Case-Studies in Physiology: The exercise pressor response to indoor rock climbing

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Conflict of interest: NC is the owner of a commercial climbing gym. There are no other competing interests in relation to the described research.

ABSTRACT

Introduction. This paper assessed the blood pressure, heart rate, and mouth-pressure responses to indoor rock climbing (bouldering) and associated training exercises. **Case Presentation.** Six well-trained, normotensive male rock climbers (age = 27.7 ± 4.7 y; stature = 177.7 ± 7.3 cm; mass = 69.8 ± 12.1 kg) completed two boulder problems (6b and 7a+ on the Fontainebleau Scale) and three typical training exercises (MVC isometric pull, 80% MVC repetitions to fatigue, campus-board to fatigue). Blood pressure and heart rate were measured via an indwelling femoral arterial catheter, and mouth pressure via a mouthpiece manometer. Bouldering evoked a peak systolic pressure of 200.4 ± 16.9 mmHg (43.6 ± 20.5% increase from baseline), diastolic pressure of 141.6 ± 25.7 mmHg (70.4 ± 32.4% increase), mean arterial pressure of 163.4 ± 18.1 mmHg (56.4 ± 24.8% increase), and heart rate of 157 ± 20 b·min^{-1} (80.8 ± 29.7% increase). The systolic pressure response was greatest during the campus-board exercise (218.3 ± 33.4 mmHg), although individual values as high as 273/189 mmHg were recorded. Peak mouth pressure during climbing was 31.1 ± 45.5 mmHg and increased independent of climb difficulty. **Conclusions**. Indoor rock climbing and associated exercises evoke a substantial pressor reflex, resulting in high blood pressures that may exceed those observed during other resistance exercises. These findings may inform risk stratification for climbers.

Keywords: blood pressure; bouldering; cardiovascular disease; heart rate; mouth pressure; rock climbing.

NEW & NOTEWORHY

This case-study provides original data on the cardiovascular pressor reflex during indoor rock-climbing and associated training exercises. Moreover, the use of an indwelling femoral arterial catheter to record blood pressure is novel among climbing-related research. Our subjects exhibited systolic/diastolic blood pressures that exceed values often reported during resistance exercise. These data extend our understanding of the cardiovascular stress associated with indoor rock climbing.

INTRODUCTION

Rock climbing is characterized by short periods of high-intensity, intermittent contractions of the upper-limbs (3, 21). The demands of climbing are more comparable to resistance rather than aerobic exercise(14), thereby evoking a disproportionate increase in heart rate relative to oxygen uptake at a given intensity (20, 27). Rock climbing, therefore, would be expected to induce a significant cardiovascular pressor reflex and large increases in blood pressure to optimize oxygen delivery to working muscle (26), but there are currently no data on the magnitude of the response.

Indoor rock climbing is a fast-growing commercial sport to be contested at the Olympic Games in 2021. Data on the typical pressor reflex may be important, therefore, for climbing-related risk stratification, particularly given that high peripheral vascular resistance increases stress on the myocardial wall, and has been deemed the principal stimulus for left ventricular hypertrophy in the pressure-overloaded heart of strength and power athletes (13, 23).

Only two studies provide any data on blood pressure responses in trained climbers, both during submaximal forearm exercise. Using the volume clamp method (7) and sphygmomanometry (19), climbers exhibited peak systolic pressures of 160 – 170 mmHg. However, the blood pressure response to isolated forearm exercise is unlikely to reflect the complex nature of rock climbing which involves movements of both upper- and lower-limbs, in addition to co-contractions of the various trunk stabilizers. Breath-holding or straining during climbing tasks would also be expected to increase the pressor reflex via transmission of intrathoracic and intraabdominal pressures to the left heart and aorta (23). Studies evaluating the BP responses to dynamic, whole-body climbing would, therefore, be informative. Finally, the aforementioned studies are limited by their use of non-invasive measures. Indeed, sphygmomanometry, specifically, has been shown to underestimate systolic pressure by ~13% (30).

We presently propose the use of arterial catheterization to record blood pressure responses in climbers. Arterial catheterization is considered the gold-standard for resting BP assessment, and has been used to record accurate BP responses during dynamic exercise like weightlifting (18) and rowing (5). Relative to other methods, arterial catheters also have the advantage of beat-by-beat sampling, and will provide data on the temporal BP response during climbing in which isometric contraction times can be quite brief (~8 s [29]). Finally, given that subjects are expected to breath-hold and/or strain during difficult maneuvers, we also propose to assess the magnitude of the mouth-pressure response as a possible mechanism influencing blood pressure during climbing.

