Ventilatory response to incremental and constant-workload exercise in the presence of a thoracic restriction

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METHODS

Subjects. Seven male subjects who had never engaged in aerobic training were recruited. No subject had any history of restrictive lung disease is a term used broadly to describe a number of restricted disease states, including diseases of the pleura, chest wall, or lung parenchyma (interstitial lung diseases). Methods of mimicking the effects of restrictive chest wall disease have been devised and include external thoracic restriction (1, 3, 5, 7–10, 14, 17, 21–23) and abdominal restriction (1, 3, 5, 10, 17, 22, 23).

In subjects who performed incremental exercise in the presence of an inelastic corset, maximum minute ventilation ($\dot{V}E$) decreased compared with the unrestricted condition (22). Unaltered or reduced maximum minute ventilation ($\dot{V}E$) was reported for patients with scoliosis performing incremental exercise (6, 12, 13, 18). In marked contrast, most studies of the ventilatory response to constant-workload exercise performed by normal subjects in the presence of restriction and by patients with interstitial lung disease demonstrated hyperventilation (9, 15, 19), although a single study reported no change in $\dot{V}E$ from normal (10). Possible explanations for the discrepancy of results between incremental and constant-workload tests in different studies include differences in subject characteristics and the degree of restriction present, either as a consequence of the disease state or from the application of an external thoracic restriction. Alternatively, chest wall restriction may affect the ventilatory response to incremental and constant-workload exercise in different ways.

It has previously been shown that the ventilatory response to constant-workload exercise performed below the gas-exchange threshold (GET) is well described by a monoexponential function characterized by a time constant and a steady-state ventilation value (24). This implies that the ventilatory response to exercise depends not only on the workload at any time but also on the rate at which the workload changes. Thus it is possible that, if, as previously reported, the steady-state response of the system increases during thoracic restriction, an appropriate prolongation of the time constant would allow the ventilatory response to an incremental exercise test to remain unchanged.

The aim of this study was to investigate the ventilatory response to incremental and constant-workload exercise in the presence of an externally applied thoracic restriction in a single group of subjects and to determine whether the differing effects are a result of differing exercise protocols. We also used a previously described model (24) to determine whether altered ventilatory dynamics due to thoracic restriction, i.e., an increased steady-state value for $\dot{V}E$ and an appropriately prolonged time constant, could account for the observed ventilatory responses to the two exercise protocols.

METHODS

Subjects. Seven male subjects who had never engaged in aerobic training were recruited. No subject had any history of...
respiratory or cardiovascular disease, and all subjects were normal on clinical examination. The study was undertaken with the approval of the Ethics Committee of St. Vincent’s University Hospital, Dublin, Ireland, and each subject gave written, informed consent. Subjects were aware of the procedures to be undertaken but were uninformed as to the objectives of the study. Each individual was advised not to eat for 1 h before the experimental sessions and not to engage in strenuous exercise before the test.

The subjects attended the laboratory on three different occasions and completed four exercise tests on an electrically braked cycle ergometer (Excalibur, Lode, Groningen, The Netherlands). These included two ramped exercise tests to exhaustion, one performed in the presence and one in the absence of a thoracic restriction, and two constant-workload exercise tests, performed either in the presence or absence of a thoracic restriction. On days 1 and 2, subjects performed an incremental exercise test, and on day 3 subjects performed the two constant-workload exercise tests. The subjects’ work rate was independent of pedaling frequency, and they were instructed to maintain the resistance between 50–80 rpm throughout all tests. Restriction of the movement of the rib cage was achieved by use of an inexpandable corset (T&S Surgical Appliances) that was fitted to the subject after he had expired to residual volume and that was tightened with the aid of Velcro straps to achieve a minimum reduction in forced vital capacity (FVC) of at least 35%.

Measurements. Subjects wore a nose clip and mouthpiece connected to a heated wire anemometer (Sensormedics) that allowed inspiratory and expiratory flows to be measured continuously. Signals were digitally integrated to obtain volume measurements. Respired gases were continuously analyzed by rapidly responding O2 (paramagnetic) and CO2 (infrared) analyzers (Sensormedics Vmax 229). Calibrations were carried out before each test by using a calibration syringe and precision O2 and CO2 gas mixes (Sensormedics). An estimate of arterial blood O2 saturation was obtained by using standard formulas. Breath-by-breath end-expiratory O2 uptake (V˙O2) was calculated by using the modified V-slope method of Sue et al. (20). European Community for Coal and Steel Working Party prediction equations were used when calculating predicted values of FVC and FEV1 (16).

