Strength Training in the Elderly
Effects on Risk Factors for Age-Related Diseases

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Contents

Abstract ................................................................. 249
1. Sarcopenia .............................................................. 250
   1.1 Strength, Muscle Mass and Strength Training .................. 250
   1.2 Mechanisms for Increases in Strength ....................... 251
2. Coronary Heart Disease ............................................ 251
   2.1 Low Cardiovascular Fitness Levels ............................. 251
   2.2 Strength Training and Cardiovascular Fitness ................ 252
   2.3 Abnormal Plasma Lipoprotein-Lipid Profiles ................ 253
   2.4 Strength, Strength Training and Lipoprotein-Lipid Profiles 253
   2.5 Aerobic Training Versus Strength Training ................... 254
3. Hypertension .......................................................... 254
4. Diabetes Mellitus ..................................................... 255
   4.1 Glucose Intolerance and Insulin Resistance .................. 255
   4.2 Aerobic Training Versus Strength Training ................... 256
5. Metabolic Syndrome ................................................ 256
   5.1 Intra-Abdominal Fat ............................................ 257
   5.2 Resting Metabolic Rate ....................................... 257
6. Osteoporosis .......................................................... 259
   6.1 Fracture Risk Increases with Age ............................... 259
   6.2 Bone Mineral Density .......................................... 259
7. Osteoarthritis ........................................................ 260
8. Prevention of Disability ............................................ 260
   8.1 Loss of Flexibility ............................................ 260
   8.2 Fall Prevention ................................................ 261
9. Conclusion ............................................................ 261

Abstract

Strength training (ST) is considered a promising intervention for reversing the loss of muscle function and the deterioration of muscle structure that is associated with advanced age. This reversal is thought to result in improvements in functional abilities and health status in the elderly by increasing muscle mass, strength and power and by increasing bone mineral density (BMD). In the past couple of decades, many studies have examined the effects of ST on risk factors for age-related diseases or disabilities. Collectively, these studies indicate that ST in the elderly: (i) is an effective intervention against sarcopenia because it produces substantial increases in the strength, mass, power and quality of skeletal muscle; (ii) can increase endurance performance; (iii) normalises blood pressure in those...
with high normal values; (iv) reduces insulin resistance; (v) decreases both total and intra-abdominal fat; (vi) increases resting metabolic rate in older men; (vii) prevents the loss of BMD with age; (viii) reduces risk factors for falls; and (ix) may reduce pain and improve function in those with osteoarthritis in the knee region. However, contrary to popular belief, ST does not increase maximal oxygen uptake beyond normal variations, improve lipoprotein or lipid profiles, or improve flexibility in the elderly.

The well documented losses of muscular strength and muscle mass with age,[1-3] known as sarcopenia,[4] have important health consequences[5] because they are associated with an increased susceptibility to disability among the elderly,[6-9] an increased risk of falls[10] and hip fractures,[11] a decrease in bone mineral density (BMD)[12] and an increase in glucose intolerance.[13] These changes can predispose the elderly to an increased risk for a variety of diseases and disabilities.[7,8] Whether this results directly from losses of muscle mass or secondary to low strength levels, which then leads to disability and functional limitations, is unknown. Nevertheless, there has been an increasing body of evidence, in recent years, indicating that sarcopenia is associated with adverse public health and economic consequences and that strength training (ST) can delay or reverse some of these effects. Therefore, this review will discuss and critically evaluate the research literature on the effects of ST on risk factors for age-related diseases and disabilities that have been most commonly studied. For the purpose of this review, the topics will be limited to include the effects of ST on risk factors for sarcopenia, coronary heart disease (CHD), hypertension, diabetes mellitus, metabolic syndrome, obesity, osteoporosis and osteoarthritis. In addition, the prevention of disability will be discussed by focusing on the research literature that pertains to the effects of ST on the loss of flexibility with age and fall prevention.

1. Sarcopenia

1.1 Strength, Muscle Mass and Strength Training

The loss of strength with advanced age is associated with a deterioration of health status.[5,7,8] Whether the objective is to improve functional abilities or health status in the elderly, interventions should focus on preventing disability and progression of disease through modification of risk factors.[6] In addition to the more common goals of improving cardiovascular and metabolic function, these interventions should positively affect muscle mass, strength, power, flexibility and BMD.[6,14] Muscular strength alone is independently associated with functional ability in the elderly.[15,16] Because aerobic exercise training does not improve muscular force production in the elderly[17,18] and muscular strength may become more limiting for activities of daily living than cardiovascular function in frail elderly individuals,[19] ST may be the training modality of choice for some segments of the elderly population. The loss of muscle function is at least partially responsible for many functional limitations and disabilities in the elderly.[19]

There is a remarkable similarity between the losses in strength and body composition with aging and those resulting from physical inactivity.[20] There is also a comparable counteraction of these age-associated losses following a period of muscular activity.[20] Early reports that increases in strength levels following ST in the elderly were due entirely to neurological factors[21] were later refuted when direct assessments of muscle tissue were made from imaging techniques and/or muscle biopsies, showing that ST increases muscle mass in older men and women.[22-32]

We now have suggestive evidence for how much of the age-associated losses in strength and muscle mass can be reversed with ST. Strength losses assessed from isokinetic peak torque values occur at the rate of about 12 to 14% per decade after the age
of about 50 years, and strength gains, assessed from 1 repetition maximum (1RM) values, of >30% occur within the first couple of months of heavy resistance ST in 65- to 75-year-old men and women. Thus, about 2 months of ST essentially reverses at least 2 decades of strength loss with advanced aging. Similar reversals can be observed with muscle mass, which is lost at a rate of about 6% per decade after the age of 50 years and increased by about 12% within the first couple of months of ST. Thus, 2 decades of age-induced muscle mass loss can be reversed with only about 2 months of ST.

