Elevated Aerobic Fitness Sustained Throughout the Adult Lifespan Is Associated With Improved Cerebral Hemodynamics

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Background and Purpose—Age-related impairments in cerebral blood flow and cerebrovascular reactivity to carbon dioxide (CVR$_{CO_2}$) are established risk factors for stroke that respond favorably to aerobic training. The present study examined to what extent cerebral hemodynamics are improved when training is sustained throughout the adult lifespan.

Methods—Eighty-one healthy males were prospectively assigned to 1 of 4 groups based on their age (young, ≤30 years versus old, ≥60 years) and lifetime physical activity levels (trained, ≥150 minutes recreational aerobic activity/week versus sedentary, no activity). Middle cerebral artery blood velocity (MCAv, transcranial Doppler ultrasound), mean arterial pressure (MAP, finger photoplethysmography), and end-tidal partial pressure of carbon dioxide (PETCO$_2$, capnography) were recorded during normocapnia and 3 mins of iso-oxic hypercapnea (5% CO$_2$). Cerebrovascular resistance/conductance indices (CVRi/CVCi) were calculated as MAP/MCAv and MCAv/MAP, respectively, and CVR$_{CO_2}$ as the percentage increase in MCAv from baseline per millimeter of mercury (mm Hg) increase in PETCO$_2$. Maximal oxygen consumption (V0$_{2\text{MAX}}$, online respiratory gas analysis) was determined during cycling ergometry.

Results—By design, older participants were active for longer (49±5 versus 6±4 years, P<0.05). Physical activity attenuated the age-related declines in V0$_{2\text{MAX}}$, MCAv, CVCi, and CVR$_{CO_2}$ and increase in CVRi (P<0.05 versus sedentary). Linear relationships were observed between V0$_{2\text{MAX}}$ and both MCAv and CVR$_{CO_2}$ ($r = 0.58$–0.77, P<0.05).

Conclusions—These findings highlight the importance of maintaining aerobic fitness throughout the lifespan given its capacity to improve cerebral hemodynamics in later-life. (Stroke. 2013;44:00-00.)

Key Words: aerobic exercise ◼ aging ◼ cerebrovascular circulation ◼ perfusion ◼ stroke

Materials and Methods

Participants

Recruitment

After ethical approval and written informed consent, we recruited both young (aged ≤30 years) and old (≥60 years) males who according to self-report lifetime physical activity levels$^6$ were either trained (≥150 minutes of moderate to vigorous intensity recreational aerobic activity/week sustained during the adult lifespan consistent with...
current recommendations or sedentary (no formal recreational activity outside of everyday living). We specifically chose to exclude females given our inability to control for differences in estrogen levels (during the menstrual cycle, menopause, and hormone replacement therapy), which has been shown to cause intracranial vasodilatation and increase CBF. 

**Screening**

All potential participants were subject to a detailed clinical examination that included a 12-lead ECG. They were included if they were nonsmokers, nonobese (body mass index <30 kg/m²), and free of any cardiovascular (eg, type 2 diabetes mellitus, coagulopathy, hypertension), cerebrovascular (eg, stroke, transient ischemic attack, migraine), or respiratory (eg, asthma, chronic obstructive pulmonary disorder) diseases. Participants were also screened for any psychiatric or neurological disorders, including dementia and depression and were not prescribed any medications.

**Assignment**

Eighty-one males were considered eligible for the study. They were prospectively assigned to 1 of 4 groups based on their age and physical activity levels and included the following: young sedentary (n = 19), young trained (n = 20), old sedentary (n = 19), and old trained (n = 23). Every attempt was made to match the trained groups for (weekly) exercise duration, frequency, and intensity.

