

Effect of Caffeine on Quadriceps Muscle Pain during Acute Cycling Exercise in Low versus
High Caffeine Consumers

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Running head: CAFFEINE, PAIN, AND EXERCISE

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Abstract

This experiment examined the effect of a moderate dose of caffeine on quadriceps muscle pain during a bout of high-intensity cycling in low versus high caffeine consuming males. College-aged males who were low (i.e., $\leq 100 \text{ mg}\cdot\text{d}^{-1}$; $n = 12$) or high (i.e., $\geq 400 \text{ mg}\cdot\text{d}^{-1}$; $n = 13$) habitual caffeine consumers ingested caffeine ($5 \text{ mg}\cdot\text{kg}^{-1}$ body weight) or a placebo in a counter-balanced order and 1 h later completed 30 min of cycle ergometry at 75-77% of peak oxygen consumption ($\dot{V}\text{O}_{2\text{peak}}$). Perceptions of quadriceps muscle pain as well as oxygen consumption, heart rate, and work rate were recorded during both bouts of exercise. Caffeine ingestion resulted in a statistically significant and moderate reductions in quadriceps muscle pain intensity ratings during the 30 min bout of high-intensity cycle ergometry compared to placebo ingestion in both low ($d = -0.42$) and high ($d = -0.55$) caffeine consumers. Our results suggest that caffeine ingestion is associated with a moderate hypoalgesic effect during high-intensity cycling in college-aged males who are low or high habitual caffeine consumers, but future work should consider better defining and differentiating pain and effort when examining the effects of caffeine during acute exercise.

Pain has been defined by the International Association for the Study of Pain (1979, p. 250) as “an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.” There is an expanding body of evidence that acute exercise is a natural stimulus that might transiently, safely, and reliably produce muscle pain (Cook et al., 1997, 1998, 2004; O’Connor & Cook, 1999, 2001). Indeed, moderate-to-high intensity exercise is associated with reports of transient, naturally occurring pain in the activated musculature (Cook et al., 1997). The pain is described as exhausting, intense, sharp, burning, tiring, cramping, pulling, and rasping (Cook et al., 1997). Those same descriptors have been used for characterizing clinical pain conditions including menstrual pain, arthritic pain, cancer pain, chronic back pain, and fibromyalgia (Cook, 2006). We further note that pain ratings during exercise as measured by the short-form of the McGill Pain Questionnaire are nearly 1 standard deviation (SD) above the mean scores associated with other laboratory methods for inducing pain (Cook et al., 1997).

Experiments have demonstrated that caffeine, an adenosine receptor antagonist (Fredholm, Bättig, Holmén, Nehlig, & Zwartau, 1999; Nehlig, Daval, & Debry, 1992), has resulted in a reduction of quadriceps muscle pain during moderate and high intensity cycling exercise among low caffeine consumers (Gliottoni & Motl, 2008; Motl, O’Connor, & Dishman, 2003; Motl, O’Connor, Tubandt, Peutz, & Ely, 2006; O’Connor, Motl, Broglio, & Ely, 2004). For example, one experiment indicated that ingestion of a large dose of caffeine (10 mg·kg⁻¹ body weight) reduced quadriceps muscle pain intensity during moderate intensity cycling (i.e., 60% $\dot{V}O_{2peak}$) among males who reported low daily caffeine consumption (i.e. < 100 mg·d⁻¹; Motl et al., 2003). Another experiment supported that ingestion of a moderate (5 mg·kg⁻¹ body weight)

and a large ($10 \text{ mg}\cdot\text{kg}^{-1}$ body weight) dose of caffeine dose-dependently reduced quadriceps muscle pain intensity during moderate intensity cycling among males who reported low daily caffeine consumption (i.e. $< 100 \text{ mg}\cdot\text{d}^{-1}$; O'Connor et al., 2004).

