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**VITAMIN D AND OMEGA-3 POLYUNSATURATED FATTY ACID
SUPPLEMENTATION IN ATHLETES WITH EXERCISE-INDUCED
BRONCHOCONSTRICTION: A PILOT STUDY**

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ABSTRACT

Objective: The aim of this pilot study was to determine the combined effect of vitamin D and omega-3 PUFA supplementation on airway function and inflammation in recreational athletes with exercise-induced bronchoconstriction (EIB). **Methods:** Ten recreational athletes with EIB participated in a single blind, placebo-controlled trial over six consecutive weeks. All subjects attended the laboratory on three occasions. Each visit was separated by a period of 3 weeks; visit 1 (usual diet), visit 2 (placebo) and visit 3 (SMARTFISH® NutriFriend 2000; 30µg vitamin D3 - 3000mg EPA, 3000mg DHA) consumed once daily for a period of 3-weeks. Venous blood was collected at the beginning of each trial to determine vitamin D status. Spirometry was performed pre and post eucapnic voluntary hyperpnea (EVH). **Results:** The ΔFEV_{1max} post EVH was not different between visits (usual diet: $-15.9 \pm 3.6\%$; placebo: $-16.1 \pm 6.1\%$; vitamin D + omega-3 PUFA: $-17.8 \pm 7.2\%$). Serum vitamin D remained unchanged between visits. **Conclusion:** Vitamin D and omega-3 PUFA supplementation does not attenuate the reduction in lung function post EVH. These findings should be viewed as preliminary until the results of randomised controlled trials are made available.

Key words: Airway dysfunction, Exercise-induced bronchoconstriction, Inflammation, Omega-3 polyunsaturated fatty acids, Vitamin D.

2 INTRODUCTION

3 Exercise-induced bronchoconstriction (EIB) describes the phenomenon of acute, transient
4 airway narrowing in association with physical activity [1] and is highly prevalent in both
5 recreational and elite level athletes [2,3]. Although the precise pathogenesis of EIB is not
6 completely understood, it is generally acknowledged that exercise hyperpnea initiates
7 bronchoconstriction by inducing osmotic changes at the distal airway surface [4]. This
8 precipitates the release of pro-inflammatory mediators including histamine, neuropeptides,
9 cytokines, cysteinyl leukotrienes and prostaglandins, ultimately resulting in airway smooth
10 muscle contraction [5]. In the chronic setting, repeated, prolonged periods of exercise
11 hyperpnea have been associated with injury-repair cycling of the airway epithelium resulting
12 in smooth muscle remodelling [6,7] and the development of EIB in athletes [2].

13 The mainstay of treatment for EIB consists of pharmacological medication (e.g. short acting
14 inhaled beta-2 agonists (SABA)) [1]. However, there is accumulating evidence that non-
15 pharmacological interventions, such as dietary modification, may have utility in the treatment
16 of EIB in athletes [8]. This is pertinent given the possible side effects of chronic beta-2
17 agonist therapy (e.g. development of tachyphylaxis and degenerative changes in lung function)
18 [9]. One of the most promising dietary interventions is fish oil supplementation. Specifically,
19 omega-3 polyunsaturated fatty acids (PUFA) (eicosapentaenoic acid (EPA) and
20 docosahexaenoic acid (DHA)) have previously been shown to attenuate airway inflammation
21 and the bronchoconstrictor response to exercise hyperpnea [10,11]. The purported therapeutic
22 effect of omega-3 PUFA for the treatment of EIB in athletes is biologically plausible;
23 however the findings to date remain equivocal [10-16]. The proposed mechanism of omega-3
24 PUFA protecting against EIB consists of EPA and DHA competitively inhibiting arachidonic
25 acid metabolism and therefore reducing the generation of pro-inflammatory leukotrienes,
26 prostaglandins and cytokine production from inflammatory cells [17].

27 Indeed, other dietary interventions may also be important. Recently, epidemiological studies
28 have highlighted a direct association between vitamin D deficiency and the incidence and
29 severity of asthma [18]. Although the evidence is sparse, low serum vitamin D levels have
30 previously been associated with reduced lung function and increased airways hyper-reactivity
31 to exercise in asthmatic children with EIB [19]. Mechanisms by which vitamin D may
32 prevent EIB are likely multifactorial. The vitamin D receptor is expressed in most tissues and
33 it has been proposed that vitamin D deficiency may result in an increase in mast cells,
34 histamine release and apoptosis [20,21]. Furthermore, a reduction in the expression of pro-
35 inflammatory interleukins (i.e. interleukin (IL)-13) associated with bronchoconstriction has
36 been observed [22]. Vitamin D receptors in respiratory epithelial cells and bronchial smooth
37 muscle have also been reported to regulate the expression of genes implicated in the
38 pathogenesis of asthma [23] and smooth muscle proliferation (i.e. airway remodelling) [24].
39 Consequently, as vitamin D deficiency may play a role in the pathogenesis of lung disease,
40 supplementation may present a novel preventative and/or therapeutic strategy for athletic
41 individuals with EIB.

42 The principal aim of this pilot study was to evaluate the combined effect of a commercially
43 available vitamin D and omega-3 PUFA supplement (SMARTFISH® NutriFriend 2000), on
44 airway function in recreational athletes with EIB. We hypothesised that lower levels of
45 vitamin D would be associated with reduced lung function, and that vitamin D and omega-3
46 PUFA supplementation would attenuate airway inflammation and bronchoconstriction
47 following an indirect bronchoprovocation challenge. Eucapnic voluntary hyperpnea (EVH)
48 was selected as the bronchoprovocation challenge since it is the test currently favoured by the
49 International Olympic Committee-Medical Commission (IOC-MC) for diagnosing EIB in
50 elite athletes [25].

51

52 **METHODS**

53 **Preliminary screening**

54 One hundred and one endurance trained recreational athletes (mean \pm SD: 6 \pm 1 hours
55 training/week) were recruited and subsequently tested for EIB via a EVH challenge
56 (described below). Sixteen athletes (17%) were positive for EIB (i.e. \geq 10% fall in FEV₁ post
57 EVH) and thus considered eligible for participation.