**Experimental Procedures**

**Cerebral Hemodynamics: CBF, MAP, and CVR**

The middle cerebral artery (MCA) was insonated using 2 MHz pulsed transcranial Doppler ultrasound (Multi-Dop X4, DWL Elektronische Systeme GmbH, Sippelingen, Germany) and mean arterial pressure (MAP) determined by finger photoplethysmography (Finometer PRO, Finapres Medical Systems, Amsterdam, The Netherlands). Data were sampled continuously at 1 kHz and stored for off-line analysis. Cerebrovascular resistance and conductance indices (CVRi and CVCi) were calculated as MAP/MCAv and MCAv/MAP respectively. CVRi was calculated as the percentage increase in MCAv from baseline per mm Hg increase in PETCO2, determined by capnography (ML 206, ADInstruments Ltd, Oxford, UK) in response to 3 minutes breathing 5% CO2 (balanced air).

**Cardiorespiratory Fitness**

Maximal oxygen consumption (VO2MAX) was determined during an incremental cycling test to volitional exhaustion. Expired gas fractions were determined online (MedGraphics, Ultima Series) and VO2MAX confirmed according to established criteria.

**Statistics**

After confirmation of distribution normality using Shapiro–Wilk W tests, between group differences were analyzed using a 2-way (age, young versus old × status, sedentary versus trained) factorial analysis of variance (ANOVA). After an interaction effect, differences were located using a 1-way ANOVA and post hoc Tukey tests. Relationships were determined using Pearson Product Moment Correlations. Significance was established at P <0.05 and data expressed as mean±SD.

**Results**

By design, old participants were physically active for longer than the young (49±5 versus 6±4 years, P <0.05). Aging was associated with a lower VO2MAX, MCAv, CVCi, and CVRi, and elevations in body mass index and CVRi, whereas MAP remained unchanged (Table). Physical activity was associated with an elevation in VO2MAX and corresponding improvement in cerebral hemodynamics. Indeed, positive linear relationships were observed between VO2MAX and both MCAv and CVRi (pooled sedentary and trained data sets) in both young and old participants (Figure, A–D). Furthermore, at an approximate average MCAv of 50 cm/s and CVRi of 2%/mm Hg, the difference between trained and sedentary participants equated to ≈11- and 18-year reduction, respectively in the brain’s hemodynamic age. In contrast, physical activity did not alter the age-related rate of decline in MCAv (sedentary, –0.3 cm/s/year versus trained, –0.4 cm/s/year; P >0.05) or CVRi (sedentary, –0.02%/mm Hg/year versus trained, –0.02%/mm Hg/year; P >0.05).

**Discussion**

The major finding of the present study is that elevated cardiorespiratory fitness was shown to attenuate the age-related decline in cerebrovascular hemodynamics given its association with improved cerebral perfusion and CO2 vasoreactivity. This highlights the neuroprotective benefits of active living given its capacity to improve cerebral hemodynamics throughout the adult lifespan.

To our knowledge, this is the first cross-sectional study to assess the association between aerobic fitness and both MCAv and CVRi across the extremes of healthy human aging. Our findings confirm the age-related decline in MCAv originally documented by Ainslie et al1 and corresponding increase incurred through regular exercise training. Indeed, when comparing the two extremes of chronological age, physical activity was shown to reduce the brain’s hemodynamic age by more than a decade, which is in agreement with previous estimates.

Our study extends these original works by further documenting exercise-induced improvements in CVRi, which seemed to be even more marked with physical activity conferring ≈18-year reduction in the brain’s functional age. These findings are in agreement with another transcranial Doppler–based study, though in conflict with recent MRI-based studies focused on regional as opposed to global cerebral perfusion that have used alternative hypercapnic challenges. Furthermore, the consistent relationships observed between VO2MAX and both MCAv and CVRi confirm that the benefits of aerobic exercise are not simply confined to the cardiovascular circulation but can equally extend to the cerebrovasculature. This was clearly evident in later-life, indicating that the human brain retains a life-long capacity for exercise adaptation further justifying exercise prescription in the elderly.

