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Kristin J. Stuempfle
Gettysburg College

Donald R. Lehmann
Sitka Medical Center

H. Samuel Case
McDaniel College

See next page for additional authors

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Hyponatremia in a Cold Weather Ultraendurance Race

Abstract
We assessed the incidence and etiology of hyponatremia in the 100-mile (161 km) Iditasport ultramarathon. Subjects (8 cyclists, 8 runners) were weighed and serum sodium was measured pre- and post-race. Race diets were analyzed to determine fluid and sodium consumption. Subjects were split by post-race serum sodium concentration into hyponatremic and normonatremic groups for statistical analyses. Seven of 16 subjects (44%) were hyponatremic. The hyponatremic group exhibited a significant decrease in serum sodium concentration (137.0 to 132.9 mmol/L, and the normonatremic group experienced a significant decrease in weight (82.1 to 80.2 kg) pre- to post-race. The hyponatremic group drank more fluid per hour (0.5 versus 0.4 L/h) and consumed less sodium per hour (235 versus 298 mg/h) compared to the normonatremic group. In conclusion, hyponatremia is common in an ultraendurance race held in the extreme cold, and may be caused by excessive fluid consumption and/or inadequate sodium intake.

Keywords
hyponatremia, ultraendurance, race diet, sodium consumption, ultramarathon

Disciplines
Other Medicine and Health Sciences | Sports Sciences

Authors
Kristin J. Stuempfle, Donald R. Lehmann, H. Samuel Case, Stephen Bailey, Sherri Lind Hughes, Jennifer McKenzie, and Deborah Evans

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Hyponatremia in a Cold Weather Ultraendurance Race

Kristin J. Stuempele, PhD, ATC
Donald R. Lehmann, MD
H. Samuel Case, PhD
Stephen Bailey, PhD
Sherri Lind Hughes, PhD
Jennifer McKenzie, BS
Deborah Evans, MS

ABSTRACT

We assessed the incidence and etiology of hyponatremia in the 100-mile (161 km) Iditarod ultramarathon. Subjects (8 cyclists, 8 runners) were weighed and serum sodium was measured pre- and post-race. Race diets were analyzed to determine fluid and sodium consumption. Subjects were split by post-race serum sodium concentration into hyponatremic and normonatremic groups for statistical analyses. Seven of 16 subjects (44%) were hyponatremic. The hyponatremic group exhibited a significant decrease in serum sodium concentration (137.0 to 132.9 mmo/L), and the normonatremic group experienced a significant decrease in weight (82.1 to 80.2 kg) pre- to post-race. The hyponatremic group drank more fluid per hour (8.5 versus 6.4 L/h) and consumed less sodium per hour (235 versus 298 mg/h) compared to the normonatremic group. In conclusion, hyponatremia is common in an ultraendurance race held in the extreme cold, and may be caused by excessive fluid consumption and/or inadequate sodium intake.

(1) Gettysburg College, Gettysburg, PA.
(2) Sitiu Medical Center, Sitiu, AK.
(3) McDaniel College (founded in 1867 as Western Maryland College), Westminster, MD.
(4) Elon University, Elon, NC.
(5) Anchorage, AK.

Corresponding author:
Kristin J. Stuempele, PhD, ATC, Health and Exercise Sciences Department, Campus Box 432, Gettysburg College, Gettysburg, PA 17325.
Phone: (717) 337-6467
Fax: (717) 337-6528
E-mail: kstuempf@gettysburg.edu

INTRODUCTION

Hyponatremia, defined as a serum sodium level below 135 mmo/L, is a serious consequence of endurance events lasting longer than six hours (1). Possible signs and symptoms include light-headedness, nausea, vomiting, malaise, exhaustion, altered mental status, headache, seizures, and in extreme cases, death (2).

Figure 1 shows the two leading theories that attempt to explain the hyponatremia associated with prolonged exercise (1,3,4). One theory suggests that hyponatremia is caused by an increase in total body water, resulting from excessive fluid consumption or a failure to excrete excess volume. The second theory suggests that a decrease in sodium content resulting from excessive sodium loss in sweat or inadequate sodium intake causes hyponatremia. These two theories are not mutually exclusive. Any combination of the factors displayed in Figure 1 could lead to the development of hyponatremia.

Numerous papers have been published on the occurrence of hyponatremia in triathletes (2,5-12), ultramarathoners (13-17), marathons (18-20), Grand Canyon hikers (21-22), military recruits (23,24), and subjects in laboratory studies (25,26). All of these events took place in mild to hot environments, and the studies did not include an analysis of race diets to determine both fluid and sodium consumption.