58 **Study population**

59 Ten athletes (runners, cyclists and triathletes) (male: $n = 9$) with EIB (63%) agreed to take
60 part in the study. All subjects were non-smokers, free from respiratory, cardiovascular,
61 metabolic and psychiatric disease, and any other significant medical condition except mild
62 asthma. Four subjects had a previous physician-based diagnosis of clinical asthma and were
63 prescribed a SABA; two of the four were also prescribed maintenance-inhaled corticosteroid.

64 **Experimental design**

65 The study was conducted as a single blind placebo-controlled trial over six consecutive
66 weeks (June – September, United Kingdom). A randomised double-blind crossover design
67 was not practical due to the half-life (~15 days) of vitamin D [26] (i.e. approximately 6-
68 month wash-out period) and the effect of seasonal variation on airway calibre in atopic
69 individuals [27]. All subjects were required to attend the laboratory on three occasions. Each
70 visit was separated by a period of 3 weeks; visit 1 (usual diet), visit 2 (placebo; matching the
71 treatment beverage for appearance, taste, quantity and packaging) and visit 3 (treatment;
72 vitamin D + omega-3 PUFA consisting of a 600 ml fruit and berry flavoured beverage -
73 SMARTFISH[®] NutriFriend 2000; 30 μ g vitamin D3 i.e. cholecalciferol, 3000mg EPA,
74 3000mg DHA) consumed once daily for a period of 3-weeks. SMARTFISH[®] provided

75 documented evidence (i.e. quality assurance) of the content of both placebo and experimental
76 beverages.

77 Subjects arrived at the laboratory 1 h postprandial at a similar (\pm 1 h) time of day following
78 their usual diet. At visit 1 an assessment of respiratory health and evaluation of allergy status
79 was determined via completion of the Allergy Questionnaire for Athletes (AQUA) and
80 aeroallergen skin prick testing. For all visits, venous blood was collected at the beginning of
81 each trial to determine serum vitamin D status. Spirometry was performed pre- and post-EVH
82 provocation. Airway inflammation was determined via fractional exhaled nitric oxide (FE_{NO})
83 (indirect marker for up-regulation of airway inflammation) pre- and 30 min post-EVH. Urine
84 samples were obtained pre- and 60 min post-EVH for cysteinyl leukotriene (LTE₄) and
85 prostaglandin (9 α , 11 β - prostaglandin F₂) quantification (markers of airway inflammation and
86 mast cell activation, respectively). With the exception of AQUA and aeroallergen skin prick
87 testing, all visits were replicated precisely on subsequent visits (Figure 1).

88 Subjects were excluded from follow-up assessment if changes in training and/or health status,
89 respiratory tract infection, allergen or sunlight exposure were reported between visits.
90 Subjects were asked to abstain from dietary supplements (e.g. vitamins and anti-oxidants)
91 throughout the duration of the study and SABA and inhaled corticosteroid medication for 24
92 and 72 h, respectively, prior to each visit. Northumbria University ethics committee approved
93 all tests and procedures, and all subjects provided written informed consent for
94 experimentation with human subjects.

95 **Atopic Status**

96 Sensitivity to seven common airborne allergens (early blossom tree, mid blossom tree, grass,
97 weed, mould, cat and dust mite) were assessed via skin prick testing [28]. A subject was
98 classified as atopic if, in the skin prick test, at least 1 allergen caused a wheal of at least 3 mm

99 in diameter, in the presence of a negative saline control and positive histamine. Subjects also
100 completed AQUA to assess allergic symptoms [29]. An athlete was considered to be allergic
101 if they presented with a positive skin prick test and a positive AQUA score ≥ 5 .

102 **Pulmonary function**

103 **Spirometry**

104 Lung function was assessed by forced flow-volume spirometry (MicroLoop ML3535;
105 Cardinal Health, UK) [30].

106 **Eucapnic voluntary hyperpnea**

107 Bronchoprovocation challenge testing with EVH was performed as described previously
108 [31,32]. In brief, subjects were required to inhale a mixture of dry compressed gas (21% O₂,
109 5% CO₂, balance N₂) at a ventilation rate equivalent to approximately 85% maximal
110 voluntary ventilation (MVV)—calculated as $30 \cdot FEV_1$ for a period of 6 min. Subjects viewed
111 their ventilatory volume in real-time in order to ensure they maintained the target level. A
112 positive diagnosis for EIB was defined by a post-EVH reduction in FEV₁ of $\geq 10\%$ compared
113 to resting spirometry.

114 **Airway inflammation**

115 Fraction of exhaled nitric oxide (FE_{NO}) was the first test performed during each visit and
116 measured using a hand-held measuring device (NIOX MINO[®]) (Aerocrine AB, Stockholm,
117 Sweden). FE_{NO} levels were obtained in accordance with international guidelines [33].

118 **Vitamin D status**

119 The Elecsys Total 25-hydroxyvitamin D assay (Roche Diagnostics GmbH, Germany) was
120 used for the quantitative determination of total serum 25-hydroxyvitamin D (25(OH)D)
121 (nmol/L) [34]. Intra-assay coefficient of variation was $< 10\%$. Vitamin D status was classified

122 according to previous recommendations as sufficient: 75 – 100 nmol/L; insufficient: 50-75
123 nmol/L; deficient: < 50 nmol/L [19,35].

124 **Urinary inflammatory markers**

125 Enzyme immunoassays of LTE₄ and 9 α , 11 β - prostaglandin F₂ were performed in serially
126 diluted urine (Cayman Chemical Company, Ann Arbor, MI) as previously described [36,37].
127 Inter- and intra-assay coefficient of variation was <10%. All data were normalised and
128 presented as nanograms of excreted mediator per millimole of creatinine. Creatinine analyses
129 were performed using a modification of Jaffe's creatinine protocol [38].

130 **Nutrient intake and compliance**

131 Subjects were instructed to maintain their usual diet (maximum of one fish meal per week)
132 and physical activity levels throughout the duration of the study. Adherence to treatment
133 regimens was monitored by athletes documenting the time and date of consumption and
134 returning any supplements that were not consumed. In accordance with comparable research
135 a compliance of $\geq 90\%$ was considered acceptable [36].

