Impact of dietary nitrate supplementation on exercise capacity and cardiovascular parameters in chronic respiratory disease: a systematic review and meta-analysis

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ABSTRACT

Background Dietary nitrate supplementation, usually in the form of beetroot juice, may improve exercise performance and endothelial function. We undertook a systematic review and meta-analysis to establish whether this approach has beneficial effects in people with respiratory disease.

Methods A systematic search of records up to March 2021 was performed on PubMed, CINAHL, MEDLINE (Ovid), Cochrane and Embase to retrieve clinical trials that evaluated the efficacy of dietary nitrate supplementation on cardiovascular parameters and exercise capacity in chronic respiratory conditions. Two authors independently screened titles, abstracts and full texts of potential studies and performed the data extraction.

Results After full-text review of 67 papers, eleven (two randomised controlled trials and nine crossover trials) involving 282 participants met the inclusion criteria. Three were single dose; seven short term; and one, the largest (n=122), done in the context of pulmonary rehabilitation. Pooled analysis showed that dietary nitrate supplementation reduced systolic blood pressure (BP), diastolic BP and mean arterial pressure (mean difference (95% CI), −3.39 mm Hg (−6.79 to −0.01); p=0.05 and −2.20 mm Hg (−4.36 to −0.03); p=0.05 and −4.40 mm Hg (−7.49 to −1.30); p=0.005, respectively). It was associated with increased walk distance in the context of pulmonary rehabilitation (standardised mean difference (95% CI), 0.47 (0.11 to 0.83), p=0.01), but no effect was identified in short-term studies (0.08 (−0.32 to 0.49).

Conclusion Dietary nitrate supplementation may have a beneficial effect on BP and augment the effect of pulmonary rehabilitation on exercise capacity. Short-term studies do not suggest a consistent benefit on exercise capacity.

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INTRODUCTION

Exercise limitation is a common feature in individuals with chronic respiratory disease (CRD) despite optimum medical treatment including pulmonary rehabilitation (PR) and pharmacotherapy. Factors contributing to breathlessness and reduced physical activity include altered pulmonary mechanics and cardiovascular function as well as skeletal muscle impairment. Nitric oxide (NO) is a ubiquitous signalling molecule with a key role in endothelial function, and a relationship between plasma nitrite (NO2−) levels and exercise performance has been identified. Dietary NO3− supplementation, which increases NO availability via a NO3−→NO2−→NO pathway, has therefore been proposed as a potential complementary approach to improve exercise capacity in people with cardiorespiratory disease.

In healthy adults, endurance exercise capacity increases following dietary NO3− supplementation and evidence suggests that NO3− supplementation with beetroot juice (BRJ) can reduce oxygen consumption...
Of note, dietary NO\textsuperscript{3} \textsuperscript{-} supplementation has been shown to improve exercise performance under hypoxic conditions,\textsuperscript{13-14} and there is evidence for an effect in some clinical conditions, for example, chronic obstructive pulmonary disease (COPD)\textsuperscript{16-19}, peripheral vascular disease\textsuperscript{20} and heart failure.\textsuperscript{21 22}

In addition to exercise limitation, vascular comorbidities are common in people with lung disease, and clinical guidelines highlight the need to identify and optimally treat them.\textsuperscript{23} If dietary NO\textsuperscript{3} \textsuperscript{-} supplementation can be shown to have a beneficial effect on exercise capacity and/or vascular comorbidities, it has the potential to improve outcomes in this patient group.

We therefore aimed to evaluate the available evidence regarding the impact of NO\textsuperscript{3} \textsuperscript{-} supplementation on exercise capacity and cardiovascular parameters in individuals with respiratory disease.

**METHODS**

The review was registered in the International Prospective Register of Systematic Reviews database. It was conducted based on the Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines.

**Search strategy**

The first author (ASA) searched PubMed, CINAHL, MEDLINE (Ovid), Cochrane and Embase from inception to March 2021. The terms used in this search were ‘respiratory diseases’, ‘chronic obstructive pulmonary disease’, ‘COPD’, ‘chronic obstructive airways disease’, ‘emphysema’, ‘bronchitis’, ‘bronchiectasis’, ‘interstitial lung disease’, ‘ILD’, ‘cystic fibrosis’, ‘pulmonary hypertension’, ‘PHT’, ‘nitrate’, ‘beetroot’, ‘dietary nitrate’ and ‘nitrate supplementation’. A search filter was applied by using medical subject heading terms. This search strategy was conducted in collaboration with a librarian to ensure this review contained the appropriate and necessary keywords. Full search strategy from all databases is presented in online supplemental appendix 1.