1.2 Mechanisms for Increases in Strength

The mechanisms responsible for ST-induced increases in strength in the elderly are not entirely understood, but increases in motor unit firing frequency and maximal motor unit recruitment rates are likely contributors to the substantial increases in strength after short term ST. In addition, an improved efficiency of motor unit firing rates is a probable mechanism explaining the improved ability to maintain steady submaximal contractions with ST in older individuals. There is some evidence that the local insulin-like growth factor (IGF; somatomedin) system may be involved in the mechanism for ST-induced muscle hypertrophy in the elderly. However, this does not appear to result in an increase in baseline serum levels of growth hormone or IGF-1. Although it has been reported that specific training regimens may determine how blood levels of these anabolic factors respond, there is no evidence that these responses are indicative of muscle IGF-1 levels (either mRNA levels for IGF-1, IGF-1 receptors, or IGF-1 binding proteins) or that they are related to muscle hypertrophy. Although investigators have often shown little or no effect of increased circulating IGF-1 on muscle hypertrophy, Adams and McCue and others have demonstrated that local production or infusion of IGF-1 is directly related to muscle hypertrophy. Specific mechanisms for this relationship have been investigated recently. Increased circulating IGF-1 appears to stimulate general increases in fat free mass (FFM), rather than increases in muscle mass specifically. These data indicate the importance of assessing local IGF-1 production when assessing the effects of ST interventions on muscle hypertrophy. In this regard, a recent study demonstrated for the first time an increase in local (muscle) IGF-1 levels with ST.

ST can stimulate muscle fibre hypertrophy in all fibre types in older individuals and fibre type transitions have also been reported. These results suggest that the muscles of older individuals can adapt to a ST stimulus, such that age-related muscle fibre atrophy may be completely reversed in some individuals. Several investigations have demonstrated that satellite cell proportions increase following muscle stimulation or exercise in young and older animals. As satellite cells appear necessary for the hypertrophic response to muscle overload, assessing the role of ST on satellite cell activation in humans is important. For a more detailed overview of potential mechanisms for increased strength and muscle hypertrophy with ST among the elderly, the reader is referred to our recent review on this topic.

Regardless of what mechanisms are responsible for training-induced muscle hypertrophy in the elderly, it is clear that when older people maintain muscular activity, the losses in strength with age are reduced substantially.

2. Coronary Heart Disease

2.1 Low Cardiovascular Fitness Levels

Cardiovascular fitness, as assessed by time to exhaustion on a treadmill test, is an important risk factor for all-cause mortality as well as mortality and morbidity associated with CHD in both men and women. The relative risk (RR) of death associated with a lack of cardiovascular fitness (3.44 for men, 4.65 for women) is greater than or similar to the RR associated with cigarette smoking (2.60 for men, 2.08 for women), high cholesterol levels (2.21 for men, 2.69 for women), hypertension (1.74 for men, 3.24 for women), a family history of car-
diovascular disease (1.60 for men, 1.50 for women) and elevated fasting glucose levels (2.74 for men, 3.73 for women). Furthermore, the RR of developing CHD from being physically inactive (RR = 1.9) is similar to the RR associated with cigarette smoking (2.5), hypertension (2.3) and hypercholesterolaemia (2.1). Aging is associated with a marked decrease in cardiovascular fitness as indicated by a decline in maximal oxygen uptake (VO2max). However, it appears that as much as half of this reduction may be caused by secondary factors, such as increased body fat and decreased physical activity.

2.2 Strength Training and Cardiovascular Fitness

It is well established and obvious that aerobic exercise training leads to substantial improvements in cardiovascular fitness, but the effects of ST have been more controversial. It is thought by many investigators in the field that ST can improve cardiovascular fitness in elderly people, but whether this conclusion is actually supported by evidence depends on how cardiovascular fitness is defined and what magnitude of change constitutes a real improvement. For example, Frontera and co-workers reported an increase of 5% in VO2max measured on a cycle ergometer after 12 weeks of ST in healthy 60- to 72-year-old men. Although this change was statistically significant, it is substantially below the magnitude of changes reported with aerobic exercise training, and it is within the range of normal biological and/or methodological drifts reported from inactive control groups during similar time periods. Furthermore, because noncyclists are usually unable to achieve true VO2max on a cycle ergometer, it is unlikely that a true VO2max was measured on these individuals. This is an important distinction because, in contrast to VO2max measured on a treadmill using an appropriate protocol, cycle ergometer performance among noncyclists appears to be limited by noncardiovascular factors, such as leg strength or power and lactate threshold.

A more recent report by Hagerman et al. showed a 9% increase in a Bruce protocol treadmill peak VO2 test with ST. This was reduced to a 5.7% increase when peak VO2 values were corrected for gains in fat free mass.

Evidence supporting the conclusion that true VO2max does not change appreciably with ST, even when there is an increase in peak VO2, are the data of Hickson et al. who found that 10 weeks of ST in young men resulted in a significant increase in peak VO2 tested on a cycle ergometer, but did not change true VO2max measured during a maximal treadmill exercise test. Similar conclusions were made from a study by Marcinik et al. in our laboratory, in which time to exhaustion on a cycle ergometer was increased by 33% with circuit ST, despite no significant change in treadmill VO2max. Furthermore, most evidence indicates that ST, even when performed with short rest intervals, does not increase VO2max much beyond normal biological or methodological variation.

A mechanism has been reported that explains why ST fails to produce substantial improvements in aerobic capacity, even when training heart rates are maintained to the same level as high intensity aerobic exercise training. The explanation is that ST stimulates a catecholamine surge approximately 7-fold higher than aerobic training in the same individual at the same oxygen cost. This results in heart rate elevations that are disproportionate to the low aerobic demands of the muscle during training, leading to an oxygen pulse during exercise below the threshold necessary to elicit the kind of cardiovascular adaptations observed with aerobic exercise training.

