Original article

Whole-body strength training with Huber Motion Lab and traditional strength training in cardiac rehabilitation: A randomized controlled study

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ARTICLE INFO

Article history:
Received 14 May 2016
Accepted 20 July 2016

Keywords:
Strength training
Cardiac rehabilitation
Isometric contraction

ABSTRACT

Background: Isometric strengthening has been rarely studied in patients with coronary heart disease (CHD), mainly because of possible potential side effects and lack of appropriate and reliable devices.

Objective: We aimed to compare 2 different modes of resistance training, an isometric mode with the Huber Motion Lab (HML) and traditional strength training (TST), in CHD patients undergoing a cardiac rehabilitation program.

Design: We randomly assigned 50 patients to HML or TST. Patients underwent complete blinded evaluation before and after the rehabilitation program, including testing for cardiopulmonary exercise, maximal isometric voluntary contraction, endothelial function and body composition.

Results: After 4 weeks of training (16 sessions), the groups did not differ in body composition, anthropometric characteristics, or endothelial function. With HML, peak power output (P = 0.035), maximal heart rate (P < 0.01) and gain of force measured in the chest press position (P < 0.02) were greater after versus before training.

Conclusion: Both protocols appeared to be well tolerated, safe and feasible for these CHD patients. A training protocol involving 6 s phases of isometric contractions with 10 s of passive recovery on an HML device could be safely implemented in rehabilitation programs for patients with CHD and improve functional outcomes.

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1. Introduction

Physical activity is considered an effective non-pharmacological intervention for both primary and secondary prevention of coronary heart disease (CHD) [1]. For the last 30 years, resistance training combined with aerobic endurance exercises has been an integral part of international recommendations for prevention and rehabilitation in patients with CHD [2–5] and is now considered by the medical community as an essential part of exercise programs. Muscle mass and muscle strength decrease by about 30% between the third and sixth decades of life [6]. With aging, the total number of muscle fibres decreases, especially fast-twitch muscle fibres, which are recruited during the development of force. In CHD patients, increasing muscle strength and function can help improve health features such as insulin resistance, endothelial function, and quality of life [7]. As well, resistance exercise positively affects proprioceptive abilities, thereby leading to a...

http://dx.doi.org/10.1016/j.rehab.2016.07.385
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gradual improvement in coordination and gait control, which reduces the risk of falls [7–9].

Unfortunately, the range of techniques or devices available to increase the efficacy of cardiac rehabilitation (CR) remains limited [10]. Among new devices, the Huber Motion Lab (HML), a motorised rotating platform, seems to feature the qualities needed in such programs because it allows patients to perform exercises that simultaneously involve balance, coordination and strength training. In 2015, our team showed that exercise sessions with the HML, based on very short periods of exercise (6 s) at 70% of the maximal isometric voluntary contraction (MVC), interspersed with short periods of passive recovery were safe and well tolerated for selected patients with stable coronary disease [11]. Moreover, a recent study showed that 8 weeks of training on the HML had a positive impact on body composition (especially decreased body fat), anthropometric data (reduced waist circumference), muscle performance (strength) and walking economy in healthy people [12].

HML training and traditional strength training (TST) have never been compared for efficacy in patients with CHD. We aimed to compare a conventional rehabilitation program associating global aerobic reconditioning with dynamic/segmental aerobic muscle strength training and a program combining aerobic training and isometric exercises predominantly based on the HML in such patients.

2. Materials and methods

2.1. Patients

We recruited 50 patients with CHD from the cardiovascular rehabilitation centre of Saint Orens (France). Inclusion criteria were ≥70% arterial diameter narrowing of at least one major coronary artery and/or documented previous myocardial infarction. Exclusion criteria were recent acute coronary syndrome (≤1 month), significant resting electrocardiography (ECG) abnormality, severe arrhythmia, history of congestive heart failure, uncontrolled hypertension, bypass surgery ≤3 months, percutaneous coronary intervention ≤1 month, left ventricular ejection fraction <45%, pacemaker installation, modification of medication <2 weeks, and musculoskeletal conditions making exercise on a cycle ergometer difficult or contraindicated. Patients provided written informed consent. The research protocol was approved by the Committee for the Protection of Human Subjects (Toulouse, France).

