The effect of exercise on nasal uptake of ozone in healthy human adults

Keegan Sawyer, James S. Brown, Milan J. Hazucha, and William D. Bennett

Center for Environmental Medicine, Asthma, and Lung Biology, University of North Carolina, Chapel Hill, North Carolina

Submitted 1 March 2006; accepted in final form 18 October 2006

Sawyer K, Brown JS, Hazucha MJ, Bennett WD. The effect of exercise on nasal uptake of ozone in healthy adults. *J Appl Physiol* 102: 1380–1386, 2007. First published November 2, 2006; doi:10.1152/japplphysiol.00269.2006.—The nose may help protect the lower respiratory tract from the effects of ambient ozone by scrubbing ozone from inspired air. Reductions in both nasal resistance and nitric oxide production with exercise may influence the efficiency of ozone uptake in the nose. Nasal ozone uptake was determined by comparing the ozone concentration entering the nostrils to that exiting the mouth. Average preexercise uptake of ozone was 56 ± 7.8 and 37 ± 4.9% at 10 and 20 l/min, respectively. These averages did not significantly differ from those immediately postexercise (55 and 37%). Nasal ozone uptake increased significantly (P < 0.001) with decreasing flow rate, but intersubject variability in uptake could not be predicted by nasal volume or cross-sectional areas (as measured by acoustic rhinometry) or endogenous nitric oxide production. However, the percent change in ozone uptake after exercise, within an individual, was correlated with both 1) percent change in nasal volume (r = 0.70 at 10 l/min) and 2) percent change in the rate of volumetric expansion between the nasal valve and turbinates (r = 0.82 at 10 l/min). These results may be useful for assessing human risk associated with ozone exposure during exercise.

**ozone dosimetry; nasal breathing; exercise**

The nose provides a defense for the lungs by partially filtering inhaled pollutant gases and particles before they can reach the lungs. Nasal breathing during exercise has been observed in humans up to maximum minute ventilations of 60 l/min; however, the switch from nasal to oronasal breathing usually occurs at ~35 l/min (19). In addition, exercise naturally dilates the nasal airways (23) and reduces nasal resistance (Rn) (21). These changes in nasal geometry associated with exercise may affect the nasal filtering of inhaled pollutants.

Ozone (O3), a highly reactive water insoluble gas, is a primary component of photochemical smog that readily oxidizes biochemical components in the upper and lower airways. Successive clinical research demonstrates decreases in forced expiratory volume in 1 s (FEV1) and forced vital capacity in exercising healthy adults exposed to O3 at ambient concentrations (8, 10). Increased airway reactivity (5, 7), as well as acute airway inflammation (18), have also been observed in healthy adults exposed to ambient O3 concentrations during intermittent exercise. In addition, research suggests that the number of centriacinar lung lesions in Los Angeles youth [0.099 parts/million (ppm) O3, 8-h annual mean] is greater than lung lesions in Miami youth (0.034 ppm, 8-h annual mean), indicating that chronic O3 exposure may lead to lung tissue injury and potentially lung disease (25). Abnormalities in nasal mucosa have also been observed in Mexico City residents exposed to O3 concentrations of >0.25 ppm (3).

Santiago et al. (24) investigated nasal uptake of O3 in healthy nonsmokers by exposing subjects to protocols of varying inspiratory flow rates and O3 concentrations. The authors proposed two main hypotheses associated with fractional nasal uptake of O3: 1) diffusion-reaction processes control O3 uptake in the nasal mucosa and 2) during short (<10 s) exposure durations, O3 uptake is independent of O3 concentration. They used acoustic rhinometry (AR) to assess nasal volume (Vn) and minimum cross-sectional area (MCA) of the nasal passage to determine a possible relationship between nasal morphometry and O3 uptake. Santiago et al. (24) discovered that fractional nasal O3 uptake decreased with increasing flow rate. The authors also observed that, at a constant flow rate, there were small but significant decreases in fractional O3 uptake with increasing O3 concentration. Finally, they found no relationship between Vn and fractional O3 uptake between subjects studied.

Endogenous nitric oxide (NO) is a highly reactive biological molecule produced in every organ. In the respiratory system, the highest production of NO is found in the paranasal sinuses (16). Although the physiological function of nasal and exhaled NO is not yet fully understood, research findings suggest that it may be important in host defense and inflammation (12). NO reacts with O3 (20) and thus may influence the uptake of O3 in the nasal passages. Exposure of healthy and asthmatic subjects to O3 (0.2 ppm for 4 h with intermittent exercise) did not seem to affect immediate postexposure exhaled NO concentration (20); however, there is no data on whether nasal NO influences uptake of O3 by the nose. Lundberg et al. (15) and Phillips et al. (22) report significant decreases in nasal NO after heavy exercise, suggesting that less NO may be available in the nose for reaction with inhaled O3 during exercise.