One general limitation of those previous experiments has been an examination of the effects of caffeine on muscle pain during exercise using low caffeine consumers (i.e., $\leq 100 \text{ mg}\cdot\text{d}^{-1}$). Individuals who reported low daily caffeine consumption were recruited in those previous experiments to minimize tolerance effects associated with habitual consumption of caffeine (Laska et al., 1984). Indeed, one possible mechanism for explaining the caffeine-induced reduction in muscle pain during exercise is that caffeine blocks adenosine A_1 and A_{2a} receptors on the sensory nerve endings in skeletal muscle that can influence pain signaling (Sawynok, 1998). Regular caffeine consumers have an increased production of adenosine receptors in the vascular and neural tissues of the brain (Fredholm et al., 1999; Griffiths & Woodson, 1988; Jacobson, von Lubitz, Daly, & Fredholm, 1996; Nehlig et al., 1992). This suggests that equal doses of caffeine might block a greater percentage of adenosine receptors for low than high caffeine consumers and produce a greater reduction in variables that are mediated by the adenosine neuromodulatory system (Bell & McLellan, 2002). Accordingly, the magnitude of reduction in muscle pain intensity during exercise after caffeine ingestion might differ based on habitual use of caffeine.

This experiment extended previous research by examining the effect of a moderate dose of caffeine ($5 \text{ mg}\cdot\text{kg}^{-1}$ body weight) on quadriceps muscle pain intensity ratings during high intensity cycling exercise (i.e., target of $80\% \dot{V}O_{2\text{peak}}$) in males who reported *low or high* daily caffeine consumption. We expected that caffeine would be associated with an overall reduction

of quadriceps pain intensity ratings during high intensity exercise compared with a placebo, and the effect of caffeine on quadriceps muscle pain would be larger in the low than high daily caffeine consumers.

Methods

Participants

The methods were approved by the University of Illinois at Urbana-Champaign Institutional Review Board and all participants provided written informed consent. We recruited a sample of college-aged males who were (a) regular exercisers with above average fitness; (b) non-smokers; (c) average body weight; and (d) no self-reported hypersensitivity to caffeine. Regular exercisers with above average fitness were recruited to ensure that capacity for undertaking and completing 30 minutes of high intensity exercise. Non-smokers of average body weight were recruited to avoid the effects of cigarette smoking (Joeres et al., 1988) and obesity (Kamimori, Somani, Knowlton, & Perkins, 1987) on the rate of caffeine metabolism. Participants who reported no hypersensitivity to caffeine were recruited to minimize the potential for extreme anxiety reactions to caffeine ingestion (Charney, Galloway, & Heninger, 1984). The sample included 24 participants who were placed into two groups based on self-reported daily caffeine consumption: low caffeine consumers (i.e., $\leq 100 \text{ mg}\cdot\text{d}^{-1}$; $n = 12$) and high caffeine consumers (i.e., $\geq 400 \text{ mg}\cdot\text{d}^{-1}$; $n = 12$). Characteristics of the overall sample and subsamples based on habitual caffeine use are provided in Table 1.

Materials

Quadriceps muscle pain ratings. Quadriceps muscle pain intensity was measured using a categorical scale with ratio-like properties (Cook, O'Connor, Eubanks, Smith, & Lee, 1997;

Cook, O'Connor, Oliver, & Lee, 1998). The categorical scale has 12 categories from 0 to 10 with verbal anchors associated with the following numbers: 0 = no pain at all, 0.5 = very faint pain (just noticeable), 1 = weak pain, 2 = mild pain, 3 = moderate pain, 4 = somewhat strong pain, 5 = strong pain, 7 = very strong pain, and 10 = extremely intense pain (almost unbearable). No verbal anchors are provided in association with number 6, 8 and 9. Prior research has demonstrated that scores from this scale are valid and reliable for assessing the perceived intensity of quadriceps muscle pain during exercise (Cook et al., 1997, 1998). The categorical scale was used in the present study both because of the evidence of its reliability and validity and because of its advantages over a visual analog scale applied during exercise (e.g., no physical mark needs to be made on a sheet of paper).

Incremental exercise test. Participants performed an incremental exercise test on an electronically-braked, computer-driven cycle ergometer (Lode BV, Groningen, The Netherlands) to measure $\dot{V}O_{2\text{peak}}$. Initially, participants were fitted to the cycle ergometer. The participants were then provided with standardized, tape-recorded instructions for correctly using the quadriceps muscle pain (see Appendix A in Cook et al., 1997 or Methods of Cook et al., 1998) and overall perceived exertion (Borg, 1998) scales. After listening to the instructions while viewing the scales, all subjects articulated that the pain scale was measuring the intensity of hurt in the quadriceps muscles of the legs during exercise, whereas the perceived exertion scale was measuring the overall amount of effort during exercise. The maximal exercise test procedures were described by an investigator and participant questions were answered. After inserting a mouthpiece for collecting expired gases, the participants performed a 5-min warm-up at 25 W. The initial work rate for the exercise test was 50 W, and the work rate continuously increased at