**Inclusion criteria**

We included both randomised clinical trials and crossover studies.

The PICO format was used in our search strategy:

- **P**: Population included adults diagnosed with CRD such as COPD, interstitial lung disease (ILD), bronchiectasis or pulmonary hypertension (PHT) either undergoing usual care or taking part in PR.
- **I**: Intervention was dietary NO\textsuperscript{3} \textsuperscript{-} supplementation delivered to patients with CRD.
- **C**: Comparator was a placebo group for interventional studies.
- **O**: Outcomes included both primary outcomes (exercise capacity and blood pressure) and secondary outcomes such as cardiovascular parameters: heart rate (HR), oxygen saturation (O\textsubscript{2} sat), plasma NO\textsubscript{2} \textsuperscript{-} and NO\textsubscript{3} \textsuperscript{-} levels, peak and iso-time VO\textsubscript{2}, endothelial function (flow-mediated dilatation (FMD)) and fractional exhaled NO (FeNO).

**Exclusion criteria**

1. Studies examining children under 18 years.
2. Any papers written in a language other than English.
3. Conference abstracts or unpublished data.

**Data extraction**

Data were extracted into a standardised Microsoft Excel spreadsheet form (Microsoft Corp., Redmond, WA, USA). We contacted the corresponding authors for missing data. Two authors (ASA and AMA) independently screened titles and abstracts of potential studies. A third reviewer (NSH) was available to resolve any disagreements. The form included data about change in exercise capacity following dietary NO\textsuperscript{3} \textsuperscript{-} supplementation. Other data such as cardiovascular parameters (HR, systolic blood pressure (SBP), diastolic blood pressure (DBP), mean arterial pressure (MAP) and O\textsubscript{2} sat), VO\textsubscript{2}, FMD, FeNO, intervention protocol (eg, dose, duration and delivery method), exercise protocol (type and duration) and placebo were extracted.

**Data analysis**

The synthesis of results described the outcomes of interest, such as exercise capacity, VO\textsubscript{2}, exercise endurance time, plasma NO\textsubscript{2} \textsuperscript{-} level, plasma NO\textsubscript{3} \textsuperscript{-} level, FeNO, SBP, DBP, MAP, HR, O\textsubscript{2} sat and FMD. Where appropriate, meta-analysis was conducted to estimate the pooled differences and 95\% CIs in the outcomes of interests between NO\textsuperscript{3} \textsuperscript{-} and placebo conditions.

For crossover studies, endpoint values were extracted from the end of the study after receiving the supplements (NO\textsuperscript{3} \textsuperscript{-} or placebo) and included in meta-analysis as if from a parallel designed trial.\textsuperscript{24 25} The random-effect model was applied because of the variety in several factors (eg, exercise protocol, dose and duration of NO\textsuperscript{3} \textsuperscript{-} supplementation).

Continuous data are reported as the mean difference (MD) (Δ). Standardised mean difference (SMD) was used when the same outcome was assessed with different measures (eg, exercise capacity assessed using different walking tests).

Heterogeneity among included studies was evaluating using the I\textsuperscript{2} value. The statistical analyses were performed using the Cochrane Collaboration’s Review Manager software (RevMan V.5.4.0).

**RESULTS**

**Selection of studies**

Initially, 2113 articles were identified through the database searches, 1554 after removing duplicates with 67 articles eligible for full-text review following title and abstract screening. Following full-text review, 11 studies met the inclusion criteria for the present systematic review (figure 1).
Study characteristics
Among the 11 randomised controlled trials (RCT), two used a parallel design, and nine used a crossover design. All 11 were published between 2015 and 2020. Eight studies were conducted in Europe, two in the USA and one in Australia. Studies were categorised based on the reported duration of NO$_3^-$ supplementation as ‘acute effect’ (single dose of NO$_3^-$ supplementation, 2.5–3 hours before exercise session) (n=3), ‘short term’ (less than 3 months in usual care) (n=7) or ‘during pulmonary rehabilitation’ (n=1). One study provided both acute effect and short-term data.\textsuperscript{26} The total number of participants was 282, including 15 with pulmonary arterial hypertension\textsuperscript{27} and 267 with COPD\textsuperscript{16–19 26 28–32} with sample sizes ranging from 8 to 122. Age of participants (mean±SD) was 66±3 years, and the majority (57%) were men. Ten trials used BRJ as the source of NO$_3^-$ (n=10), and one used sodium NO$_3^-$ (NaNO$_3^-$).\textsuperscript{26} The dose of NO$_3^-$ used ranged from 6.45 mmol\textsuperscript{28} to 16 mmol\textsuperscript{27}. A full description of the included studies is presented in table 1.