136 **Statistical analysis**

137 Normality of data was assessed using a Kolmogorov-Smirnov test and Levene's test to check
138 for homogeneity of variance between groups. A two-way repeated measures analysis of
139 variance (ANOVA) was used to analyse within subject effects. Mauchly's test was conducted
140 to determine if sphericity was violated. If sphericity was violated, the repeated measures
141 ANOVA was corrected using a Greenhouse-Geisser adjustment factor. A Bonferroni *post hoc*
142 analysis was employed for multiple comparisons ($P < 0.05$). A one way repeated measures
143 ANOVA was employed where relevant and relationships between variables were determined
144 via liner regression analysis (Pearson correlation coefficients). AUC_{0-20min} was calculated by
145 the trapezoidal method and expressed as percentage fall in FEV₁. Data was analysed using

146 PASW Statistics 21 statistical software package (SPSS Inc., Version 21, Chicago, IL) and
147 GraphPad Prism Version 5.0 (GraphPad Software, San Diego, California, USA). Data are
148 expressed as mean (\pm SD) and significance was set at $P < 0.05$.

149

150 **RESULTS**

151 **Baseline characteristics, allergy and pre-challenge lung function**

152 Ten recreational athletes (male: $n = 9$) completed the study. Subjects' characteristics are
153 presented in Table 1. Eight athletes were atopic to skin prick testing and eight had a positive
154 (≥ 5) AQUA questionnaire. Seven athletes with a positive AQUA questionnaire were also
155 atopic and therefore considered allergic. Five subjects reported respiratory symptoms (e.g.
156 cough, wheeze, dyspnea etc.) in association with exercise. All pulmonary function measures
157 were within normal predicted limits with no evidence of airflow obstruction. In addition, no
158 difference in resting lung function was observed between visits ($P > 0.05$) (Table 2).

159 **Compliance to treatment regimens**

160 Excellent adherence to treatment regimens was reported for placebo and vitamin D + omega-
161 3 PUFA ($99.5 \pm 1.1\%$ and $98.5 \pm 3.4\%$) diets, respectively ($P > 0.05$).

162 **Airway response to eucapnic voluntary hyperpnea**

163 Similar ventilation rates were achieved between all visits (usual diet: $105 \pm 25 \text{ L}\cdot\text{min}^{-1}$;
164 placebo: $101 \pm 17 \text{ L}\cdot\text{min}^{-1}$; vitamin D + omega-3 PUFA: $100 \pm 15 \text{ L}\cdot\text{min}^{-1}$) ($P = 0.854$). All
165 athletes maintained $>60\%$ MVV throughout EVH thus achieving test validation [39]. The
166 $\Delta\text{FEV}_{1\text{max}}$ post-EVH was no different between visits (usual diet: $-15.9 \pm 3.6\%$; placebo:-
167 $16.1 \pm 6.1\%$; vitamin D + omega-3 PUFA: $-17.8 \pm 7.2\%$) ($P = 0.719$). No difference was
168 observed in the reduction in FEV_1 between conditions at any time point ($P > 0.05$) (Figure 2)
169 (Table 3). Furthermore, no difference was observed for $\text{AUC}_{0-20 \text{ min}} \% \text{ fall in } \text{FEV}_1$ between
170 visits (usual diet: $198.0 \pm 75.9\%$; placebo: $239.7 \pm 99.4\%$; vitamin D + omega-3 PUFA:
171 $256.9 \pm 135.5\%$) ($P = 0.455$).

172 **Vitamin D status**

173 At visit one (usual diet), three athletes (30%) had sufficient levels of vitamin D, five were
174 insufficient, and two were deficient. At visit two (placebo), two athletes were sufficient, six
175 were insufficient and two were deficient. At visit three (vitamin D + omega-3 PUFA), three
176 were sufficient, six were insufficient and one was deficient. No difference in serum vitamin D
177 was observed between visits (usual diet: 64.2 ± 17.4 nmol.L⁻¹; placebo: 65.1 ± 16.5 nmol.L⁻¹;
178 vitamin D + omega-3 PUFA: 69.0 ± 16.9 nmol.L⁻¹ ($P = 0.798$). In addition, change in serum
179 vitamin D status between visits did not correlate with Δ FEV_{1max} ($r = 0.11$; $P = 0.559$).

180 **Airway inflammation**

181 No difference in FE_{NO} was observed pre-EVH between visits (usual diet: 28 ± 16 ppb;
182 placebo: 31 ± 23 ppb; vitamin D + omega-3 PUFA: 37 ± 27 ppb) ($P = 0.182$) or post-EVH
183 between visits (usual diet: 27 ± 19 ppb; placebo: 25 ± 19 ppb; vitamin D + omega-3 PUFA: 28
184 ± 18 ppb) ($P = 0.834$). However, a reduction in FE_{NO} post-EVH was observed within
185 condition for placebo (-20.1%) and vitamin D + omega-3 PUFA (-28.9%), respectively
186 ($P < 0.05$) (Figure 3).

187 **Urinary inflammatory markers**

188 ***Cysteinyl leukotriene LTE₄***

189 LTE₄ was higher pre-EVH following vitamin D + omega-3 PUFA: 104.1 ± 26.7 ng/mmol
190 creatinine compared to both usual diet: 72.6 ± 16.6 ng/mmol creatinine and placebo: $72.6 \pm$
191 22.9 ng/mmol creatinine ($P < 0.05$). No difference was observed between usual diet and
192 placebo ($P > 0.05$). LTE₄ was higher post-EVH following vitamin D + omega-3 PUFA: $99.1 \pm$
193 29.2 ng/mmol creatinine compared to placebo: 61.0 ± 13.7 ng/mmol creatinine ($P = 0.007$).
194 No difference was observed between usual diet and placebo or usual diet and vitamin D +

195 omega-3 PUFA respectively ($P>0.05$) (Figure 4). LTE₄ did not correlate with Δ FEV₁max ($r =$
196 0.30; $P = 0.107$).