2.2. Study design

All patients were enrolled in an outpatient CR program (CRP). On the first and last visit, patients underwent a complete medical evaluation that included measurement of height, weight, body composition, resting ECG variables, endothelial function, muscular function, quality of life, quality of sleep, and fitness based on a maximal cardiopulmonary exercise test (CPET) performed on a cycle ergometer. After the first visit, patients were randomly assigned to the HML or TST group. The sole difference between groups was the strength training activity (HML or resistance training machines). The CRP focused on optimizing the medical treatment, controlling cardiovascular risk factors, diet monitoring, therapeutic education sessions and psychological support when needed.

The exercise program lasted 3 hr/day, 4 days/week. The daily activity training included 1) a 45-min strength training activity using machines (TST) or HML (HML group) and 2) a 45-min walking session outside or 45-min of cycling at the target heart rate determined during the stress test (i.e., 60–80% of the heart rate reserve) [13,14]. Furthermore, the patients participated in relaxation sessions or aquatic relaxation sessions (45 min). Each session was monitored by a physiotherapist and was supervised by a cardiologist. In addition to the exercise protocol, patients were involved in therapeutic education sessions conducted by a multidisciplinary team with workshops and conferences on cardiovascular risk factors and treatment knowledge (~3–4 hr/week).

2.3. Exercise sessions

2.3.1. Whole-body strength training with HML and assessment of MVC

The Huber Motion Lab (LPG Systems, France) is an oscillating platform with 2 large handles mounted on a movable column. Several feet and hand positions are marked on the platform and handles, respectively (Fig. 1). HML exercises consist of adopting specific positions, defined as a combination of various foot and hand positions, and developing low-high force levels against the handles. These actions require the synergistic activation of various

Fig. 1. The Huber Motion Lab, an oscillating platform with 2 large handles mounted on a movable column. Several feet and hand positions are marked on the platform and handles, respectively.

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muscle groups of the lower limbs, trunk and upper limbs. The
handles are equipped with strain gauges, and feedback about the
force developed is provided to users. Additionally, an interactive
interface, shown as a target, informs the subject about their ability
to maintain the required force level. This “game-like” control panel
is intended to increase the user's motivation to practice and adhere
to the MVC training program [12].

MVC was measured in standardized positions before each
subsequent position (Fig. 1). Patients were asked to exert maximal
isometric pushing and pulling forces (i.e., opposite actions with the
2 hands on the handles). For each position, pulling and pushing
forces were recorded by the strain gauges on the handles. Patients
performed two 6 s MVCs for each position. A third trial was
performed when the difference in results between the first 2 trials
was > 5%. Verbal encouragement and visual feedback about the
force developed were provided to patients during each MVC. The
greatest mean force produced over the 6 s period was retained
as the MVC value for each action (i.e., pulling and pushing force).

2.3.2. HML sessions

The velocity/inclination of the plate (rotation) was set at 30/30
(See HML instructions manual). Both exercises consisted of
6 exercise blocks in different postures. The positions are presented
in Fig. 1. Each block consisted of 6 s alternating pushes and
pulls with 10 s of passive recovery, repeated twice. The total duration of
the session, which included a 3 min warm-up, 10 min of MVC
assessment, 27 min of exercise and 5-min recovery, was 45 min.

The intensity of isometric contraction was set at 70% of the MVC
[11]. All patients performed a familiarization session in the days
before the protocol. To validate and start the protocol, patients had
to validate a coordination score corresponding to a minimum of
60% [11]. Because the MVC was calculated at each session, the
exercise intensity was automatically adapted to enable progress.

2.3.3. TST sessions and assessment of MVC

TST sessions involved a circuit training including 6 different
machines: leg press, chest press, vertical traction (shoulder press),
low row (working back), pectoral (butterfly) and leg extension.
Movements allowed for dynamically working the same muscle
groups as with the HML. According to the guidelines for resistance
training in cardiac rehabilitation, we set the intensity at 60% of
MVC. At each position, patients were asked to repeat 3 series of
12 repetitions. With TST, the MVC was calculated by using the one-
repetition maximum test (1-RM) on each machine at the beginning
of each week during the program.

2.4. Measures

Measures were recorded twice by a cardiologist, a physiother-
apist and a nurse the day after admission (pre) and the evening
before hospital discharge (post).

2.4.1. Anthropometric variables and body composition

The formula used for calculating BMI was weight in kilograms
(kg) divided by height in meters (m) squared. The waist
circumference was determined by use of a measuring tape (e.g.,
K & E type) placed halfway between the lower part of the ribcage
and the hipbone. Body composition was measured by bioelectrical
impedance by using the BODYSAT 1500 (Bodystat Ltd., British
Isles).

