

**Effect of hand cooling on body temperature,  
cardiovascular and perceptual responses during  
recumbent cycling in a hot environment**

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## **Abstract**

The purpose of this study was to quantify physiological and perceptual responses to hand immersion in water during recumbent cycling in a hot environment. Seven **physically-active** males (body mass  $79.8 \pm 6.3$  kg; stature  $182 \pm 5$  cm; age  $23 \pm 3$  years) immersed their hands in 8, 14 and 34°C water whilst cycling at an intensity (W) equivalent to 50%  $\dot{V}O_{2\text{peak}}$  for 60 min in an environmental chamber (35°C 50% relative humidity). 8 and 14°C water attenuated an increase in body temperature, and lowered cardiorespiratory and skin blood flow demands. These effects were considered to be practically beneficial (standardised effect size  $> 0.20$ ). There was a tendency for 8 and 14°C to extend exercise duration versus 34°C ( $>7\%$ ). Heart rate, **intestinal, mean skin and mean body temperature were less in 8°C compared to 14°C; these differences were considered practically beneficial.** Augmented heat loss at the palm-water surface might enable cooler blood to return to the body and limit physiological strain. These findings provide a mechanistic basis for continuous hand cooling and indicate that endurance exercise in hot environments could be improved using this method. Future research should investigate its effectiveness during cycling and running performance.

**Key Words:** Heat; per-cooling; thermoregulation; body temperature; hyperthermia

## **Introduction**

During fixed intensity and self-paced exercise athletes benefit from artificial heat transfer through protocols that cool the body. These protocols are grouped into pre and-per cooling. Pre-exercise cooling includes cold water immersion (Duffield, Green, Castle, & Maxwell, 2010), iced towels (Minett, Duffield, Marino, & Portus, 2011), ice vests (Duffield & Marino, 2007) and ice slurry ingestion (Siegel et al., 2009). A reduction in body temperature prior to exercise is thought to increase heat storage capacity, core-to-skin gradient and reduce thermal perception enabling exercise at a higher intensity, or for longer before reaching a regulatory limit for performance and body temperature (Marino, 2002). Neck (Tyler, Wild, & Sunderland, 2010), head (Ansley et al., 2008), torso (Kenny et al., 2011) and palm cooling (Grahn, Cao, & Heller, 2005; Hsu, Hagobian, Jacobs, Attallah, & Friedlander, 2005) have been used as per-cooling techniques. These might be applied continuously throughout exercise or at intervals between bouts to attenuate a rise in body temperature, reduce body temperature between bouts and lower perception of heat strain. In a recent meta-analysis on cooling methods (Tyler, Sunderland, & Cheung, 2013) the majority of per-cooling studies were shown to improve exercise performance with similar beneficial effects compared to pre-cooling ( $d = 0.76$ ;  $d =$

0.73 respectively). These findings were supported by Bongers et al. (2015) who found pre-cooling and per-cooling also had similar beneficial effects on exercise performance ( $d = 0.44$ ;  $d = 0.40$ , respectively).

Hand or palm cooling has been used as a per-cooling method to attenuate a rise in body temperature (Livingstone, Nolan, & Cattroll, 1989), extend low-intensity cycling, stepping and walking exercise capacity (Allsopp & Pool, 1991; Giesbrecht, Jamieson, & Cahill, 2007; Grahn et al., 2005; House, Holmes, & Allsopp, 1997; Khomenok et al., 2008), improve short-term high intensity wheelchair ergometer (1 km) and cycling performance (3 km) (Goosey-Tolfrey, Swainson, Boyd, Atkinson, & Tolfrey, 2008) and improve endurance cycling performance (30 km) (Hsu et al., 2005) in environmental temperatures greater than 30°C. The hands have a large surface to mass ratio (Taylor, Machado-Moreira, van den Heuvel, & Caldwell, 2014) and low metabolic heat production that suit high rates of conductive heat transfer. Additionally, the glabrous skin of the palms contain dense proportions of arteriovenous anastomoses and retia venosa (Manelli et al., 2005; Sangiorgi et al., 2004) enabling blood flow. A large volume of blood flow through the palm is conducive to heat transfer between warm arterial blood, the palmar surface and cooler contacting media such that heat is conducted and cooler blood returns to the body through venous networks.