In this study, we assessed the incidence of hyponatremia in the Iditarod, a 100-mile (161 km) ultraendurance race held in Alaska each February. Additionally, race diets were analyzed to determine racers' fluid and sodium consumption.

METHODS

The study was approved by the McDaniel College Institutional Review Board. All 122 entrants in the 2000 Iditarod Human Powered Ultra-Mara-
Figure 1. Possible causes of hyponatremia. Figure modified from Montain (1).

...were invited to participate in the study at a mandatory informational meeting held two days prior to the race. Sixteen athletes (eight cyclists and eight runners) volunteered to be subjects and gave their written informed consent. All pre-race measurements were made at the informational meeting. Temperatures during the race ranged from -8°C to 4°C. The cyclists and runners competed on the same 100-mile (161 km) snowpacked course that winds through the Alaska Range. Four pre-race and five post-race checkpoints were located approximately every 15-20 miles (24-32 km), where food and fluid were available. In addition, athletes were required to carry 15 pounds (7 kg) of equipment at all times, including two liters of fluid in an insulated container, and 3000 kcal of food. Post-race measurements were made within 15 minutes of each athlete completing the race.

Pre- and post-race weight was measured using the Tanita Body Fat Monitor/Scale (TBF-622), accurate to 0.1 kg. Pre- and post-race blood samples were collected by routine venipuncture, with athletes in a sitting position. Duplicate hematocrits were measured immediately on the samples using standard procedures. Assays for serum sodium concentration were carried out at the Carroll County General Hospital Medical Laboratory in Westminster, MD with a Spectra-Cell Selective Electrode analyzer using standard methods and the manufacturer’s reagents on serum that was obtained by centrifugation, frozen immediately on dry ice, and stored at -20°C until thawed for analysis. Changes in plasma volume were calculated according to the formula of van Beunomont (27);

\[ \% \text{ change plasma volume} = \frac{100(100/\text{hematocrit}_{\text{pre}} - \text{hematocrit}_{\text{post}})}{\text{hematocrit}_{\text{pre}}} \]

where hematocrit_{pre} and hematocrit_{post} are pre- and post-race hematocrit samples, respectively.

Subjects carried out a complete dietary recall of food and fluid consumption immediately following the race. Competitors were required to carry all their garbage to the finish line, so during the dietary recall, it was possible to count the number and type of food wrappers in each subject’s garbage bag. This process helped to ensure the accuracy of the dietary recall. The race diets were analyzed using the Nutritionist Five computer program (First Data Bank). Food items that were not listed in the Nutritionist Five program were added to the program using the nutrition facts from the food wrappers.

Additionally, the recipes for specific foods that were available at checkpoints during the race were added to the program to assess the nutritional content. Immediately following the race, subjects were interviewed to determine which, if any, hyponatremia (light-headedness, nausea, vomiting, malaise, exhaustion, altered mental status, seizures, mood-ache) (2) or gastrointestinal (nausea, vomiting, diarrhea, cramps) (28) symptoms they experienced during the race.

Subjects were split by post-race serum sodium concentration into hyponatremic (serum sodium concentration < 135 mmol/L) and normonatremic (serum sodium concentration ≥ 135 mmol/L) groups (1) for statistical analyses. Comparisons between the hyponatremic and normonatremic groups were made using unpaired t-tests, while comparisons within each group (pre- and post-race measurements) were accomplished using paired t-tests. Statistical significance was set at p ≤ 0.05 for all analyses.

RESULTS

Table 1 shows descriptive characteristics of the hyponatremic (serum sodium concentration < 135 mmol/L; n = 7) and normonatremic (serum sodium concentration ≥ 135 mmol/L; n = 9) groups. The hyponatremic group included three male cyclists, two male runners, one female cyclist, and one female runner, with an average finish time of 25.7 hours. The normonatremic group included four male cyclists and five male runners, with an average finish time of 29.2 hours. All subjects reported experiencing at least one symptom of hyponatremia, whereas 43% of the hyponatremic and 67% of the normonatremic group complained of gastrointestinal symptoms during the race.

As shown in Table 2, the hyponatremic group was significantly lighter than the normonatremic group both pre-race (71.0 vs 82.1 kg) and post-race (70.2 vs 80.2 kg). The normonatremic group exhibited a significant decrease in weight pre-race (-1.9 kg). The hyponatremic group did not experience a significant change in weight. The hyponatremic group exhibited a significant decrease in serum sodium concentration pre-race to post-race (137.0 to 132.9 mmol/L) (Table 2). Six of the seven subjects had mild hyponatremia (post-race serum sodium concentration ranged from 132-134 mmol/L) (2), and one subject had severe hyponatremia (post-race serum sodium concentration = 129 mmol/L) (2). None of the athletes required medical attention. Both the hyponatremic and normonatremic groups exhibited a statistically significant decrease in hematocrit pre- to post-race (hyponatremic group: 42.4 to 39.8; normonatremic group: 42.9 to 41.2). Plasma volume increased in both the hyponatremic (+12.4 ± 19.3%) and normonatremic (+9.0 ± 30.9%) groups post-race.