Currently, there is no information on the impact of exercise-induced changes on nasal uptake of O3. Thus the purpose of this study was to examine the impact of moderate exercise on nasal uptake of O3 in healthy adults. Because O3 uptake by the nose cannot be measured during exercise, we obtained uptake measurements immediately postexercise. In addition, we assessed the dependence of nasal O3 uptake on 1) flow rate through the nasal passages, 2) changes in nasal geometry induced by exercise, and 3) changes in nasal NO production due to exercise.

The costs of publication of this article were defrayed in part by the payment of page charges. The article must therefore be hereby marked “advertisement” in accordance with 18 U.S.C. Section 1734 solely to indicate this fact.
MATERIALS AND METHODS

Human subjects and screening. This study was approved by the Committee on the Protection of Human Rights of Human Subjects, School of Medicine, University of North Carolina at Chapel Hill. Before participating in this study, all subjects were informed of study-associated risks and signed a statement of informed consent. Recruited subjects were between 18 and 35 yr of age with no history of smoking, lung disease, nasal surgery or obstructions, or regular use of recreational drugs inhaled either orally or nasally. Included subjects had no prolonged prior usage or use within 4 wk of nasal steroids, antihistamines, or decongestants and were free of upper and lower respiratory infections for at least 4 wk before the study. Also, included subjects were able to close their epiglottis for a minimum of 10 s. Fifty percent of screened volunteers could not maintain a closed epiglottis.

We prescreened subjects to determine their maximal exercise capacity on a bicycle ergometer while pedaling at a rate between 60 and 70 rpm. The 15-min prescreening was split into three graded and increasing 5-min submaximal exercise workloads (ranging from 25 to 125 W), concurrently monitoring heart rate with a three-lead ECG. A subject’s maximum physical work capacity was then predicted via linear extrapolation of the exercise workload (Watts) – heart rate relationship to individual predicted maximum heart rate adjusted for age (2, 20). Eight women and two men, recruited from the area in and around Chapel Hill, NC, passed screening to participate in the study.

O3 uptake measurements. To measure the nasal uptake of O3, we used a nasal O3 exposure system (Fig. 1) in which O3 is pulled through a subject’s nose and out through his/her mouth. Subjects were required to hold their breath and keep their epiglottis closed during the measurement. Normally, closing the epiglottis tends to be an involuntary response that causes the upper airways to be isolated from the remainder of the study. Fifty percent of screened subjects were unable to perform this maneuver.

A 0.2 ppm O3 concentration was generated by a photometric O3 calibrator (API, model 410 San Diego, CA) and stored in a 60-liter Tedlar bag. Teflon tubing led from the Tedlar bag to a pneumotachograph (Hans Rudolph, Kansas City, MO) and ultimately to hollowed-out nose olives that the subject inserted into each nostril. Subjects clamped their lips around a pear-shaped Teflon mouthpiece, which filled the mouth cavity. Tubing connected the mouthpiece to a flow-regulating valve and then a vacuum source. Flow rate was regulated by a valve between the vacuum pump and the mouthpiece. The actual flow entering the nose was measured by the pneumotachograph connected to a pressure transducer (Validyne Engineering; Northridge, CA). O3 sampling ports were positioned at the nostrils and mouth. A three-way Teflon valve connected lines from the sampling ports to a fast-acting O3 analyzer (6). O3 samples were collected at a rate of 3 ml/s through 22-gauge Teflon tubing. Before each measure of O3 uptake, we sampled O3 entering and exiting the mouth for 1–3 s to allow the sampled signal to reach a steady-state value. To avoid O3 reaction with condensate, the three-way valve was positioned to pull room air through the sample line from the mouth port to the O3 analyzer between maneuvers. Both flow and O3 concentration were acquired at a rate of 20 Hz by a MacLab data acquisition system and saved for subsequent analysis. The nasal uptake of O3 was calculated as:

\[
\text{Uptake} = 1 - \left(\frac{[O_3] \text{ exiting the mouth}}{[O_3] \text{ entering the nose}}\right)
\]