In most hand or palm cooling studies the treatment has been applied between bouts of exercise (Allsopp & Pool, 1991; Giesbrecht et al., 2007; Goosey-Tolfrey et al., 2008; Khomenok et al., 2008; Kuennen, Gillum, Amorim, Kwon, & Schneider, 2010; Selkirk, McLellan, & Wong, 2004) or after exercise (House et al., 1997; Livingstone et al., 1989) in hot environments. However, Hsu *et al.* (2005) demonstrated that

continuous hand cooling alleviated an increase in tympanic temperature during 60 min of fixed intensity cycling exercise at 60%  $\dot{V}O_{2\text{peak}}$  in 32°C 25% relative humidity ( $1.2 \pm 0.2^\circ\text{C}$ ;  $1.8 \pm 0.2^\circ\text{C}$  with and without hand cooling respectively). Similarly, Grahn *et al.* (2005) reported that hand cooling attenuated a rise in oesophageal temperature during walking at 5.7 km·hour<sup>-1</sup> in 40°C 25% relative humidity ( $2.1 \pm 0.4^\circ\text{C}$ ;  $2.8 \pm 0.5^\circ\text{C}$  (with and without hand cooling respectively). However, only a single-palm was used and the results are only applicable to the vacuum assisted heat extraction device used (RTX CoreControl, AVAcore Inc., CA, USA) which is impractical to use during competition. Moreover, Amorim, Yamada, Robergs, & Schneider (2010) did not report any benefit of the vacuum assisted heat extraction device whilst walking at 6.7 km/h 4% gradient, in  $42 \pm 1^\circ\text{C}$ ,  $30 \pm 5\%$  relative humidity whilst wearing military uniform and body armour. However this study is limited by several methodological issues. A practical approach to hand cooling was addressed by Schedler, Saunders, Hanson, & Devor (2013) who secured a gel pack to the non-dominant hand during a running time-trial to exhaustion task at 75%  $\dot{V}O_{2\text{peak}}$ . The rate of change in intestinal temperature was similar between control and gel pack trials and participants ran for longer in the control trial than the gel pack trial ( $46.7 \pm 32.1$  min;  $41.3 \pm 26.3$  min respectively). However, the authors only applied the gel to a single palm and did not report its temperature or palm skin temperature, raising doubts as to whether sufficient palm cooling occurred. Furthermore, given the large standard deviation in time to exhaustion it is difficult to make confident interpretations regarding the effectiveness of continuous application of a gel pack during exercise from this study.

Given that the physical properties of the hands are conducive to heat exchange and previous research has identified the potential effectiveness of continuous hand during

exercise, alternative methods of should be investigated. Indeed, the ergogenic mechanisms, optimal cooling temperature and whole body physiological and perceptual responses when cooling both hands continuously during exercise are unclear. Therefore, the aim of this study was to provide a mechanistic basis for the development of practical hand cooling techniques by assessing body temperature, cardiovascular and perceptual responses to continuous hand immersion in water during exercise in a hot environment.

## **METHODS**

### **Participants**

*A priori* sample size calculation based upon finding a  $0.20^{\circ}\text{C}$  intestinal temperature difference between experimental and control conditions at the end of exercise, a standard deviation of  $0.40^{\circ}\text{C}$ ,  $\beta = 0.20$  and  $\alpha = 0.05$  suggested a sample size of 6 participants would be adequate. This data was based on findings from a previous study (Hsu et al., 2005). Nine non-heat-acclimated physically active males volunteered for the study that was approved by the local ethics committee and conducted according to the principles of the Declaration of Helsinki. All experimental trials were conducted between the months of August and October where mean ambient temperatures ranged  $12 - 22^{\circ}\text{C}$ . Seven participants (age  $24 \pm 3$  years; body mass  $78.3 \pm 7.2$  kg; stature  $180 \pm 7$  cm) completed all trials; drop-outs were due to illness and one participant being unable to tolerate hand immersion in cold water. All participants provided written informed consent before the study. Participants were told that they were required to place their hands in three different water temperatures whilst exercising but were not told the temperatures or the true



purpose of the study. Participants were asked to refrain from strenuous exercise, caffeine and alcohol 24 h before each trial and food 3 h before each trial. Each participant recorded their diet 24 h prior to the first trial and replicated their diet for the remaining trials. Adherence to the standardised diet was verified by the investigator before each trial.