2.4.2. Endothelial function

Reactive hyperemia index (RHI), a measure of endothelial
function, was assessed by using the EndoPAT 2000 device (Itamar
Medical, Israel). This measurement was calculated by using a
computersised automated algorithm provided with the accompa-
nying software (v3.1.2) and performed according to the manu-
facturer’s instructions. Briefly, patients were in a supine position
for a minimum of 20 min before measurement in a quiet,
temperature-controlled (21–24 °C) room with dimmed lights.
Patients were asked to remain as still as possible and silent during
the entire measurement period. Each recording consisted of 5 min
baseline measurement, 5 min occlusion measurement, and 5 min
post-occlusion measurement (hyperemic period). Occlusion of the
brachial artery involved the nondominant upper arm. The
occlusion pressure was at least 60 mmHg above the systolic blood
pressure (BP) (minimally 200 mmHg, and maximally 300 mmHg).
The natural logarithmic scaled RHI (L_RHI) was calculated from the
ratio between the digital pulse volume during RH and at baseline
[15].

2.4.3. MVC

Patients were seated on the extremity of a bench. The bench
was raised to ensure that the feet did not contact the floor. The
knee joint tested was set in the gravity-neutral position. The thigh
was strapped to the bench. The MVC of the quadriceps was tested
by using a strain gauge system, the Meas FN3148 Load cell with mechanical stops (Measurement Specialties, Aliso Viejo, CA). This
strain gauge has an accuracy of 0.05% and range of 0–2000 N. It is
quality certified. Extremities of the strain gauges were attached to
steel cables by hooks. One of the steel cables was attached to
a bench hook and the other end to the ankle by use of a strap.
The strain gauge and strap were set perpendicular to the line of
force. Analogic strain gauge readings were transferred to software on
a computer via a sensor interface. Once installed in the apparatus,
patients, with their arms crossed over their chest, were asked to
extend their knee as strongly as possible against the resistance of
the cable steel for a contraction period with a 1 s transition period
and a 4- to 5 s plateau that is supposed to be sufficient to achieve
maximal isometric contraction. The time force motion was
numerically registered and visualized during extension. The peak
force was identified on the curve according to the reliability of the
decision by 2 assessors. Three trials separated by 1-min rest
intervals were proposed. The best peak force between the trials
was recorded as the maximal force contraction of the quadriceps
for the study. The same method was used in the chest press
position to measure the strength of the upper body.

2.4.4. Cardiopulmonary stress test

The peak power output (PPO) was determined by a test on an
ergocycle with electromagnetic braking (Ergometrics 900, Ergo-
line, Germany). The PPO corresponds to the power reached at the
last threshold of the test. The initial power was set to 30 W with an
increment of 15 W/min. This progressive increase test was
performed with continuous 12-lead ECG monitoring. Blood
pressure was checked every 2 min during the stress test and
during 6-min recovery (3-min active recovery and 3-min passive
recovery). The Borg scale was used to evaluate the rate of perceived
exertion from 6 to 20 [5]. The stress test was stopped when
the patient was not able to maintain the required power or when the
score of perceived exertion was 15–17/20, in case of severe angina
pectoris (> 5/10), severe arrhythmia, decrease in BP > 10 mmHg or
ST-segment elevation > 2 mm [16]. Metabolic equivalents (METs)
were calculated from the Watts obtained at PPO, considering
that 1 litre of O2 = 5.05 Kcal and 1 MET = 3.5 ml O2/kg body
weight/min.

2.4.5. Quality of life

Health-related quality of life was measured by using the French
version of the Medical Outcomes Study Short Form 36 (SF-36)
[17]. The SF-36 includes 36 questions grouped into 8 categories

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corresponding to physical activity, limits due to the physical state, physical pain, self-perceived health, vitality, relationships with others, psychological health and limits related to the psychological state. For each category, the sum of the item scores was translated linearly to a scale from 0 (maximum exhaustion) to 100 (no exhaustion). Physical activity, physical pain and limits related to the physical state reflect the physical component score (PCS), and self-perceived health, vitality, psychological health, relationships to others and limits related to the psychological state reflect the mental component score (MCS). PCS and MCS were computed by using equations developed by Ware and Kosinski [18].