The present findings need to be interpreted with a degree of caution given some experimental limitations. A cross-sectional design cannot establish causality and also relies on self-report approaches when recalling lifelong participation in physical activity. However, we sought to minimize this potential confound through the combined use of a validated physical activity questionnaire and direct measurement of cardiorespiratory fitness. Furthermore, we did not explore the molecular mechanisms underlying enhanced neuroplasticity such as exercise-induced increases in the vascular bioavailability of nitric oxide, brain-derived neurotrophic factor, and insulin-like growth factor. Likewise, it remains unclear whether these hemodynamic adaptations would have translated into improved cognitive function and stroke risk in later-life as previously suggested, which would have placed our findings into clearer clinical context.
Rigorous inclusion criteria meant that we were only able to recruit relatively small sample sizes into each group. However, retrospective power analysis revealed that we were adequately powered to detect main effects with values exceeding 0.90 for all dependent variables examined. Furthermore, given that our study was exclusively restricted to males, it would be of future interest to determine whether physical activity has an equivalent impact on females given the known sex differences in baseline cerebral hemodynamics to make our findings more applicable to the general population. Finally, we relied on transcranial Doppler measurements of blood flow velocity as an indirect surrogate of global CBF, a limitation that is well established though MCAv is considered a reliable indicator of cerebral perfusion both at rest and when assessing the dynamic response to hypercapnia.

In conclusion, the present findings highlight the importance of being physically active and maintaining aerobic fitness throughout the lifespan given the improvements observed in cerebrovascular hemodynamics. Larger-scale, longer-term, mixed-sex, interventional studies are warranted to confirm

Table. Participant Demographics

<table>
<thead>
<tr>
<th>Activity</th>
<th>Age, y</th>
<th>BMI, kg·m⁻²</th>
<th>VO₂MAX, L·min⁻¹</th>
<th>VO₂MAX, mL·kg⁻¹·min⁻¹</th>
<th>MCAv, cm·s⁻¹</th>
<th>MAP, mmHg</th>
<th>CVRI, mmHg·cm⁻³·s⁻¹</th>
<th>CVCi (cm·s⁻¹·mmHg⁻¹)</th>
<th>CVRCO₂ (%·mmHg⁻¹)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sedentary</td>
<td>25±5</td>
<td>26.2±2.9</td>
<td>3.05±0.52</td>
<td>36.5</td>
<td>52±11</td>
<td>89±11</td>
<td>1.77±0.43</td>
<td>0.60±0.16</td>
<td>2.10±0.73</td>
</tr>
<tr>
<td>Trained</td>
<td>23±4</td>
<td>23.9±2.7</td>
<td>4.75±0.73</td>
<td>62±9*</td>
<td>64±13</td>
<td>85±6</td>
<td>1.38±0.33</td>
<td>0.76±0.19</td>
<td>3.70±0.84</td>
</tr>
<tr>
<td>Sedentary</td>
<td>68±5</td>
<td>27.5±2.3</td>
<td>1.77±0.25†</td>
<td>24±4†</td>
<td>37±8</td>
<td>89±7</td>
<td>2.45±0.46</td>
<td>0.42</td>
<td>1.45±0.74</td>
</tr>
<tr>
<td>Old</td>
<td>67±5</td>
<td>25.6±2.8</td>
<td>2.77±0.45†</td>
<td>39±6†</td>
<td>46±11</td>
<td>88±7</td>
<td>2.02±0.56</td>
<td>0.54</td>
<td>2.88±1.03</td>
</tr>
</tbody>
</table>

BMI indicates body mass index; CVRi/CVCi/CVRCO₂, cerebrovascular resistance/conductance indices/reactivity to carbon dioxide; MAP, mean arterial pressure; MCAv, middle cerebral artery velocity; and VO₂MAX, maximal oxygen uptake.

*†Difference within/between age groups (P<0.05).

Figure. Relationships between cardiorespiratory fitness and cerebrovascular hemodynamics in young (A and B) and old (C and D) adults as a function of physical activity status. CVR_CO2 indicates cerebrovascular reactivity to carbon dioxide; MCAv, middle cerebral artery velocity; and VO₂MAX indicates maximal oxygen uptake.
our findings and further explore the mechanistic bases underlying the neuroprotective benefits of physical activity.

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**Disclosures**

None.

**References**

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