**Participants** visited the laboratory 4 times, each visit separated by 3 days to 7 days. Trials were performed at least 3 hours after waking and 3 hours before sleep to minimise the circadian rhythm impact on body temperature and gastrointestinal function (Manfredini, Manfredini, Fersini, & Conconi, 1998). **Exercise trials were conducted on an externally-verified, electromagnetically-braked ergometer (Lode Angio, Groningen, The Netherlands) positioned for recumbent cycling.**

### **Visit 1: Pre-experimental trial testing and accustomisation**

**In a temperature controlled laboratory (18°C 60% relative humidity) a continuous 25 W·min<sup>-1</sup> incremental exercise test to maximal volitional exhaustion was used to determine peak oxygen uptake ( $\dot{V}O_{2\text{peak}}$ ) (Ultima, CardiO<sub>2</sub>, Medgraphics, USA) and peak minute power ( $W_{\text{peak}}$ ).** Heart rate was recorded continuously during exercise (RS400, Polar OY, Finland).

After 60 min of rest in a temperate environment, nude body mass (kg) was recorded using beam balance scales (Weylux, UK) before the accustomisation trial. Participants performed 30 min of recumbent cycling within the environmental chamber (28.5°C Wet bulb globe temperature **[35°C, 50% relative humidity]**) at an intensity of 50%  $W_{\text{peak}}$  to accustomise to the experimental procedures. During the exercise session heart rate, rating of perceived exertion (RPE) (Borg, 1970) and thermal perception **( 9 point scale)** (Nielsen, Gavhed, & Nilsson, 1989) were assessed

every 5 min. Whole body sweat rate ( $\text{L}\cdot\text{hour}^{-1}$ ) was estimated from the change in body mass adjusted for fluid intake and urine output.

### **Experimental trials**

An ingestible temperature pill was used to assess intestinal core temperature (CorTemp, HQinc, USA). The validity of temperature measurement of each pill was verified according to recommended guidelines (Hunt & Stewart, 2008). Participants ingested the pill at the same time of day, 6 h prior to each visit (Byrne & Lim, 2007), a procedure demonstrated to provide reliable responses under similar conditions (Ruddock, Tew, & Purvis, 2014).

On arrival, participants voided and nude body mass (kg) and urine osmolality ( $\text{mOsmol}\cdot\text{kg}^{-1} \text{H}_2\text{O}$ ) (Advanced Model 3320 Micro-Osmometer, Advanced Instruments, Inc., USA) were assessed. A urine osmolality of  $\leq 700 \text{ mOsmol}\cdot\text{kg}^{-1} \text{H}_2\text{O}$  was used to verify pre and post-trial euhydration status (Sawka et al., 2007). Participants rested for 60 min in the environmental chamber set at  $28.5^\circ\text{C}$  WBGT. Participants wore the same clothing (shorts, socks and running shoes) for all trials. Air currents from the environmental chamber fans were  $\approx 0.5 \text{ m}\cdot\text{s}^{-1}$ , no cooling fans were used.

Thirty minutes before the start of exercise, participants were fitted with a chest strap for the measurement of heart rate, and skin thermistors (Grant Instruments, Cambridge, UK) were attached to the left side of the body at the medial calf, anterior mid-thigh, anterior mid-forearm, chest and index finger using acrylic dressing (Tegaderm, 3M Healthcare, USA), secured in place using hypoallergenic surgical

tape (Transpore, 3M Healthcare, USA). A 7-point integrating laser Doppler flowmeter probe (Probe 413, Perimed AB) was positioned on the volar aspect of the upper left forearm and on the left middle fingertip within a housing disc surrounding the probe (Model 455, Perimed AB) for measurement of arbitrary perfusion units (APU). The position of the site was standardised for each participant. Blood pressure (mmHg) was assessed using auscultation and an aneroid sphygmomanometer. APU (mean of last 60 s for each 5 min period), rating of perceived exertion and whole body, right hand and left hand thermal perception were recorded at -10, -5 min and immediately before exercise (0 min) and then at 5-min intervals throughout the exercise trial. Expired air was assessed breath-by-breath every 15 min for 3 min. Participants were asked to cycle for 60 min within the environmental chamber (28.5°C Wet bulb globe temperature [35°C, 50% relative humidity]) at an intensity of 50%  $W_{peak}$ . This intensity and duration was chosen to balance muscular fatigue, due to recumbent cycling, with an ethically acceptable magnitude of heat strain. The exercise test was terminated when one of the following criteria was met: 1) participants voluntarily stopped exercising, 2) when intestinal core temperature reached 39.5 °C or 3) participants completed 60 min of exercise.

Ten minutes before exercise (-10 min) participants immersed their hands up to the ulna head in buckets filled with water controlled at 8, 14 or 34 ± 2°C. Hands remained immersed in water until the exercise trial was complete. These temperatures were chosen because of the similarity to previous hand cooling research.