Exercise capacity
Data on exercise capacity or endurance were reported in ten studies using different tests including the incremental shuttle walk test (ISWT) (n=3), 6-minute walk distance (6MWD) (n=3), endurance time during cycle ergometry (n=3) and endurance shuttle walk test (ESWT) (n=1) in individuals with COPD\textsuperscript{16–19 26 28–32} and PHT.\textsuperscript{27}

The impact of NO$_3^-$ supplementation on peak exercise capacity measured using walking tests (ISWT and 6MWD) in people with COPD is shown in (figure 2).\textsuperscript{26} Pooled analysis from five trials demonstrated an improvement in exercise capacity following NO$_3^-$ supplementation compared with placebo (SMD (95% CI), 0.30 (0.03 to 0.57), p=0.03),\textsuperscript{17–19 30 32} although this effect was driven by the study in the context of PR. Thus, supplementation was associated with increased walk distance in the context of PR (SMD (95% CI), 0.47 (0.11 to 0.83), p=0.01), but no effect was identified in short-term studies (0.08 (−0.32 to 0.49)). A single trial in 15 patients with PHT taking BRJ for 1 week did not show a significant effect on 6MWD.\textsuperscript{27}

Berry \textit{et al} found an improvement in endurance exercise capacity during cycle ergometry at 75% maximal workload.\textsuperscript{16} In contrast, results from two trials providing NO$_3^-$ supplementation (one using BRJ and one NaNO$_3^-$) did not demonstrate a significant improvement in endurance exercise time during cycle ergometry.\textsuperscript{26 29}

Similarly, Leong \textit{et al} investigated the effect of 3 days of BRJ on exercise endurance via ESWT at 85% VO$_2$ max, among patients with stable moderate COPD, and found no difference in exercise endurance following BRJ compared with placebo.\textsuperscript{31}