The aim of this case-study, therefore, was to assess the acute effects of indoor rock climbing, and common training exercises, on the magnitude of the blood pressure, heart rate, and mouth-pressure response in well-trained climbers.

CASE PRESENTATION

Subjects

Six well-trained male rock climbers volunteered to participate (Table 1). All had a minimum of five years' climbing experience, were engaged in 11.3 ± 3.1 h of climbing or sports-specific training per-week (range 6 - 15 h), and were of a moderate-to-high proficiency (IRCA mean 25 ± 3.5; range 21 - 30 redpoint[6]). The study was approved by the institutional Research Ethics Committee and conformed to the principles outlined in the Declaration of Helsinki. Before participation, subjects provided written, informed consent and completed a pre-test medical questionnaire. Subjects were normotensive, free from known cardiovascular disease, and were not taking medication. Subjects abstained from intense exercise for 48 h, alcohol and caffeine for 12 h, and food for 3 h prior to testing.

Experimental Overview

Subjects attended the laboratory on a single occasion. Basic anthropometry was performed via bioelectrical impedance (InBody 720, Seoul, Korea). Subjects subsequently completed two bouldering problems (short climbing tasks not requiring a rope) and three training exercises, each separated by ~5 min to reflect the rest-periods of a typical climbing session. Intra-arterial blood pressure, heart rate, and mouth-pressure were continuously assessed.

Boulder Problems

Boulder problems were created by an internationally-accredited climbing route setter, and were designed to prevent excessive perturbations in the phlebostatic axis. Each route was six moves in length, was previously unattempted by our subjects, and was performed above in-situ safety matting. The difficulty and subjective intensity of the boulder problems was agreed by consensus of three expert climbers, and equated to 6b and 7a+ on the Fontainebleau scale for climb one and two, respectively (IRCRA scale 17 & 21 [6]). Both problems had an overhanging angle of 45 degrees, with minimal requirement for flexion of the right hip. The intended sequence of moves was described to subjects prior to their first attempt, and each climb was attempted once. Duration of ascent was measured from the moment contact was lost with the floor and terminated when the subject fell or reached the finishing hold with both hands.

Training Exercises

Maximum voluntary contraction (MVC) isometric pull. A maximal isometric pull was performed on a pull-up bar with the elbow at 90 degrees of flexion. A waist harness was attached to anchor the subject to an immovable point directly below, in-series with a load-cell, and MVC was expressed as the peak force from the load cell, in addition to the total mass including the arterial line, manometer, giving set, rucksack, and body mass.

80% MVC pull-up. Subjects performed isotonic pull-ups to fatigue from straight arms to a position whereby the chin was above the level of the bar. Mass was added via the waist harness to achieve a load equivalent to 80% of the MVC isometric pull.

Campus-board. Subjects undertook a three-movement footless 'laddering' sequence on a standard campus-board (23 mm holds at 21 cm spacing, on a 20-degree overhanging board; see Abreu *et al.* [2] for basic description of apparatus), repeating the sequence up and down to fatigue (defined as contact with the floor). Duration and movement number were recorded from a single attempt.

Measurements

Blood Pressure and heart rate. Following 5 min quiet sitting, normotension was confirmed via arm-cuff sphygmomanometry (Boso Varius, Jungingen, Germany). Thereafter, the right femoral artery was located using ultrasound and cannulated aseptically with an 8 cm, 20 G Teflon-coated catheter (Vygon Leadercath, Vygon, Ecouen, France). The femoral artery was chosen to allow uninhibited movement of the arms during the physical assessments, and to facilitate a pressure trace that most accurately reflected central haemodynamics. The catheter was connected to a standard arterial line giving-set with an incorporated transducer (DPT-6000, Codan, Forstinning, Germany; range −300 to +300 mmHg; sensitivity ± 1%; hysteresis 1.66%). The giving-set contained 0.9% sodium chloride, running at 3 $ml \cdot hr^{-1}$ from a pressurized 500 ml reservoir bag which was stored in a small rucksack (total 1.94 kg) worn by the subject. Beat-by-beat BP and heart rate were obtained via the arterial line, and the system was zeroed while subjects were in a standing position immediately before each task. Mean arterial pressure (MAP) was automatically calculated as the average of all data points sampled in each waveform. Heart rate was taken as the peak-to-peak pressure interval and averaged every three waveforms.