## Calculations

Weighted mean skin temperature ( $T_{sk}$ ) was calculated using the equation of Ramanathan (1964). Mean body temperature ( $T_{body}$ ) was calculated using the equation of Colin, Timbal, Houdas, Boutelier, & Guieu (1971). Mean arterial pressure (MAP) was calculated as using the equation of Razminia et al. (2004). Raw cutaneous vascular conductance (CVC), an index of skin blood flow was calculated as:  $CVC = APU \div MAP$ .

### **Statistical analysis**

#### **INSERT TABLE 1 HERE**

Reliability data for measurements in the study are presented in table 1. Normal distribution was assessed using Kolmogorov-Smirnov test and homogeneity of variance using Levene's test in IBM SPSS statistics version 20 (IBM Armonk, NY, USA). Data were assessed for meaningful between-trial differences using a magnitude-based approach (Hopkins, Marshall, Batterham, & Hanin, 2009). The analysis was performed using a statistical spreadsheet (Hopkins, 2003) that calculates trial means, standard deviations, standardised effect sizes (Cohen's  $d$ ) using the pooled standard deviation and confidence intervals. Cohen's  $d$  was assessed according to accepted thresholds;  $\leq 0.2$  (trivial),  $> 0.2 - 0.59$  (small),  $0.60 - 1.19$  (moderate),  $1.20 - 1.99$  (large),  $> 2.0 - 3.99$  (very large) and  $> 4.0$  (extremely large) (Hopkins et al., 2009). 90% confidence intervals were calculated for  $d$ . The probability (% chance) that the between-trial differences were less than, similar to or greater than the smallest worthwhile difference (calculated as  $0.2 \times$  between-trial pooled standard deviation) was assessed using a statistical spreadsheet (Hopkins, 2003). When data violated assumptions of normality the Wilcoxon Signed Rank Test

was used to assess between-group differences. Statistical significance was set at  $P < 0.05$ .

## **Results**

### **Pre-trial measures**

Mean  $\dot{V}O_{2\text{peak}}$  for the recumbent cycling incremental exercise test was  $41 \pm 5 \text{ mL}\cdot\text{kg}^{-1}\cdot\text{min}^{-1}$ . Wet bulb globe temperature was similar between 8 ( $28.6 \pm 0.4^{\circ}\text{C}$ ) and  $34^{\circ}\text{C}$  ( $28.5 \pm 0.2^{\circ}\text{C}$ ) trials;  $d = 0.16$  [0.07 to 0.25], there was a moderate difference between 8 and  $14^{\circ}\text{C}$  ( $28.3 \pm 0.2^{\circ}\text{C}$ );  $d = 0.70$  [0.42 to 0.97] and a moderate difference between 14 and  $34^{\circ}\text{C}$  trials;  $d = 0.72$  [0.16 to 1.29]. Pre-trial urine osmolality was  $257 \pm 255$ ;  $291 \pm 225$ ;  $387 \pm 259 \text{ mOsmol}\cdot\text{kg}^{-1} \text{ H}_2\text{O}$  for 8, 14 and  $34^{\circ}\text{C}$  trials respectively and within the limit for euhydration.

### **Initial physiological responses to hand immersion**

Hand immersion at rest had no influence on physiological variables (Table 2). Whole body rating of thermal perception was lower after hand immersion (-5 min), irrespective of water temperature, compared to -10 min (difference in thermal perception -0.4 units;  $d = 0.52$  [0.00 to 1.04]). Rating of right and left hand thermal perception was lower than whole body thermal perception when immersed in water at all temperatures (difference in thermal perception -3.6 units;  $d = 1.48$  [1.06 to 1.98]) and corresponded to the qualitative descriptor “cool”.