Effect of NO$_3^-$ supplementation on physiological and cardiovascular parameters
Oxygen consumption
The impact of NO$_3^-$ supplementation on peak VO$_2$ was reported in six studies (figure 3).\textsuperscript{16 26–30} Pooled analysis from four trials demonstrated that peak VO$_2$ did not change following NO$_3^-$ supplementation compared with placebo (MD (95% CI), 0.09 mL/min/kg (−1.36 to 1.53), p=0.91).\textsuperscript{16 26 28 29} However, VO$_2$ at iso-time
<table>
<thead>
<tr>
<th>Authors/design</th>
<th>Study sample</th>
<th>Nitrate (NO₃⁻) dose</th>
<th>Placebo</th>
<th>Duration</th>
<th>Wash-out</th>
<th>Results (following NO₃⁻ vs placebo)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behnia et al., 2018/RXT¹⁸</td>
<td>N=25 GOLD stage 1–4 Age (y): 68±9 Sex (M/F): 13/12</td>
<td>70 mL BRJ + 180 mL black currant juice</td>
<td>70 mL water + 180 mL black currant juice</td>
<td>8 days</td>
<td>No</td>
<td>No effect on VO₂ at peak (p=0.05) ► Significant change in SBP: 11 mm Hg (p=0.05) at peak exercise in the NO₃⁻ group only compared with pre-NO₃⁻ ► Significant increase in FeNO (ppb) in NO₃⁻ group (p&lt;0.05) ► No effect on DBP (p=0.05) ► No effect on heart rate (HR) (p=0.05)</td>
</tr>
<tr>
<td>Beijers et al., 2018/RXT²⁶</td>
<td>N=18 GOLD stage 1–2 Age (y): 67±8 Sex (M/F): 13/5 FEV₁%=-69.2</td>
<td>Sodium NO₃⁻ (8mmol)</td>
<td>NaCl ingestion</td>
<td>Acute and 7 days</td>
<td>7 days</td>
<td>No effect on endurance cycle time (p=0.08) ► No effect on VO₂ on day 1 and day 7 during submaximal cycling at 70% Wmax (p=0.56) ► Significant increase in plasma NO₃⁻ level on day 1 and day 7 (p=0.001) ► Significant increase on NO₂⁻ level on day 1 (p&lt;0.001) and day 7 (p=0.003) ► No effect on SBP on day 1 and day 7 at 150 min (p=0.66) ► No effect on DBP on day 1 and day 7 at 150 min (p=0.35) ► No effect on physical activity, counts/min (p=0.53) ► No effect on HR on day 1 and day 7 at 150 min (p=0.76)</td>
</tr>
<tr>
<td>Berry et al, 2015/ RXT¹⁶</td>
<td>N=15 GOLD stage 1–2 Age (y): 70±9 Sex (M/F): 12/3 FEV₁%=-61.8</td>
<td>140 mL BRJ (7.58mmol)</td>
<td>163 mL prune juice (0.01mmol NO₂⁻)</td>
<td>Acute</td>
<td>7 days</td>
<td>28.8±8 longer in endurance cycle time (p=0.031) ► No effect on VO₂ at end exercise (p=0.43) ► Significant increase in plasma NO₂⁻ level (p=0.001) ► Significant increase in plasma NO₃⁻ level (p=0.001) ► Significant change in resting SBP: 8.2 mm Hg, p=0.019 ► Significant change in iso-time DBP: 4.4 mm Hg (p=0.001) ► Significant change end exercise in DBP: 5.6 mm Hg (p=0.08) ► No effect on HR, p=0.70 ► No effect on O₂ saturation, p=1.0</td>
</tr>
<tr>
<td>Curtis et al, 2015/ RXT⁵⁷</td>
<td>N=21 GOLD stage 2–4 Age (y): 68±7 Sex (M/F): 16/5 FEV₁%=-50.1</td>
<td>140 mL BRJ (12.9mmol)</td>
<td>140 mL ND-BRJ</td>
<td>Acute</td>
<td>7 days</td>
<td>No effect on median endurance time (p=0.50) ► Significantly lower iso-time VO₂ (p=0.04) ► No significant increase in plasma NO₃⁻ level (p=0.0001) No effect on SBP ► Significant change in DBP: 7 mm Hg (p=0.01) ► No effect on MAP (p=0.07) ► No effect on HR (p=0.06) ► No effect on O₂ saturation (p=0.26)</td>
</tr>
<tr>
<td>Friis et al, 2015/ RXT⁵⁷</td>
<td>N=15 GOLD stage 2–4 Age (y): 63±13 Sex (M/F): 9/6 FEV₁%=-44.7</td>
<td>140 mL BRJ</td>
<td>140 mL ND-BRJ</td>
<td>7 days</td>
<td>7 days</td>
<td>No effect on exercise capacity (p=0.46) ► No effect on VO₂ (p=0.31) ► Significant increase in plasma NO₃⁻ level (p=0.01) ► No effect on SBP (p=0.80) ► Significant reduction on DBP (p&lt;0.05) ► No effect on HR (p=0.86) ► No effect on physical activity (p=0.05)</td>
</tr>
<tr>
<td>Henrhon et al, 2018/RXT²⁷</td>
<td>N=15 Pulmonary hypertension, WHO group 1 Age (y): 60±15 Sex (M/F): 7/8</td>
<td>140 mL BRJ (16mmol)</td>
<td>140 mL ND-BRJ (0.118mmol NO₂⁻)</td>
<td>7 days</td>
<td>4–9 days</td>
<td>No effect on exercise capacity (p=0.445) ► No effect on VO₂ (p=1.00) ► Significant higher in FeNO levels (p=0.001) ► Significant increase in plasma NO₂⁻ level (p=0.001) ► Significant increase in plasma NO₃⁻ level (p=0.001) ► No effect on SBP (p=0.492) No effect on DBP (p=1.000) ► No effect on HR p=0.191</td>
</tr>
<tr>
<td>Kerley et al, 2015/RXT¹⁷</td>
<td>N=11 GOLD stage 2–4 Age (y): 69±7 Sex (M/F): 5/6 FEV₁%=-43.4</td>
<td>140 mL BRJ + 200 mL black currant cordial</td>
<td>140 mL water + 200 mL black currant cordial</td>
<td>Acute</td>
<td>7 days</td>
<td>ISWT distance increased 25 m (p=0.005) ► Significant increase in plasma NO₂⁻ level (p=0.000005) ► Significant increase in plasma NO₃⁻ level (p=0.01) ► Significant change in SBP: 12 mm Hg (p=0.03) ► Significant change in DBP: 2 mm Hg (p=0.045) ► Significant change in MAP: 5 mm Hg (p=0.018) ► No effect on HR (p=0.19) ► No effect on O₂ saturation (p=0.71)</td>
</tr>
<tr>
<td>Kerley et al, 2019/RXT¹⁸</td>
<td>N=8 GOLD stage 1–3 Age (y): 63±7 Sex (M/F): 5/3 FEV₁%=-55</td>
<td>140 mL BRJ (12.9mmol)</td>
<td>140 mL ND-BRJ (0.5mmol NO₂⁻)</td>
<td>14 days</td>
<td>NA</td>
<td>ISWT distance increased 56 m (p=0.0004) ► Significant increase in plasma NO₂⁻ level (p=0.015) ► Significant increase in plasma NO₃⁻ level (p=0.02) ► No effect on FeNO level (p=0.095) ► No effect on SBP (p=0.14) ► No effect on DBP (p=0.35)</td>
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<tr>
<td>Leong et al, 2015/RXT³¹</td>
<td>N=19 GOLD stage 2 Age (y): 69±14 Sex (M/F): 5/14 FEV₁%=-62</td>
<td>140 mL BRJ (9.6mmol)</td>
<td>140 mL ND-BRJ (0.0056–0.020mmol NO₂⁻)</td>
<td>3 days</td>
<td>4 days</td>
<td>Endurance distance increased 79 m (p=0.494) ► Increase time to fatigue by 6% (p=0.693) ► Significant change SBP in safety phase: 10 mm Hg at 1-hour standing (p=0.001) and 7.5 mm Hg at 4-hour standing (p=0.029) ► No effect on DBP in safety phase: 0.1 mm Hg at 1-hour standing (p=0.966) and 2.7 mm Hg at 4-hour standing (p=0.352)</td>
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Continued
was reported in two studies; Curtis et al report a significant decrease in iso-time VO2 after NO3 supplementation compared with a placebo (BRJ 16.6±6.0 mL/min/kg; placebo 17.2±6.0 mL/min/kg; p=0.043).29 Differently, Berry et al failed to find lower iso-time oxygen uptake (median +IQR; BRJ 14.1+5.4; placebo 13.4+5.5; p=0.099).16 We were unable to perform a meta-analysis of iso-time oxygen uptake due to incomplete data. Iso-time VO2 and other cardiopulmonary exercise parameters are provided in (table 2).