AR. AR (Hood Laboratories, Pembroke, MA) was used to assess nasal cavity geometry. For this technique, sound pulses are emitted from a wave tube into the nasal cavity via a nose tip inserted a few millimeters inside a nostril. The nose tip of the wave tube is coated with vaseline to ensure a good acoustic seal. A microphone within the wave tube recaptures the incident and reflected sound waves from the nasal cavity. EcoVision Software converts the collected wave signals into a rhinograph (Fig. 2) depicting nasal cavity cross-sectional area as a function of distance from the wave tube tip. Most rhinographs show three distinct “valleys” referred to as the MCA, cross-sectional area two (CSA2), and cross-sectional area three (CSA3). These cross-sectional areas (i.e., the MCA, CSA2, and CSA3) correspond to the nasal valve, the anterior edge of the nasal turbinates, and the posterior edge of the turbinates, respectively (14). The nasal valve, the narrowest cross-sectional area, is the major “resistive segment” within the nasal passageway (4) and dictates the flow condition of inhaled air (27). The EcoVision software also calculates Vn and resistance values between selected points within the rhinograph (9). For any given AR assessment, we performed two measurements on each subject’s right and
left nostrils. Cross-sectional area, Vn, and Rn from each of the four measurements were averaged.

**NO measurement.** Nasal NO concentration was measured with NO chemiluminescence analyzer (Siever, model 270B, Boulder, CO). A sample line was connected from the NO analyzer to one nostril via a nasal olive, while the other nostril was open to ambient air. Steady-state concentration of NO was obtained during closure of the soft palate for 15–30 s by making a “k” sound during expiration after a full inspiration. A closed soft palate separates the nasal passages from the rest of the respiratory system and helps ensure that the measured nasal NO is undiluted by air from the nasopharynx. NO was repeatedly measured from both the right and left nostrils of each subject. NO production, in nanoliters of NO per minute, was calculated by multiplying NO concentration (parts/billion) by the sampling rate (0.5 l/min).

**Study design.** Fractional O3 uptake measurements were conducted on subjects before and after moderate exercise. Nasal O3 uptake measurements were repeated three times at each of two flow rates (10 l/min). Before and immediately after the O3 uptake measurements, AR and NO measurements were completed. Subjects exercised 15 min at between 40 and 60% of their maximum physical work capacity (determined during screening) on a bicycle ergometer. AR and NO measurements were conducted immediately after the exercise period to assess any changes in these nasal characteristics.

**RESULTS**

Intersubject variation in mean O3 uptake ranged from 26.8 to 64.8% (preexercise) and 27.2 and 65.4% (postexercise). The intrasubject variability for each set of triplicate uptake measures was low. The coefficient of variation was always <10% at any flow condition pre- or postexercise. The results of the paired t-tests for mean nasal uptake of O3 are given in Table 2. There was a significant difference in O3 uptake between the two flow rates 10 and 20 l/min both pre- and postexercise (Fig. 3). The percent difference (±SD) in O3 uptake at the 10 l/min flow was nearly 50% greater than that at the 20 l/min flow rate (51.8 ± 9.7 and 48.9 ± 10.3 pre- and postexercise, respec-

**Table 2. Comparison of nasal ozone uptake pre- and postexercise at 10 and 20 l/min**

<table>
<thead>
<tr>
<th>Pairs</th>
<th>Ozone Uptake, %</th>
<th>Correlation (r) Between Pairs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre 10 l/min</td>
<td>55.7 ± 7.82</td>
<td>0.88</td>
</tr>
<tr>
<td>Pre 20 l/min</td>
<td>36.7 ± 4.93*</td>
<td></td>
</tr>
<tr>
<td>Post 10 l/min</td>
<td>54.6 ± 7.97</td>
<td>0.89</td>
</tr>
<tr>
<td>Post 20 l/min</td>
<td>36.8 ± 5.53*</td>
<td>0.96</td>
</tr>
</tbody>
</table>

Values are means ± SD. *Significantly different (P = 0.001) from uptake at 10 l/min.
Exercise did not have a significant effect on O₃ uptake at either flow rate. To determine the approximate amount of O₃ delivered to the lung (i.e., after passing through the nose), a dose rate was calculated.

Five nasal parameters (Vn, Rn, MCA, CSA2, CSA3) and NO production were compared pre- and postexercise. Vn and Rn were determined for the area that extends between MCA and CSA3. There were statistically significant (P = 0.05) increases in Vn, MCA, CSA2, and CSA3 post- vs. preexercise (Fig. 4). Rn decreased 35% post- relative to preexercise (P < 0.01). There was a 10.6% decrease in nasal NO production postexercise, but this finding was not statistically significant.