**INSERT TABLE 2 HERE**

## INSERT FIGURE 1 HERE

### Exercise duration and cardiorespiratory responses

Mean intensity of exercise was  $148 \pm 17$  W and the duration was  $50:48 \pm 16:18$  min,  $51:30 \pm 15:00$  min and  $47:24 \pm 14:24$  min for 8, 14 and  $34^{\circ}\text{C}$  conditions. Exercise duration in  $14^{\circ}\text{C}$  was 1.3% longer than  $8^{\circ}\text{C}$  and 8.7% longer than  $34^{\circ}\text{C}$ . Exercise duration in  $8^{\circ}\text{C}$  was 7.3% longer than  $34^{\circ}\text{C}$ . However, there were no statistically significant differences between conditions. Five participants completed 60 min of exercise in 8 and  $14^{\circ}\text{C}$  and 3 participants completed 60 min of exercise in  $34^{\circ}\text{C}$ . Exercise trials were self-terminated by participants due to volitional exhaustion. None of participants reached ethical limit of intestinal temperature and there were no instances of heat illness. Percentage of peak heart rate (figure 1A) was likely (94%) lower in  $8^{\circ}\text{C}$  versus  $34^{\circ}\text{C}$  from 25 min onwards ( $87 \pm 4\%$  and  $90 \pm 5\%$  respectively);  $d = 0.69$  [0.18 to 1.20]. Percentage of peak heart rate during  $8^{\circ}\text{C}$  was also likely (77%) lower than  $14^{\circ}\text{C}$  ( $89 \pm 10\%$ ) from 25 min onwards;  $d = 0.28$  [0.10 to 0.46]. Peak percentage heart rate in  $14^{\circ}\text{C}$  and  $34^{\circ}\text{C}$  were similar (68%) from 25 min onwards;  $d = 0.13$  [-0.09 to 0.36]. Mean  $\dot{V}\text{O}_2$  during  $8^{\circ}\text{C}$  was possibly (62%) less than  $34^{\circ}\text{C}$  ( $27.1 \pm 3.1$  ml·kg<sup>-1</sup>·min<sup>-1</sup> and  $28.0 \pm 1.9$  ml·kg<sup>-1</sup>·min<sup>-1</sup> respectively);  $d = 0.37$  [-0.55 to 1.28]. Mean  $\dot{V}\text{O}_2$  during  $8^{\circ}\text{C}$  ( $27.5 \pm 3.7$  ml·kg<sup>-1</sup>·min<sup>-1</sup>) was possibly (50%) less than  $34^{\circ}\text{C}$ ;  $d = 0.18$  [-2.62 to 2.99] and possibly similar (49%) to  $8^{\circ}\text{C}$ ;  $d = 0.12$  [-0.33 to 0.58].

### Perceived exertion and thermal perception

Figure 1B shows RPE responses during exercise. There were no statistically significant differences ( $P > 0.05$ ) in mean RPE between 8°C and 14°C ( $15.3 \pm 2.0$  and  $15.2 \pm 1.7$  respectively) and 8°C and 34°C ( $15.6 \pm 1.9$ ). However, mean RPE for 14°C was significantly less ( $P < 0.05$ ) than 34°C. Figure 1C shows responses for thermal perception during exercise. **Mean** thermal perception for 8°C was statistically ( $P < 0.05$ ) less than 14°C ( $7.3 \pm 0.8$ ,  $7.5 \pm 0.8$  respectively) and 34°C ( $8.0 \pm 0.7$ ). **Mean** thermal perception for 14°C was statistically less than 34°C. **Mean** qualitative descriptors for 8, 14 and 34°C corresponded to "warm", "warm-hot" and "hot".

### **Intestinal temperature**

Figure 2A shows intestinal temperature responses during exercise. Intestinal temperature was similar between trials for the first 15 min of exercise but increases were attenuated by hand cooling. From 15 min onwards until the end of exercise the change was likely (77%) less in 8°C compared to 14°C ( $0.74 \pm 0.29^\circ\text{C}$  and  $0.83 \pm 0.31$  respectively);  $d = 0.35$  [-0.01 to 0.69]. There was a very likely (99%) difference for change in intestinal temperature between 8°C and 34°C ( $1.00 \pm 0.38^\circ\text{C}$ ) from 15 min onwards until the end of exercise;  $d = 0.84$  [0.42 to 1.25] and a likely (85%) difference between 14°C and 34°C over the same time period;  $d = 0.55$  [-0.01 to 1.11]. Figure 3 shows these changes from 0 min until the end of exercise for each participant.

**INSERT FIGURE 2 HERE**

**INSERT FIGURE 3 HERE**

### **Mean skin temperature**

Change in mean skin temperature (Figure 2B) was less after 5 min and onwards to cessation of exercise in 8°C compared to 34°C ( $-0.09 \pm 0.72^{\circ}\text{C}$  and  $0.77 \pm 0.30^{\circ}\text{C}$  respectively);  $d = 1.24$  [0.45 to 2.03]. Change in mean skin temperature for 8°C was also very likely (98%) less throughout exercise compared to 14°C;  $d = 1.09$  [0.43 to 1.76]. Change in mean skin temperature was likely (94%) less in 14°C versus 34°C throughout exercise;  $d = 0.63$  [0.17 to 1.10].

