasoconstriction in subjects with orthostatic intolerance is amplified by hypocapnia related to postural hyperventilation.36 The ‘15% orthostatic reduction in MCA $V_{mean}$ on standing is comparable to data from Bode3 and Levine et al32 and even larger than noted for elderly subjects6 with the NIRS-determined cerebral oxygenation following this pattern,9 indicating that the postural reduction in cerebral perfusion in the young is substantial.

Pa CO2 is an important determinant for the cerebral perfusion. At the levels of hypocapnia37–39 and hypercapnia29 attained in this study, the MCA diameter remains stable and a reduction in PaCO2 is followed by a decline in cerebral blood flow and equally in MCA $V_{mean}$. The lower PaCO2 during standing has been ascribed to an increase in breathing rate and an improved ventilation-perfusion relationship,30,41 which in

![Figure 3. Average cerebral oxygenation and blood velocity responses to standing and leg tensing (n=10). *P<0.05 standing vs supine. #P<0.05 leg tensing vs standing.]

### Table 2. Individual Changes in $V_{mean}$ Corresponding Changes in PaCO2 and Calculated CO2 Reactivity at 1-Minute Leg Tensing

<table>
<thead>
<tr>
<th>Subject</th>
<th>$P_{aCO2}$ (kPa)</th>
<th>$V_{mean}$ (cm/s)</th>
<th>$P_{aCO2}$ (kPa)</th>
<th>$V_{mean}$ (cm/s)</th>
<th>CO2 Reactivity, (%/mm Hg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4.25</td>
<td>47</td>
<td>4.45</td>
<td>53</td>
<td>63.8 (8.5)</td>
</tr>
<tr>
<td>2</td>
<td>4.87</td>
<td>76</td>
<td>5.20</td>
<td>77</td>
<td>4.0 (0.5)</td>
</tr>
<tr>
<td>3</td>
<td>5.44</td>
<td>39</td>
<td>5.35</td>
<td>41</td>
<td>-57.0 (-7.6)</td>
</tr>
<tr>
<td>4</td>
<td>4.60</td>
<td>58</td>
<td>4.78</td>
<td>66</td>
<td>76.6 (10.2)</td>
</tr>
<tr>
<td>5</td>
<td>4.41</td>
<td>52</td>
<td>4.70</td>
<td>62</td>
<td>66.3 (8.8)</td>
</tr>
<tr>
<td>6</td>
<td>4.20</td>
<td>56</td>
<td>4.83</td>
<td>67</td>
<td>31.2 (4.2)</td>
</tr>
<tr>
<td>7</td>
<td>4.19</td>
<td>34</td>
<td>4.48</td>
<td>37</td>
<td>30.4 (4.1)</td>
</tr>
<tr>
<td>8</td>
<td>5.15</td>
<td>54</td>
<td>5.41</td>
<td>61</td>
<td>49.9 (6.6)</td>
</tr>
</tbody>
</table>

$V_{mean}$ indicates middle cerebral artery mean blood velocity.
tension does not influence ventilation or the respiratory frequency, although arterial and end-tidal CO₂ tension increased. Changes in MCA \(V_{\text{mean}}\) induced by hypercapnia reflect changes in \(^{133}\text{Xe}\) clearance–determined cerebral blood flow,\(^{42}\) supporting that the increase in \(V_{\text{mean}}\) by muscle tensing reflects changes in blood flow in the MCA territory. It should therefore be considered that an increase in \(\text{Paco}_2\) induces cerebral vasodilatation with a rise not only in cerebral blood flow but also in MCA \(V_{\text{mean}}\).\(^{43}\) Poulin et al\(^{37}\) analyzed in resting volunteers the dynamic response of MCA \(V_{\text{mean}}\) to changes in end-tidal CO₂ and found that the onset of the MCA \(V_{\text{mean}}\) response was delayed \(\approx 4\) seconds with time constants of \(\approx 7\) and \(\approx 4\) seconds for the MCA \(V_{\text{mean}}\) responses to a step decrease or increase in CO₂, respectively. During leg tensing, the \(\approx 11\%\) increase in MCA \(V_{\text{mean}}\) was associated with a gradual rise in \(\text{Paco}_2\) with a time course of 16 seconds to attain the maximal value (Figure 2). In contrast, the increase in MCA \(V_{\text{mean}}\) by leg tensing was immediate onset, whereas the contribution of \(\text{Paco}_2\) would be expected to be manifest later. We examined an effect of an elevated CO₂ tension on MCA \(V_{\text{mean}}\) at the later stages of tensing and analyzed the steady-state MCA \(V_{\text{mean}}-\text{Paco}_2\) relationship at standing and after 1 minute of leg tensing (Table 2). The values found were considerably larger than the normal cerebrovascular response to CO₂ reported in healthy subjects \((\approx 19.5\% / \text{kPa} \text{ or } 2.6\% / \text{mm Hg})\).\(^{44}\) The observed increase in \(\text{Paco}_2\) and equally in \(\text{PETCO}_2\) by \(\approx 0.3\) kPa (Table 1 and Figure 2) could explain a \(\approx 6\%\) rise in MCA \(V_{\text{mean}}\) and probably less when accounting for the smaller slope of the MCA \(V_{\text{mean}}-\text{Paco}_2\) relationship during orthostatic stress.\(^{44}\) It is therefore likely that the produced increase in \(\text{Paco}_2\) is not the only factor for the increase in cerebral perfusion and oxygenation.

Besides an influence of \(\text{Paco}_2\), it is to be considered whether sympathetic activity influenced cerebral perfusion and oxygenation. In the sequence from supine rest to free standing, standing with the legs pressed against each other and again to free standing, the changes in MCA \(V_{\text{mean}}\) and NIRS-determined cerebral oxygenation followed the indices of sympathetic activity in that they decreased as the indices of sympathetic activity increased. MCA \(V_{\text{mean}}\) and sympathetic activity are also inversely related during exercise in that MCA \(V_{\text{mean}}\) decreases when the ability to increase CO is limited by cardioselective \(\beta\)-blockade.\(^{45}\) and under those conditions, the reduction in MCA \(V_{\text{mean}}\) is blunted by sympathetic blockade at the level of the neck.\(^{46}\)

In conclusion, the orthostatic reduction in cerebral perfusion and oxygenation is attenuated by pressing the legs against each other, suggesting that leg tensing alleviates the symptoms sometimes associated with postural stress by stabilizing central circulatory variables at a reduced sympathetic activity.

Acknowledgments

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References

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