Predicting incremental V˙E from a constant-workload test. The phase 2 ventilatory component of constant-load exercise of moderate intensity has been described by a monomolecular function of the form

$$\Delta V\dot{E}(t)_{cwl} = \Delta V\dot{E}(ss)(1 - e^{-t/\tau})$$ (1)

where ∆V˙E(t)cwl represents the difference between V˙E at any time t after the onset of constant-workload exercise and the mean V˙E during the last minute of cycling at 20 W, ∆V˙E(ss) is the difference between mean final steady-state V˙E (average of final 3 min of constant-workload exercise) and mean V˙E at 20 W (see above), and τ is the phase 2 time constant (24). The value for τ is obtained graphically by plotting ∆V˙E(ss) − ∆V˙E(t)cwl against time (excluding the phase 1 component of the response) on a semilogarithmic scale. The τ value is then derived from the slope of the resulting straight line.

During a ramped exercise test, V˙E at any workload will be less than V˙E at that workload in a constant-workload steady-state test (24) because of the time delay in the ventilatory response. The change in V˙E at any time t during a ramped incremental test [ΔV˙E(t)incr] is given by

$$\Delta V\dot{E}(t)_{incr} = \Delta V\dot{E}(ss)_{pred}[t - \tau(1 - e^{-t/\tau})]$$ (2)

where ∆V˙E(ss)pred is the change in V˙E that would occur after the change in workload at time t if a steady state were achieved.
In the sub-lactate-threshold range, the relationship between \( \Delta V\bar{E}(ss) \) and the corresponding increase in steady-state workload above 20 W \([\Delta W(ss)]\) is linear and is given by

\[
\Delta V\bar{E}(ss) = s\Delta W(ss)
\]

where \( s \) is a constant of proportionality. Furthermore, \( \Delta W \) at any time \( t \) during an incremental test \([\Delta W(t)_{incr}]\) is represented by

\[
\Delta W(t)_{incr} = bt
\]

where \( b \) represents the work rate ramp. Combining Eqs. 2, 3, and 4 gives the following equation

\[
\Delta V\bar{E}(t)_{incr} = sb\tau(1 - e^{-\tau t})
\]

Equation 5 was used to predict \( V\bar{E} \) for any time \( t \) in the ramped incremental tests with use of the time constant derived from the constant-workload exercise test (Eq. 1).

Data analysis. All restricted spirometry data were expressed as percents of the unrestricted value.

In the unrestricted and restricted incremental exercise tests, cardiorespiratory variables were averaged over 20-W intervals. During the tests, the value of a variable for any 20-W period was expressed as the change (\( \Delta \)) from the value during warm-up cycling at 20 W (mean value over the minute before change in workload).

For the constant-workload exercise tests, a similar analysis was applied to measured variables to produce \( \Delta \) values with the last minute of the 4-min warm-up at 20 W being subtracted from the mean value obtained at each minute interval. Values for \( \Delta \) were then averaged for the last 3 min of exercise in a single individual, and this value was taken as the steady-state response of that individual.

To allow for a direct comparison between the two exercise protocols, values at the end of the submaximal constant-workload exercise tests would need to be compared with values at an equivalent workload in the incremental exercise tests. Therefore, the workload at which the subjects exercised in the constant-workload test was identified in the incremental test, and the variables were compared with the average value of the variables for the last 3 min of constant-workload exercise.

Statistical analysis. The mean spirometric values obtained for the restricted condition on the consecutive days of restriction and also before and after exercise were compared by using paired \( t \)-analysis. For the incremental tests, the \( \Delta \) values were compared between the two experimental conditions for workloads that all subjects completed by using an appropriately designed ANOVA. Paired \( t \)-tests were performed on maximum data (last minute of exercise). The average of the last 3 min of constant-workload exercise was compared between the two conditions by using paired \( t \)-analysis. For a direct comparison between the two exercise protocols, a paired \( t \)-test was performed between the two conditions in the incremental test and between the two conditions at an equivalent workload in the constant-workload test. A paired \( t \)-test was used to compare the calculated phase 2 time constants and predicted \( V\bar{E} \) for the unrestricted and restricted incremental tests. An ANOVA for repeated measures was performed between the unrestricted and restricted conditions for predicted ventilatory data at three different workloads (20, 40, and 60 W). In all comparisons, \( P < 0.05 \) was taken to indicate statistical significance. All data are shown as means \( \pm \) SE.