**INSERT FIGURE 4 HERE**

### **Mean body temperature**

Change in mean body temperature (figure 2C) at the end of exercise was likely (82%) lower in 8°C compared to 14°C ( $0.47 \pm 0.33^{\circ}\text{C}$  and  $0.71 \pm 0.35^{\circ}\text{C}$  respectively);  $d = 0.69$  [-0.24 to 1.61] and very likely (99%) less than 34°C ( $1.09 \pm 0.38^{\circ}\text{C}$ );  $d = 1.32$  [0.60 to 2.04]. Change in mean body temperature at the end of exercise was likely (93%) lower in 14°C compared to 34°C;  $d = 0.95$  [0.09 to 1.81].

### **Fingertip temperature**

During water immersion fingertip temperature (Figure 4) was statistically ( $P < 0.05$ ) less in 8°C than 14°C ( $15.20 \pm 3.46$  and  $18.50 \pm 3.30$  respectively) and 34°C ( $34.93 \pm 0.93$ ). 14°C was also statistically ( $P < 0.05$ ) less than 34°C.

### **Skin blood flow**

Figures 5 and 6 show skin blood flow responses during exercise. Mean fingertip CVC was significantly ( $P < 0.05$ ) less in 14°C than 8°C ( $2.9 \pm 1.6$  and  $3.2 \pm 1.7$  respectively) and 34°C ( $3.9 \pm 1.4$ ). 8°C was significantly ( $P < 0.05$ ) less than 34°C



for mean fingertip CVC during exercise. Mean forearm CVC was very likely (99%) less in 8°C compared to 34°C ( $1.30 \pm 0.39$  and  $1.75 \pm 0.47$  respectively);  $d = 0.68$  [0.51 to 0.86]. Mean forearm CVC was also very likely less (99%) in 14°C ( $1.34 \pm 0.44$ ) compared 34°C;  $d = 0.69$  [0.48 to 0.91]. Mean forearm CVC was similar (86%) for 8°C and 14°C;  $d = 0.12$  [0.00 to 0.23].

**INSERT FIGURE 5 HERE**

**INSERT FIGURE 6 HERE**

### **Sweat rate**

Post-exercise body mass loss was  $1.3 \pm 1.2\%$  in 8°C,  $0.5 \pm 0.8\%$  in 14°C and  $0.9 \pm 0.9\%$  in 34°C. Sweat rate was similar (45%) between 8°C and 34°C ( $0.97 \pm 0.21$  L·hour<sup>-1</sup> and  $0.94 \pm 0.21$  L·hour<sup>-1</sup> respectively);  $d = 0.13$  [-1.13 to 0.86]. Sweat rate was likely (94%) lower in 14°C ( $0.69 \pm 0.29$  L·hour<sup>-1</sup>) compared to 8°C;  $d = 0.69$  [-0.12 to 1.84] and likely lower (88%) compared to 34°C;  $d = 0.81$  [0.09 to 1.71].

### **Discussion**

The aim of this study was to assess the body temperature, cardiovascular and perceptual responses to hand cooling during exercise. In general, hand cooling attenuated an increase in body temperature, limited heat storage and lowered cardiorespiratory and skin blood flow demands. These effects were considered to be practically beneficial. There was a tendency for participants to exercise longer with

hand cooling, however magnitude-based statistical analysis could not be performed as the data was not normally distributed and differences between groups were not statistically significant.

Previous research has demonstrated that hand immersion in cold water can reduce body temperature between bouts of exercise (Allsopp & Pool, 1991; Giesbrecht et al., 2007; Goosey-Tolfrey et al., 2008; House et al., 1997; Khomenok et al., 2008) and single-palm cooling using a heat extraction device applied continuously during exercise can extend exercise duration and improve cycling performance (Grahn et al., 2005; Hsu et al., 2005).

Heat transfer from warm circulating blood is the likely mechanism responsible for these findings. For effective heat transfer there needs to be a balance between thermal gradient (hand cooling) and blood flow (limited vasoconstriction). In the present investigation fingertip temperature was greater than water temperature for 8 and 14°C trials providing evidence of a thermal gradient. Fingertip temperature was also lower than mean skin temperature, providing evidence that the hands were cooled during the exercise trials. However, cooler temperatures might have limited fingertip blood flow and restricted heat transfer as cutaneous vascular conductance was lower in 8°C and 14°C than during 34°C trials.