ST may, however, elicit other more generalised adaptations that might benefit the cardiovascular systems of older men and women. Ades et al. found that 12 weeks of ST increased treadmill walking endurance at 80% VO2max by 38% in 65- to 79-year-old women, even though their VO2max did not change. Improvements in treadmill endurance time were significantly related to increased leg strength. Parker and co-workers reported that 16 weeks of ST decreased heart rate, blood pressure (BP) and rate pressure product, as an index of myocardial oxygen uptake, significantly during a weight-
loaded submaximal treadmill walking test in 60- to 77-year-old women. Heart rate, BP and rate pressure product during short term resistive exercise are also lower after ST. Thus, endurance performance may increase with ST despite little or no changes in VO2max. The specific mechanisms for these submaximal cardiovascular adaptations are not well understood, but possible explanations include changes in fibre type recruitment (i.e. greater rate of type I and a reduced rate of type II muscle fibre recruitment), less occlusion of blood flow and increased lactate threshold.

2.3 Abnormal Plasma Lipoprotein-Lipid Profiles

Studies on the relationship of age, lipoprotein-lipid profiles, morbidity and mortality from cardiovascular disease in the elderly have produced conflicting results. For example, Wilson et al. in an 8-year follow-up of some 4900 men and women 20 to 79 years of age, found that total blood cholesterol levels actually declined with age. Others have suggested that this may be caused by disease rather than age, although individuals with cardiovascular disease and cancer were excluded from the study of Wilson et al. Nevertheless, declines in high-density-lipoprotein cholesterol (HDL-C) levels with age were still observed. The total cholesterol to HDL-C ratios increased slightly from young to middle-aged and stayed about the same in middle-aged to elderly men, whereas this ratio continued to increase from young to middle-aged and from middle-aged to the oldest women.

Studies investigating the predictive value of lipid profiles in the elderly have also produced mixed results. Krumholz et al. concluded that neither high total cholesterol nor low HDL-C levels predict all-cause mortality, mortality caused by cardiovascular disease, or cardiovascular events in people >70 years of age. In contrast, Frost et al. reported that lipid profiles do predict cardiovascular events for people over the age of 60 years, and Schaefer et al. found that both low density lipoprotein-cholesterol (LDL-C) and HDL-C are important predictors of longevity. Thus, it appears that abnormal lipoprotein-lipid profiles confer increased cardiovascular disease risk in individuals at least until the age of 70 years.

2.4 Strength, Strength Training and Lipoprotein-Lipid Profiles

Two epidemiological studies have addressed the relationships among muscular strength, ST and plasma lipoprotein-lipid profiles. Kohl et al. examined the association between muscular strength and serum lipoprotein-lipid levels in 1193 women and 5460 men. They found no association between strength and total or LDL-C for either men or women. However, there was a direct association between both upper and lower body strength and triglyceride levels in men, and an inverse relationship between muscular strength and HDL-C. In contrast, Tucker and Silvester studied 8499 male employees of more than 50 companies, and observed a reduced risk of hypercholesterolaemia among individuals undergoing ST. However, only those who participated in ST 4 to 7 hours per week maintained this reduced risk when other potentially confounding variables were controlled.

Published reports on the effects of ST on plasma lipoprotein-lipid profiles have been limited preponderantly to adolescent, young and middle-aged individuals. Some of these studies have shown improvements in lipid profiles with ST in young and middle-aged individuals, but most of these studies either did not control for normal variations in lipoproteins, used individuals who were not at risk for cardiovascular disease, lacked proper dietary controls, or did not control for other factors that influence lipid profiles. When an attempt is made to control for at least some of these factors, most studies show no improvements in lipid profiles with ST. This may be because of the methodological differences or because bodyweight loss is needed to improve lipid profiles.

To address the bodyweight loss issue, we recently studied the effects of 16 weeks of heavy resistance ST with or without bodyweight loss and found that ST does not elicit beneficial changes in lipoprotein-lipid levels in obese postmenopausal
women (ages 50 to 69 years) regardless of whether bodyweight loss is involved. Similar findings of no improvements in lipid profiles in older women with ST have been reported by others. Thus, we are not aware of any studies using elderly individuals that have demonstrated improvements in lipid profiles with ST.

2.5 Aerobic Training Versus Strength Training

Considering there are many more studies showing improved lipid profiles with aerobic exercise training than with ST in middle-aged and older individuals, it is quite surprising that out of the 5 published studies we could find that compared these 2 training modalities, none of them showed any differences in the effectiveness of aerobic exercise training compared with ST for improving lipoprotein-lipid profiles. In fact, all of these studies showed that neither training modality improved plasma lipoprotein-lipid profiles significantly. However, recent work by Hagberg et al. suggests that genotype, particularly ApoE genotype, may be an important determinant as to whether aerobic exercise training improves lipoprotein-lipid profiles. It is conceivable that the same is true for lipoprotein-lipid responses to ST, but at the time of writing evidence for this is unavailable.

3. Hypertension

Resting BP increases with age, and elevated resting BP is a major cardiovascular disease risk factor in the elderly. By age 60 to 70 years, approximately 50% of men and women are hypertensive. Elevated BP remains a major cardiovascular disease risk factor in the elderly, except for those over 85 years of age.

The limited information that is available on the effects of ST on resting BP in middle-aged and older individuals is conflicting. For example, while there is some evidence of a possible lowering effect of ST on BP, not all studies have supported this finding. In the only previous study we could find addressing the effects of ST on BP in elderly men and women, Cononie and Graves investigated the effects of 6 months of moderate resistance ST on resting BP in a group of 70- to 79-year-old men and women. There were no changes following ST in either systolic blood pressure (SBP) or diastolic blood pressure (DBP) in individuals characterised as having normal or elevated BP. A similar group of individuals performing 6 months of aerobic training in the same study showed significant BP reductions, but no significant differences in SBP when compared with the ST or control groups following training. Until recently this was the only study we were aware of that investigated the effects of ST on resting BP in older adults and reported no improvements. Consequently, the conclusion from the American College of Sports Medicine Position Stand is that ST by itself does not consistently elicit significant reductions in BP in hypertensive individuals.