### RESULTS

All seven subjects completed the four exercise tests. Anthropometric and pulmonary function data in the unrestricted condition are shown in Table 1. Each subject was within the normal predicted range of \( FVC \) and \( FEV_1 \).

**Pulmonary function tests.** Table 2 shows the mean \( \pm \) SE spirometric values during restriction before and after exercise expressed as percentages of the unrestricted value for the incremental and constant-workload exercise tests. There were no significant differences between the percentage decreases in \( FVC \) and \( FEV_1 \) from before to after exercise, indicating that the degree of restriction was maintained throughout exercise in the incremental and constant-workload exercise tests. It can be seen that subjects were restricted by the same amount on both occasions.

**Incremental exercise tests.** Figure 1 illustrates \( \Delta \)mean \( \pm \) SE values for workloads that all subjects completed and also for maximum exercise in the presence and absence of restriction.

No difference in total \( V\bar{E} \) was observed between the unrestricted and restricted conditions at submaximal exercise workloads (Fig. 1A). There was no evidence of alveolar hyperventilation at these submaximal workloads because there were no differences in the \( PCO_2 \) values between the two conditions (Fig. 1B). With restriction, there was a trend for respiratory frequency to be increased and tidal volume to be decreased at submaximal workloads (Fig. 1, C and D).

Table 1. **Anthropometric and spirometric data**

<table>
<thead>
<tr>
<th>Subject no.</th>
<th>Age, yr</th>
<th>Height, cm</th>
<th>Weight, kg</th>
<th>FVC, liters</th>
<th>FEV1, liters</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>29</td>
<td>174.0</td>
<td>77.0</td>
<td>5.9</td>
<td>5.1</td>
</tr>
<tr>
<td>2</td>
<td>25</td>
<td>178.0</td>
<td>68.0</td>
<td>5.7</td>
<td>4.7</td>
</tr>
<tr>
<td>3</td>
<td>23</td>
<td>180.0</td>
<td>75.0</td>
<td>5.6</td>
<td>4.9</td>
</tr>
<tr>
<td>4</td>
<td>24</td>
<td>185.0</td>
<td>63.0</td>
<td>5.1</td>
<td>4.1</td>
</tr>
<tr>
<td>5</td>
<td>22</td>
<td>190.0</td>
<td>81.0</td>
<td>6.2</td>
<td>5.7</td>
</tr>
<tr>
<td>6</td>
<td>23</td>
<td>184.0</td>
<td>80.0</td>
<td>5.4</td>
<td>4.9</td>
</tr>
<tr>
<td>7</td>
<td>23</td>
<td>183.0</td>
<td>81.0</td>
<td>6.3</td>
<td>5.1</td>
</tr>
<tr>
<td>Mean ± SE</td>
<td>24.1 ± 0.9</td>
<td>182.0 ± 2.0</td>
<td>75.0 ± 2.6</td>
<td>5.7 ± 0.2</td>
<td>4.9 ± 0.2</td>
</tr>
</tbody>
</table>

\( FVC \), forced vital capacity; \( FEV_1 \), forced expiratory volume in 1 s.

Table 2. **Spirometric values before and after exercise in the restricted condition during incremental and constant workload tests**

<table>
<thead>
<tr>
<th></th>
<th>Pre</th>
<th>Post</th>
<th>Pre</th>
<th>Post</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FVC, %</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incremental</td>
<td>42.4 ± 3.1</td>
<td>39.9 ± 3.2</td>
<td>41.5 ± 2.3</td>
<td>39.6 ± 3.6</td>
</tr>
<tr>
<td>Constant-workload</td>
<td>39.8 ± 3.1</td>
<td>38.0 ± 2.8</td>
<td>38.5 ± 3.4</td>
<td>37.6 ± 4.3</td>
</tr>
</tbody>
</table>

Values are means \( \pm \) SE expressed as a percentage of the unrestricted values. Pre, before exercise; Post, after exercise.
During constant-workload exercise, chest restriction resulted in a significant increase in total \( \dot{V}_E \) (Fig. 2A). A concomitant significant drop in \( PCO_2 \) values (Fig. 2B) suggested alveolar hyperventilation. Although respiratory frequency increased at all time points throughout the test, the increase failed to reach significance for the average of the last 3 min of exercise (Fig. 2C). The \( VO_2 \) value at the end of exercise, expressed as the average of the last 3 min of the constant-workload test, did not differ between conditions.