Mouth-Pressure. In an effort to elucidate the influence of intrathoracic and intraabdominal pressures on BP, mouth-pressure was obtained using a digital manometer (Amecal ST-8890, Newcastle, UK; sensitivity 0.03%) attached to a well-sealing mouthpiece and contained within the rucksack. After a period of coaching, subjects were asked to maintain an open glottis during any periods of breath-holding or straining, as per MacDougall *et al*.(18), thus allowing transmission of the intrathoracic air column to the transducer via the mouthpiece. In-task pressures were compared to atmospheric conditions (i.e., 0 mmHg gauge-pressure).

Data Processing

Blood pressure and heart rate signals were amplified using a Powerlab Amplifier and Powerlab 4/35 data acquisition system (ADInstruments, Dunedin, New Zealand), sampled at 200 kHz, and displayed digitally in LabChart (ADInstruments, Dunedin, New Zealand). Mouth-pressure was sampled at 1 Hz and recorded via the manometer’s proprietary software to the same laptop computer used for BP and heart rate. All digital signals were aligned in Microsoft Excel from their individual timestamps recorded in relation to the computer’s internal clock. Force data during the MVC isometric pull was recorded using an S-type load cell (Weone YZC-516, Guangdong, China; range: 0-100kg, sensitivity: 0.02%, hysteresis: 0.1%) amplified by a USB-run Wheatstone bridge amplifier (PhidgetBridge, Phidgets Inc., Calgary, Canada) and recorded to a laptop computer running a bespoke program.

RESULTS

Boulder problems

Blood pressure, heart rate, and mouth pressure responses to the boulder problems and training exercises are shown in Table 2. All subjects completed boulder problem 1 in 6.0 ± 0.0 moves and in a mean duration of 14.2 ± 3.3 s (range 9.3 – 17.7 s). Three subjects successfully completed boulder problem 2 (all 6 moves), and the group mean (n = 6) for total moves was 5.0 ± 1.1 moves (range 3 – 6) and duration was 17.2 ± 2.5 s (range 13.2 – 19.8 s). Pre-task systolic BP for boulder problem 1 was 125.8 ± 12.8 mmHg, and this peaked at 175.1 ± 27.4 mmHg (an increase of 40.1 ± 24.6%). Pre-task systolic BP for boulder problem 2 was 140.9 ± 14.4 mmHg, and this peaked at 200.4 ± 16.9 mmHg (an increase of 43.6 ± 20.5 %). The individual BP response range was 142/88 – 213/145 mmHg for boulder problem 1, and 181/110 – 223/185 mmHg for boulder problem 2. Mean arterial pressure, heart rate, and mouth pressure all increased substantially above pre-task values (Table 2).

Training Exercises

MVC isometric pull. Peak force delivered to the load cell was 552.6 ± 185.6 N (range 295.4 - 799.9 N), equating to a total suspended mass of 126.1 ± 26.7 kg (range 97.1 - 171.5 kg; Table 1). Mean time to peak force during the manoeuvre was 5.5 ± 2.1 s (range 3.9 – 9.5 s). Peak systolic pressure increased above pre-task values by 49.7 ± 27.4 % (Table 2). The individual BP response range was 157/92 – 245/163 mmHg.

80% MVC Pull-Up. Subjects achieved 3.3 ± 1.4 repetitions (range 2 – 6). The mean total mass lifted was 102.5 ± 21.4 kg (range 77.65 – 137.2 kg). Data from one subject was omitted due to sample line occlusion, and so data for BP and heart rate are presented for n=5. Peak systolic pressure increased above pre-task values by 51.2 ± 21.6 % (Table 2). The individual BP response range was 173/113 – 273/189 mmHg.

Campus-board. The campus-board task elicited the longest task duration of 29.7 ± 13.7 s (range 6.9 – 44.4 s) with subjects performing 20.0 ± 12.7 distinct hand movements (range 6.0 – 42.0). Peak systolic pressure increased above pre-task values by 66.5 ± 29.2 % (Table 2). The individual BP response range was 166/118 – 260/177. For the five subjects who performed the campus-board task for longer than 20 s, data were divided into quartiles based on time (Q2 versus Q4). Relative to Q2, there was an increase in Q4 systolic pressure (200.9 ± 30.7 vs. 221.1 ± 28.9 mmHg) and heart rate (153.6 ± 23.8 vs. 172.6 ± 21.3 b.min^{-1}). Similarly, there was an increase in Q2 to Q4 diastolic pressure (132.0 ± 22.1 vs 146.8 ± 19.9 mmHg), and MAP (160.0 ± 24.4 vs. 174.9 ± 21.4 mmHg).