However, the results from a recent study from our laboratory shows that heavy resistance, high volume ST can reduce resting BP in 65- to 73-year-old men and women whose average values are in the high normal range for resting BP. The reductions were maintained for up to 48 hours following a ST session and were sufficient to shift mean values from the high normal to the normal category, as defined by the Joint National Committee on the Detection, Evaluation and Treatment of High Blood Pressure. When the BP responses to ST were analysed by gender, men showed reductions in BP that were not observed in the women (i.e. 48 and 72 hours after a ST session for SBP and at 24 hours after a ST session for DBP). Because a large proportion of cardiovascular disease occurs in people with high normal BP, this category shift has important implications, especially if corroborated by others, because overall cardiovascular morbidity and mortality is reduced in individuals who shift from the high normal to the normal BP category.

Although most studies show significant reductions in resting BP as a result of aerobic exercise training, other studies comparing the effects of ST and aerobic training on resting BP have also shown no differences between aerobic and ST for the effectiveness in reducing resting BP.
et al. \cite{93} compared 20 weeks of moderate to heavy resistance ST to aerobic training and no exercise in 37 previously sedentary middle-aged men. No significant changes in resting BP were detected following training in any of the groups. Blumenthal et al. \cite{110} studied 99 men and women with untreated mild hypertension (SBP 140 to 180mm Hg, DBP 90 to 105mm Hg) randomly assigned to 4 months of either aerobic exercise training, strength and flexibility training, or a control group. Despite significant within-group reductions of 7 to 9mm Hg in resting SBP and 5 to 6mm Hg in resting DBP following ST, there were no significant differences between any of the groups. There were also no significant group differences when comparing ambulatory BP readings before and after the training period. No studies could be found that independently assessed the effect of ST on the BP of older adults with essential hypertension.

4. Diabetes Mellitus

4.1 Glucose Intolerance and Insulin Resistance

Aging is associated with impaired glucose metabolism. \cite{111,112} predisposing older men and women to the development of insulin resistance syndrome, \cite{113} diabetes mellitus, \cite{112} and CHD. \cite{114} Since age-associated reductions in muscle mass are thought to be related to a deterioration in glucose metabolism, \cite{13} it has been hypothesised that ST and subsequent increases in FFM may improve glucose and insulin responses to a glucose load in older populations. \cite{93,115} However, ST does not usually change glucose tolerance, \cite{71,115-117} or glycaemic control regardless of age, unless baseline glucose tolerance is abnormal. \cite{93,118-122} Nevertheless, ST reduces insulin responses during an oral glucose tolerance test (OGTT) in young, middle-aged and older men in many \cite{71,115-117} but not all \cite{96} studies. In addition, ST studies have shown improvements in insulin sensitivity during hyperglycaemic and hyperinsulinaemic-euglycaemic clamps in healthy and diabetic middle-aged men \cite{115,123,124} and women. \cite{125} In addition to being important in the aetiology of diabetes mellitus, glucose intolerance and insulin resistance are independent risk factors for CHD, \cite{114,126,127} and are also associated with hypertension, \cite{128} elevated blood levels of LDL and reduced levels of HDL-C. \cite{129} The prevalence of glucose intolerance increases with age, \cite{13,130-133} because of insulin resistance. \cite{112} This leads to hyperinsulinaemia \cite{111,113} and may be caused by increased adiposity and/or decreased physical activity. \cite{134-136} Evidence for this comes from Pacini et al. \cite{136} who found no independent association between age and glucose tolerance when the effects of obesity and physical activity were eliminated from consideration. Broughton and Taylor \cite{134} reached a similar conclusion based on their analysis of previous studies. Glucose intolerance has also been found to be associated with age-related losses of muscle mass. \cite{13} However, the age-associated deterioration in glucose tolerance and increase in hyperinsulinaemia are not observed in older athletes who do not participate in the type of exercise that leads to muscular hypertrophy, \cite{137} whereas such deterioration is observed in older athletes who have substantially greater muscle mass. \cite{138} Moreover, aerobic exercise training reduces plasma insulin responses to an oral glucose challenge in older individuals even though it does not increase muscle mass. \cite{139} Thus, the evidence does not support the hypothesis that a reduced muscle mass with age is responsible for a deterioration in glucose tolerance.

It has commonly been believed, based on the notion that improvements in glucose metabolism were dependent on reductions in body fat \cite{140} and increases in VO$_{2\text{max}}$. \cite{141} that only aerobic exercise training should be recommended for improving glucose homeostasis. \cite{142} However, ST has been observed to improve glucose metabolism in individuals with normal \cite{71,93} and abnormal \cite{122} glucose metabolism, even when body fat or VO$_{2\text{max}}$ is not changed. Some individuals with impaired glucose tolerance become normalised following ST. \cite{93} Glucose metabolism is improved in both young \cite{117,118} and older \cite{116,143} individuals with ST, most often in the form of blunted plasma insulin responses to an
OGTT, but a blunted glucose response has also been demonstrated in middle-aged individuals.\cite{93,122}

Improvements in glucose tolerance\cite{144,145} or glycaemic control\cite{146-148} have been shown preponderantly in ST studies involving middle-aged individuals with impaired glucose tolerance and/or type 2 diabetes mellitus, but most other studies show no change in glucose tolerance with ST in young,\cite{23,149} middle-aged\cite{86,150} and older\cite{149,151} men, as well as older women.\cite{153} Similarly to these findings, Hersey et al.\cite{98} found that ST did not improve glucose responses to an OGTT in healthy 70- to 79-year-old men and women, but in contrast to others who found improved insulin responses, they also found no improvement in insulin responses. Other ST studies using hyperinsulinaemic-euglycaemic clamps and intravenous insulin tolerance tests have shown improvements in glucose uptake and insulin sensitivity in normally glucose-tolerant middle-aged\cite{115} and elderly\cite{153} men, middle-aged women,\cite{125} as well as individuals with type 2 diabetes mellitus.\cite{124}