**Comparison between incremental and constant-workload exercise tests.** Table 4 shows the absolute mean ± SE for the average of the final 3 min of constant-workload exercise and at an equivalent workload for incremental exercise. Total \( \dot{V}_E \) was significantly increased in the constant-workload test in the presence of restriction compared with the unrestricted state. In the incremental exercise test at an equivalent workload, no difference in ventilation was revealed between the unrestricted and restricted conditions. A significant drop in \( PCO_2 \) during the restricted constant-workload test confirmed the presence of an alveolar hyperventilation, whereas no difference was observed for \( PCO_2 \) in the incremental tests. In both exercise protocols, respiratory frequency was significantly increased in the presence of restriction. Tidal volume was significantly decreased in the constant-workload test but not in the incremental test in the presence of restriction. Visual analog scale scores of respiratory discomfort were significantly increased in both the constant-workload test and the incremental test in the presence of restriction.

**Predicting incremental \( \dot{V}_E \) from a constant-workload test.** After the onset of constant-workload exercise, \( \dot{V}_E \) appeared to follow the pattern of a monoexponential function, as shown in Fig. 3A, which represents a typical response of one individual to unrestricted and restricted constant-workload exercise. A log plot of the same individual’s unrestricted and restricted ventilatory data resulted in a linear pattern, as shown in Fig. 3B. Also depicted in this figure are the equations of the lines of best fit from which the time constants were derived.

**Table 3. Absolute values shown for final minute of maximum exercise**

<table>
<thead>
<tr>
<th></th>
<th>Unrestricted</th>
<th>Restricted</th>
</tr>
</thead>
<tbody>
<tr>
<td>( \dot{V}_E ), l/min</td>
<td>103.7 ± 7.8</td>
<td>81.9 ± 4.3*</td>
</tr>
<tr>
<td>( PCO_2 ), Torr</td>
<td>35.5 ± 1.3</td>
<td>37.1 ± 2.2</td>
</tr>
<tr>
<td>( f ), breaths/min</td>
<td>38.6 ± 2.6</td>
<td>47.7 ± 3.7*</td>
</tr>
<tr>
<td>( V_t ), liters</td>
<td>2.6 ± 0.1</td>
<td>1.9 ± 0.2*</td>
</tr>
<tr>
<td>( SaO_2 ), %</td>
<td>95.9 ± 0.3</td>
<td>94.8 ± 0.3*</td>
</tr>
<tr>
<td>( VAS ), %</td>
<td>78.8 ± 6.3</td>
<td>88.1 ± 4.9</td>
</tr>
<tr>
<td>( HR ), beats/min</td>
<td>189.6 ± 2.9</td>
<td>179.6 ± 5.5</td>
</tr>
<tr>
<td>( VO_2 ), ml·kg(^{-1})·min(^{-1})</td>
<td>43.8 ± 2.1</td>
<td>35.6 ± 2.4*</td>
</tr>
</tbody>
</table>

Values are means ± SE. \( \dot{V}_E \), minute ventilation; \( PCO_2 \), Jones-corrected \( CO_2 \); \( f \), respiratory frequency; \( V_t \), tidal volume; \( SaO_2 \), estimate of arterial blood \( O_2 \) saturation; VAS, visual analog scale scores of respiratory discomfort; \( HR \), heart rate; \( VO_2 \), \( O_2 \) consumption.

*Significant difference between two conditions (\( P < 0.05 \), paired \( t \)-test).

Fig. 1. Mean ± SE changes in minute ventilation (\( \Delta \dot{V}_E \); A), Jones-corrected \( CO_2 \) (\( \Delta PCO_2 \); B), respiratory frequency (\( \Delta f \); C) and tidal volume (\( \Delta V_t \); D) in 7 subjects presented every 20 W for workloads that all subjects completed. Data are also illustrated at maximum workload. *Significant difference between conditions at maximum exercise (\( P < 0.05 \), paired \( t \)-test). Where error bars are not seen, they are enclosed within symbols.

Significantly decreased in the presence of the corset. Subjects reached 83.6 ± 4.4% of unrestricted maximal work capacity with restriction, with a significant decrease in \( VO_2 \) evident at maximum restricted exercise (Table 3).

