Effect of transcranial direct current stimulation on supramaximal intermittent exercise performance

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Abstract - Aims: Our purpose was to determine whether Transcranial Direct Current Stimulation (tDCS) improves performance in untrained individuals for supramaximal intermittent exercise.

Methods: In a cross-over design, 11 healthy male subjects (26.8 ± 4.6 years) performed four Wingate trials after 20 minutes of anodal or sham tDCS over the left Insular Cortex (IC). For performance indexes, Relative Peak Power (RPP), Relative Average Power (RAP) and Fatigue Index (FI) were computed. Also, a Rating of Perceived Exertion (RPE) and Electromyography (EMG) signal were used to assess central and muscle fatigue development.

Results: There was a significant difference over trials on all performance indexes, but there were no significant condition x trial interactions for any of the indexes. RPE increased significantly over trials, but there was no condition x trial interaction. There was no significant difference over trials on EMG for the rectus femoris and vastus medialis muscles; however, EMG decreased over trials for the vastus lateralis muscle. Furthermore, there was no condition x trial interaction on the EMG signal for any of the muscles.

Conclusion: Our findings suggest that the anodal tDCS technique has no impact on physical performance, perceived exertion nor muscle fatigue development for supramaximal intermittent exercise.

Keywords: exercise; neurophysiology; transcranial direct current stimulation; athletic performance; rating of perceived exertion.

Introduction

The transcranial Direct Current Stimulation (tDCS) is a non-invasive and painless technique, which induces changes in the excitability of the cerebral cortex in humans¹. The depth of the electric stimulus produced by tDCS can reach both the cortical and subcortical area². This kind of stimulation produces a variation in the resting potential of the membrane, facilitating or hindering the neural firing depending on the polarity applied. Anodal stimulation aims to increase cortical excitability and cathodal stimulation decreases cortical excitability³.

The tDCS has been used to modulate the Central Nervous System (CNS) and delay the onset of fatigue during the physical task⁴. When applied over Insular Cortex (IC) the tDCS modulated the Rating of Perceived Exertion (RPE) positively, and improved performance, in an incremental exercise test to exhaustion⁵. Some regions of the brain, such as the IC have been active and responded to afferent signals with an increase in RPE during exercise⁶. In addition, IC is one of the regions responsible for the consciousness of subjective body sensations, like comfort and discomfort, and pleasure and displeasure⁷. Probably the IC along with other areas of the CNS can influence decision-making to maintain or stop the physical exercise⁸.
supramaximal physical task\textsuperscript{18} used to evaluate the anaerobic performance evaluation in 30 seconds bout of exercise\textsuperscript{18} and can be executed in an intermittent form as a Sprint Interval Training\textsuperscript{19}. Therefore, we investigated the impact of anodal tDCS over insular cortex on performance, RPE and muscle activity while completing a supramaximal intermittent exercise. We compared anodal tDCS versus sham condition on exercise performance, RPE and surface Electromyography (EMG) in untrained individuals during a supramaximal intermittent exercise (Wingate test).

Methods

Subjects

Eleven healthy men (26.8 ± 4.6 years old; 78.9 ± 7.1 kg body mass; 12.4 ± 4.3 fat percentage) volunteered for participation in this study. A physician evaluated the subjects before the study and no one had metabolic, endocrine, cardiac disorders or any other health disorder that could limit their ability for physical exercise. All subjects were untrained and although they were recreational cycling practitioners no one was engaged in any systematic exercise program\textsuperscript{20}. The subjects signed informed consent before their participation and were given detailed information about the study, as well as the possible risks and benefits involved. The experimental procedures of this study were approved by a local Research Ethics Committee (nº 1.373.005) and were conducted in accordance with the standards set by the Declaration of Helsinki.

Experimental design

All subjects attended the laboratory sessions on three occasions separated by one week. On the first occasion, subjects became familiar with procedures and on occasions, two and three experimental test procedures with anodal tDCS or sham were performed (detailed in Figure 1).

The Wingate test was performed on a cycle ergometer mechanical braking system (CEFISE\textsuperscript{3}, Biotec model 1800). The tests occurred at the same time of the day (morning) to reduce the variability related to physiological changes due to circadian rhythm. We performed the experiment in an exercise physiology laboratory with the temperature maintained at 21 °C. The subjects were instructed to have a similar diet 24 hours before an experiment occasion, to refrain from eating 2-3 hours before the experiment and do not consume caffeine 12 hours before the experiment. Subjects were verbally encouraged (by the same researcher) to maintain the highest rhythm as they could during all trials.