Heavy resistance ST increased insulin action and reduced hyperinsulinaemia in postmenopausal women with or without bodyweight loss,\cite{125} and increased glucose uptake by 23% in middle-aged and older (50 to 70 years) men.\cite{115} A potential mechanism that explains how ST might improve glucose tolerance and/or insulin sensitivity has not yet been reported. However, the reduced plasma insulin response to an OGTT with ST appears to result from an increase in insulin clearance, not a decrease in insulin secretion.\cite{143}

4.2 Aerobic Training Versus Strength Training

We could only find 3 studies that compared the effects of aerobic exercise training to ST on glucose homeostasis in middle-aged to older men and women.\cite{93,98,122} Hersey et al.\cite{98} found that only aerobic training lowered plasma insulin responses to an OGTT, whereas Smutok et al.\cite{93,122} observed from our laboratory that both aerobic and moderate to heavy resistance ST reduced glucose and insulin responses to an OGTT. There are a number of potentially important differences among these studies. Hersey and co-workers\cite{98} studied older persons than Smutok and co-workers\cite{93,122} (70- to 79- vs 50- to 70-year-olds). Hersey and co-workers\cite{98} also studied both men and women, whereas Smutok et al.\cite{93,122} studied only men. The resistance used and the relative increases in both upper and lower body muscular strength were also much greater in the Smutok et al.\cite{93,122} study compared with those in the Hersey et al.\cite{98} study. Thus, it is possible that older individuals may require heavy resistance ST to improve their glucose and insulin responses to an OGTT.

To further address these issues, we recently studied the effects of a heavy resistance ST programme on glucose and insulin responses to an OGTT and compared these responses in young (20 to 30 years) and older (65 to 75 years) men and women who received the same relative training stimulus.\cite{152} Until this investigation, no other studies had compared glucose-stimulated glucose and insulin responses with ST between older men and older women using the same relative training protocol. This comparison has potentially important health implications for elderly people, because elevated blood glucose levels are associated with a higher RR of mortality in women than in men.\cite{67} The results demonstrate that the effects of ST on insulin response to an OGTT may be different for older men than for older women. In response to ST, men had reduced insulin responses at several time points with no changes in glucose responses to an OGTT, whereas women showed nonsignificant trends for increases in glucose and insulin responses at the same time points during the OGTT.\cite{152}

Thus, substantial evidence exists to support the conclusion that ST can improve glucose homeostasis in men, and that ST may be just as effective as aerobic exercise training as an intervention against insulin resistance in men, but this does not appear to be the case in women.

5. Metabolic Syndrome

Abdominal obesity is thought to be the first step in a series of events that leads to insulin resistance, glucose intolerance, abnormal lipoprotein-lipid profiles and hypertension.\cite{131,154,155} This constell-
tion of risk factors for cardiovascular disease, diabetes mellitus and hypertension has been called many names, including syndrome X, the deadly quartet, the Reaven syndrome, the insulin resistance syndrome, the atherothrombogenic syndrome,[149] the plurimetabolic syndrome,[97] the abdominal obesity syndrome and the metabolic syndrome.[131,154,155] Although there may be a genetic predisposition for abdominal obesity, increasing age, high fat diets and a sedentary lifestyle are also thought to be important determinants.[154,155]

5.1 Intra-Abdominal Fat

ST can reduce total body fat stores in older men and women, even when individuals are not undergoing restriction of energy intake.[31] However, since abdominal obesity is more consistently related to a metabolic profile predictive of cardiovascular disease risk than is general obesity,[97] a more important issue may be the effects of ST on abdominal visceral fat depots. Aging is associated with a preferential deposition of fat in the abdominal region, especially in men.[156] Abdominal obesity may increase the risk for cardiovascular disease independent of other cardiovascular disease risk factors,[157] but it is also closely associated with other risk factors.[154,155]

There is very little information available on the effects of ST on visceral fat in older individuals. Using dual energy x-ray absorptiometry, Treuth et al.[31] observed reductions in truncal fat mass of middle-aged and older (50 to 70 years) men after 16 weeks of total body ST. In a follow-up study using computed tomography, Treuth et al.[94] found significant ST-induced reductions in intra-abdominal fat in older women. However, diet cannot be ruled out as a factor that could have affected the results from ST studies addressing intra-abdominal fat.

Although no studies measuring abdominal fat have controlled diet adequately throughout the entire training programme, Ross and co-workers[158,159] have performed some of the best controlled studies assessing the effects of diet and exercise training. They used magnetic resonance imaging to provide a direct measurement of fat tissue in studies comparing regional fat losses with diet combined with either aerobic exercise training or ST. In their first study,[158] there were no differences between the 2 groups (i.e. diet and aerobic exercise training vs diet and ST) for losses in either whole body subcutaneous fat or visceral fat, but within each group there was a significantly greater visceral fat loss compared with subcutaneous fat loss. In a follow-up study[106] they isolated the effects of aerobic exercise training and ST by comparing the responses to diet alone and diet combined with each training modality in 33 middle-aged obese men. All 3 groups lost a substantial amount of whole body subcutaneous and visceral fat, and all 3 groups experienced a significantly greater visceral fat loss compared with whole body subcutaneous fat loss. The changes amounted to a 39% reduction in visceral fat in the diet and aerobic training group, a 40% reduction in the diet and ST group and a 32% reduction in the diet only group. These differences among the groups were not significant. We estimated that the low volume ST programme required less than a third of the energy required for the aerobic training programme. When comparing losses from the abdominal subcutaneous fat depot to those from the gluteofemoral (leg) region, there was a preferential loss from the abdominal region in the 2 training and diet groups, but no preferential losses in the diet-only group. Both training and diet groups had the advantage of maintaining whole body skeletal muscle tissue, whereas the diet only group lost muscle tissue.

It is somewhat surprising that the aerobic training programme did not result in significantly greater fat losses compared with ST because the caloric expenditure associated with ST sessions is substantially less than generally occurs during aerobic training sessions. It is unclear exactly what accounts for this discrepancy in energy balance, but one possible explanation could be increases in resting metabolic rate (RMR) with ST.