Blood pressure

SBP and DBP were reported in all included studies, while MAP was reported in three studies.17 19 29 Meta-analysis for systolic, diastolic and mean arterial blood pressure in people with COPD found significant reductions compared with placebo (figure 4) (MD (95% CI) was −3.39 mm Hg (−6.79 to 0.01), p=0.05, for SBP; −2.20 mm Hg (−4.36 to −0.03), p=0.05, for DBP; and −4.40 mm Hg (−7.49 to −1.30), p=0.005, for mean arterial blood pressure).16–19 26–32 However, in one study in individuals with PHT, SBP and DBP did not significantly change following NO3 supplementation compared with placebo.27

Heart rate

The impact of NO3 supplementation on HR was reported in seven studies.16 17 26–30 Pooled analysis from four trials of HR at rest and at peak of exercise in people with COPD is shown in figure 5. Following the meta-analysis, the MD (95% CI) was 0.23 (−3.58 to 4.03), p=0.91, for HR at rest and 0.22 (−5.80 to 6.24), p=0.94, for HR at peak of exercise, showing no change in HR following NO3 supplementation compared with placebo.17 26 28 29

Endothelial function

Pavitt et al assessed the impact of NO3 supplementation during PR on endothelial function using brachial artery flow-mediated dilatation,19 finding an improvement...
(increase) in FMD in the treatment group (n=10) compared with placebo (n=10) (median (IQR) percent change: +6.6% (0.6 to 17.6), placebo: −4.7% (−21.5 to 11.8), and estimated treatment effect: −20.3% (95% CI −33.8 to 3.4); p=0.046).

