Hypotensive response after water-walking and land-walking exercise sessions in healthy trained and untrained women

Daniel Rodriguez¹
Valter Silva²
Jonato Prestes³
Roberta Luksevicius Rica⁴
Andrey Jorge Serra⁵
Danilo Sales Bocalini⁶
Francisco Luciano Pontes Junior⁷

¹ São Judas Tadeu University, São Paulo, SP, Brazil; ² College of Physical Education of Sorocaba, Sorocaba, SP, Brazil; ³ Graduation Program in Physical Education, Catholic University of Brasilia, Brasilia-DF, Brazil; ⁴ Department of Physical Education, Arbos College, São Bernardo do Campo, SP, Brazil; ⁵ Department of Physical Education and Laboratory of Rehabilitation Science, Nove de Julho University, São Paulo, SP, Brazil; ⁶ Department of Medicine, Federal University of São Paulo – Escola Paulista de Medicina, São Paulo, SP, Brazil; ⁷ School of Arts, Sciences and Humanities, University of São Paulo, São Paulo, SP, Brazil

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Background: The aim of this study was to compare post-exercise hypotension after acute sessions of water-walking and land-walking in healthy trained and untrained women.

Methods: Twenty-three untrained (n = 12) and trained (n = 11) normotensive women performed two walking sessions in water and on land at 40% of peak VO₂ for 45 minutes. Systolic and diastolic blood pressure and mean arterial pressure were measured 15, 30, 45, and 60 minutes after the exercise sessions.

Results: No differences were found between the groups for age and anthropometric parameters, but peak VO₂ for the trained women (45 ± 8 mL/kg/minute) was higher than for the untrained women (31 ± 3 mL/kg/minute). No differences were found between the groups with regard to systolic and diastolic blood pressure and mean arterial pressure after water immersion. The heart rate in the trained group (62 ± 3 beats per minute [bpm]) was significantly lower (P < 0.05) than in the untrained group (72 ± 4 bpm) on land, and after water immersion, this difference disappeared (58 ± 5 bpm in the trained women and 66 ± 5 bpm in the untrained women). Sixty minutes after water-walking, systolic blood pressure (108 ± 8 mmHg vs 97 ± 3 mmHg), diastolic blood pressure (69 ± 5 mmHg vs 62 ± 5 mmHg), and mean arterial pressure (82 ± 6 mmHg vs 74 ± 4 mmHg) decreased significantly with rest in the untrained group, and no differences were found after land-walking. In the trained group, significant (P < 0.05) differences were found only for systolic blood pressure (110 ± 9 mmHg vs 100 ± 9 mmHg) after 60 minutes of water-walking; decreases in systolic blood pressure were found after 45 minutes (99 ± 7 mmHg) and 60 minutes (99 ± 6 mmHg) compared with rest (107 ± 5 mmHg) after land-walking.

Conclusion: Single water-walking and land-walking sessions induced important hypotension following exercise. Additionally, walking performed in chest-deep water has a better effect on exercise-induced hypotension in untrained healthy women than walking at a similar intensity on land.

Keywords: water-based exercise, post-exercise hypotension, blood pressure, cardiovascular response, normotensive women

Introduction

Physical activity is currently considered to be a nonpharmacological strategy for treatment of hypertension.¹ Among the effects of physical activity on the cardiovascular system, post-exercise hypotension (PEH) has been studied in hypertensive subjects with clinically relevant implications.²⁻³

Aerobic exercise is recommended in most guidelines for hypertension control.¹⁴ At present, water-based exercise is considered a popular aerobic activity,⁵ and numerous benefits are found, including decreased contact force and stress on weight-bearing joints, bones, and muscles, which reduces pain.⁶ These activities have been used in
rehabilitative, therapeutic, and general conditioning programs, and are thought to be particularly useful for people with lower extremity injuries. For this reason, water-based exercises are considered to be suitable for individuals with weight-bearing problems and those of middle or advanced age.7,8

Several physiological adaptations occur with water-based exercise, including a greater reduction in sympathetic drive, reduced catecholamine release, reduction of peripheral vascular resistance, and suppression of the vasopressin and renin-angiotensin systems than those observed with land exercise.9–13 However, few studies have investigated the PEH response after water-based exercise.14 Thus, the aim of this study was to evaluate the effect of water-walking on the PEH response in healthy trained and untrained women. Additionally, the effectiveness of an acute water-walking session was compared with that of an acute session of land-walking.

**Materials and methods**

**Subjects**

Twenty-three normotensive women without any physical limitations participated in this study. The women were allocated to one of two groups, ie, trained (n = 11) or untrained (n = 12) in water-based exercise. To be included in the trained group, women had to have participated for a minimum of 12 months in a regular water-based exercise program and those who had not participated in any exercise program before the study were assigned to the untrained group. All procedures followed the principles of the Declaration of Helsinki (www.wma.net/e/policy/b3.htm). This research was approved by the ethics committee of the Federal University of São Paulo. Exclusion criteria were recent hospitalization, symptomatic cardiorespiratory disease or cardiac alterations, hypertension or metabolic syndrome, severe renal or hepatic disease, cognitive impairment, a progressive or debilitating problem, and those of middle or advanced age.7,8

Electro, Kempele, Finland) and subjective level of exertion on the Borg scale as described elsewhere20 The same parameters were measured for land-walking exercise. The subjects were instructed to move through the full range of motion, without exceeding the exercise intensity stipulated.