5.2 Resting Metabolic Rate

Aging is associated with a loss of FFM and an increase in fat mass.[156] FFM loss is accompanied...
by a decline in RMR, which can lead to obesity. Although FFM is by far the major determinant of RMR, explaining approximately 60 to 70% of the interindividual variability, the age-related reduction in Na⁺-K⁺ pump activity also contributes to the decline in RMR with age.

In a cross-sectional study, Poehlman et al. found higher RMR values in ST athletes compared with untrained controls. Investigators who have examined the effect of ST on RMR have shown mixed results, whether men and women were studied separately or combined. Most studies have demonstrated an increase in RMR in older individuals in response to ST. In contrast, investigations in young individuals have found a consistent lack of change in RMR with ST. One study that compared age responses of RMR to ST showed no change in RMR for either young (age 26 years) or older (age 70 years) individuals. This finding could be related to the fact that neither group increased FFM in response to ST. Pratley et al. from our group, studied 50- to 65-year-old men before and after 16 weeks of heavy resistance ST and observed a 2.6% increase in FFM, a 7.7% increase in RMR and a 36% increase in resting plasma noradrenaline levels. We concluded that the increases in FFM and the increased activity of the sympathetic nervous system may be responsible for the training-induced increase in RMR. Campbell et al. also found increases in FFM and RMR in older men and women with heavy resistance ST. However, they concluded that the increase in RMR was caused by an increase in the metabolic activity of lean tissue and not an increase in FFM, since the increase in FFM was reported to be caused by an increase in body water. Ryan et al. observed a significant rise in RMR in postmenopausal women aged 50 to 69 years as a result of heavy resistance ST with and without bodyweight loss. In another study, during bodyweight loss from a very low energy diet, lean body mass and RMR were preserved by the addition of a high volume ST programme.

However, other studies failed to show increases in RMR with ST. Taaffe et al. for example, reported that neither low- nor high-intensity ST altered RMR significantly. In addition, Treuth et al. found that increases in RMR as a result of ST in postmenopausal women were not significant when increases in FFM were taken into account. Similar findings were reported by Van Etten et al. who observed no significant increases in metabolic rate with ST during sleep. Differences in training regimens and testing conditions may explain some of the discrepancies on this issue. As has been previously well established for aerobic training, both Van Etten et al. and Treuth et al. reported that ST significantly increased fat oxidation.

It has been suggested that increases in RMR and energy expenditure from physical activity outside of training could explain fat losses that sometimes occur with ST by increasing the total energy expenditure outside of training. However, we recently observed no changes in energy expenditure from physical activity outside of training following a 6-month ST programme in 65- to 75-year-old men and women. In addition, we found that changes in RMR in response to ST were affected by gender, but not by age. When young (20 to 30 years) and older (65 to 75 years) men were pooled as a group, there was a significant increase in RMR with training, whereas young (20 to 30 years) and older (65 to 75 years) women showed no change. When all groups were combined, there was again an increase in RMR. Furthermore, when RMR was corrected for FFM there was still a significant gender effect, with the men showing a significant increase in RMR, while women showed no change, despite having similar increases in total body FFM. Others have observed increases in RMR with ST when older men and women are pooled together, but the finding that this change is not significantly different from young men and women had not been reported previously. The finding of a lack of change in RMR in women is consistent with some previous studies in both young and older women and may be related...
to differences in sympathetic nervous system activity.\[165\]

6. Osteoporosis

6.1 Fracture Risk Increases with Age

Osteoporosis is one of the most prevalent conditions in postmenopausal women and the prevalence of osteoporosis also increases with age in men, though it is a greater public health concern in women. The morbid events associated with osteoporosis are fractures that primarily occur in the neck of the femur, the vertebrae and the forearm in older men and women. The loss of BMD after menopause in women results in a doubling of hip fracture risk for every 5 years of age past the age of 50 years.\[178\] A third of 80-year-old women will have had a hip fracture and a third of those affected will have had 2 hip fractures.\[178\] The end result is that osteoporosis affects 25 million people, with most of them women, and osteoporosis is the primary cause of 1.5 million fractures annually.\[179\]

6.2 Bone Mineral Density

One major risk factor for hip fracture is low BMD. BMD decreases markedly in women in the 2 to 5 years immediately after menopause and continues to decline at a slower rate thereafter.\[179\] As a result, maintenance or enhancement of BMD in older persons, especially older women, is a major public health concern. Determining whether various forms of physical activity enhance BMD at critical skeletal sites in postmenopausal women has been a major area of research in recent years.

Because BMD is related to the strength of the proximal muscle groups\[12,180\] and because positive associations have been reported between BMD and muscle strength\[181-183\] and between bone mass and FFM,\[184\] ST has been hypothesised as an exercise intervention of choice for preserving age-associated losses in BMD. In this regard, Bevier et al.\[185\] in a cross-sectional study reported that muscular strength was a better predictor of BMD in older men and women than \(\text{VO}_{2\text{max}}\). Similarly, a number of studies have documented that those who participate in ST have markedly enhanced BMD compared with their sedentary peers.\[186,187\]

In 50- to 70-year-old women, Nelson and co-workers\[175\] found that heavy resistance ST essentially maintained BMD (0.9 and 1.0% increases at femoral neck and lumbar spine, respectively), whereas BMD decreased by 2.5% at the femoral neck and 1.8% in the lumbar spine in the control group. The elevated values for both femoral neck and the lumbar spine BMD were significantly different in the ST intervention group compared with the losses in the control group. Notelevitz and co-workers\[188\] found that 1 year of ST combined with estrogen replacement therapy increased spine, radial midshaft and total body BMD more in surgically postmenopausal women than did estrogen replacement therapy alone. Pruitt and colleagues\[189\] reported that 9 months of ST increased BMD at the lumbar spine, but not the femoral neck and distal wrist, in women with an average age of 54 years.