DISCUSSION

The aim of this study was to assess the cardiovascular pressor reflex during indoor rock climbing and associated training exercises. We observed large increases in arterial blood pressure relative to pre-task values, with the greatest absolute BP exhibited during the sport-specific training exercises. We also found that mouth-pressure was elevated periodically during all tasks. These data indicate that indoor climbing exercises induce a substantial pressor response which may partly be underpinned by increases in intrathoracic pressures.

Our use of an indwelling arterial catheter to record the BP response is novel among climbing-related research, and demonstrates that the technique may be a viable and safe method for obtaining temporal BP data during climbing. Arterial catheterization is a more sensitive means of assessing BP, and records beat-by-beat values at very high frequencies. According to the Association for the Advancement of Medical Instrumentation (AAMI), intra-arterial measures are considered to be the 'gold standard' in the assessment of resting BP (12), although there are currently no such standards for the assessment of exercise measures. A disadvantage of the technique is that as the measurement site is moved peripherally from the heart (i.e., from the aorta to brachial and radial arteries), the pulse wave-form changes in morphology and is amplified, thereby potentially overestimating systolic pressure (4, 24). In our case, a site at the femoral artery was chosen because it provided a pressure trace that most accurately reflected central hemodynamics, and because the location was safely accessible and allowed uninhibited movement of the arms during the physical assessments. We are confident, therefore, that our data are the closest representation to date of the *true* BP response to climbing activities.

The campus-board - a common training activity among both competitive and recreational climbers - elicited the greatest absolute systolic BP relative to pre-task values (218.3 ± 33.4 versus 132.1 ± 12.6 mmHg), with one subject exhibiting peak pressures of 260/171 mmHg (Fig. 1). The highest individual BP was 273/189 mmHg, exhibited during the 80% MVC pull-up. Not only are these values substantially higher than those previously reported in climbers during isolated forearm exercise (7, 19), but they also exceed the peak pressures observed during other high-intensity exercises including rowing (192 ± 20 mmHg; [5]), and upper-limb 1-RM weight-lifting (197 ± 6 mmHg; [8]). Our values are also comparable to those observed during upper-limb exhaustive weight-lifting (255/190 mmHg; [18]).

There may be several mechanisms that underpin these high exercise blood pressures during climbing and related activities. First, given that the campus-board elicited the longest exercise duration (29.7 ± 13.7 s), and that systolic BP increased from 200.9 ± 30.7 to 221.1 ± 29.9 mmHg in the second-through-final time quartiles, BP cannot be explained exclusively by mechanical forces acting on the vascular tree and muscle mechanoreflex. Longer exercise durations are associated with greater stimulation of Group III & IV afferent fibers (26), and the large BP response was likely associated with the muscle metaboreflex and/or an increase in centrally-mediated sympathetic output, both of which warrant further study in climbers of mixed ability.

Second, it is likely that thoracoabdominal pressure influenced the BP response during climbing. In this study, we assessed mouth pressure as a non-invasive surrogate for intrathoracic pressure (18). Despite the simplicity of our measurement technique, it is well accepted that the Valsalva Maneuver plays a role in augmenting the BP response (17, 18, 23), and we present the first evidence that well-trained climbers exhibit a degree of breath-holding and/or straining during difficult movements, manifesting as mouth-pressures that were intermittently raised (mean 31.1 ± 45.5 cmH_2O). Forceful contractions of various trunk muscles will increase thoracoabdominal pressure (11) which, in turn, stiffens and stabilizes the trunk to provide postural support (1), as observed during weight lifting (9). Breath-holding, therefore, may serve an important function in supporting climbing-specific movements, particularly on overhanging wall inclines. While not directly assessed in this study, the transmission of intrathoracic pressures to the left heart and aorta was a likely contributor to the arterial pressures observed (23). Interestingly, despite the substantially lower effort required for boulder problem 1 relative to problem 2, breath-holding was exhibited by our group during both climbs, suggesting that the phenomenon is somewhat independent of exercise intensity. Collectively, we propose that the large blood pressures observed presently may result from a combination of the high-intensity effort, the large active muscle mass including trunk musculature, and the elevated mouth-pressures attributable to straining and/or breath-holding.