2.4.6. Sleep quality

The Pittsburgh Sleep Quality Index (PSQI) assesses sleep quality during the previous month and differentiates “good” and “bad” sleepers [19]. Sleep quality is a complex phenomenon that implies several dimensions, each analysed by the PSQI. This questionnaire includes 19 self-assessment questions and 5 questions asked of the life partner, spouse or roommate (as appropriate). The questions correspond to 7 components: subjective sleep quality, sleep latency, sleep duration, habitual sleep efficiency, sleep disturbances, use of sleeping medication, and daytime dysfunction. Only the self-assessment questions are included in the final score. Scores for the 7 components add to a final global score from 0 to 21 points, 0 meaning no sleep difficulty and 21 major difficulties. A global PSQI score > 5 suggests significant sleep disturbances.

3. Statistical analysis

Data are presented as mean ± SD. Shapiro-Wilk and Bartlett tests were used to assess normality and equality of variance among variables analysed, respectively. Chi-square test or Student t test was used to compare data between groups, ANOVA for repeated measures was used to compare times (pre vs post), with training groups (i.e., HML vs TST) entered as a co-factor. When a main effect was found, Fisher least significant difference post-hoc analysis was used to identify potential significant variables discriminating training procedure (HML vs TST). In a second step, we used logistic multiple regression with significant variables found on bivariate analysis as explanatory variables and improvement with training group (HML or TST) as a binary outcome variable. All statistical analyses involved use of SPSS 20.0 (SPSS, Inc., Chicago, IL, USA). P < 0.05 was considered statistically significant.

4. Results

Baseline characteristics are presented in Table 1. All patients (94% men) underwent percutaneous angioplasty. The main cardiovascular risk factors were dyslipidemia (62%), smoking (48%), hypertension (44%) and type 2 diabetes (8%) and the treatment groups did not differ in risk factors. The program attendance was 100%. No adverse event was observed in either group.

Table 1
Baseline characteristics of patients undergoing isometric training with the Huber Motion Lab (HML) and traditional strength training (TST).

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Total (n = 50)</th>
<th>HML (n = 25)</th>
<th>TST (n = 25)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>54.8 ± 10.1</td>
<td>51.2 ± 9.4</td>
<td>58.4 ± 9.5</td>
</tr>
<tr>
<td>Height (m)</td>
<td>1.74 ± 0.08</td>
<td>1.75 ± 0.06</td>
<td>1.73 ± 0.09</td>
</tr>
<tr>
<td>Weight (kg)</td>
<td>84.5 ± 13.2</td>
<td>85.6 ± 11.9</td>
<td>83.4 ± 14.6</td>
</tr>
<tr>
<td>Gender (male/female)</td>
<td>47 (94.3%)</td>
<td>25 (100)/0(0)</td>
<td>22 (88.0%)</td>
</tr>
<tr>
<td>Hypertension</td>
<td>22 (44.0%)</td>
<td>10 (40)</td>
<td>12 (48)</td>
</tr>
<tr>
<td>Currently smoking</td>
<td>24 (48.0%)</td>
<td>15 (60)</td>
<td>9 (36)</td>
</tr>
<tr>
<td>Diabetes</td>
<td>4 (8%)</td>
<td>2 (8)</td>
<td>2 (8)</td>
</tr>
<tr>
<td>Dyslipidemia</td>
<td>31 (62)</td>
<td>16 (64)</td>
<td>15 (60)</td>
</tr>
<tr>
<td>Disease, n (%)</td>
<td>50 (100)</td>
<td>50 (100)</td>
<td>50 (100)</td>
</tr>
<tr>
<td>Coronary disease</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Coronary bridging</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Angioplasty</td>
<td>50 (100)</td>
<td>50 (100)</td>
<td>50 (100)</td>
</tr>
<tr>
<td>Medications, n (%)</td>
<td>4 (8%)</td>
<td>2 (8)</td>
<td>2 (8)</td>
</tr>
</tbody>
</table>

No significant differences at P < 0.05.

After 4 weeks of training (16 sessions), body composition and anthropometric characteristics were not modified, nor was endothelial function, in either group (Table 2). With HML, as compared with before training, training conferred improvement in PPO (P = 0.035), maximal heart rate (P < 0.01) and strength (P < 0.02) (Table 3). The CRP was beneficial in the entire group for both life and sleep quality, with no difference between groups (Table 4).