At the onset of water immersion vasoconstriction occurred at the fingertip but not at the forearm (Figure 5 and 6). This is likely because of an increase in local sympathetic noradrenergic vasoconstrictor activity in response to cold stress (Ekenvall, Lindblad, Norbeck, & Etzell, 1988). Fingertip skin blood flow remained similar in 34°C before and after hand immersion but was lower at the onset of exercise. This probably occurred because of increased sympathetic vasoconstrictor

activity at the onset of exercise (Johnson & Park, 1982; Johnson, 1992). After 10 min of exercise fingertip skin blood flow began to increase in all conditions, probably because of vasoconstrictor withdrawal as autonomic heat loss mechanisms were activated (Roddie, Shepherd, & Whelan, 1957). Thereafter, dilation of arteriovenous anastomoses, dense microvascular networks and poor insulative properties of the hand (Manelli et al., 2005; Sangiorgi et al., 2004; Taylor et al., 2014) allowed heat from the blood to be conducted to the water down a thermal gradient. Thus cooler blood returned to the central circulation and presumably less body heat was stored. **Therefore, the rate at which intestinal temperature increased** during exercise was attenuated in 8 and 14°C (Figure 2A). This was likely because of; 1) cooler blood returning directly from the hands; and 2) relatively cooler blood returning from the active muscles.

**Mean skin temperature increase was also attenuated in** 8°C and 14°C trials (Figure 2B). Whether this resulted from cooler blood returning to the central circulation through venous structures close to the skin, cold conductance from the hand to forearm, lower-temperature arterial blood circulated to the skin or less skin blood flow is unclear. However, **forearm cutaneous vascular conductance** was less in 8°C and 14°C compared to 34°C suggesting there was less demand for skin blood flow to aid thermoregulation. This was evident up to 40 min, thereafter CVC in the control trial decreased and was similar to 8°C and 14°C. This likely occurred due to a combination of participant attrition and poor test-retest reliability. Less demand for skin blood flow also attenuated the demands on the **cardiovascular system** as evidenced by lower heart rates from 25 min onwards in the 8°C condition compared to 14°C and 34°C.

Sweat rate was less in 14°C than 8°C and 34°C but similar between 8°C and 34°C.

The reason for the difference in sweat rate between 14°C and 8°C is unclear.

However, the similarity between 8°C and 34°C sweat rate suggests that evaporative cooling was not impaired by hand cooling at this temperature. These results indicate that heat transfer via the hands was responsible for limiting body heat storage rather than evaporative cooling mechanisms.

However, despite associations between RPE and cardiovascular demand (Borg, 1982), there were no statistically significant differences in mean RPE (Figure 1B) between trials. This might have been a consequence of the difficulty of the exercise trials where perceived exertion reached near maximal ratings towards the end.

However, whole body thermal perception scores were statistically less during the cooling trials with 8°C statistically less than 14°C.

Hsu et al. (2005) used a cooling device (RTX CoreControl, AVAcore Inc., CA, USA) that circulated 22°C water over one palm during fixed intensity (60%  $\dot{V}O_{2peak}$ ) cycling in a hot environment (32°C 25% RH). Similar to the present investigation core temperature change from baseline, measured at the tympanic membrane was less with palm cooling compared to no cooling ( $1.2 \pm 0.2^\circ\text{C}$ ;  $1.8 \pm 0.2^\circ\text{C}$  with and without hand cooling respectively). Using the same device during exercise in 40°C 25% RH, Grahn et al. (2005) reported an improved exercise tolerance ( $57.0 \pm 6.4$  min;  $34.1 \pm 3.0$  min with and without hand cooling respectively) and attenuated rise in oesophageal temperature when compared to no cooling ( $2.1 \pm 0.4^\circ\text{C}$ ;  $2.8 \pm 0.5^\circ\text{C}$  with and without hand cooling respectively). The authors attributed these benefits to the vacuum induced negative pressure because hand cooling alone had little benefit over no cooling, however, the temperature of the water was 22°C and much warmer