With respect to heart rate, all tasks evoked a degree of prehension prior to exercise; i.e., active readiness before the commencement of the task. With the longest task duration of 29.7 ± 13.7 s, it was the campus-board that elicited the highest peak heart rate (169 ± 21 $b \cdot min^{-1}$). The second boulder problem, the more difficult of the two, elicited peak values of 157 ± 20 $b \cdot min^{-1}$. Peak heart rate responses in our group were below that seen in other climbing studies using tasks of longer duration; e.g., intermittent climbing to exhaustion (peak heart rate = 185 ± 11 $b \cdot min^{-1}$[25]), and simulated bouldering competition (peak heart rate = 93% HRmax [15]). Notwithstanding, the observation that heart rate is substantially elevated during climbing, congruent with high femoral arterial pressures, suggests that rock climbing and associated activities are likely to evoke considerable myocardial demand.

Our data may have implications for future study of BP responses during exercise. High-intensity, intermittent activities that evoke periods of elevated vascular resistance, with little-to-no change in cardiac output, have been proposed to stimulate chronic modifications in cardiac size and shape (22), including myocardial hypertrophy (13). Although speculative, it is plausible that chronic exposure to the blood pressures we have observed during climbing may also be sufficient to induce myocardial and vascular remodeling. While the clinical significance of such long-term adaptations continue to be debated (10, 28), future echocardiographic studies in sport climbers would be informative, particularly in guiding physician/athlete decisions on sports participation at the recreational and elite levels (16).

In summary, this is the first report of the blood pressure responses to indoor rock climbing. In our trained subjects, we show arterial catheterization to be a viable means of BP assessment which may, in turn, inform future mechanistic research. Our data show that indoor climbing and associated training exercises induce a pronounced cardiovascular pressure reflex that elevates intra-arterial pressure, mean arterial pressure, and heart rate substantially relative to pre-task values. The responses are likely attributable, at least in part, to elevated intrathoracic pressures associated with a degree of straining and/or breath-holding. More research is needed to elucidate the effect of chronic training on cardiovascular structure and function and its clinical implications.

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Author contributions:

Study concept and design: NC, NBT, PWH, PC & AJP. Acquisition of data: NC, NBT, PWH & CB. Analysis of data: NC, NBT, GR, AJP & CB. Drafting and critical review of manuscript: NC, NBT, PWH, GR, PC, AJP & CB. All authors have reviewed and approved the final version.

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REFERENCES

1. **Abraham KA**, **Feingold H**, **Fuller DD**, **Jenkins M**, **Mateika JH**, **Fregosi RF**. Respiratory-related activation of human abdominal muscles during exercise. *J Physiol* 541: 653–663, 2002.

2. **Abreu EA de C**, **Araújo SRS**, **Cançado GH da CP**, **Andrade AGP de**, **Chagas MH**, **Menzel H-JK**. TEST-retest reliability of kinetic variables measured on campus board in sport climbers. *Sport Biomech* 18: 649–662, 2019.

3. **Billat V**, **Palleja P**, **Charlaix T**, **Rizzardo P**, **Janel N**. Energy specificity of rock climbing and aerobic capacity in competitive sport rock climbers. *J Sports Med Phys Fitness* 35: 20–24, 1995.

4. **Bruner JM**, **Krenis LJ**, **Kunsman JM**, **Sherman AP**. Comparison of direct and indirect measuring arterial blood pressure. *Med Instrum* 15: 11–21, 1981.

5. **Clifford PS**, **Hanel B**, **Secher NH**. Arterial blood pressure response to rowing. *Med Sci Sports Exerc* 26: 715–719, 1994.

6. **Draper N**, **Giles D**, **Schöffl V**, **Konstantin Fuss F**, **Watts P**, **Wolf P**, **Baláš J**, **Espana-Romero V**, **Blunt Gonzalez G**, **Fryer S**. Comparative grading scales, statistical analyses, climber descriptors and ability grouping: International Rock Climbing Research Association position statement. *Sport Technol* 8: 88–94, 2015.

7. **Ferguson RA**, **Brown MD**. Arterial blood pressure and forearm vascular conductance responses to sustained and rhythmic isometric exercise and arterial occlusion in trained rock climbers and untrained sedentary subjects. *Eur J Appl Physiol Occup Physiol* 76: 174–180, 1997.

8. **Fleck SJ**, **Dean LS**. Resistance-training experience and the pressor response during resistance exercise. *J Appl Physiol* 63: 116–120, 1987.

9. **Hackett DA**, **Chow C-M**. The Valsalva maneuver: its effect on intra-abdominal pressure and safety issues during resistance exercise. *J Strength Cond Res* 27: 2338–2345, 2013.