On logistic multiple regression analysis, improvement with HML versus TST was explained by 3 independent variables: variation in PPO and METs and strength measured in the chest press position after rehabilitation (P < 0.01). The odds ratio (OR) was maximal for strength in the chest press position after rehabilitation (OR = 1.06, 95% CI 0.98–1.15, chi-square P < 0.009) and negligible for variation in PPO and METs (OR = 1.01, –9.5–12.5, and OR = 1.04, –15.9–18). The coefficients of determination (R²) between the baseline variables and these 3 independent variables were all < 0.5, thereby indicating no robust variable predicting change.

5. Discussion

Despite its widespread use in physiotherapy clinics worldwide, the HML has been poorly studied among patients with chronic disease. The HML is an alternative form of exercise known to have a positive effect on both equilibrium and strength in different situations.

Table 2
Four-week changes in anthropometric features, body composition and endothelial function before (pre) and after (post) exercise training.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Total (n = 50)</th>
<th>HML (n = 25)</th>
<th>TST (n = 25)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight (kg)</td>
<td>84.5 ± 13.2</td>
<td>84.1 ± 13.2</td>
<td>85.6 ± 11.9</td>
</tr>
<tr>
<td>Body mass index (kg/m²)</td>
<td>28 ± 4.1</td>
<td>27.9 ± 4.1</td>
<td>28.3 ± 3.8</td>
</tr>
<tr>
<td>Waist circumference (cm)</td>
<td>100 ± 11.5</td>
<td>98.7 ± 11.1</td>
<td>100.7 ± 12</td>
</tr>
<tr>
<td>Fat mass (kg)</td>
<td>21 ± 6.8</td>
<td>20.3 ± 6.44</td>
<td>20.5 ± 6.1</td>
</tr>
<tr>
<td>Fat-free mass (kg)</td>
<td>63.2 ± 9.9</td>
<td>63.3 ± 9.7</td>
<td>65 ± 7.6</td>
</tr>
<tr>
<td>Logarithmic-scaled RH-PAT index (Endopath)</td>
<td>0.71 ± 0.27</td>
<td>0.75 ± 0.27</td>
<td>0.70 ± 0.29</td>
</tr>
</tbody>
</table>

Data are mean ± SD. No significant differences between groups at P < 0.05. ** Time effect (P < 0.01).

* Time effect (P < 0.05)
populations: older people, and those with stroke and obesity. In our study, we compared the effects of long-term HML versus TST in CHD patients to verify the potential superiority of this “all-in-one” machine. We found that both types of strength exercise sessions improved cardiovascular health parameters. However, both types did not improve body composition features.

Our results show a large inter-individual heterogeneity concerning the response to strength training. We found no relationship between changes in variables, so for example, a patient can improve physical fitness without improving endothelial function. Patients receiving HML treatment showed improved upper body muscles to a greater extent than with TST. As well, we still do not have good predictors of response to whatever training, yet it is one of the main challenges to study, rather than the efficiency.

6. Strength training and endothelial function

The patients who benefited from HML showed improvement, although non-significant, in endothelial function (pre, 0.70 ± 0.29; post, 0.78 ± 0.29), with no change in the TST group. Current guidelines recommend both aerobic and dynamic resistance exercise-training modalities to reduce BP and induce vascular adaptations [20]. Most studies suggest that isometric exercise training in normotensive and hypertensive (medicated and non-medicated) cohorts of young and old participants may produce similar, if not greater, reductions in BP, with meta-analyses reporting mean reductions of 10 to 13 mmHg SBP and 6 to 8 mmHg DBP [20–22]. Although the mechanisms responsible for these adaptations remain to be fully clarified, conduct- and resistance- vessel endothelium-dependent dilation, oxidative stress, and autonomic regulation of the heart rate and BP have been improved [20].

In our study, the isometric exercise training protocols differed from dynamic resistance training but were close to that typically used (consisting of 4 sets of 2-min handgrip or leg contractions sustained at 20–50% MVC, with each set separated by a rest of 1–4 min). During a brief submaximal isometric manoeuvre, both cardiac output and total peripheral resistance are increased [23], which significantly increases wall shear stress on the entire arterial tree. This pressure response continues as long as the isometric contraction is maintained and produces a small but significant increase in mean arterial pressure during submaximal effort [24]. Dynamic exercise produces a transient increase in shear stress, which is offset by the subsequent nitric oxide (NO) release, which leads to dilatation, decreased shear stress, and increased flow during the effort. Isometric exercise produces a sustained, increasing shear stress, which is not completely offset by NO release during the effort. Maintaining an isometric effort could be a stimulus for upregulating endothelial NO synthase activity by initiating signalling events that are activated by shear stress response elements in the endothelium [25]. We have few studies of BP control with isometric exercises, involving moderate isometric contractions (<30 or 50% MVC) and low solicited muscle volume [26].