Experimental occasions

Occasion 1 – Familiarization with Wingate test

The test started with a 5-minute warm-up with work at 50 Watts and 80 rpm. Two trials on the cycle ergometer were performed for familiarization, one at the end of the third minute and the other at the fifth-minute mark of the warm-up period. After passive resting for 4 minutes, subjects performed a Wingate test, i.e., the 30-second trial at the highest possible speed with a load of 7.5% of body mass (kg), as a fixed load\textsuperscript{18}.

Occasions 2 and 3 – Anodal or Sham tDCS and repeated Wingate tests

Occasions 2 and 3 were crossover procedures that were randomized (counter-balanced) and double-blinded. We applied both anodal and sham tDCS with the subjects at rest in a chair in different sessions. After tDCS, the subjects performed the warm-up procedure as described above for occasion 1\textsuperscript{18}, followed by a passive resting period of 4 minutes.

Subjects then performed four all-out Wingate test trials of 30 seconds, with 4 minutes of passive rest between each trial\textsuperscript{19}. In the passive rest periods during tests, subjects remained seated on the cycle ergometer. Subjects rated the intensity of RPE immediately after each trial by the use of the Borg RPE scale (ranging from 6 to 20 points)\textsuperscript{21}. Although all participants claimed experience with the Borg RPE scale from previous studies, all received detailed instructions about its use for the context of the present study.

Transcranial direct current stimulation

The equipment used to generate direct current stimulation consisted of a pair of electrodes (anode and cathode) connected to an electrical stimulator with three energy batteries (9 V) connected in parallel. The system was capable of generating 10 mA and was controlled by a professional digital multimeter (DT832, Weihua Electronic Co., Ltd, China) with a standard error of ± 1.5%. This device has been used in other studies\textsuperscript{5,12,22} A pair of sponge electrodes humidified with saline (150 mmol of NaCl diluted in water) was placed over silicone electrodes (35 cm\textsuperscript{2}). The electrodes were fixed on the head with a silicone cap. Tricho-
tomy of the region was made, reducing impedance and avoiding possible skin reactions. The anodal stimulation electrode was placed on the scalp over the left temporal cortex (T3 area) and the cathode electrode was placed over the right contralateral supraorbital area (Fp2 area); this cathodal stimulating area was commonly used in previous studies and was selected in the present study to optimize current flow to the IC. This electrode montage has shown to be effective to stimulate insular cortex area.

The electrodes were placed visually at the anatomical site according to the standardization of the international system of electrode placement 10-20 for electroencephalogram.

For the anodal tDCS condition, a constant electrical current of 2 mA was applied for 20 minutes before the exercise. The tDCS device was placed behind the subject and was covered in a way that could not be seen by the subject when turned on. For the sham tDCS condition, the electrodes were placed at the same positions as for the anodal tDCS. However, the equipment was slowly turned off after 30 seconds of stimulation. The subjects reported a similar slight sensation of itching or tingling in the stimulated area for both conditions that lasted 20 seconds. After that, the sensation was no longer perceived assuring that the sham tDCS was not noticed by the subjects.

Motor performance indexes

The Wingate test motor performance indexes produced were Relative Peak Power (RPP), Relative Average Power (RAP) and Fatigue Index (FI). These were determined by the software Ergometric (CEFISE) version 6.0. RPP and RAP were expressed in relative terms (watts/kg) to allow better comparison between individuals with different body mass. RPP was identified as the highest power produced during the trial, and the RAP was identified by average power production during the trial. The FI was identified by the following formula:

\[ FI(\%) = \frac{[\text{peak power} - \text{less power in the last 20 seconds}]}{100} \times \frac{1}{\text{peak power}} \]

Electromyography (EMG)

Surface EMG signals were recorded throughout tests for both the anodal and sham tDCS trials. Bipolar electrodes with silver and silver chloride coating were placed on the right rectus femoris, vastus lateralis and vastus medialis muscles with an inter-electrode distance of 20 mm. The muscle group selected includes three of the prevailing muscles on the front of the thigh. Before electrode placement, the skin was cleaned with alcohol to avoid possible interferences in the conduction of electrical stimulus. The reference electrode was placed on the ulnar styloid process.