Linear regression analysis was used to examine the dependence of nasal O₃ uptake on Vn, Rn, NO production, and the CSA2-to-MCA ratio. The CSA2-to-MCA ratio was thought to represent the rapid changes in flow velocity and associated flow separation that may occur distal to the nasal valve. None of these parameters were found to be significant predictors of nasal O₃ uptake either pre- or postexercise. The O₃ exposure that occurred during the uptake measurements did not significantly affect Vn, Rn, MCA, CSA2, or NO production (Table 3).

The percent change in nasal O₃ uptake (from pre- to postexercise) was significantly associated with percent changes in nasal Vn and CSA2-to-MCA ratio (see Figs. 5 and 6, respectively). At 10 l/min, there were significant linear relationships between percent change uptake and both percent change in Vn and percent change in CSA2-to-MCA ratio. At 20 l/min, there was also a significant linear relationship between percent change nasal uptake and percent change in Vn but not with percent change in CSA2-to-MCA ratio.

**DISCUSSION**

The aim of this study was to determine the effects of exercise-induced physiological changes in the nasal passages on the O₃ uptake in the nose at two different flow rates. Mean nasal uptake of O₃ at 10 l/min was ~50% greater than at 20 l/min (P = 0.001). This flow effect is consistent with Santiago et al. (24), who also showed a decreasing fractional uptake as flow rate through the nose increased. Santiago et al. (24) attributed this relationship to a decreased residence time with increasing flow rate, i.e., reducing the time available for O₃ to diffuse to the airway walls and chemically react with substrates in the mucus lining layer. Because O₃ is also known to react with NO in the nose (20), increasing the O₃ delivery rate relative to the steady-state production of NO in the nose might have also contributed to reduced fractional uptake at the higher flow rates. On the other hand, there was no correlation between O₃ uptake and nasal NO concentrations across all subjects at any given flow rate, suggesting that, although NO may play a minor role in O₃ uptake in the nose, it is likely not the principal determinant for removing O₃ from inspired air.

Although the nasal O₃ uptake efficiency was 50% greater at the 10 l/min volumetric flow, the inhaled O₃ rate (delivered dose) to the lung was greater at the 20 l/min volumetric flow due to the higher minute ventilation. To determine the approximate rate of O₃ delivered to the lung (i.e., after passing through the nose), a delivered dose rate was calculated as follows:

\[
\text{Delivered dose rate} = \text{flow rate} \times [\text{O}_3\ \text{ppm}] \times (100 - \%\ \text{nasal O}_3\ \text{uptake})
\]

Preexercise the delivered dose rate to the lungs was 0.89 ppm·l·min⁻¹ and 2.53 ppm·l·min⁻¹ at 10 and 20 l/min respectively. Postexercise, the delivered dose rate at 10 l/min was 0.91 ppm·l·min⁻¹ and 2.53 ppm·l·min⁻¹ at the 20 l/min flow rate. Both pre- and postexercise, the delivered dose rate at the high flow rate (20 l/min) was ~1.6 times higher than the delivered dose rate at the low flow rate (10 l/min).

Similar to Santiago et al. (24), we found no significant intersubject relationship between Vn and nasal uptake of O₃ at either 10 or 20 l/min. In theory, O₃ uptake should be proportional to the transit time through a defined airspace. Thus increasing Vn should increase the transit time and ultimately increase O₃ uptake. There are several plausible reasons why this relationship was not observed. First, airflow through the nasal cavity does not encompass the entire volume of the nasal cavity (4, 27). In fact, airflow seldom reaches many parts of the nasal cavity. As a result, measurements on the total increase in nasal Vn may not truly reflect the relative increase in volume along the main airflow passageways. Total nasal Vn, therefore, may be an insensitive parameter by which to predict percent O₃ uptake. Second, we only observed relatively small changes in nasal Vn with exercise. On average, we observed a 30% increase in Vn following exercise. With greater nasal dilation (i.e., greater changes in percent volume), there may have been a more readily observable volume effect on O₃ uptake. On the other hand, even with heavy exercise, others have only observed a 50% reduction in Rn (26) compared with the 35% we observed here. There is certainly a maximum dilatory capacity
for the nose that we were already approaching in these healthy subjects.