197 ***9 α , 11 β - prostaglandin F₂***

198 No difference in 9 α , 11 β - prostaglandin F₂ was observed pre-EVH between visits (usual diet:
199 88.9 \pm 59.1 ng/mmol creatinine; placebo: 82.8 \pm 37.6 ng/mmol creatinine; vitamin D +
200 omega-3 PUFA: 79.2 \pm 43.7 ng/mmol creatinine) or post-EVH between visits (usual diet:
201 (usual diet: 104.0 \pm 41.7 ng/mmol creatinine; placebo: 101.1 \pm 56.8 ng/mmol creatinine;
202 vitamin D + omega-3 PUFA: 90.3 \pm 48.0 ng/mmol creatinine) ($P>0.05$) (Figure 4). A
203 correlation was observed between 9 α , 11 β - prostaglandin F₂ post-EVH and Δ FEV₁max ($r =$
204 0.45; $P = 0.017$).

205

206 **DISCUSSION**

207 This study has shown, contrary to our hypothesis, that the combination of vitamin D and
208 omega-3 PUFA supplementation over a 3-week period does not reduce markers of airway
209 inflammation or attenuate the reduction in lung function post EVH in recreational athletes
210 with EIB. Furthermore, serum vitamin D status does not appear to correspond directly to the
211 severity of bronchoconstriction following indirect bronchoprovocation. The study design and
212 intervention of the present study was based on the premise that dietary modification with a
213 commercially available self-administrated supplement would be pragmatic and overall
214 applicable to ‘real-life’.

215 Vitamin D deficiency (serum 25-hydroxyvitamin D <50 nmol.L⁻¹) has previously been
216 associated with a reduction in lung function and increased reactivity to exercise in asthmatic
217 children with EIB [19]. However, the precise role of vitamin D in the pathogenesis of EIB
218 has yet to be determined. In the current study 20% (2/10) of athletes presented with vitamin
219 D deficiency following their usual diet. This is in contrast to previous findings where 51%
220 (23/45) of asthmatic children with EIB were vitamin D deficient [19]. The dissociation
221 between studies is somewhat surprising, however supports the notion that physical activity is
222 directly related to the level of sun light exposure [40]. However, it is important to
223 acknowledge that the comparison of prevalence estimates of vitamin D deficiency between
224 studies may be confounded by the population studied (i.e. adults versus children). In addition,
225 as the current study was conducted in the summer months (June – September, United
226 Kingdom), this may, in part, explain the limited number of athletes presenting with vitamin D
227 deficiency. However, it must be acknowledged that the long half-life of vitamin D [26]
228 combined with controlling environmental factors (e.g. sunlight exposure and diet) limits the
229 standardisation of vitamin D trials *in vivo* (i.e. human studies). Nevertheless, further work is

230 required to fully determine the extent of vitamin D deficiency and thus requirement of
231 supplementation in athletic individuals.

232 In the present study adherence to the treatment regimens was high, however no difference
233 was observed in serum vitamin D following supplementation. Previous epidemiological
234 studies have highlighted a positive correlation between lung function and serum vitamin D
235 levels [19,41], whereas others have shown no association [42]. However, observational
236 studies do not confirm causality. Our findings show a poor relationship between vitamin D
237 status and severity of bronchoconstriction, thus disputing a direct association. These findings
238 are supported by a recent comparable study demonstrating no effect of vitamin D
239 supplementation in children with mild asthma [43]. However, a general consensus regarding
240 the optimal vitamin D dose has yet to be established (see recent review by Owens et al. [44]).
241 It is therefore reasonable to speculate that the dose employed within the current study (30
242 $\mu\text{g}/\text{day}$) or indeed length of supplementation was not sufficient to elicit a therapeutic effect.
243 Thus, the optimal level of vitamin D supplementation remains elusive and clinical trials are
244 required before informed recommendations can be employed.

245 Mickleborough et al. [10,11] previously reported that omega-3 PUFA (3.2g/day EPA and
246 2.2g/day DHA) derived from fish oil results in a reduction in markers of airway inflammation
247 (e.g. LTE_4 and $9\alpha, 11\beta$ - prostaglandin F_2) and an attenuated bronchoconstrictor response
248 following exercise in EIB and asthmatic patients, respectively. More recently, similar
249 findings have been reported by the same group following EVH bronchoprovocation [12,36].
250 Although Arms et al. [16] also observed a 50% inhibition of total leukotriene count in
251 peripheral blood in mild asthmatics following 10 weeks of daily fish oil supplementation
252 (3.2g EPA and 2.2g DHA), in agreement with our findings no change was observed in
253 $\Delta\text{FEV}_{1\text{max}}$ post indirect bronchoprovocation. In further support of this concept, Brannan et
254 al. [15] recently found that a 3-week period of omega-3 supplementation (4.0g/day EPA and

255 2.0g/day DHA) does not improve bronchial hyper-responsiveness to mannitol or inhibit
256 urinary excretion of mast cell mediators in adults with mild-moderate asthma.

257 This observation is comparable with findings from the present study where no difference was
258 observed in urinary 9α , 11β - prostaglandin F_2 between visits. Although urinary LTE_4
259 increased pre and post EVH following vitamin D + omega-3 PUFA, the majority of athletes
260 within our cohort were atopic (80%) and allergic (70%), and thus any potential anti-
261 inflammatory effect of vitamin D and omega-3 PUFA may have been counteracted by the
262 variation in allergen exposure (e.g. pollen count, house dust mite etc.) between visits [27]. In
263 keeping with our findings however, Moreira et al. [45] observed no difference in FE_{NO}
264 following short-term dietary supplementation with omega-3 PUFA in woman with stable
265 asthma.

266 Our finding of a correlation between ΔFEV_{1max} and urinary excretion of 9α , 11β -
267 prostaglandin F_2 ($P < 0.05$) further supports the role of mast cells in EIB [37]. Although the
268 urine sampling time-points post challenge were not identical, similar to Kippelen et al. [37]
269 no association existed between ΔFEV_{1max} and urinary excretion of LTE_4 . This observation
270 could suggest that 9α , 11β - prostaglandin F_2 is a more sensitive marker of EIB in atopic
271 individuals than LTE_4 , which warrants further investigation.