**Body composition**

Biometric parameters were assessed according to the method described by Serra et al.19 Height was measured to the nearest 0.1 cm using a Cardiomed stadiometer. Body mass was measured to the nearest 0.1 kg using a Filizola scale (Personal Line 150 model). Body mass index (kg/m²) was calculated as body mass/height × height.

**Blood pressure and heart rate**

Subjects arrived in the laboratory at around 8–10 am and remained resting in a seated position for 20 minutes before initiation of exercise. Blood pressure was measured by auscultation (sphygmomanometer and stethoscope, Becton Dickinson, Franklin Lakes, NJ) as described elsewhere,20 and the average of three measurements was considered representative for each subject. The subjects did not perform any physical activity for at least 24 hours before evaluation and did not take any caffeine or alcohol. All measurements were performed by one experienced researcher. To assess the influence of water immersion on heart rate and blood pressure, all subjects were immersed in water and then remained standing for 60 minutes (control session). Measurements were performed every 5 minutes and the water temperature was adjusted to 30°C ± 1°C. Water depth was maintained at the xiphoid process for the study period.

All measurements were performed in a seating position before (baseline) and 15, 30, 45, and 60 minutes after both types of exercise.
of exercise session. Heart rate was continuously measured and recorded on a beat-by-beat basis using Polar Electro equipment during exercise and following exercise bouts.

Statistical analysis
Data are presented as means ± standard deviation and were analyzed using SigmaStat 3.5 (www.Systat.com). The Shapiro–Wilk test was applied to evaluate normal distribution of the data, and Levene’s test was used to verify the homogeneity of variances. Student’s t-test was used as appropriate and repeated-measures analysis of variance was used to determine the degree of difference in blood pressure between resting values and 15, 30, 45, and 60 minutes following exercise. Newman–Keuls post hoc test was used to determine differences. A value of $P \leq 0.05$ was accepted as being statistically significant.

Results
There were no significant differences between the groups for age, height, and weight (Table 1). However, the maximum aerobic power of the trained group was significantly higher than that of the untrained group (Table 1). The influence of the exercise environment on blood pressure levels is shown in Figure 1. No significant differences were found for systolic blood pressure between exercise performed on land and on water immersion (land, 108 ± 8 mmHg; water, 102 ± 3 mmHg; $P > 0.05$), diastolic blood pressure (land, 69 ± 6 mmHg; water, 60 ± 3 mmHg; $P > 0.05$) and mean arterial pressure (land, 82 ± 6 mmHg; water, 74 ± 3 mmHg; $P > 0.05$) in the untrained group. Similar results were found in the trained group, for which blood pressure levels were not statistically different according to training environment. No differences was found in heart rate between land-walking and water-walking for untrained women (73 ± 4 bpm and 66 ± 3 bpm, respectively) or trained women (62 ± 24 bpm and 58 ± 5 bpm), but there was differences between the groups for land parameters, as shown in Figure 1D.

Figure 2 shows the systolic and diastolic blood pressure and mean arterial pressure results in untrained and trained women performing water-walking and land-walking at 40% of peak VO$_2$. There was a decrease ($P < 0.05$) in systolic blood pressure after 30 ($99 \pm 4$ mmHg), 45 ($98 \pm 2$ mmHg), and 60 ($97 \pm 3$ mmHg) minutes compared with resting conditions ($108 \pm 8$ mmHg). There was no significant decrease in systolic blood pressure after land-walking (Figures 1A and B). When trained women executed water-walking, systolic blood pressure decreased ($P < 0.05$) after 15 ($102 \pm 6$ mmHg), 30 ($101 \pm 7$ mmHg), 45 ($101 \pm 6$ mmHg), and 60 minutes ($100 \pm 9$ mmHg) compared with resting conditions ($111 \pm 9$ mmHg). On the other hand, systolic blood pressure decreased ($P < 0.05$) only after 45 ($99 \pm 7$ mmHg) and 60 ($97 \pm 6$ mmHg) minutes compared with rest ($107 \pm 5$ mmHg) after land-walking. The untrained group showed a significant reduction ($P < 0.05$) in diastolic blood pressure at 45 ($64 \pm 6$ mmHg) and 60 ($62 \pm 5.0$ mmHg) minutes after water-walking as compared with rest ($69 \pm 5$ mmHg). No modifications in diastolic blood pressure were observed after land-walking. In the trained group, diastolic blood pressure showed a decrease ($P < 0.05$) only until 60 minutes after land-walking ($63 \pm 4$ mmHg) compared with rest ($67 \pm 6$ mmHg). Mean arterial pressure decreased ($P < 0.05$) only at 60 minutes ($82 \pm 6$ mmHg at rest vs $74 \pm 4$ mmHg) after water-walking in untrained women.