There appears to be a great deal of conflicting results in the literature on the effects of age and gender on BMD in response to ST, even from our own laboratory. For example, we reported that 50- to 70-year-old men increase femoral neck BMD and tend to increase lumbar spine BMD with 16 weeks of heavy resistance ST.\[190,191\] However, in a more recent study (Ryan AS, Ivey FM, Hurbut DE, et al., unpublished data), we observed significant increases in BMD in several regions in young men and young women (20- to 30-year-olds), but no significant changes were observed in any regions in older men or in older women. Other studies have indicated that ST increased,\[192,193\] did not change\[194\] or decreased\[195\] BMD in premenopausal women and increased\[175\] or maintained\[181,189\] BMD in postmenopausal women. Ward’s triangle BMD increased after 16 weeks of ST in elderly men,\[196\] but lumbar spine and femoral neck BMD have shown inconsistent responses in middle-aged and older men, with some studies showing increases\[190,191\] and other studies showing no significant changes in these regions.\[196\]

Because of the many conflicting reports it is difficult to make any definitive conclusions about the
effects of ST on specific regions of BMD. However, there does seem to be evidence from the best controlled studies that ST can at least prevent some of the losses in BMD that occur over time in older persons. Even among the studies that show significant increases in BMD with ST, the magnitude of these changes are not usually substantial enough to markedly reduce an older person’s risk of bone fracture once a fall occurs. It has been estimated that increases in BMD of >20% would be required to provide adequate protection against bone fractures resulting from falls. Given the fact that most studies report <5% increase in BMD from any exercise training modality, it is more likely that exercise training could play a role in the prevention of falls rather than the prevention of fractures once a fall occurs.

7. Osteoarthritis

Osteoarthritis, the most common form of arthritis, is characterised by a progressive loss of articular cartilage around the affected joint leading to pain and functional disability. The prevalence of osteoarthritis increases with age and is seen most often in older women. Muscle atrophy and weakness have been hypothesised to contribute to the disability and pain of patients with osteoarthritis. Thus, ST is thought to reduce functional instability and pain in older osteoarthritis patients by preventing sarcopenia and by improving the strength and function of the surrounding connective tissue, which is often damaged by the disease. Early research indicated that both moderate and heavy resistance training resulted in improvements in pain and disability; however, possible methodological and research design flaws may have affected the results in these studies.

Recent evidence, however, provides similar support for a role for ST in osteoarthritis therapy programmes. Schilke et al. demonstrated that an 8-week ST programme improved strength and mobility and decreased joint pain and stiffness in patients with knee osteoarthritis. Further, improvements in both the Osteoarthritis Screening Index and the Arthritis Impact Measurement Scale indicated a significant decrease in arthritis activity in patients who underwent ST. Ettinger et al. assessed 365 community-dwelling adults with knee osteoarthritis and self-reported physical disability. The individuals underwent either an aerobic exercise training programme, a ST programme or a health education programme. Significant but modest improvements were reported for self-reported disability, knee pain and other indices of physical function and strength in individuals from both the aerobic and ST programmes. The researchers concluded that both moderate-intensity aerobic and ST were generally well tolerated and effective therapies for older individuals with knee osteoarthritis. Most recently, Rogind et al. examined the role of a general physical activity programme that included progressive ST exercises in patients with severe knee osteoarthritis, and reported improved quadriceps strength, decreased pain, improved walking speed and decreased Algofunctional Index scores (an indicator of pain, discomfort and dysfunction). The researchers concluded that including strengthening exercises in a physical activity programme was beneficial for patients with severe knee osteoarthritis, although possible adverse effects such as knee joint effusions were discussed.

In summary, research provides evidence for the benefits of ST in patients with knee osteoarthritis, although the appropriate level of resistance and possible long term consequences of ST in these patients are unclear. Further work is necessary to determine the most appropriate ST programme for osteoarthritis patients. Nevertheless, specific guidelines for the use of exercise in the treatment of osteoarthritis have been discussed recently.

8. Prevention of Disability

8.1 Loss of Flexibility

The loss of flexibility or joint range of motion (ROM) with age is well documented and is related to physical dysfunction and a decline in health status. This loss in flexibility may be associated with difficulty in climbing stairs, getting up from a chair or bed and the need for walking.
Much of this loss is thought to be caused by inactivity, suggesting that increasing muscular activity might at least delay losses in flexibility. Kligman and Pepin concluded that older adults who maintain high levels of muscular strength and flexibility are rarely candidates for long term healthcare.

It has often been concluded that as long as ST exercises are performed through the full ROM and both the agonist and antagonist muscle groups are exercised, ST will improve flexibility; however, we were unable to find any published data to support this conclusion. Despite this potential link between muscular strength and flexibility, little information is available from well controlled published studies concerning the impact of ST on flexibility in older adults. Furthermore, most studies that have investigated the effects of ST on flexibility have included stretching exercises in the training programme, and thus the independent effects of ST on flexibility have not been studied appropriately. In a study from our laboratory, joint ROM was assessed in older individuals (mean 61 years) before and after they performed either strength and flexibility training, flexibility-only training, or no training for 10 weeks. Despite performing all exercises through the full ROM, training both the agonist and antagonist muscle groups, and performing stretching exercises before and after every ST session, as is recommended for improving flexibility, no significant improvements in flexibility were demonstrated in the individuals who performed both strength and flexibility training compared with the inactive control group. Moreover, there was significantly greater improvement in shoulder abduction in the individuals who performed the flexibility-only training compared with the strength and flexibility training and to the inactive control groups.

Other investigations that have assessed whether ST can improve flexibility either used only young individuals, did not indicate if stretching exercises were incorporated, included aerobic exercise in the training programme, used only low-resistance exercise, or did not control for other factors that can affect flexibility. These methodological differences may explain why investigators have reported increases, no change or losses in flexibility with ST. Thus, there is no definitive evidence that a total body ST programme in itself improves flexibility in older adults. To the contrary, based on our work on this topic, it is more likely that ST inhibits flexibility.