272 Although Mickleborough and Rundell [17] have highlighted statistical limitations to explain
273 the inconsistency in results between studies [17], the majority of trials have consisted of a
274 comparable sample size to the present study [10,11,16]. However, it should be acknowledged
275 that the diagnostic methodology used to quantify the extent of bronchoconstriction often
276 varies between studies [10-12,15]. Furthermore, it has previously been shown that a poor
277 relationship exists between indirect bronchoprovocation challenges (i.e. exercise and EVH)
278 [46,47]. It is therefore possible that the purported therapeutic effect of treatment varies
279 according to the specific bronchoprovocation challenge employed.

280 Nonetheless, the disparities in findings are still somewhat surprising given the similarities in
281 study design, population, sample size and similar dose of the respective interventions
282 [10,11,16]. Whilst the form of vitamin D and omega-3 PUFA administration in the present
283 study differed from previous research, there is currently no consensus in the literature to
284 suggest that the absorption or indeed effect of supplementation significantly varies according
285 to the form of consumption (i.e. encapsulated supplement versus commercially available
286 nutritional beverage). However, it should be acknowledged that in contrast to previous work
287 [6,10,14,19,40,41] equal quantities of EPA and DHA (3.0g/day) were employed in the
288 current study. It is therefore possible that EPA may be more important than DHA in
289 attenuating EIB. This theory is consistent with a previous pilot study by Head et al. [13]
290 where supplementation with 4.0g/day of DHA did not attenuate bronchoconstriction or
291 airway inflammation in asthmatic patients following EVH. Moreover, a recent mouse model
292 of asthma observed pro-inflammatory effects following the consumption of DHA over a six
293 week period [48].

294 Overall however, the results of the present study support the current recommendation by the
295 American Thoracic Society that the evidence is not currently strong enough to confirm that
296 omega-3 PUFA's are effective in the large majority of patients with EIB [1].

297 Pertinent to the present study and previous research [10-12,16,36], poor short-term test re-test
298 clinical reproducibility of indirect bronchoprovocation (i.e. exercise and EVH) [49,50] has
299 recently been observed in patients with mild EIB. Therefore, although the combination of
300 vitamin D and omega-3 PUFA does not appear to attenuate the ΔFEV_{1max} post
301 bronchoprovocation, the inherent variability of a test employed to determine changes in lung
302 function should be considered when advocating the efficacy of a treatment intervention to
303 avoid masking or overestimating the proposed therapeutic benefit. Likewise, the use of FE_{NO}

304 as a marker of airway inflammation may be confounded given the high ventilatory demand of
305 EVH (i.e. exhaled nitric oxide often falls from baseline values even when EIB is confirmed).

306 **Methodological considerations / future research**

307 Although this study is the first interventional trial to address the impact of combining vitamin
308 D and omega-3 PUFA supplementation in athletic individuals with EIB, there are a number
309 of important considerations. Firstly, given the small sample size of the cohort, the results
310 should be viewed with some caution. Whilst we are confident that false negative results (i.e.
311 type II error) have not been reported, further work with a larger sample size is still required to
312 provide a definitive answer. Secondly, the optimal level of vitamin D supplementation
313 remains elusive and clinical trials are required before informed recommendations can be
314 employed. Once established, randomised controlled trials are required to determine the
315 individual and combined efficacy of vitamin D and omega-3 PUFA for the treatment of EIB
316 in athletes. Whilst highly speculative, the possibility exists that the lipophilic properties of
317 vitamin D may compete with omega-3 PUFA by an unknown mechanism. Thirdly, to
318 understand the mechanism of action of specific interventions, future studies should assess
319 nutritional deficiencies (i.e. vitamin D and omega-3 PUFA status) prior to study entry and
320 recruit homogenous cohorts of athletes according to severity of disease and specific clinical
321 phenotypes (e.g. asthma, EIB, airway hyper-responsiveness, atopy etc.) rather than ‘pooling’
322 heterogeneous cohorts. Finally, the longitudinal impact of vitamin D and/or omega-3 PUFA
323 supplementation has yet to be established. Conducting randomised double-blind crossover
324 design studies (acknowledging the limitations of vitamin D washout) may provide value in
325 this setting.

326 **Conclusion**

327 In conclusion, this pilot study has shown that a 3-week period of vitamin D and omega-3
328 PUFA supplementation does not reduce markers of airway inflammation nor attenuate the
329 reduction in lung function post EVH. In addition, vitamin D status does not appear to
330 correspond directly to the severity of bronchoconstriction in recreational athletes with EIB.
331 However, these findings should be viewed as preliminary until the results of randomised
332 controlled trials are made available.

333

334 **KEY ISSUES**

335 • Vitamin D deficiency has previously been associated with the development and
336 severity of asthma, with low serum vitamin D levels associated with reduced lung
337 function and increased reactivity to exercise in children with EIB.

338

339 • Omega-3 PUFA supplementation has been shown to attenuate airway inflammation
340 and bronchoconstriction following indirect bronchoprovocation.

341

342 • The aim of this pilot study was to determine the combined effect of acute vitamin D
343 and omega-3 PUFA supplementation on airway function in recreational athletes with
344 EIB.

345

346 • The combination of vitamin D and omega-3 PUFA supplementation does not reduce
347 markers of airway inflammation nor attenuate the reduction in lung function
348 following EVH.

349

350 • Serum vitamin D status does not appear to directly correspond to the severity of
351 bronchoconstriction.

352

353 • The inherent variability of a test (i.e. indirect bronchoprovocation) employed to
354 determine changes in lung function should be considered when advocating the
355 efficacy of a treatment intervention to avoid masking or overestimating the proposed
356 therapeutic benefit.

357

358 • Further work is required to determine the individual and combined effect of omega-3
359 PUFA and vitamin D as a non-pharmacological treatment for EIB. The findings of the
360 present study should be viewed as preliminary until the results of randomised
361 controlled trials are made available.

362

363

364

365 **TABLE HEADINGS**

366 **Table 1:** Subject clinical characteristics.

367

368 **Definitions of abbreviations: BMI,** body mass index.

369

370 **Table 2:** Baseline pulmonary function.

371

372 **Definitions of abbreviations: FEV₁,** forced expiratory volume in 1^s; **FVC,** forced vital
373 capacity; **PEF,** peak flow rate.