a rate of $24 \text{ W}\cdot\text{min}^{-1}$ until the participant reached volitional fatigue. Using an open-circuit spirometry system (TrueOne, Parvo Medics, Sandy, UT), ventilation (\dot{V}_E), oxygen consumption ($\dot{V}O_2$), carbon dioxide production ($\dot{V}CO_2$), and respiratory exchange ratio (RER) were measured every 20 s. Heart rate was continuously displayed using a Polar heart rate monitor (Polar Electro Oy, Kempele, Finland). Heart rate, rating of perceived exertion, work rate, and perceptions of quadriceps muscle pain were recorded every min during the test of $\dot{V}O_{2\text{peak}}$. $\dot{V}O_{2\text{peak}}$ was defined as the highest recorded $\dot{V}O_2$ value when two of three criteria were satisfied: (1) $\text{RER} \geq 1.10$; (2) peak heart rate within $10 \text{ beats}\cdot\text{min}^{-1}$ of age-predicted maximum (i.e., $\sim 1 \text{ SD}$); or (3) peak rating of perceived exertion ≥ 18 .

Procedures

Participants completed one day of preliminary testing and two days of experimental testing. The two days of experimental testing were separated by one week. Experimental testing was conducted in the morning ($0700 \text{ h} \pm 1 \text{ h}$). Consistent with previous research (Gliottoni & Motl, 2008; Motl et al., 2003, 2006; O'Connor et al., 2004) participants were asked to abstain from (1) caffeine consumption for 12 hours, (2) alcohol consumption for 24 hours, and (3) eating a large meal and exercising for 12 hours before the experimental testing,

Preliminary day. Prior to incremental exercise testing, the participants completed a seven-day caffeine recall questionnaire (James, Bruce, Lader, & Scott, 1989) and medical history questionnaire. The medical history questionnaire was used to identify contraindications to caffeine consumption and exercise testing. The incremental exercise test provided an opportunity for participants to experience and rate cycle ergometry-induced quadriceps muscle pain throughout the full range of possible stimulus intensities.

Experimental days. On the experimental days, the participant ingested capsules that contained caffeine ($5 \text{ mg}\cdot\text{kg}^{-1}$ body weight) or placebo with ~250 ml of water, and then sat and read quietly. One hour after ingesting the capsules, a time that consistently has coincided with peak plasma caffeine concentrations (Charney et al., 1984; Kamimori et al., 1987, 1995; Kaplan et al., 1997), the participant performed 30 min of cycling on an ergometer at a target intensity of $80\% \dot{V}O_{2\text{peak}}$. The participant's perception of quadriceps muscle pain intensity, work rate, and heart rate were recorded every 5 minutes during the exercise bouts. Expired gases were analyzed using open-circuit spirometry after 5, 15, and 25 minutes of exercise. An investigator reduced the work rate every 5 minutes consistent with previous research (Gliottoni & Motl, 2008; Motl et al., 2003, 2006; O'Connor et al., 2004) so that each participant exercised at a target intensity of approximately $80\% \dot{V}O_{2\text{peak}}$ throughout the first exercise bout. The reduction in workrate was not based on pain or heart rate, but rather our collective experience and was confirmed for maintaining the target intensity based on expired gases after 5, 15, and 25 minutes of exercise. This procedure was adopted to control for O_2 drift and thereby ensure that participants would complete the entire 30-minute bout of cycling exercise. The workrate during the second day of experimental tests was identical as a means of controlling the physical stimulus associated with quadriceps muscle pain.

Drug delivery and content. Caffeine (Caffeine Anhydrous, USP/NF, Gallipot, St. Paul, MN) and placebo were delivered in gelatin capsules (No. 1, Eli Lilly & Company, Indianapolis, IN). The dose of caffeine ($5 \text{ mg}\cdot\text{kg}^{-1}$ body weight) was moderate and equivalent to consuming approximately two-and-a-half to three 8-oz cups of ground roasted coffee (Barone & Roberts, 1996). The dose of placebo was an equal number of gelatin capsules containing white, all-

purpose flour. Caffeine was administered using a double-blind procedure to protect against possible subject and experimenter expectancy effects. The order of drug administration was counter-balanced.