O2 saturation
The impact of dietary NO3− supplementation on O2 sat was reported in three studies.16–17 29 Pooled analysis from two trials for oxygen saturation at rest and at peak exercise in COPD is shown in figure 6. The MD (95% CI) was 0.20 (−1.72 to 2.12)%, p=0.84, for oxygen saturation at rest and −0.37 (−2.88 to 2.14)%, p=0.77, for oxygen saturation at peak of exercise, showing no effect on oxygen saturation following NO3− supplementation compared with placebo.17 29 Curtis et al did demonstrate a reduction in area under the curve for oxygen saturation during exercise with NO3− supplementation compared with placebo.29 Of note, this study excluded individuals with resting hypoxia.

Plasma NO3− and NO2− levels
Plasma NO3− and NO2− levels were measured in seven studies.16–18 26 27 29 32 Pooled analysis from six trials for plasma NO3− and NO2− levels in COPD individuals is shown in figure 7. Following the meta-analysis, the MD (95% CI) was 445.61 (254.69 to 636.53), p<0.00001, for plasma NO3− level and 367.07 (232.87 to 501.27), p<0.00001, for plasma NO2− level, showing that levels of plasma NO3− and NO2− significantly increased following NO3− supplementation compared with placebo.16–18 20 29 32

Fractional exhaled NO
The impact of NO3− supplementation on FeNO was measured in three trials two conducted in individuals with COPD18 28 and one with PHT.27 Pooled analysis from two trials for FeNO in COPD individuals is shown in figure 8. Following the meta-analysis, the MD (95% CI) was 17.23 (−3.35 to 37.80) ppb, p=0.10, for FeNO, showing no consistent effect on FeNO following NO3− supplementation compared with placebo.18 28 However, Henrohn et al (2018) found that the level of FeNO in individuals with PHT increased at all flow rates (50–300 mL/s) following NO3− supplementation compared with placebo, at a flow rate of 50 mL/s (median of differences 18, 95% CI 11 to 26, p<0.001).27

Risk of bias and evidence quality assessment
Using the Cochrane risk-of-bias assessment tool,33 the included studies showed considerable variation in the risk of bias, but most were limited by a lack of allocation concealment, blinding and incomplete reporting of data (figure 9).

The Grading of Recommendations, Assessment, Development and Evaluations (GRADE) criteria were used...
to assess the overall evidence around specific outcomes (eg, exercise capacity and blood pressure endpoints). For exercise capacity, the majority of studies were small and short term, which limit the precision of estimates. Studies did not focus clearly on disease severity, limiting the directness of the evidence to COPD phenotypes, particularly hypoxic patients. Further, studies used a variety of interventions (eg, doses, duration and delivery method) and outcome measures contributing to heterogeneity or inconsistency. Therefore, the quality of evidence by GRADE to support an effect of NO₃⁻ supplementation on exercise capacity in people with lung disease is low. In the specific context of PR, only a single high-quality RCT, the largest and the longest of the included studies, was identified. Therefore, the total evidence by GRADE to support the impact of NO₃⁻ supplementation on exercise capacity in the context of PR is moderate. Regarding blood pressure endpoints, studies were consistent, although the longest duration study is only 8 weeks, so taken together, the evidence to support an impact of NO₃⁻ supplementation on blood pressure is moderate.
DISCUSSION

The main findings of this review into the effects of dietary NO\textsubscript{3}\textsuperscript{-} supplementation in people with CRD are that, although it can augment the effects of PR on exercise performance, a consistent short-term effect on exercise capacity in the absence of exercise training has not so far been demonstrated. However, studies to date do suggest that dietary NO\textsubscript{3}\textsuperscript{-} supplementation can lower blood pressure, perhaps by improving endothelial function, which is potentially important given the high prevalence of cardiovascular disease in people with COPD, especially if a single intervention could address both issues.