374

375 **Table 3:** Baseline lung function and response to eucapnic voluntary hyperpnea.

376 **Definitions of abbreviations: FEV₁,** forced expiratory volume in 1^s

377 **Table 1.**

Subject	Sex (M:F)	Age (years)	Height (cm)	Weight (kg)	BMI (kg•m⁻²)	Training (hrs•wk⁻¹)	Physician diagnosed asthma	Medication	Self-report symptoms	Allergy
1	M	42	177.7	90.3	28.6	6	No	Nil	Asymptomatic	No
2	M	27	185.6	87.4	25.4	6	No	Nil	Asymptomatic	No
3	M	36	178.5	72.5	22.8	6	No	Nil	Asymptomatic	Yes
4	M	28	181.3	79.4	24.2	6	No	Nil	Asymptomatic	Yes
5	M	48	173.7	75.6	25.1	6	No	Nil	Asymptomatic	Yes
6	M	28	177.0	78.8	25.2	6	Yes	SABA + ICS	Symptomatic	Yes
7	F	42	166.6	64.2	23.1	6	Yes	SABA	Symptomatic	No
8	M	39	177.9	88.7	28.0	6	Yes	SABA + ICS	Symptomatic	Yes
9	M	34	181.1	72.7	22.2	6	Yes	SABA + ICS	Symptomatic	Yes
10	M	24	183.3	84.5	25.1	4.5	No	Nil	Symptomatic	Yes
Total	9:1	35 ± 8	178.3 ± 5.5	79.4 ± 8.4	25.0 ± 2.1	6 ± 1	4/10	4/10	5/10	7/10

378 **Table 2.**

Baseline pulmonary function			
	Visit 1	Visit 2	Visit 3
	Usual diet	Placebo	Vitamin D + Omega-3
FEV ₁ (L)	4.04 ± 0.85	4.12 ± 0.77	4.00 ± 0.80
FEV ₁ (% predicted)	96.5 ± 15.4	98.4 ± 12.0	95.4 ± 12.2
FVC (L)	5.61 ± 0.81	5.69 ± 0.78	5.61 ± 0.86
FVC (% predicted)	111.6 ± 10.7	113.1 ± 9.5	111.2 ± 10.4
FEV ₁ /FVC (%)	71.4 ± 5.4	71.9 ± 4.2	71.0 ± 4.7
PEF (L/min)	552.4 ± 103.3	569.5 ± 85.6	556.1 ± 107.5
PEF (% predicted)	97.7 ± 13.7	100.6 ± 7.9	97.9 ± 11.5

379 Data presented as Mean ± SD. *n* =10.

Table 3.

Subject	Baseline	ΔFEV₁max		
	Visit 1: FEV ₁ (% predicted)	Visit 1: Usual diet	Visit 2: Placebo	Visit 3: Vitamin D + Omega-3 PUFA
1	87.0	-19.6	-12.5	-17.5
2	104.9	-17.2	-20.8	-20.5
3	102.6	-11.5	-20.1	-16.5
4	95.2	-12.9	-13.2	-14.7
5	89.8	-12.1	-12.1	-7.5
6	130.0	-13.6	-9.0	-12.0
7	80.2	-14.4	-17.6	-14.7
8	95.8	-16.8	-9.4	-25.1
9	104.4	-18.2	-16.9	-16.1
10	75.4	-22.6	-28.9	-33.4
Mean \pm SD	96.5 \pm 15.4	-15.9 \pm 3.6	-16.1 \pm 6.1	-17.8 \pm 7.2

381 **FIGURE LEGENDS**

382 **Figure 1.** Schematic depicting the experimental design.

383 **Definitions of abbreviations:** AQUA, The Allergy Questionnaire for Athletes; **EIB**,
384 exercise-induced bronchoconstriction; **FEV₁**, forced expiratory volume in 1^{-s}; **EVH**;
385 Eucapnic voluntary hyperpnea; **FE_{NO}**, fractional exhaled nitric oxide.

386

387 **Figure 2.** Percentage change in FEV₁ post EVH between visits. Usual diet (*open circles*);
388 placebo (*closed circles*); vitamin D + omega-3 PUFA (*closed triangles*). Broken horizontal
389 line represents abnormal lung function (i.e. $\geq 10\%$ fall in FEV₁). Placebo SD error lines
390 omitted to improve clarity of graph.

391

392 **Figure 3.** Fractional exhaled nitric oxide (FE_{NO}) concentration (ppb) pre-EVH (*closed bar*)
393 and 30 min post-EVH (*open bar*) between visits. * denotes significant difference within
394 condition between pre- and post-EVH ($P < 0.05$)

395

396 **Figure 4.** Panel a). Urinary LTE₄ concentration pre EVH (*closed bar*) and 60 min post EVH
397 (*open bar*) between visits. Panel b). Urinary 9 α , 11 β - prostaglandin F₂ pre EVH (*closed bar*)
398 and 60 min post EVH (*open bar*) between visits. * denotes significant difference pre-EVH
399 between condition ($P < 0.05$). # denotes significant difference post-EVH between condition
400 ($P < 0.05$).