EMG signals were acquired with a module of biological data acquisition with 8 channels (Miotec®) that were calibrated with signals amplified to 1000 times. A high-pass filter of 10 Hz and a low-pass filter of 500 Hz were included. The sampling frequency was 2000 Hz and a common rejection module of 120 dB.

For EMG data, the signal obtained during 30 seconds of each trial was selected and submitted to the EMG signal processing in the frequency domain through Fast Fourier Transform (FFT) (Hanning window processing, 512 points), followed by the spectrum for MPF, as a sign of fatigue, computed for 28 seconds into each trial. The first and last seconds of each trial were removed from analyses. The signal processing was done with the software Matlab 9.0 (MathWorks, Natick, MA, USA).

Statistical analysis

Statistical analyses were performed in SPSS 20.0 (SPSS Inc., Chicago, IL, USA). Descriptive analyses of averages and standard deviations were performed. Initially, the Shapiro-Wilk test was used to check the normality of the data. For motor performance indexes (RPP, RAP and FI), and for RPE and EMG parameters full factorial repeated-measures analyses of variance (ANOVA) were used to determine if significant differences existed over trials and between conditions. If the assumption of sphericity was not achieved Greenhouse-Geisser corrections were applied. The analyses were completed by Bonferroni’s test for multiple comparisons. The level of significance accepted was \( p \leq 0.05 \). Also, we calculated the Effect Size (ES) with the Hedge’s g approach with respective 95% confidence interval.

Results

For motor performance indexes, ANOVA showed a significant difference of trials on all three performance indexes, RPP \( (F=5.86; \ p=0.003; \ \text{observed power} \ 0.92) \), RAP \( (F=3.13; \ p<0.001; \ \text{observed power} \ 1.00) \) and FI \( (F=6.06; \ p=0.003; \ \text{observed power} \ 0.93) \). However, there was no difference between conditions x trials interactions for any of the parameters, RPP \( (F=1.17; \ p=0.34; \ \text{observed power} \ 0.28) \), RAP \( (F=0.31; \ p=0.82; \ \text{observed power} \ 0.10) \) and for FI \( (F=0.13; \ p=0.83; \ \text{observed power} \ 0.06) \). It is in opposition to our hypothesis since we had expected performance improvement for anodal tDCS condition. Figure 2 shows performance data for both anodal tDCS and sham conditions over trials.

For RPE there were significant changes over trials \( (F=43.31; \ p<0.001; \ \text{observed power} \ 1.00) \). However, there was no difference between condition x trial interaction \( (F=0.77; \ p=0.52; \ \text{observed power} \ 0.19) \). Therefore, the anodal tDCS applied over IC did not modulate the RPE positively, as hypothesized. Figure 3 shows the changes in RPE for the anodal tDCS and sham conditions over trials.

The ANOVA showed no significant differences over trials \( (F=1.16; \ p=0.32; \ \text{observed power} \ 0.19) \) and no conditions x trials interaction \( (F=0.13; \ p=0.95; \ \text{observed power} \ 0.07) \) for the rectus femoris muscle. For the vastus lateralis muscle there was a significant difference over trials \( (F=10.64; \ p<0.001; \ \text{observed power} \ 1.00) \), but no conditions x trial interaction \( (F=0.15; \ p=0.76; \ \text{observed power} \ 0.07) \). For the vastus medialis muscle, there were no differences over trials \( (F=2.73; \ p=0.06; \ \text{observed power} \ 0.60) \), and no conditions x trial interaction \( (F=2.13; \ p=0.12; \ \text{observed power} \ 0.50) \). Figure 4 shows the mean changes in MPF over trials for both anodal tDCS and sham conditions.

The ES analysis showed an insignificant and small ES for most of the results, except for RPP 2nd trial and RPE 3rd and 4th

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trial that showed a medium ES. Thus, in Table 1 shown below, it is possible to verify all ES results about performance, RPE and EMG between conditions.

Discussion

Here, we investigated whether the anodal tDCS applied over IC could modulate the performance, RPE and muscle fatigue in supramaximal intermittent physical exercise. Our main findings were that anodal tDCS compared to sham was not able to improve physical performance, modulate RPE or muscle fatigue development during supramaximal intermittent exercise for untrained individuals.