Significance of findings

NO is a vital physiological mediator in the body. It is produced in two different ways: by an endogenous pathway (oxygen-dependent) via the L-arginine NO synthase system and by an exogenous pathway (oxygen-independent) via the reduction of dietary NO\textsubscript{3}\textsuperscript{-} via NO\textsubscript{2}\textsuperscript{-} to NO\textsuperscript{3}\textsubscript{.}35 36 In the human diet, the main source of NO\textsubscript{3}\textsuperscript{-} is green leafy vegetables, which have high concentrations of NO\textsubscript{3}\textsuperscript{-}. NO\textsubscript{3}\textsuperscript{-} reduction to NO is favoured by conditions found in exercising muscle, in particular hypoxia, acidosis and the presence of deoxyhaemoglobin and myoglobin. Effects on exercise in people with respiratory...
disease could be mediated through improved muscle mitochondrial efficiency or through effects on vascular endothelium in either the systemic or pulmonary circulation. Endothelial effects of NO are also likely to underpin the effects on blood pressure that were observed.

Regarding the impact of dietary NO₃⁻ supplementation on exercise capacity, the current meta-analysis includes studies in COPD, which found an improvement in exercise capacity,¹⁶⁻¹⁹ and others that did not.²⁶⁻³² Studies included heterogeneous COPD populations (eg, COPD severity and age) and used different exercise protocols (eg, ISWT, 6MWD and endurance time during cycle ergometry). Furthermore, hypoxic patients who required oxygen supplementation, a patient phenotype that might be expected to benefit most given that NO₂⁻ to NO conversion is enhanced in hypoxic conditions, were typically excluded. The duration of treatment and doses of NO₃⁻ used in trials also differed. The results from trials indicate that longer-term studies in specific patient phenotypes are needed to see if NO₃⁻ supplementation can improve exercise capacity in the absence of a training stimulus.

Likewise, although dietary NO₃⁻ supplementation was associated with a greater increase in walk distance during PR, it is not clear how long this benefit might be sustained for—the 8-week ON-EPIC trial¹⁹ is the longest study to date of this intervention in people with CRD.

Physiological parameters at peak exercise including VO₂ did not change significantly with NO₃⁻ supplementation compared with placebo,¹⁶ ²⁶⁻³⁰ ³² although one study found a significant reduction in VO₂ at iso-time during cycle exercise in patients with COPD.²⁹ Again, these negative results could be due to an absence of effect or a result of using insufficient dose or duration of supplementation. A dose–response effect for reduction in VO₂ during exercise has previously been described in healthy individuals.³⁷

Dietary NO₃⁻ supplementation has been shown to reduce blood pressure in individuals who are either normotensive³⁸ or hypertensive.³⁹ We found an overall effect to lower systolic, diastolic and mean arterial blood pressure in the studies reviewed here. People with lung disease are at high risk of cardiovascular disease, and this

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**Figure 7** Forest plot for the effect of nitrate supplementation on (A) plasma nitrate (µM) and (B) plasma nitrite (nM) levels in patients with chronic obstructive pulmonary disease. (1) sodium nitrate (8 mmol); (2) beetroot juice (BRJ) (7.58 mmol); (3) BRJ (12.9 mmol); (4) 140 mL of BRJ + 200 mL black currant cordial; (5) BRJ (6.75 mmol).

**Figure 8** Forest plot for the effect of nitrate supplementation on fractional exhaled nitric oxide (ppb) in patients with chronic obstructive pulmonary disease.
includes damage to the pulmonary vascular bed, which can lead to PHT.\(^\text{40}\) There is also interesting data in individuals with idiopathic PHT, which demonstrate that a low level of plasma NO\(^3\)- is associated with increased mortality risk making it a potential prognostic indicator for PHT.\(^\text{41}\) Although one study with PHT was identified by our search strategy to be small, we advise against over-interpreting it, and further studies are needed.

Plasma NO\(^3\)- and NO\(^2\)- levels have potential to be used as a biomarker for NO availability.\(^\text{42}\) As expected, the available evidence showed that plasma NO\(^3\)- and NO\(^2\)- levels increased following dietary nitrate supplementation. The FeNO has been used as a diagnostic test for asthma.\(^\text{43} \text{ 44}\) However, studies describing the FeNO level in people with COPD are inconclusive. In this review, two studies showed that FeNO level increased following NO\(^3\)- supplementation,\(^\text{27} \text{ 28}\) while another study had a negative result,\(^\text{18}\) so further work is needed to clarify this.

Further work is needed to establish if FeNO can be used as a biomarker to monitor compliance in therapeutic trials of NO\(^3\)- supplementation or even to adjust dose in individuals.