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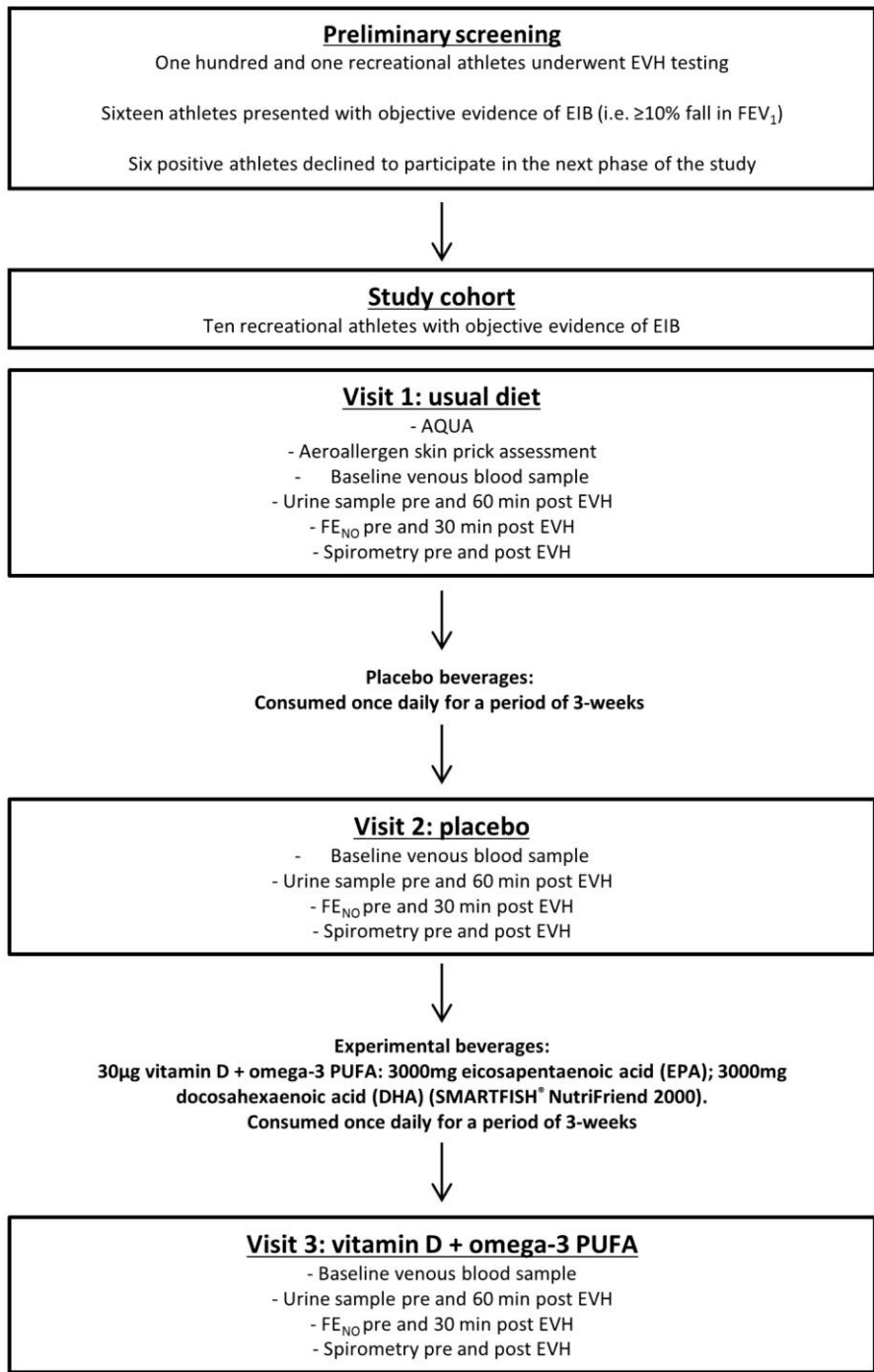
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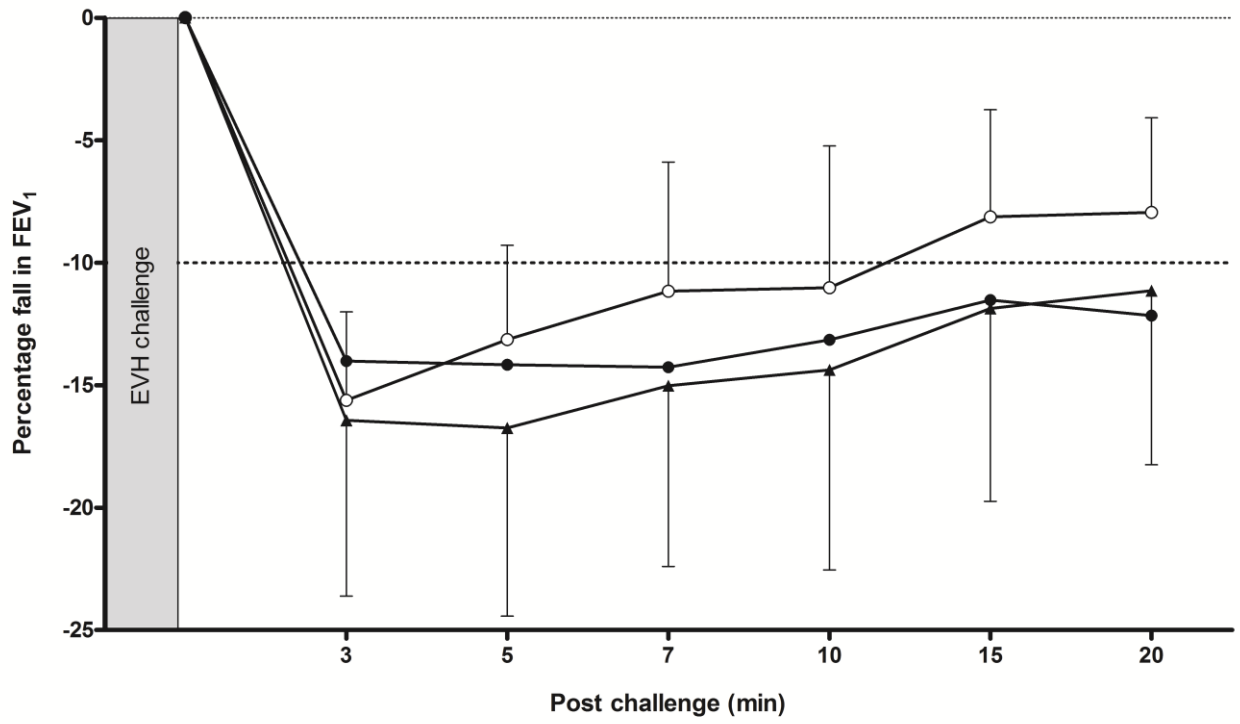
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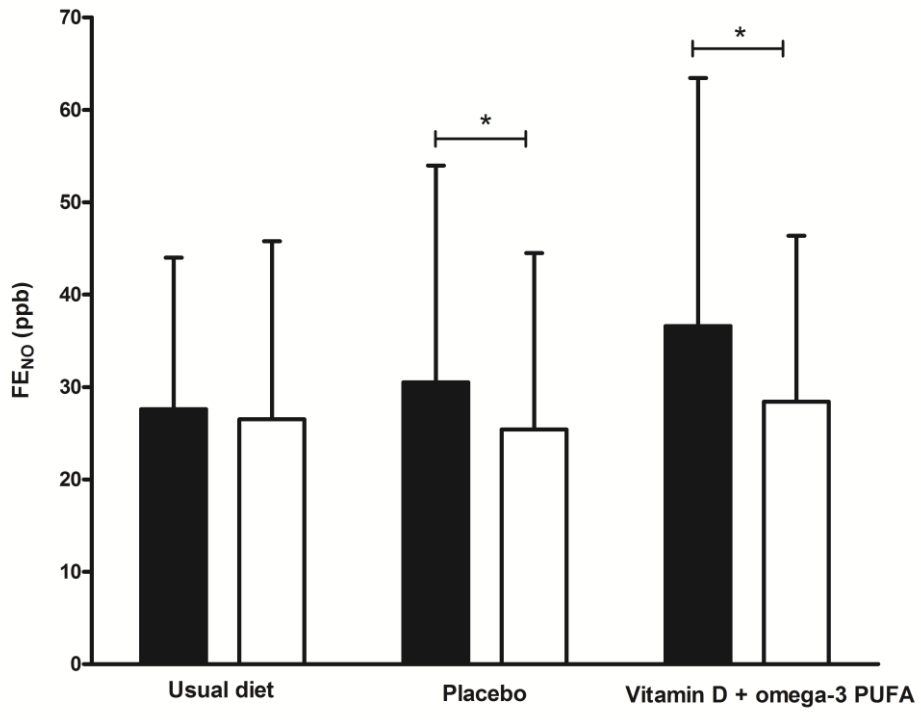
415 **Figure 1.**