Data Analysis

Descriptive statistics are presented in text and Tables as mean \pm SD and in Figures as mean \pm SEM. The workrate data recorded during exercise were analyzed with a 2 (Group: Low-users & High-users) \times 6 (Time: 5, 10, 15, 20, 25, & 30 min) mixed-model ANOVAs based on the multivariate F-statistic; Drug was not included in the model as the work rate was identical between the two experimental exercise sessions. The $\dot{V}O_2$ data were analyzed with a 2 (Group: Low-users & High-users) \times 2 (Drug: 5 mg \cdot kg⁻¹ body weight caffeine & placebo) \times 3 (Time: 5, 15, & 25 min) mixed model ANOVA based on the multivariate F-statistic. The heart rate and quadriceps muscle pain intensity data recorded during exercise were analyzed with 2 (Group: Low-users & High-users) \times 2 (Drug: 5 mg \cdot kg⁻¹ body weight caffeine & placebo) \times 6 (Time: 5, 10, 15, 20, 25, & 30 min) mixed-model ANOVAs based on the multivariate F-statistic. Within all analyses, Group was a between-subjects factor, whereas Drug and Time were within-subjects factors. The judgment of significance of the main effects and interactions in the mixed model ANOVAs was based on the univariate F-statistic and we used the Greenhouse-Geisser adjustment when violating the assumption of sphericity based the significance of Mauchly's test of sphericity. Effect sizes for F-statistics were expressed as eta-squared (η^2). Effect sizes for mean differences were expressed as Cohen's d (Cohen, 1988).

Results

Effect of Caffeine on Absolute and Relative Exercise Intensity

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The work rate and heart rate data are presented in Figure 1. The 2×6 mixed model ANOVA indicated no statistically significant Group main effect on work rate ($p = .46$), but there was a statistically significant Group \times Time interaction [$F(1.3, 27.7) = 3.98, p = .05, \eta^2 = .15$]. The interaction indicated that there was a larger reduction in workrate across time in the group of low caffeine users ($d = -1.12$; ~ 41 W reduction over time) than high caffeine users ($d = -0.89$; ~ 31 W reduction over time). The $2 \times 2 \times 6$ mixed model ANOVA indicated that there were neither statistically significant main effects for Group ($p = .15$) and Drug ($p = .33$) nor statistically significant interactions for Group \times Drug ($p = .78$), Group \times Time ($p = .10$), Drug \times Time ($p = .42$), and Group \times Drug \times Time ($p = .55$) on heart rate.

The next analysis examined the effects of Group and Drug on oxygen consumption ($\dot{V}O_2$) during the exercise sessions. The $2 \times 2 \times 3$ mixed model ANOVA indicated no statistically significant main effects for Group ($p = .38$) and Drug ($p = .62$) on $\dot{V}O_2$. There were no statistically significant interactions for Group \times Drug ($p = .90$), Group \times Time ($p = .20$), Drug \times Time ($p = .31$), and Group \times Drug \times Time ($p = .92$) on $\dot{V}O_2$. The mean $\dot{V}O_2$ values during exercise after ingestion of caffeine and placebo were $46.9 \pm 6.1 \text{ ml}\cdot\text{kg}^{-1}\cdot\text{min}^{-1}$ and $46.5 \pm 6.1 \text{ ml}\cdot\text{kg}^{-1}\cdot\text{min}^{-1}$, respectively, for the low caffeine users; the corresponding values for the high caffeine users were $44.7 \pm 5.8 \text{ ml}\cdot\text{kg}^{-1}\cdot\text{min}^{-1}$ and $44.4 \pm 6.6 \text{ ml}\cdot\text{kg}^{-1}\cdot\text{min}^{-1}$, respectively. Those $\dot{V}O_2$ values represented relative exercise intensities of $77\% \dot{V}O_{2\text{peak}}$ and $76\% \dot{V}O_{2\text{peak}}$ for the caffeine and placebo conditions, respectively, for the low caffeine users, and relative exercise intensities of $76\% \dot{V}O_{2\text{peak}}$ and $75\% \dot{V}O_{2\text{peak}}$ for the caffeine and placebo conditions, respectively, for the high caffeine users. Those values fall within a range that would classify the intensity of

exercise as hard or vigorous (American College of Sports Medicine, 2006).