10. **Haykowsky MJ**, **Dressendorfer R**, **Taylor D**, **Mandic S**, **Humen D**. Resistance Training and Cardiac Hypertrophy. *Sport Med* 32: 837–849, 2002.

11. **Hodges PW**, **Eriksson AEM**, **Shirley D**, **Gandevia SC**. Intra-abdominal pressure increases stiffness of the lumbar spine. *J Biomech* 38: 1873–1880, 2005.

12. **Association for the Advancement of Medical Instrumentation**. *American National Standard for Electronic or Automated Sphygmomanometers*. 1st ed. Arlington: Association for the Advancement of Medical Instrumentation, 1992.

13. **Kasikcioglu E**, **Oflaz H**, **Akhan H**, **Kayserilioglu A**, **Mercanoglu F**, **Umman B**, **Bugra Z**. Left ventricular remodeling and aortic distensibility in elite power athletes. *Heart Vessels* 19: 183–188, 2004.

14. **Kuepper T**, **Morrison A**, **Gieseler U**, **Schoeffl V**. Sport climbing with pre-existing cardio-pulmonary medical conditions. *Int J Sports Med* 30: 395–402, 2009.

15. **La Torre A**, **Crespi D**, **Serpiello FR**, **Merati G**. Heart rate and blood lactate evaluation in bouldering elite athletes. *J Sports Med Phys Fitness* 49: 19, 2009.

16. **Levine BD**, **Baggish AL**, **Kovacs RJ**, **Link MS**, **Maron MS**, **Mitchell JH**. Eligibility and disqualification recommendations for competitive athletes with cardiovascular abnormalities: task force 1: classification of sports: dynamic, static, and impact. *J Am Coll Cardiol* 66: 2350–2355, 2015.

17. **MacDougall JD**, **McKelvie RS**, **Moroz DE**, **Sale DG**, **McCartney N**, **Buick F**. Factors affecting blood pressure during heavy weight lifting and static contractions. *J Appl Physiol* 73: 1590–1597, 1992.

18. **MacDougall JD**, **Tuxen D**, **Sale DG**, **Moroz JR**, **Sutton JR**. Arterial blood pressure response to heavy resistance exercise. *J Appl Physiol* 58: 785–790, 1985.

19. **MacLeod D**, **Sutherland DL**, **Buntin L**, **Whitaker A**, **Aitchison T**, **Watt I**, **Bradley J**, **Grant S**. Physiological determinants of climbing-specific finger endurance and sport rock climbing performance. *J Sports Sci* 25: 1433–1443, 2007.

20. **Mermier CM**, **Robergs RA**, **McMinn SM**, **Heyward VH**. Energy expenditure and physiological responses during indoor rock climbing. *Br J Sports Med* 31: 224–228, 1997.

21. **Michailov ML**, **Mladenov L V**, **Schöffl V**. Anthropometric and strength characteristics of world-class boulderers. *Med Sport* 13: 231–238, 2009.

22. **Mihl C**, **Dassen WRM**, **Kuipers H**. Cardiac remodelling: concentric versus eccentric hypertrophy in strength and endurance athletes. *Netherlands Hear J* 16: 129–133, 2008.

23. **Narloch JA**, **Brandstater ME**. Influence of breathing technique on arterial blood pressure during heavy weight lifting. *Arch Phys Med Rehabil* 76: 457–462, 1995.

24. **O'Rourke MF**. What is blood pressure? *Am J Hypertens* 3: 803–810, 1990.

25. **Schöffl VR**, **Möckel F**, **Köstermeyer G**, **Roloff I**, **Küpper T**. Development of a performance diagnosis of the anaerobic strength endurance of the forearm flexor muscles in sport climbing. *Int J Sports Med* 27: 205–211, 2006.

26. **Secher NH**, **Amann M**. Human investigations into the exercise pressor reflex. *Exp Physiol* 97: 59–69, 2012.

27. **Sheel AW**, **Seddon N**, **Knight A**, **McKenzie DC**. Physiological responses to indoor rock-climbing and their relationship to maximal cycle ergometry. *Med Sci Sports Exerc* 35: 1225–1231, 2003.

28. **Spence AL**, **Naylor LH**, **Carter HH**, **Buck CL**, **Dembo L**, **Murray CP**, **Watson P**, **Oxborough D**, **George KP**, **Green DJ**. A prospective randomised longitudinal MRI study of left ventricular adaptation to endurance and resistance exercise training in humans. *J Physiol* 589: 5443–5452, 2011.