**Strengths and limitations**

A variety of lessons can be learnt from this review. First, most of the trials covering the effect of dietary NO\(^3\)- supplementation on exercise capacity in people with respiratory disease have focused on COPD, with only one on PHT. Most trials were short term. Second, trials involved a variety of study designs, outcome measures, clinical phenotypes (severity of the disease and of hypoxia in particular), exercise protocols and dose and duration of NO\(^3\)- supplementation. Third, it will be important to define whether there are different COPD phenotypes or subpopulations that can be categorised as NO\(^3\)- responders or non-responders. Fourth, in most studies, BRJ was used as the source of NO\(^3\)-. It is possible that other bioactive compounds in the juice that have antioxidant and anti-inflammatory properties including vitamin C, carotenoids, phenolics and betalains could contribute to beneficial effects. Many but not all studies have used NO\(^3\)--depleted BRJ as a control, which is ideal for identifying effects of NO\(^3\)- itself but runs the risk of underestimating the effect of BRJ itself if these other components have a role. Finally, none of the trials we identified for this review evaluate the effect of dietary NO\(^3\)- supplementation on exercise capacity or cardiovascular parameters in people with rarer lung diseases such as ILD and cystic fibrosis.

**CONCLUSION**

Dietary NO\(^3\)- supplementation has potential to reduce cardiovascular risk by lowering blood pressure in people with COPD as well as improving exercise capacity, though evidence for the latter is largely in the context of PR. Importantly, further work is needed to understand whether it is the rehab setting that is giving the benefit (ie, combining supplementation with exercise) or whether it is purely due to the fact that participants were followed for a longer duration than in other non-PR studies. To date, no data exist that might support dietary NO\(^3\)- supplementation for lung diseases other than COPD. The data support trials of dietary NO\(^3\)- supplementation in patients with COPD to address vascular endpoints, and we would suggest that exercise capacity also be measured in such trials to see whether a ‘dual benefit’ can be elicited. Outside the context of PR, further trials are indicated to evaluate the value of dietary NO\(^3\)- supplementation on exercise capacity in COPD and specifically to identify the phenotypes most likely to profit from this intervention.

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Figure 9 Risk of bias summary: review authors' judgements about each risk-of-bias item for each included study.
tional and secondary prevention of cardiovascular disease.

3.3.6 C-reactive protein

C-reactive protein (CRP) is a marker of inflammation and an independent predictor of cardiovascular disease. CRP levels are elevated in patients with COPD and are associated with poorer health outcomes, including mortality.

3.3.7 Body mass index

Body mass index (BMI) is an indicator of body fat and is calculated as weight (kg) divided by height (m) squared. BMI is a useful tool for assessing the risk of developing chronic obstructive pulmonary disease (COPD) and other chronic diseases.

3.3.8 Physical activity

Physical activity is defined as any bodily movement produced by skeletal muscles that consumes energy. It is an important determinant of health, and regular physical activity can reduce the risk of chronic diseases, including COPD.

3.3.9 Smoking status

Smoking status is a key factor in the development of chronic obstructive pulmonary disease (COPD). Smoking can cause lung damage and inflammation, leading to the development of COPD.

3.3.10 Pulmonary function tests

Pulmonary function tests are used to assess the function of the lungs. They include spirometry, which measures the amount of air that can be exhaled, and lung volumes, which measure the amount of air in the lungs.

3.3.11 Quality of life

Quality of life is a subjective measure of health that includes physical, emotional, social, and mental well-being. It is an important outcome measure in the assessment of the effectiveness of interventions for chronic obstructive pulmonary disease (COPD).

3.3.12 Exercise capacity

Exercise capacity is the amount of physical activity that a person can perform. It is an important measure of overall health and is a key outcome measure in the assessment of the effectiveness of interventions for chronic obstructive pulmonary disease (COPD).

3.3.13 Other comorbidities

Other comorbidities, such as diabetes, cardiovascular disease, and osteoporosis, can affect the course and outcome of chronic obstructive pulmonary disease (COPD) and should be considered when evaluating the health of patients with COPD.

3.4 Conclusion

In conclusion, chronic obstructive pulmonary disease (COPD) is a serious and common chronic disease that affects millions of people worldwide. It is a major public health concern and requires a multidisciplinary approach for its effective management.

References


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