A comparison of the race diets of the hyponatremic and normonatremic groups is shown in Table 3. No statistically significant differences were seen. However, the hyponatremic group consumed fewer kcal (212 versus 252 kcal/lt), less sodium (235 versus 298 mg/l), and drank more liters of fluid (0.5 versus 0.4 L/hr) compared to the normonatremic group.

DISCUSSION

This study represents the first report of the incidence of hyponatremia in a cold weather ultramarathon event. Hyponatremia occurred in 44% of the Iditarod athletes in this study, which is...
Table 3. Race diet; values expressed as mean ± SD.

<table>
<thead>
<tr>
<th></th>
<th>Hypnormetric</th>
<th>Nonnormetric</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n = 7)</td>
<td>(n = 9)</td>
</tr>
<tr>
<td>Total kcal</td>
<td>5.48 ± 2.499</td>
<td>7.33 ± 5.322</td>
</tr>
<tr>
<td>Kcal/h</td>
<td>212 ± 64</td>
<td>252 ± 166</td>
</tr>
<tr>
<td>Percent carbohydrate</td>
<td>69.0 ± 1.61</td>
<td>68.0 ± 1.44</td>
</tr>
<tr>
<td>Percent fat</td>
<td>21.7 ± 1.64</td>
<td>22.4 ± 1.16</td>
</tr>
<tr>
<td>Percent protein</td>
<td>9.1 ± 2.5</td>
<td>9.6 ± 4.1</td>
</tr>
<tr>
<td>Total Na* (mg)</td>
<td>6.216 ± 3.299</td>
<td>8.558 ± 4.730</td>
</tr>
<tr>
<td>Na*/h (mg)</td>
<td>235 ± 92</td>
<td>298 ± 144</td>
</tr>
<tr>
<td>Total fluid (L)</td>
<td>11.9 ± 5.7</td>
<td>12.2 ± 4.0</td>
</tr>
<tr>
<td>Fluid/h (L)</td>
<td>0.5 ± 0.2</td>
<td>0.4 ± 0.2</td>
</tr>
</tbody>
</table>

Inadequate sodium intake. The normonormetric group exhibited a statistically significant weight loss (-1.9 kg) during the race, compared to the hypnormetric group that experienced a statistically insignificant weight loss (-0.8 kg). Others (9, 11, 31) have reported that fluid loss during very prolonged exercise may occur for about as much as 2 kg of weight loss during the event. Sources of nonfluid weight loss include loss of fat, glycogen, and water stored with glycogen. The corollary of this observation is that athletes who drink sufficiently to maintain their weight during an ultramarathon event may in reality be overhydrated by 2 liters. This suggests that the hypnormetric ultraendurance athletes may have had a fluid excess of 1.2 L, and that the normonormetric athletes were essentially euhydric.

The hypothesis and nonnormetric groups exhibited a decrease in hematocrit and an increase in plasma volume following the race, although these changes were more pronounced in the hypnormetric group. These findings agree with the reports of others (5, 9, 10, 23, 25), and may be indicative of hypervolemia (9, 10).

Race dietary analysis revealed that the hypnormetric group drank most of fluid per hour (0.5 L/h vs. 0.4 L/h) and consumed less sodium per hour (235 mg/h vs. 298 mg/h) than the normonormetric group, although differences were not statistically significant. The ACSM recommends that athletes drink 0.6 – 1.2 liters of fluid per hour during exercise, with the addition of 0.5 – 0.7 g of sodium per liter for exercise lasting more than one hour (32). Using these guidelines and an average finish time of 27.6 h, the athletes in this study should have consumed 16.6 – 33.1 L of fluid and 6.3 – 23.2 g of sodium. Both the hypnormetric and the normonormetric groups consumed less fluid than the ACSM recommendations. However, the ACSM guidelines were established based on research from much shorter events than ultramarathon competitions, and they are aimed at preventing heat injuries during events held in a hot environment. The guidelines may be inappropriate high for any endurance competition (33, 34), and most certainly are too high for an ultramarathon event held in Alaska in February. The hypnormetric athletes (6.2 g sodium) consumed less than the recommended amount of sodium, but the normonormetric athletes (8.6 g sodium) were within the ACSM guidelines, suggesting that inadequate sodium intake may have been a contributing factor in the development of hyponatraemia.