To explore the possibility that those with the greatest exercise-induced nasal dilation would have the greatest change in O₃ uptake, we plotted the percent change in Vₙ vs. the percent change in nasal O₃ uptake at each flow rate (Fig. 5). Strong correlations between percent change in Vₙ and percent change in O₃ uptake were observed at both flow rates. Despite the strong correlation, the overall effect is small. The highest percent change in volume, 71%, effected no greater than a 20% and 6% increase in nasal O₃ uptake at the 20 and 10 l/min flows, respectively. It should be noted that this 71% increase in volume was by far the largest we observed. The relationship between percent change in volume and percent change in uptake is not significant when these values are excluded. Also important, many percent changes in O₃ uptake were negative at both flow rates despite increases in Vₙ (Fig. 5). This implies that other factors tend to reduce nasal O₃ uptake following exercise. For example, other studies report statistically significant reductions in NO following exercise that could contribute to reduced O₃ uptake (15, 22). Although we observed a tendency for reduced NO production following exercise, these changes were not correlated with the changes in O₃ uptake. Finally, there may have been other effects of exercise on nasal physiology that were not measured in our study. As discussed by Santiago et al. (24), the airways produce antioxidant species like uric acid and glutathione that readily react with O₃. Exercise-induced reductions in the airway concentrations of these components may counteract the effect of increased nasal Vₙ on nasal O₃ uptake.

Our study augments knowledge obtained from previous studies by also investigating the relationship between exercise-induced changes in Rₙ, MCA, CSA₂, and nasal NO production on nasal O₃ uptake. Pairwise comparisons of these values before and after exercise demonstrated significant changes among all parameters except for nasal NO production (see Fig. 6).
4). Despite these changes, there were no significant relationships between nasal O₃ uptake and any of these parameters, nor was there a net effect of exercise on O₃ uptake. A statistically significant relationship emerged between changes in O₃ uptake and changes in CSA2-to-MCA ratio (Fig. 6). Similar to the analysis of changes in nasal Vn (Fig. 5), changes in CSA2-to-MCA ratio affected small (<20%) changes in O₃ uptake. However, both relationships may be driven by gender differences, since individuals with the largest changes in Vn and CSA2-to-MCA ratios are men. When the male subjects are dropped from the analysis, the relationship disappears.

To verify that O₃ exposure during the uptake measurement did not affect AR endpoints, pairwise comparisons were made between the preexercise pre-O₃ AR parameters and the preexercise post-O₃ AR parameters (Table 3). There was no statistically significant effect of the O₃ uptake measurements on any of the AR parameters. In addition, to make certain nasal dilation associated with exercise (determined by Vn and AR parameters) did not diminish over time (i.e., time during which postexercise O₃ uptake measurements were being made), comparisons were made between the postexercise pre-O₃ data and the postexercise post-O₂ data. Again, no statistically significant differences in AR parameters were observed.

The measurement technique, breath holding by closing the epiglottis, was too difficult for 50% of the screened subjects. Some subjects were not able to sustain a closed epiglottis for longer than a few seconds. Other subjects were possibly closing their soft palate while trying to close the epiglottis. The soft palate closes off the nasal passageway from the oral cavity, whereas the epiglottis separates the upper and lower airways. To determine whether selection bias affected our results, an analysis of Rns between the selected and dismissed subjects was conducted. No significant differences were observed to indicate a selection bias.