The use of tDCS in humans is recent, and there are a few studies using tDCS through responses related to physical exercise\(^4\,\,^30\). The effects of anodal tDCS targeting IC to reduce the RPE and improve performance\(^5\,\,^10\,\,^12\) are controversial. These controversies can be explained by protocol applied, ergometer used, exercise intensity or fitness level of the subjects, since the electrode assembly and tDCS application in the studies are similar. On one hand, the RPE reduction and performance improvement were reported in an incremental cycling exercise and for well-trained cyclists\(^5\). On the other hand, the RPE was lower only for submaximal intensity. The other two studies do not show RPE reduction and performance improvement\(^10\,\,^12\). They evaluated untrained\(^10\) and physically active\(^10\) subjects, respectively, during submaximal cycling exercise, in an ergometer that they were not familiar with. The time trial of 20-km and time to exhaustion at 75% of maximum power were not improved\(^10\), nor was the pleasure and displeasure sensations during 30 minutes of

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Figure 2 - A) Relative Peak Power (RPP), B) Relative Average Power (RAP), and C) Fatigue Index (FI) for anodal and sham tDCS over Wingate trials.

Figure 3 - Rating of Perceived Exertion (RPE) after each Wingate trial for anodal and sham tDCS.
cycling at 82% of heart rate maximum\textsuperscript{12}. Differently, our study analyzed the RPE response and performance after tDCS applied over IC 20 minutes before an all-out supramaximal intermittent cycling exercise. The similarity between the three studies cited above was the use of the same ergometer, as well as the subject characteristics in Okano’s\textsuperscript{12} and Barwood’s studies\textsuperscript{10}. The all-out supramaximal exercise promotes pain sensation, i.e., displeasure during the exercise as well as performance reduction\textsuperscript{31}. Currently, studies aiming to decrease the onset of fatigue and displeasure sensations have a great interest in the scientist community, coaches, and practitioners. Here, we found no change in RPE or performance between anodal tDCS and Sham conditions. Therefore, the tDCS efficacy when applied over IC seems to be restricted to exercise, when subjects are familiarized with ergometer and for untrained subjects.

There is a controversial approach about to perceived exertion origin, in which some scientists argue that afferent signals modulate the RPE during exercise\textsuperscript{32}, while others state that RPE has a CNS origin\textsuperscript{17}. A consensus between these approaches is that when performance improves by training or ergogenic strategies, the RPE is lower than before\textsuperscript{33}. However, the exercise intensity could help explain the absence of RPE response after

|                  | 1\textsuperscript{st} Trial - ES (CI) | 2\textsuperscript{nd} Trial - ES (CI) | 3\textsuperscript{rd} Trial - ES (CI) | 4\textsuperscript{th} Trial - ES (CI) |
|------------------|----------------------------------------|----------------------------------------|----------------------------------------|----------------------------------------|
| RPP              | 0.0 (-0.4 to 0.5)                      | -0.5 (-0.8 to -0.2)                    | -0.4 (-0.8 to 0.0)                     | 0.2 (-0.4 to 0.8)                      |
| RAP              | 0.0 (-0.2 to 0.2)                      | -0.1 (-0.3 to 0.1)                     | -0.4 (-0.6 to -0.1)                    | -0.1 (-0.5 to 0.2)                     |
| FI               | 0.0 (-3.3 to 3.2)                      | 0.0 (-5.6 to 5.6)                      | 0.0 (-8.3 to 8.3)                      | 0.3 (-8.1 to 8.7)                      |
| RPE              | 0.0 (-1.2 to 1.3)                      | 0.0 (-0.8 to 0.8)                      | 0.5 (0.0 to 1.1)                       | 0.6 (0.3 to 1.0)                       |
| RF               | -0.1 (-3.9 to 3.6)                     | 0.0 (-4.1 to 4.1)                      | 0.0 (-3.8 to 3.7)                      | 0.0 (-3.9 to 3.9)                      |
| VL               | 0.4 (-3.4 to 4.2)                      | 0.3 (-4.2 to 4.8)                      | 0.4 (-4.0 to 4.9)                      | 0.4 (-3.3 to 4.1)                      |
| VM               | -0.1 (-3.7 to 3.6)                     | -0.3 (-4.7 to 4.2)                     | 0.0 (-4.3 to 4.3)                      | -0.4 (-4.5 to 3.7)                     |

ES - effect size; CI - confidence interval; RPP - relative peak power; RAP - relative average power; FI - fatigue index; RPE - rating of perceived exertion; RF - rectus femoris; VL - vastus lateralis; VM - vastus medialis.