**Constant-workload exercise tests.** Figure 2 illustrates \( \Delta \)mean ± SE values for the full 12 min of exercise in both the unrestricted and restricted conditions.
Table 5 shows the individual and mean time constants and V̇E values for the unrestricted and restricted conditions. In the restricted condition, the mean steady-state V̇E value and the mean time constant were significantly increased compared with the unrestricted condition. We then asked the following question: do the altered steady-state V̇E and time constant values derived in the presence of restriction predict a ventilatory response to incremental exercise similar to that predicted in the unrestricted condition? To examine this, the ventilatory response of each individual to unrestricted and restricted incremental exercise at 20, 40, and 60 W was predicted by using each individual’s steady-state V̇E and time constant values. The mean predicted values at each of these workloads are shown in Table 6. There were no significant differences between the unrestricted and restricted conditions.

The 20-, 40-, and 60-W workload levels were arbitrarily chosen, but the model can also be used to predict V̇E at any given workload. Figure 4 is an illustration of the predicted V̇E for the unrestricted and restricted conditions in which the mean ΔV̇E(ss) and time constants in both conditions were used (Table 5) and substituted into Eq. 5. Despite the differences in time constants and steady-state values for ventilation between the unrestricted and restricted constant-workload exercise tests, similar ventilatory values were predicted for the unrestricted and restricted incremental tests. The V̇E data were not predicted for workloads >60 W because, at higher workloads, some subjects had reached their GET and their ventilatory responses had become nonlinear. Because this model assumes a linear relationship between steady-state ventilation and workload, model predictions above the GET would be invalid.

**DISCUSSION**

The findings of the present study indicate that, in the presence of an externally applied thoracic restriction, the ventilatory response to exercise is dependent on the protocol utilized. Subjects hyperventilated in the presence of restriction during the constant-workload test, whereas, at an equivalent workload during the incremental test, ventilation was similar to unrestricted values. V̇E was predicted for the unrestricted and restricted incremental tests by using the time constants and steady-state values for V̇E from the constant-workload tests, and no differences were found in the predicted ventilatory data for the two conditions. This would suggest that a hyperventilation does not occur in the restricted incremental test because of...
slower ventilatory dynamics, because it takes almost twice as long to reach a given ventilation in the presence of an externally applied thoracic restriction as in the unrestricted state. Whereas earlier studies have described the ventilatory response to either incremental or constant-workload exercise in the presence of a thoracic restriction (9, 10, 22), this was the first study to document the ventilatory response to both incremental and constant-workload exercise in the same subject.

Table 5. Individual and mean time constants and minute ventilation values for the unrestricted and restricted conditions

<table>
<thead>
<tr>
<th>Subject No.</th>
<th>Unrestricted</th>
<th>Restricted</th>
</tr>
</thead>
<tbody>
<tr>
<td>τ, min</td>
<td>ΔV̇E, l/min</td>
<td>τ, min</td>
</tr>
<tr>
<td>1</td>
<td>1.4</td>
<td>1.8</td>
</tr>
<tr>
<td>2</td>
<td>2.1</td>
<td>2.8</td>
</tr>
<tr>
<td>3</td>
<td>1.5</td>
<td>1.3</td>
</tr>
<tr>
<td>4</td>
<td>1.7</td>
<td>2.8</td>
</tr>
<tr>
<td>5</td>
<td>2.1</td>
<td>4.2</td>
</tr>
<tr>
<td>6</td>
<td>0.6</td>
<td>1.7</td>
</tr>
<tr>
<td>7</td>
<td>0.9</td>
<td>3.3</td>
</tr>
<tr>
<td>Mean ± SE</td>
<td>1.5 ± 0.2</td>
<td>11.9 ± 1.6</td>
</tr>
<tr>
<td></td>
<td>2.6 ± 0.4</td>
<td>18.3 ± 3.3</td>
</tr>
</tbody>
</table>

τ, Time constants; ΔV̇E, change in V̇E. *Significant difference between the unrestricted and restricted values (P < 0.05, paired t-test).

Table 6. Mean predicted ventilatory data for the unrestricted and restricted conditions

<table>
<thead>
<tr>
<th>Workload, W</th>
<th>Unrestricted ΔV̇E_{predicted}, l/min</th>
<th>Restricted ΔV̇E_{predicted}, l/min</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>1.4 ± 0.3</td>
<td>1.4 ± 0.4</td>
</tr>
<tr>
<td>40</td>
<td>4.0 ± 0.9</td>
<td>4.2 ± 1.0</td>
</tr>
<tr>
<td>60</td>
<td>7.3 ± 1.5</td>
<td>8.1 ± 1.9</td>
</tr>
</tbody>
</table>

Values are means ± SE. No significant differences between unrestricted and restricted conditions for predicted ΔV̇E (ΔV̇E_{predicted}; P > 0.05, ANOVA).
spiration to the second exercise test completed in the presence of restriction. Therefore, the significantly increased $V_E$ observed in the presence of restriction is due to the effects of restriction alone.