Other investigators also measured nasal O₃ uptake efficiency (6, 24). We previously discussed the similarities between our findings and Santiago et al. (24). Gerrity et al. (6) investigated nasal vs. oral O₃ uptake in 18 healthy adult men between the ages of 18 and 35. Subjects were exposed to three O₃ concentrations (0.1, 0.2, and 0.4 ppm) within an environmental chamber. Subjects breathed in one of three manners (nose only, mouth only, or oronasally) at 12 or 24 breaths/min, respectively. A pediatric feeding tube was used to introduce the O₃ into the posterior pharynx. Their inspiratory flow rates were generally higher than those used by us or Santiago et al. (24). The mean flow rate in Gerrity et al. (6) was 27 l/min, whereas our highest flow rate was 20 l/min. Under these conditions, Gerrity et al. (6) found extrathoracic uptake by nasal breathing to be 36%, which compares to our mean uptake of 37% at 20 l/min (again assuming the extrathoracic uptake was negligible in our case). The fact that Gerrity et al. (6) found no flow-dependent change in O₃ uptake as they increased flow between 21 and 38 l/min suggests that the efficiency of the extrathoracic uptake in these conditions is relatively constant. However, both relationships may be driven by gender differences, since individuals with the largest changes in Vn and CSA2-to-MCA ratios are men. When the male subjects are dropped from the analysis, the relationship disappears. It is also difficult to determine how much of the measured uptake is due to flow in the inspiratory vs. expiratory direction for their method. Likewise, our method of drawing the O₃ in the nose and out the mouth is confounded by the inability to distinguish the influence of nasal inspiratory vs. oral expiratory uptake. For our purposes, however, distinguishing the different routes of uptake was not necessary to assess the nasal changes induced by exercise. If we ignore as negligible the respiratory efficiency through the single nasal passage (24) and the expiratory efficiency through the oral cavity (current study), then O₃ uptake at 5 l/min for Santiago et al. (24) was 65% compared with our mean 56% at 10 l/min (assuming 5 l/min through each nostril). Gerrity et al. (6) measured uptake under spontaneous breathing conditions and was better able to isolate inspiratory extrathoracic uptake by sampling in the posterior pharynx. Their inspiratory flow rates were generally higher than those used by us or Santiago et al. (24). The mean flow rate in Gerrity et al. (6) was 27 l/min, whereas our highest flow rate was 20 l/min. Under these conditions, Gerrity et al. (6) found extrathoracic uptake by nasal breathing to be 36%, which compares to our mean uptake of 37% at 20 l/min (again assuming the extrathoracic uptake is negligible in our case). The fact that Gerrity et al. (6) found no flow-dependent change in O₃ uptake as they increased flow between 21 and 38 l/min suggests that the efficiency of the upper airways for removing O₃ approached a minimum. Although consideration of these absolute measures of uptake may be useful for dosimetry modeling, care should be taken to consider the conditions and methodologies by which they were determined.

A few investigators (1, 11) compared O₃ health effects associated with different routes of breathing. Adams et al. (1) and Hynes et al. (11) both investigated FEV₁ response to 0.4 ppm O₃, comparing the difference in FEV₁ response from oral, oronasal, and nasal exposures. Hynes et al. (11) exposed healthy young adults for 30 min during moderate continuous exercise. Adams et al. (1) exposed healthy young men during moderate and heavy continuous exercise for oral vs. oronasal breathing. In these two studies, the researchers found no significant difference in FEV₁ response to 0.4 ppm O₃ exposure based on route of exposure. Results from Adams et al. (1) and Hynes et al. (11) suggest that there is little difference in O₃ uptake efficiency between the oral and nasal respiration routes, consistent with findings by Gerrity et al. (6). On the other hand, Kabel et al. (13), comparing uptake of serial inhaled O₃ boluses for oral vs. nasal breathing, found that the nasal passages are 60% more efficient at removing O₃ than the oral pathway. Furthermore, Kabel et al. (13) found that O₃ penetrated deeper into the lung during oral breathing than during nasal breathing, suggesting that the distal lung may be more susceptible to O₃ toxicity under oral breathing conditions. It is important to emphasize that the findings of Adams et al. (1) and Hynes et al. (11) are specific to changes in FEV₁, an acute response to O₃ exposure. Differences in oral vs. nasal O₃ uptake may be more important for acute inflammatory end points, for asthmatics with airway hyperresponsiveness to O₃, or for chronic lung effects associated with O₃ exposure.
An area for future study, suggested from our results, is gender differences in nasal O₃ uptake. We studied eight women and two men. The men exhibited large exercise-induced changes in nasal Vn (71.5 and 52.2%) and CSA2-to-MCA ratio (41.5 and 32.9%). These changes, when plotted against percent change in O₃ uptake, stand out from the women’s data (see Figs. 5 and 6). Three potential research questions arise from this: 1) Are there gender differences in baseline and exercise induced change in nasal O₃ uptake? 2) If there is a gender difference, is it caused by differences in nasal physiology? 3) If there is a gender difference, does it result in differential health risk from O₃ exposure? The third question has been addressed. Gender does not appear to affect O₃ sensitivity (17), and physiological responses of young healthy women to O₃ exposure appear comparable to the response of young men (8).

In conclusion, this study addressed 1) the effect of moderate exercise on the uptake of O₃ in the nose and 2) nasal physiological predictors of nasal O₃ uptake. In agreement with previous studies, nasal uptake of O₃ increased with decreasing flow rate. Since flow rate increases with exercise, higher O₃ exposures with five hours of moderate exercise to 0.08, 0.10, and 0.12 ppm Am Rev Respir Dis 142: 1158–1163, 1990.