It seems unlikely that the other possible causes of hyponatraemia shown in Figure 1 could account for the hyponatraemia seen in Iditarod athletes. A failure to excrete excess fluid could be caused by excessive ADH, but it is known that ADH secretion is decreased in the cold (33). Hypothermically, hyponatraemia can be caused by an excessive loss of sodium in sweat. There is little support for this theory in the literature for events occurring in hot environments (1), so it seems unreasonable to suggest that this is the cause of hyponatraemia in an event held in the extreme cold, where athletes are instructed in a mandatory pre-race meeting to avoid sweating in an attempt to prevent hypothermia and frostbite.

In conclusion, hyponatraemia occurred in 44% of the athletes competing in an ultramarathon event in the extreme cold. We speculate that the hyponatraemias were caused by excessive fluid consumption and/or inadequate sodium intake.

ACKNOWLEDGEMENT

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Author’s Note: These data were collected at the 2000 Iditarod Human Powered Ultra-Marathon. In 2001, the name of the race was changed to the Susitna100.

REFERENCES


(continued on pg 52)
NEURILEMMOMA: AN UNUSUAL BENIGN TUMOR OF THE CERVIX

William J. LeMaire, MD1,2,6
Connie Kreiss, MD4
Ann Commodore, RN3
Edward A. Barker, MD2

CASE PRESENTATION

A 47-year-old para 2 woman came for a routine examination and Pap smear in November of 2000. She was still having regular but somewhat heavier menses, and had recently begun to experience some peri-menopausal symptoms. She had no intermenstrual bleeding, no postcoital bleeding and neither dysmenorrhea nor dyspareunia. She had no vaginal discharge and no gastro-intestinal complaints. Her only other gynecological complaint was an occasional feeling of heaviness in the pelvis with some urinary frequency and mild urgency. Her past history and family history was unremarkable.

She had never had an abnormal Pap smear and the previous normal smear was 3 years ago. She had a normal mammogram 3 years earlier. She was taking a low dose oral contraceptive pill.

The general physical examination was entirely negative. There were no skin lesions, no lymph nodes and no evidence of Von Recklinghouse’s disease.

On gynaecologic exam the external genitalia were normal and so was the vagina. The cervix had a most unusual appearance, with a 2.5 cm in diameter round, sessile tumor on the posterior lip. This tumor was soft, with a patchy yellow red appearance and seemingly vascular. It did not involve the endocervical canal.

At colposcopy, the entire squamous-columnar junction could be seen. The anterior lip of the cervix had an exocutaneous but was otherwise normal. The tumor itself was not ulcerated and did not bleed on contact. It did not have any acetowhite areas and other than being vascular did not show any abnormal vessels (figure 1-a and 1-b).

On bimanual examination the cervix was not tender. The tumor was soft, without any induration of the surrounding areas. The uterine itself was normal in size, location and consistency. The adnexae felt normal and there was neither induration in the parametria, nor nodularity in the posterior fornix. A pap smear was taken and reported as normal.

ABSTRACT

Background: A Neurilemmoma (also called Schwannoma) is a benign, slowly growing neoplasm of the Schwann cells which may occur in association with any nerve. Its finding in the cervix of the uterus is extremely rare.

Case: At a routine annual exam, a 47-year-old woman was found to have a tumor on the posterior lip of the cervix. The patient was completely asymptomatic. The tumor was excised using a large electrical loop (LEEP) and found to be a benign Neurilemmoma. Subsequently a CT scan of the pelvis did not reveal any other abnormalities and no further treatment was contemplated.

Conclusion: A benign neurilemmoma can present on the cervix as a vascular appearing tumor. This is a most unusual location for this tumor which arises from the Schwann cell of a nerve sheath.

INTRODUCTION

Benign Neurilemmomas (also called Schwannomas) are benign and slowly growing neoplasms of the Schwann cells surrounding nerves. They may arise from nerve sheaths in any part of the body, but their occurrence in female reproductive tissues is very rare. We report a case of a benign neurilemmoma of the uterine cervix.

1. Mount Edgecumbe Hospital, South East Alaska Regional Health Consortium, Sitka Alaska
2. Department of Obstetrics & Gynecology, University of Miami School of Medicine
4. Corresponding Author: William J. LeMaire, MD, 5751 SW 45th Terrace, Miami, Florida 33155, USA
Tel: (305)666-5315
E-Mail: awlemaire@hotmail.com

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