416

417 **Figure 2.**

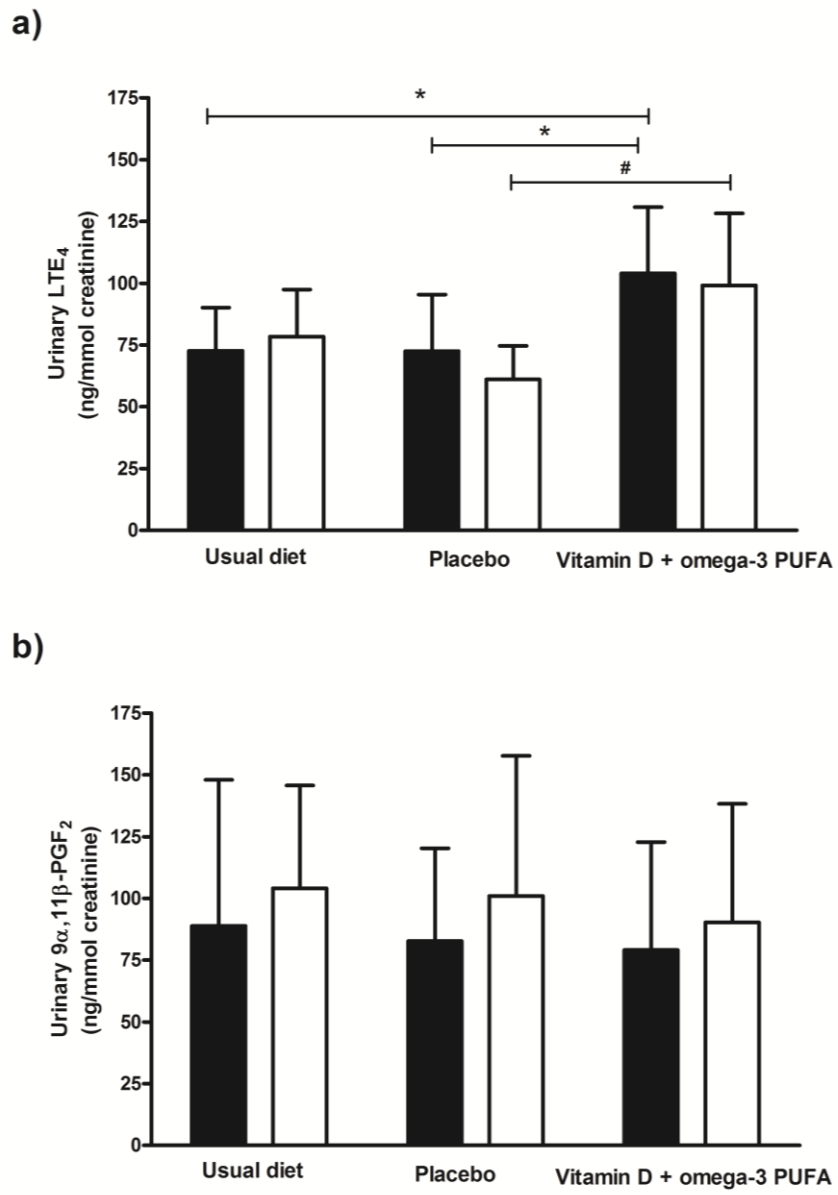
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420

421 **Figure 3.**

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424

425 **Figure 4.**

426

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624 **REFERENCE ANNOTATIONS**

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645 *in elite athletes due to their anti-inflammatory properties.*

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671 *currently strong enough to suggest that they are effective in a large majority cases.*
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687 *Bronchoconstrictor response to EVH attenuated following omega-3 PUFA supplementation*
688 *derived from New Zealand green lipped mussel (Perna canaliculus)in asthmatic patients with*
689 *EIB.*

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OP confirms full responsibility for the content of the manuscript, including data and analysis.

CONTRIBUTION STATEMENT

OP was involved in the conception and design of the study, acquisition, interpretation of data, drafting and critical revision of manuscript and final approval of the version to be published.

JH was involved in the conception and design of the study, interpretation of data, drafting and critical revision of manuscript and final approval of the version to be published

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PA was involved in the conception and design of the study, drafting and critical revision of manuscript and final approval of the version to be published.

LA was involved in the conception and design of the study, interpretation of data, drafting and critical revision of manuscript and final approval of the version to be published