29. **White DJ**, **Olsen PD**. A time motion analysis of bouldering style competitive rock climbing. *J Strength Cond Res* 24: 1356–1360, 2010.

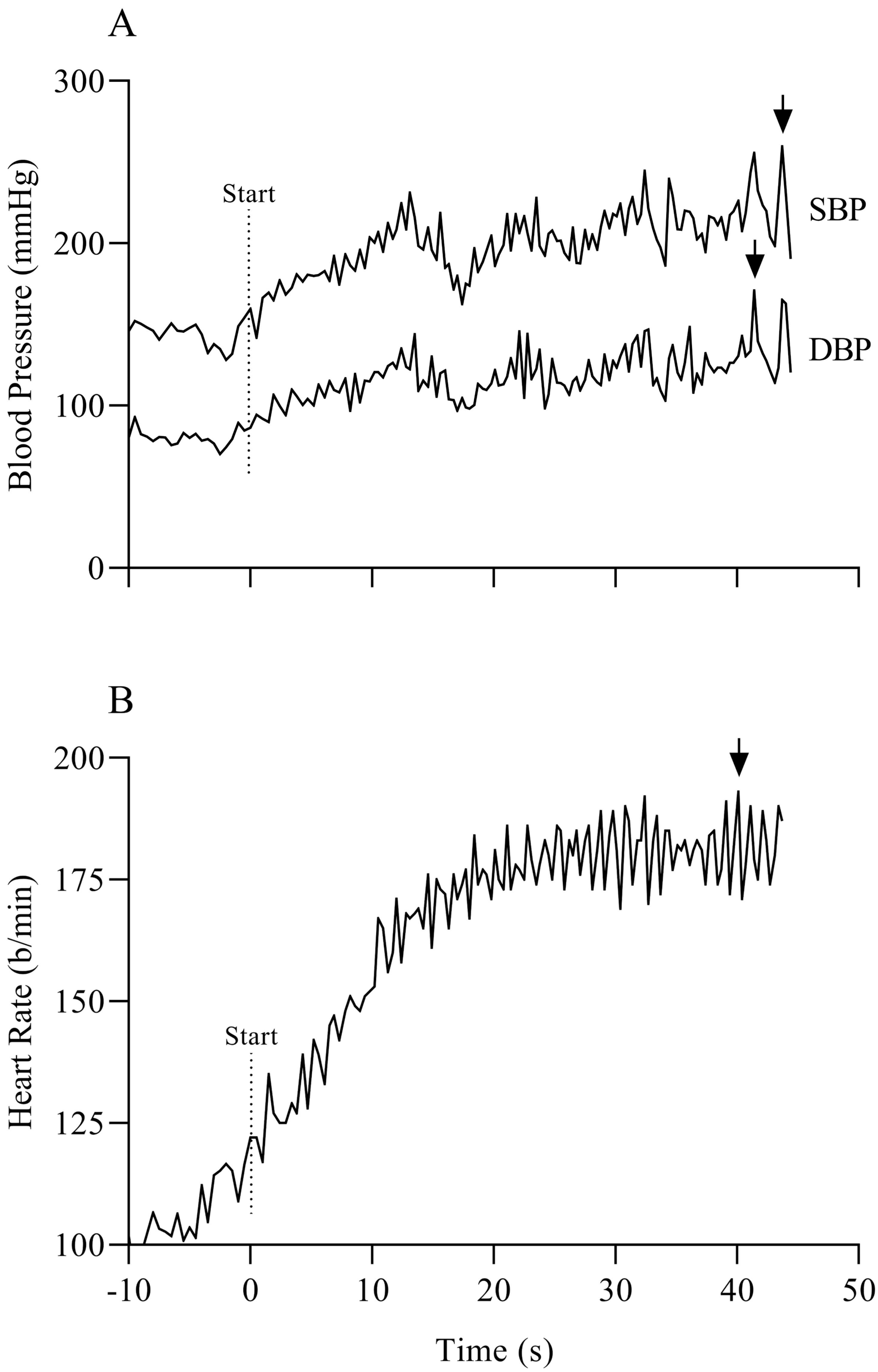
30. **Wiecek EM**, **McCartney N**, **McKelvie RS**. Comparison of direct and indirect measures of systemic arterial pressure during weightlifting in coronary artery disease. *Am J Cardiol* 66: 1065–1069, 1990.

TABLES AND FIGURES

Table 1. Subject Characteristics.