8.2 Fall Prevention

Cognitive impairment, visual deficits, environmental conditions and medication use may combine with physical activity–related risk factors such as neuromuscular, gait and balance impairments to increase the risk of falls. Although many authors have emphasised the importance of regular exercise for prevention of falls in the elderly, only very limited data are available on this topic and the information available is not conclusive. Nevertheless, ST can improve strength, muscular power, walking mechanics and walking speed in the elderly, all important risk factors for falls.

9. Conclusion

Table 1 provides an overview comparing the effects of aging to the effects of ST on indicators of muscle function and health status. The following conclusions can be made about the effects of ST on risk factors for age-related diseases or disabilities:

(i) Approximately 2 decades worth of age-associated losses in strength and muscle mass can...
be regained within the first couple of months of heavy resistance ST.

(ii) ST fails to produce substantial changes in VO\textsubscript{2max}, but can improve endurance performance.

(iii) There is little or no evidence that ST can improve mean values of lipoprotein-lipid profiles. It is possible that people with certain genotypes may be able to improve their profiles with ST, but no evidence for this exists at the present time.

(iv) There is no evidence that ST can reduce BP in elderly hypertensives, but there is now evidence for normalising BP in the high normal category.

(v) Some studies show no changes in glucose tolerance with ST and others show reductions in plasma glucose in response to oral glucose tolerance tests. However, most studies show that ST can improve insulin action either through reductions in insulin responses from oral glucose tolerance tests or increased glucose uptake from glycaemic clamp studies.

(vi) There is evidence for reductions in total body fat and intra-abdominal fat with ST. However, no studies that have reported this have been able to completely rule out the effects of diet.

(vii) There is some evidence that ST can increase RMR in older men, but there is little evidence for this effect in women. An explanation for this gender difference has not been determined, but differences in sympathetic neural activity in response to ST has been suggested.

(viii) The evidence for increases in BMD with ST is mixed, but there is good evidence for the effectiveness of ST in preventing age-associated losses in BMD.

<table>
<thead>
<tr>
<th>Disease/risk factors</th>
<th>Effects of aging</th>
<th>Reference</th>
<th>Effects of strength training</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sarcopenia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>muscular strength</td>
<td>↓↓↓</td>
<td>2, 3</td>
<td>↑↑↑</td>
<td>34</td>
</tr>
<tr>
<td>muscle mass</td>
<td>↓↓</td>
<td>156</td>
<td>↑↑</td>
<td>22-32</td>
</tr>
<tr>
<td>muscle power</td>
<td>↓↓</td>
<td>33</td>
<td>↑</td>
<td>231</td>
</tr>
<tr>
<td>muscle quality</td>
<td>↓</td>
<td>2, 3</td>
<td>↑</td>
<td>35</td>
</tr>
<tr>
<td>Coronary heart disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VO\textsubscript{2max}</td>
<td>↓↓</td>
<td>69</td>
<td>↔</td>
<td>71-74</td>
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<tr>
<td>endurance performance</td>
<td>↓↓</td>
<td>69</td>
<td>↑</td>
<td>76-78</td>
</tr>
<tr>
<td>plasma lipoprotein-lipid profile</td>
<td>↓ or ↔</td>
<td>79-83</td>
<td>↔</td>
<td>89-94</td>
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<td>102</td>
<td>↓ or ↔</td>
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<td>Diabetes</td>
<td></td>
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<tr>
<td>glucose intolerance</td>
<td>↑</td>
<td>13, 130-133</td>
<td>↓ or ↔</td>
<td>71, 93, 98, 116, 122, 143, 149, 151, 152</td>
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<tr>
<td>insulin resistance</td>
<td>↑</td>
<td>132</td>
<td>↑ men, ↔ women</td>
<td>67, 98, 115, 124, 125, 152, 153</td>
</tr>
<tr>
<td>Abdominal obesity syndrome</td>
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<td></td>
<td></td>
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<td>↑↑</td>
<td>156</td>
<td>↓</td>
<td>31</td>
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<tr>
<td>intra-abdominal fat</td>
<td>↑</td>
<td>154, 155</td>
<td>↓ or ?</td>
<td>31, 94, 158, 159</td>
</tr>
<tr>
<td>resting metabolic rate</td>
<td>↓</td>
<td>161, 162</td>
<td>↑ men, ↔ women</td>
<td>144, 165, 169-173, 177</td>
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<tr>
<td>Osteoporosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>bone mineral density</td>
<td>↓</td>
<td>12, 179</td>
<td>↑ or ↔</td>
<td>175, 181, 186-191, 196 (unpublished data)*</td>
</tr>
<tr>
<td>risk of falls</td>
<td>↑</td>
<td>10</td>
<td>↓</td>
<td>22, 175</td>
</tr>
<tr>
<td>Loss of flexibility</td>
<td>↑</td>
<td>146, 213, 214</td>
<td>↔ or ↑</td>
<td>217, 220-225, 227, 228</td>
</tr>
<tr>
<td>Osteoarthritis</td>
<td>↑</td>
<td>199</td>
<td>↓</td>
<td>203, 208-211</td>
</tr>
</tbody>
</table>


VO\textsubscript{2max} = maximal oxygen uptake; ↓ = decrease; ↓↓ = moderate to large decrease; ↓↓↓ = very large decrease; ↑ = increase; ↑↑ = moderate to large increase; ↑↑↑ = very large increase; ↔ = little or no change or conflicting evidence; ? = unknown or too little data available to conclude.
(ix) Although there is little or no evidence for ST preventing falls, there is strong evidence for reduction in several risk factors for falls.

(x) There is no evidence from properly controlled studies that ST improves flexibility, even when both the agonist and antagonist muscle groups are trained through the full ROM. There is suggestive evidence that ST in itself may even worsen flexibility. Therefore, prolonged stretching should be a part of any well designed ST programme.

(xi) There is some evidence that ST may reduce symptoms of osteoarthritis in the knee, but better controlled studies are needed.

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