Effect of Caffeine on Ratings of Quadriceps Muscle Pain Intensity

The quadriceps muscle pain intensity ratings recorded during the exercise sessions are provided in Figure 2. The $2 \times 2 \times 6$ repeated measures ANOVA indicated a statistically significant Drug main effect on pain intensity ratings [$F(1, 22) = 12.57, p = .002, \eta^2 = .36$], but no statistically significant interactions for Drug \times Group ($p = .62$), Drug \times Time ($p = .10$), and Drug \times Group \times Time ($p = .72$). The mean pain intensity scores during exercise after ingestion of caffeine and placebo were 3.00 ± 1.6 and 3.8 ± 1.7 , respectively. Ingestion of caffeine resulted in a moderate reduction in quadriceps muscle pain intensity ratings compared with the placebo ($d = -0.48$), and this effect size was similar in magnitude between the groups of low caffeine users ($d = -0.42$) and high caffeine users ($d = -0.55$).

Discussion

This experiment involved an examination of the role of habitual caffeine consumption in moderating the hypoalgesic effect of caffeine during high intensity cycling exercise among males. The primary finding was that both low and high habitual caffeine consumers reported a significant and moderate reduction in quadriceps muscle pain intensity ratings during high intensity cycling exercise after ingestion of a moderate dose of caffeine.

The results of the present study did not support our expectation that the effect of caffeine ingestion on muscle pain intensity ratings during exercise might be moderated by habitual use of caffeine. The expectation of a moderated effect by habitual caffeine use was based on literature showing that caffeine operates as an adenosine A₁ and A_{2a} receptor antagonist (Sawynok, 1998) and that regular caffeine consumption is associated with an up-regulation of adenosine receptors

(Fredholm et al., 1999; Griffiths & Woodson, 1988; Jacobson et al., 1996; Nehlig et al., 1992).

We reasoned that an equivalent dose of caffeine might block a greater percentage of adenosine receptors for low than high habitual caffeine users and, thus, potentially produce a greater reduction in muscle pain intensity during exercise. We do not have an explanation for the discrepancy between our expectations and actual results. One possibility is that high users actually had a higher plasma concentration of caffeine than non-users during exercise consistent with previous research (Bell & McLellan, 2002). If indeed there was a difference in plasma caffeine concentrations between users and non-users, this would undermine the basis of our argument that equivalent doses of caffeine would block a greater percentage of adenosine receptors in non-users and thereby yield a larger reduction in muscle pain during exercise; the possibility of a high plasma concentration of caffeine in users would potentially equilibrate the percentage of adenosine receptor blockade. Another possibility is that the groups were similar in caffeine sensitivity as a result of our screening criteria for avoiding panic-like attacks associated with caffeine ingestion in susceptible individuals. Some researchers have suggested that differences in sensitivity to caffeine might account for differences in the ergogenic effects of caffeine between users and non-users (Bell & McLellan, 2002). Another possibility is the inconsistent findings of caffeine tolerance on physiological, psychological, and perceptual variables. For example, tolerance has been reported for the actions of caffeine on blood pressure and heart rate, diuresis, plasma catecholamine levels, renin activity, and nervousness and jitteriness, but not alertness and wakefulness or cerebral glucose metabolism (Nehlig, 1999). The inconsistent findings for caffeine tolerance might be linked with individual differences in susceptibility and tolerance to caffeine-induced effects and may be overcome with large enough

doses of caffeine (Nehlig, 1999). Therefore, two possible explanations for our findings are that muscle pain does not exhibit tolerance or the dose of caffeine was sufficient for overcoming tolerance effects.