7. Rehabilitation and quality-of-life features

The scores obtained on the SF-36 questionnaire revealed improved physical and mental components after our 4-week CRP, whatever the treatment. These data match those from Stahle et al. and Yohannes et al., who reported long-term benefits of CR on quality of life [27,28]. The quick efficacy we found could be explained by the multidisciplinary rehabilitation approach, because adapted physical activity sessions (3 hr/day) were associated with relaxation sessions and personalized dietary follow-up. Furthermore, the quality of life of patients with diabetes after myocardial infarction is even more altered [29,30].

Our results agree with a previous study published by our group [11] based on 101 cardiac patients that highlighted a 25% improvement in quality of sleep, a 29% decrease in anxiety levels and a 32% decrease in depression (P < 0.0001), as well as a 28% improvement in morale (P < 0.0001) after a CRP. Finally, Schiza et al. showed that patients with acute coronary syndrome had altered sleep parameters, leading to poor sleep quality [32]. We
observed a true amelioration of sleep quality regardless of treatment.

8. Physical activity

The benefits of physical activity are widely accepted in secondary prevention and are subject to regularly updated recommendations by international societies. Nevertheless, a few controversies still exist, especially regarding the type and intensity of the activity. However, the main challenges relate to the means, making the activity “enjoyable,” and improving compliance by creating long-term lasting behaviour changes. The notion of pleasure is often forgotten in exercise prescription, but it is one of the most important features in promoting compliance [33]. An emerging trend has been inspired by a relatively new technology referred to as active gaming or exergaming. Exergaming is defined as technology-driven physical activities, such as video game play, that requires participants to be physically active or exercising to play the game. Among the range of technologies, the HML and the new version (HUBER386) can be defined as exergames. The programs are sometimes very guided and supervised. Thus, “all-in-one” devices such as HML that associate pleasure in training with equilibration, coordination, cerebral and strength training may have a place in therapy.

We need to assess the effects of a training HML (not associated with usual training) that is more prolonged, with assessment of metabolic and systemic effects, versus a dynamic global reconditioning. Moreover, the effects of HML on balance needs quantification, and determining better muscular games (kinematic analysis, electromyography) is needed to determine the respective involvement of static, concentric and eccentric contractions (related to equilibration).

9. Limitations

Our study has some limitations. First, it involved an intense and short-duration CRP (4 weeks) as compared to the recommendations (2–3 months), which most likely limited the appearance of systemic effects (autonomic, endothelial, etc.) and a decrease in fat mass. We also did not measure gas exchange, the gold standard for verifying improvements in aerobic capacity and the maximal criterion of the CPET. Furthermore, we used the EndoPAT system for measuring endothelial dysfunction, but some authors have reported that the system might reflect neurovegetative modifications rather than microcirculatory adaptations after an exercise program [34]. As well, we could have tested the effects on proprioceptive settings, particularly in the context of rehabilitation after falls in older patients. The work of balance with the HML would probably have an advantage over TST for this indicator.

10. Conclusions

Our study showed that gain of chest force and PPO were improved with a 4-week CRP involving strength training on a HML as well as TST in CHD patients. Both treatments improved all other factors in the same range. Both protocols appeared to be well tolerated, safe and feasible in this group of CHD patients. The HML training protocol, which consisted of repeating 6 s phases of contractions with 10 s of passive recovery could be implemented in programs for patients with different chronic diseases, and its innovative character can vary the types of exercises. However, possible harmful effects must be assessed. Our study is a preliminary study, because of its limitations, so the HML is not yet a validated method of reconditioning in CVD. Ultimately, the HML could be included in phase II CR and be proposed to deconditioned patients, notably older patients. The game-like aspects of the HML have a slight advantage for patient adherence to physical activity as compared to TST. Moreover, the “all-in-one” treatment aspect could be interesting for centres with limited space or financial resources.

Ethical statement

All the authors have read and agree with the manuscript as written.

Disclosure of interest

The authors declare that they have no competing interest.

Uncited reference

Q5

Acknowledgments

This study was supported by funds provided by LPG Systems, Q6 Valence, France, to the Clinic of Saint Orens, cardiovascular rehabilitation centre, Saint-Orens-de-Gameville, France. LPG Systems had no influence on the design of the study or the analyses and interpretations of the results. The authors would like to thank Richard Granger for his technical help.

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