In the study of Harty et al. (9), subjects exercised at 65% of maximum heart rate, and it is probable that a number of these subjects were exercising above their GET. Therefore, increasing circulating lactic acid levels may have augmented the magnitude of the hyperventilatory response to constant-workload exercise. In contrast to the findings of the above study, Hussain et al. (10) reported that an exercise test performed above the GET produced similar ventilation to that achieved in the unrestricted test. There was no difference in end-tidal $PCO_2$ between thoracic restriction and control conditions and, therefore, no evidence of a change in alveolar ventilation. However, the authors suggested that because there was evidence of electromyographic diaphragmatic fatigue during exercise in the presence of restriction, subjects were unable to maintain ventilation at the required level to continue exercising.

There is evidence that exercise protocol also affects the ventilatory response to exercise in patient groups. A number of studies performed in scoliotic patients reported either a normal ventilation (6, 18) or a significantly reduced ventilation (12, 13) at maximum incremental exercise. Shneerson et al. (18) documented that there was a trend for a hyperventilation at submaximal workloads during the incremental test, but it failed to reach significance. Similarly, at submaximal workloads during an incremental test performed in patients with pulmonary fibrosis, Burdon et al. (2) found that there was a tendency for ventilation to be higher than normal at each power output during an incremental test, but, once again, it failed to reach significance. Constant-workload exercise tests performed in pulmonary fibrotic patients resulted in a relative hyperventilation when the response was compared with normal healthy subjects (15, 19). The results of the present study demonstrate that the differences in the ventilatory response to incremental and constant-workload exercise do not arise because of differences in subject characteristics or degree of restriction. Rather, the differences arose because the effect of restriction on $V_E$ was dependent on the manner in which the workload changed.

We asked ourselves the question: how can restriction lead to a hyperventilation in the constant-workload exercise test and yet cause no change in ventilation at submaximal workloads during the incremental test? Whipp et al. (24) have shown that the ventilatory response to mild constant-workload exercise is well described by a first-order linear response system. It has been demonstrated that, by using the derived time constant and measured steady-state value for $V_E$ from the constant-workload test, the ventilatory response to incremental exercise is well predicted (24). The results of the present study indicate that the ventilatory response to unrestricted and restricted constant-workload exercise followed the pattern of a first-order linear response system. However, in the presence of the restriction, the mean time constant was significantly greater than the unrestricted value, and the mean change in the steady-state value for $V_E$ in the presence of restriction was significantly higher. On the basis of these results, the predicted response to $V_E$ below the GET in the incremental test was similar for both the unrestricted and restricted conditions (Fig. 4).

The aim of this study was to document the effects of an externally applied thoracic restriction on the ventilatory response to incremental and constant-workload exercise in the same subject group and to explore potential mechanisms that may explain the disparate responses observed. This study was not designed to address the mechanisms underlying the observed hyperventilation. However, it is the first to provide subjective measures of respiratory discomfort during both exercise conditions, and it is interesting to note that clear differences in the response to incremental and submaximal constant-workload exercise exist. Significant differences were observed in both tests, with the mean values obtained in the constant-workload tests being greater than those observed in the incremental tests in both the unrestricted and restricted conditions. These differences between the incremental and constant-workload tests may reflect temporal differences in the development of the sensory response to exercise in a fashion similar to that seen with ventilation. With regard to the incremental test, in the presence of restriction, the differences cannot be a reflection of an increased level of ventilation. However, in the constant-workload test, some of the increased level of respiratory discomfort could be attributed to the increase in ventilation (26) or the sensory consequences of an inappropriate hyperventilation (4). Direct measures of respiratory mechanics were not made in this study, but increased work of breathing presumably contributed to the increased respiratory discomfort scores observed.

The present study does not reveal the underlying mechanisms through which restriction alters the ventilatory response to exercise. However, the data show that the markedly different responses to the two exer-
exercise protocols can both be accounted for by the same underlying alteration in the response of the ventilatory control system.

In conclusion, the ventilatory response to thoracic restriction is dependent on the protocol utilized, with differing responses being produced in the incremental and constant-workload exercise tests. We can understand these differences by examining both the ventilatory dynamics of the response and the steady-state values for $\dot{V}e$ in the presence and absence of restriction.

We gratefully acknowledge the support of The Irish Health Research Board and Enterprise Ireland.

REFERENCES