The present findings both replicate and extend previous work on caffeine and naturally occurring muscle pain during exercise. Previous experiments have demonstrated that ingestion of large ($10 \text{ mg}\cdot\text{kg}^{-1}$) and moderate ($5 \text{ mg}\cdot\text{kg}^{-1}$) doses of caffeine reduced quadriceps muscle pain intensity ratings during moderate intensity cycling exercise in low caffeine consuming males and females (Motl et al., 2003, 2006; O'Connor et al., 2004) and during high intensity cycling exercise in low-to-moderate caffeine consuming females (Gliottoni & Motl, 2008). This experiment demonstrated that ingestion of a moderate ($5 \text{ mg}\cdot\text{kg}^{-1}$) dose of caffeine reduced quadriceps muscle pain intensity ratings during high intensity cycling exercise in males who were either *low or high habitual caffeine users*. Importantly, some previous researchers have reported no reduction in quadriceps muscle pain intensity ratings after ingestion of low doses of caffeine ($1, 2, \text{ and } 3 \text{ mg}\cdot\text{kg}^{-1}$) during 15 minutes of high intensity cycling exercise (target intensity of $80\% \dot{V}O_{2\text{peak}}$) in males who were low-to-moderate caffeine users (Jenkins et al., 2008). We further note that the pain intensity ratings in that study were substantially higher than those reported in the current study using a similar target intensity ($80\% \dot{V}O_{2\text{peak}}$). The higher pain intensity ratings in that study might be explained by the lower fitness level of the participants or a difference in the actual intensity of cycling between that previous research ($\sim 87\% \dot{V}O_{2\text{peak}}$ in placebo condition) and the current study (e.g., $75\text{-}76\% \dot{V}O_{2\text{peak}}$ in placebo condition). The emerging evidence suggests that ingestion of moderate or large, but not small, doses of caffeine are associated with a moderate-to-large reduction in pain intensity ratings in the quadriceps

during moderate and high intensity cycling exercise in both high and low caffeine consuming individuals.

The findings from this experiment have implications for several future lines of research. This study only examined the effects of a moderate dose of caffeine on muscle pain during high-intensity exercise in men who were low and high caffeine consumers. We selected high intensity exercise (i.e., 80% $\dot{V}O_{2\text{peak}}$) for examining the effects of caffeine on changes in leg muscle pain for low and high caffeine consumers because it should produce stronger perceptions of pain in the activated muscles than moderate intensity exercise (i.e., 60% $\dot{V}O_{2\text{peak}}$), and we do not have any information about such effects with a moderate exercise intensity (60% $\dot{V}O_{2\text{peak}}$). Possible benefits of evoking stronger perceptions of muscle pain involve (1) avoiding the possibility of floor effects (i.e., limited room for improvement in reducing pain) when examining caffeine's effect on muscle pain during acute exercise; (2) examining the effect of caffeine on pain using an exercise stimulus that might more closely represent the demands of athletic performance, although we did not actually measure performance; and (3) further characterizing the nature of the acute exercise stimulus for which caffeine might exert an effect on perceptions of muscle pain. Future research would benefit from an examination of the effects of both small and large doses of caffeine on muscle pain during high intensity exercise in males and females who are low and high habitual caffeine consumers. Future investigations might consider examining the synergistic effects of caffeine and other agents on muscle pain during exercise. This is based on the observation that non-exercise clinical studies have demonstrated that larger doses of an analgesic substance are equally effective in reducing pain compared with smaller doses of the same analgesic substance combined with caffeine (Laska et al., 1984). For example, one

substance of interest might be aspirin. Although previous research has reported that ingestion of aspirin had no effect on muscle pain during an incremental maximal exercise test (Cook et al., 1997), aspirin plus caffeine might demonstrate larger effects on muscle pain during exercise than either drug in isolation. Such results might have further implications for (a) understanding the mechanisms of hypoalgesia during exercise and (b) identifying safe, legal, and effective methods of reducing pain that naturally occurs as a consequence of exercise.

This study did not examine the mechanisms that might explain the effect of caffeine on muscle pain during exercise. One of the more plausible explanations is that caffeine acts on peripheral or central adenosine A_1 and A_{2a} receptors involved in the nociceptive system (Sawynok & Liu, 2003). Indeed, many of the pharmacological actions of caffeine are linked with adenosine receptor blockade (Fredholm et al., 1999; Griffiths & Woodson, 1988; Jacobson et al., 1996; Nehlig et al., 1992), and adenosine A_1 and A_{2a} receptors are located on sensory nerve endings in skeletal muscle that can influence pain signaling (Sawynok, 1998). The peripheral actions of adenosine on A_1 and A_{2a} receptors seem to be receptor specific and result in antinociceptive and pronociceptive effects, respectively (Sawynok, 1998). Caffeine might reduce muscle pain during exercise by blocking the pronociceptive effects of A_{2a} receptors on sensory afferents, and such an effect would likely exceed the blockade of the antinociceptive effects of A_1 receptors. Clearly, one major future research direction involves mechanistic examinations of the effect of caffeine on muscle pain during acute exercise.