Discussion
Utilization of several aerobic exercise modalities, such as walking, running, cycling, and swimming, as a nonpharmacological therapy for hypertension is well documented.$^{21–23}$ However, the effects of water-based exercise are not completely understood. To our knowledge, there is no study showing the hypotensive effect of water-walking vs land-walking in normotensive trained and untrained individuals.

Assuming that PEH is a consequence of several changes that occur during exercise, and that during water-walking, the cardiovascular adjustments are different from those occurring during land-walking, the objective of this study was to evaluate the PEH in response to different exercise environments. Thus, we demonstrated that blood pressure was strongly affected by the water-walking exercise in untrained and trained normotensive individuals. This finding is in agreement with previous studies obtained for land-walking exercise.$^{24–29}$ The absence of blood pressure modifications in the control water immersion states indicates that the decrease in blood pressure was induced by exercise.

The main finding in this study was the anticipated decrease in blood pressure in untrained women after a water exercise session compared with land exercise. Our results are in accordance with previous studies, which found a decrease of 6–10 mmHg in systolic blood pressure and 2–5 mmHg in

<table>
<thead>
<tr>
<th>Table 1 Demographic characteristics of patients</th>
<th>Untrained</th>
<th>Trained</th>
<th>$P$ value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>33 ± 7</td>
<td>32 ± 6</td>
<td>&gt;0.05</td>
</tr>
<tr>
<td>Body weight (kg)</td>
<td>57 ± 16</td>
<td>63 ± 8</td>
<td>&gt;0.05</td>
</tr>
<tr>
<td>Height (cm)</td>
<td>162 ± 11</td>
<td>167 ± 13</td>
<td>&gt;0.05</td>
</tr>
<tr>
<td>Body mass index (kg/m$^2$)</td>
<td>22 ± 7</td>
<td>23 ± 3</td>
<td>&gt;0.05</td>
</tr>
<tr>
<td>VO$_2$ max (mL/kg/min)</td>
<td>31 ± 3</td>
<td>45 ± 8</td>
<td>&lt;0.01</td>
</tr>
</tbody>
</table>

Note: Values expressed as means ± standard deviation.

Abbreviation: VO$_2$ max, maximum aerobic power.
diastolic blood pressure in normotensive untrained individuals performing aerobic exercise on land. These results obtained in a water-walking condition could be related to greater reduction in sympathetic activity, reduced catecholamine release, reduction of peripheral vascular resistance, and suppression of the vasopressin and renin-angiotensin systems than that seen for land-based exercise. Some studies have shown that aerobic exercise at a higher intensity produces greater and more lasting PEH as compared with moderate intensity aerobic exercise. In fact, we can also relate this result to the low intensity of aerobic exercise (40% of peak VO₂), that may not have been enough to induce a significant drop in blood pressure in the trained group.

Some limitations to our research should be mentioned. The mechanisms of hypotension were not investigated in the present study, but previous studies have shown that hypotension can be provoked by a reduction in peripheral vascular resistance, sympathetic activity, and a lower systolic volume, and that these physiological responses can be amplified by exercise performed in water. However, it is important to mention that more research involving hypertensive subjects of both gender are necessary to confirm this hypothesis. According to Halliwill, there is a sustained vasodilatation after exercise induced by neural and vascular components, which is associated with a decrease in the vasoconstrictor effect of catecholamines. The neural component is related to a decrease in the sympathetic activity of the muscle (that would involve the readjustment of the baroreflex). The vascular component is associated with an attenuation of sensitivity to sympathetic stimuli (with a lower vascular response to activation of alpha-adrenergic receptors), as well as by the effect of vasodilator substances.

Finally, our data have a clinically relevant role, in light of the comments by Forjaz et al that blood pressure values at 24 hours after an exercise session remained at lower levels than the pressure values of 24 hours after a day without exercise. In summary, exercise performed in a water environment can be an efficient and safe therapeutic approach to controlling blood pressure. Furthermore, numerous benefits could be found for water-based exercise (decreased contact force and stress on weight-bearing joints, bones, and muscles,
which reduces pain), and obese hypertensive individuals may enjoy this activity safely.

In the current study, group comparisons (e.g., untrained and trained women) were not made, so differences between water-based and land-based exercise in terms of effect on PEH were not tested according to training status. Clearly, this is a logical next step in trying to understand how differences in PEH occur as well as assess this response in hypertensive subjects.

The present study demonstrated that acute sessions of water-walking and land-walking induced important PEH.

Additionally, walking performed in chest-deep water was more effective than walking at a similar intensity on land in inducing PEH in untrained healthy women.

Disclosure
The authors report no conflicts of interest in this work.

References