than the 8 and 14°C used in the present study. Even so, hand cooling prolonged exercise time compared to 34°C by approximately 4 min, similar to Grahn et al. (2005) even without negative pressure. However, the application of negative pressure at cooler temperatures might compromise heat transfer. Amorim, Yamada, Robergs, & Schneider, (2010) used the same negative pressure cooling device during walking at 6.7 km/h 4% gradient, in  $42 \pm 1^\circ\text{C}$ ,  $30 \pm 5\%$  relative humidity whilst wearing military uniform and body armour. The authors reported 'negative' results for water temperatures of 15°C (n = 3) and 18°C (n = 3) yet assessed a further 4 participants at 22°C and grouped all the data as a single condition. This approach is misleading since each of these temperatures would have led to differing magnitudes of fingertip vasoconstriction, heat transfer and physiological responses, however these responses were not assessed or reported nor were the magnitudes of any of the basic physiological, thermoregulatory or perceptual responses. Unsurprisingly the authors reported no statistically significant effects of hand cooling and concluded that palm cooling did not reduce heat strain during exercise in hot environments. This conclusion was also reached by Schedler et al., (2013) who reported that participants performed better in the control trial versus the palm cooling trial. However, it is unclear as to whether palm cooling actually occurred since neither Amorim et al. (2010) or Schedler et al. (2013) reported fingertip or palm temperature or the magnitude of vasoconstriction so the mechanisms responsible for these findings are unclear. Unlike previous studies, we are confident that hand cooling occurred because fingertip temperature was less than mean skin temperature. We also aware that hand cooling caused vasoconstriction which was alluded to, but not investigated by previous research. However, despite this vasoconstriction, which was not maximal; and because we cooled the whole hand and not just the palm, it is

likely that cooler blood returned to the central circulation resulting in our observed beneficial effects.

### **Practical implications**

In the present study hand cooling tended to increase exercise duration and lessened the perception of heat strain. These effects were the result of an attenuated rise in body temperature. Heat strain is the principle cause of physiological strain and subsequent termination of exercise in fixed intensity trials in hot environments (González-Alonso & Calbet, 2003; González-Alonso et al., 1999; Nybo & Nielsen, 2001). Therefore, it is important that athletic, military and occupational populations have practical methods available to reduce physiological strain in hot environments. However, unlike pre-cooling the majority of per-cooling methods have little influence on body temperature and performance improvements might be attributed to a lower perception of heat strain. This has practical implications because a mismatch between thermal perception and thermal strain might impair pacing during self-paced trials and as exercise continues accelerate hyperthermia-mediated fatigue. In the present investigation both thermal perception and body temperature were less during hand cooling, alleviating concerns expressed by Tyler et al. (2010) relating to a potentially detrimental mismatch.

### **Limitations**

Our method provides a theoretical basis for future studies, however at present there are limitations to the practical application of the study. We used water buckets to cool the hands, a method that would be difficult to use outside the laboratory. Recumbent cycling was chosen because it enabled the hands to be cooled whilst

minimising upper body movements that might have caused artefacts in laser-Doppler recordings limited the intensity of exercise and potential for heat strain. Mean body temperature at the end-of-exercise for 34°C trial was around 38.5°C and could be considered as moderate heat strain. Therefore, our results might not be applicable to exercise that induces greater heat strain. Finally, we were unable to report the amount of heat transferred by hand immersion because we maintained water temperature throughout the trial.

## **Conclusion**

In this study we demonstrated that hand cooling during exercise had several practically beneficial effects. These included an attenuated rise in body temperature, reduced cardiorespiratory demands and improved thermal perception. These effects were observed because heat was transferred from the hands to the water allowing cooler blood to be circulated back to the body. Although the method we used in the present study has several logistical constraints it provides a mechanistic basis for the development of practical hand cooling methods during exercise in **hot environments** that might benefit athletic, military, occupational and athletic populations.

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## List of tables and figures

**Table 1:** Reliability data for measurements used in the investigation

**Table 2:** Initial physiological responses to hand immersion. Data presented as mean  $\pm$  standard deviation and 90% confidence intervals.

**Figure 1:** Cardiovascular and perceptual responses. A = heart rate response; B = rating of perceived exertion; C = rating of thermal perception. Data reported as mean  $\pm$  SD. Open circles = 8°C. Squares = 14°C. Closed circles = 34°C.

**Figure 2:** Body temperature responses. A = change in intestinal temperature; B = change in mean skin temperature; C = change in mean body temperature. Data reported as mean  $\pm$  SD. Open circles = 8°C. Squares = 14°C. Closed circles = 34°C.

**Figure 3:** Individual data plot of change in intestinal temperature at the end of exercise. Solid black lines = mean. Dashed lines = 90% confidence interval of mean.

**Figure 4:** A = Fingertip temperature; B = Fingertip cutaneous vascular conductance; C = Forearm cutaneous vascular conductance. Data reported as mean  $\pm$  SD. Open circles = 8°C. Squares = 14°C. Closed circles = 34°C.