This study is not without additional limitations. One of those limitations is we might not have adequately defined pain and differentiated it from effort for the participants in this study. As noted in the Introduction, pain has been defined by the International Association for the Study

of Pain (1979, p. 250) as “an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.” We defined pain for the participants as the intensity of “hurt” and this is consistent with the second part of the aforementioned definition of pain. We further provided participants with standardized, tape-recorded instructions for correctly using the quadriceps muscle pain (see Appendix A in Cook et al., 1997 or Methods of Cook et al., 1998) and overall perceived exertion (Borg, 1998) scales, and all subjects articulated that the pain scale was measuring the intensity of hurt in the quadriceps muscles of the legs during exercise, whereas the perceived exertion scale was measuring the overall amount of effort during exercise. Nevertheless, future work should consider better defining and differentiating pain and effort when examining the effects of caffeine during acute exercise, and this might be done by providing the definition of pain offered by the International Association for the Study of Pain (1979). This future work might further benefit from an attempt to detect actual tissue damage (e.g., rise in blood creatine kinase unrelated to exercise-induced hemoconcentration) as a method of verifying the occurrence of muscle pain during acute exercise.

Another limitation is that we did not measure plasma caffeine concentrations and cannot rule-out the possibility that differences in plasma caffeine concentrations between groups masked the possible moderating role of habitual caffeine use on the caffeine-induced hypoalgesia during exercise. We further note that this research was conducted in the laboratory under controlled conditions using cycle ergometry, and we cannot be certain that similar results would be observed during athletic events or in sports requiring arm motion (e.g., running) or predominantly upper extremity movements (e.g., swimming). An additional limitation is that we

did not examine withdrawal symptoms (e.g., headaches) and such symptoms could have influences leg muscle pain during exercise. This should be addressed in future research.

Overall, the results of this experiment add to the body of evidence suggesting that caffeine ingestion influences muscle pain during exercise, and provide novel evidence that caffeine is associated with a reduction in muscle pain in both habitual users and non-users of caffeine. Additional research might examine (1) the role of varying doses of caffeine on muscle pain during high intensity exercise in individuals who differ in habitual caffeine consumption; (2) the interactive effects of caffeine with other analgesic substances; and (3) mechanisms that might explain the effect of caffeine on muscle pain during exercise. Such investigations will highlight factors that might influence and underlie the effect of caffeine on naturally-occurring muscle pain during acute exercise.

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Table 1

Characteristics of the 24 college-aged male volunteers.

Characteristic	Overall (<i>N</i> = 24) Mean ± SD	Low Users (<i>n</i> = 12) Mean ± SD	High Users (<i>n</i> = 12) Mean ± SD
Age (y)	25.6 ± 4.6	23.9 ± 4.2	27.2 ± 5.0
Height (cm)	182.0 ± 6.4	182.2 ± 6.8	181.8 ± 5.9
Weight (kg)	77.0 ± 8.0	76.2 ± 6.6	77.8 ± 9.3
BMI (kg/m ²)	23.3 ± 2.1	23.0 ± 2.2	23.5 ± 2.0
DCC (mg·d ⁻¹)	286.7 ± 74.1	40.5 ± 35.7	532.8 ± 112.5
Peak power output (Watts)	379.7 ± 51.8	388.1 ± 62.5	371.3 ± 41.0
$\dot{V}O_{2peak}$ (ml·kg ⁻¹ ·min ⁻¹)	60.2 ± 7.9	61.1 ± 8.8	59.2 ± 7.0
HR _{peak} (beats·min ⁻¹)	188.9 ± 12.9	192.2 ± 10.8	185.5 ± 14.9
RER _{peak}	1.2 ± 0.05	1.2 ± 0.02	1.2 ± 0.07
RPE _{peak}	19.1 ± 1.0	19.4 ± 0.7	18.7 ± 1.2
Peak pain-intensity	8.6 ± 3.3	9.9 ± 3.8	7.2 ± 2.7

Note. SD = Standard deviation. DCC = Daily caffeine consumption. BMI = Body-mass index. $\dot{V}O_{2peak}$

O_{2peak} = Peak oxygen consumption. HR_{peak} = Peak heart rate. RER_{peak} = Peak respiratory exchange

ratio. RPE_{peak} = Peak rating of perceived exertion.