Figure 4 - A) rectus femoris, B) vastus lateralis, and C) vastus medialis muscle MPF for anodal and sham tDCS over Wingate trials.
tDCS\textsuperscript{12}. Another explanation for the absence of RPE response is the brain region stimulated. The left IC seems to have its activity diminished when high-intensity exercises are done, whereas exercises with higher sympathetic activity, characteristic in supramaximal exercises, increase the activity of right IC\textsuperscript{41}. Furthermore, there is evidence that anodal tDCS applied over the left temporal cortex is not effective for high-intensity performance\textsuperscript{14}. Unfortunately, Sasada’s study\textsuperscript{14} does not affect our short-term supramaximal intermittent exercise as depicted as a lack of differences (condition x trial interaction) (Figure 4) or effect (table 1) in MPF for all muscles during both conditions over trials. However, there was a significant difference during trials (i.e., intra-condition) only for the vastus lateralis muscle, but this observed difference is in agreement with the reduction of the physical performance of the individuals over trials. However, these results in the EMG signal did not result in a different performance when comparing both conditions. This somewhat corroborates with Cogiamanian, Marceglia, Ardolino, Barbieri, Priori\textsuperscript{43} who showed no differences in EMG between anodal tDCS over the motor cortex, control procedure, and attributed their improved endurance times to psychological reasons causing cortical changes that may determine task failure during the sustained effort. Similarly, other studies found no changes in muscle activation through EMG analysis, as evidenced by Angius, Pageaux, Hopker, Marcora, Mauguer\textsuperscript{39} and Abdelmoula, Baudry, Duchateau\textsuperscript{42} during isometric exercise and by Vitor-Costa et al.\textsuperscript{5} during constant-load cycling exercise. It is possible that tDCS might affect a long-term exercise but did not affect our short-term supramaximal intermittent exercise as previously discussed. Furthermore, Scheuermann, Hoelting, Noble, Barstow\textsuperscript{48} reported stability in MPF during high-intensity cycling exercise and discussed it as being a consequence of motor centers in the brain organizing the recruitment of a similar population of metabolically active motor units to accomplish the task, irrespective of the exercise history of the exercising limbs. We argue that, as discussed by Kan, Dundas, Nosaka\textsuperscript{45}, there may be a ceiling effect at corticospinal levels which, when there is little or no potential for improvement in a motor function tDCS, does not enhance that function.

Moreover, another fact to consider is regarding the cephalic or extracephalic electrode montage. The cathodal electrode placed over the contralateral prefrontal area (i.e., Fp2 area)
in a cephalic montage may negatively affect the effects of anodal stimulation by decreasing excitability in the brain area. Indeed, this could affect the perceived exertion and performance in exercise. Thus, an extracephalic stimulation where the reference electrode is placed on the shoulder would annul out this negative effect.

Despite the small sample size being a possible limitation, normality and homogeneity were assumed to all data and Greenhouse-Geisser correction was applied when necessary. Also, we completed the analysis through ES Hedge’s g approach, which is specific for a small sample size. Another possible limitation was not having included some affectivity analysis of the individuals in response to the different stimulation procedures, these results could contribute to the idea of the study. tDCS is a recent technique that attempts brain neuromodulation, and more studies are needed to establish its real effect as an ergogenic aid to improve physical performance and fatigue delay. Furthermore, other areas of the brain in connection with effort sensation in physical exercise should be investigated. Also, studying other models of physical exercises under tDCS in trained and untrained individuals would help further understanding of the effect of tDCS in sport and exercise activities.

Conclusions

The anodal tDCS technique was not effective to improve physical performance, reduce ratings of perceived exertion and change the muscle activity in untrained individuals during supramaximal intermittent exercise. Unlike previous reports for other exercise modes, our results may indicate that brain neuromodulation imposed by tDCS over IC has no potential as an ergogenic aid to increase physical performance in a supramaximal intermittent exercise.

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