Table 2. Blood pressure, heart rate, and mouth-pressure responses to boulder problems and training exercises.

Fig. 1. Representative blood pressure (panel A) and heart rate (panel B) responses to the campus-board task in a single subject. Note the abrupt increase in pressures relative to pre-task values. The peak data points are highlighted: systolic pressure = 260 mmHg; diastolic pressure = 171 mmHg; heart rate = 193 $b \cdot min^{-1}$.



A
Blood Pressure (mmHg)
300
200
100
0
Start
SBP
DBP
B
Heart Rate (b/min)
200
175
150
125
100
Start
-10
0
10
20
30
40
50
Time (s)

Table 1. Subject characteristics

Subject	Age (y)	Stature (cm)	Mass (kg)	Body fat (%)	Systolic BP (mmHg)	Diastolic BP (mmHg)	MVC (N)
1	20.3	182.7	88.0	6.1	128	84	799.9
2	32.9	174.6	55.7	8.3	128	72	447.2
3	26.1	168.0	65.0	16.0	124	68	295.4
4	28.5	187.0	75.9	9.0	130	78	557.0
5	26.1	182.0	74.8	9.7	127	76	490.4
6	32.4	172.0	59.3	8.7	136	88	725.7
Mean	**27.7**	**177.7**	**69.8**	**9.6**	**129**	**78**	**552.6**
SD	**4.7**	**7.3**	**12.1**	**3.4**	**4.0**	**7.4**	**185.6**
Min	**20.3**	**168.0**	**55.7**	**6.1**	**124**	**68**	**295.4**
Max	**32.9**	**187.0**	**88.0**	**16.0**	**136**	**88**	**799.9**

MVC = Maximum voluntary contraction isometric pull (force applied to load cell). NB: resting systolic/diastolic BP recorded via syhygmomanometry.

Table 2. Blood pressure, heart rate, and mouth-pressure responses to boulder problems and training exercises.

	Systolic BP (mmHg)	Diastolic BP (mmHg)	MAP (mmHg)	Heart Rate ($b \cdot min^{-1}$)	Mouth Pressure (mmHg)
Boulder problem 1					
Pre-task	125.8 ± 12.8	73.6 ± 11.7	94.8 ± 11.1	106 ± 24	0 ± 0
In-task (peak)	175.1 ± 27.4	116.0 ± 18.6	140.1 ± 22.1	147 ± 21	26.8 ± 29.5
%increase	40.1 ± 24.6	63.7 ± 50.5	50.1 ± 37.8	47.4 ± 24.4	N/A ± N/A
Boulder problem 2					
Pre-task	140.9 ± 14.4	84.0 ± 10.7	105.5 ± 10.5	104 ± 25	0 ± 0
In-task (peak)	200.4 ± 16.9	141.6 ± 25.7	163.4 ± 18.1	157 ± 20	31.1 ± 45.5
%increase	43.6 ± 20.5	70.4 ± 32.4	56.4 ± 24.8	80.8 ± 29.7	N/A ± N/A
MVC isometric pull					
Pre-task	140.9 ± 12.9	83.9 ± 10.0	104.2 ± 10.4	99 ± 29	0 ± 0
In-task (peak)	211.1 ± 38.6	144.8 ± 36.0	169.2 ± 34.6	139 ± 12	33.7 ± 28.8
%increase	49.7 ± 27.4	70.5 ± 47.7	61.6 ± 37.8	62.3 ± 38.1	N/A ± N/A
80% MVC pull-up					
Pre-task	140.0 ± 14.7	84.5 ± 13.6	105.0 ± 14.1	112 ± 23	0 ± 0
In-task (peak)	213.4 ± 40.3	151.5 ± 33.2	178.7 ± 30.7	150 ± 20	24.9 ± 19.9
%increase	51.2 ± 21.6	73.6 ± 30.8	67.3 ± 26.2	46.7 ± 18.4	N/A ± N/A
Campus-board					
Pre-task	132.1 ± 12.6	79.8 ± 9.3	100.1 ± 8.2	120 ± 17	0 ± 0
In-task (peak)	218.3 ± 33.4	147.3 ± 24.9	171.2 ± 24.9	169 ± 21	29.7 ± 13.7
%increase	66.5 ± 29.2	86.9 ± 39.7	72.4 ± 30.2	57.8 ± 24.2	N/A ± N/A

Data are mean ± SD., n = 6. BP = blood pressure; MAP = mean arterial pressure. Due to a sample line occlusion, BP and heart rate data for the *80% MVC pull-up* are n = 5.