Figure 1. Work rate and heart rate values recorded during 30-min of high-intensity cycling exercise (75-77% $\dot{V}O_{2peak}$). Values are mean \pm standard error.

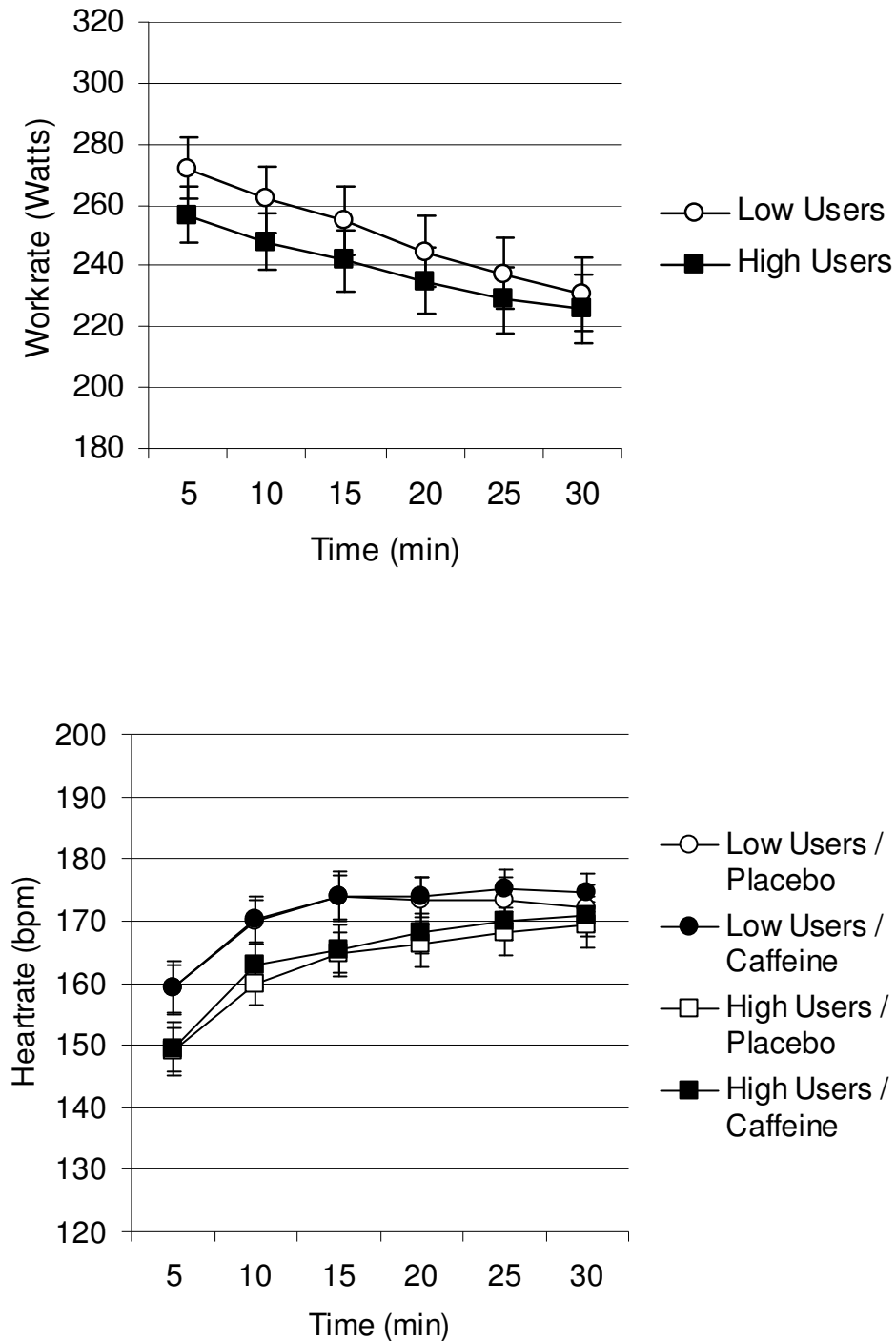


Figure 2. Quadriceps muscle pain-intensity values recorded during 30-min of high-intensity cycling exercise ($75\text{-}77\%$ $\dot{V}O_{2\text{peak}}$). Values are mean \pm standard error.

