INDOMETHACIN INHIBITS CIRCULATING PGE2 AND REVERSES POSTEXERCISE SUPPRESSION OF NATURAL KILLER CELL ACTIVITY
Indomethacin inhibits circulating PGE<sub>2</sub> and reverses postexercise suppression of natural killer cell activity

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Indomethacin inhibits circulating PGE<sub>2</sub> and reverses postexercise suppression of natural killer cell activity. Am. J. Physiol. 276 (Regulatory Integrative Comp. Physiol. 45): R1496–R1505, 1999.—Natural killer (NK) cells are important in combating viral infections and cancer. NK cytolytic activity (NKCA) is often depressed during recovery from strenuous exercise. Lymphocyte subset redistribution and/or inhibition of NK cell via soluble mediators, such as prostaglandin (PG) E<sub>2</sub> and cortisol, are suggested as mechanisms. Ten untrained (peak consumption = 40 ± 3.5 ml kg<sup>-1</sup> min<sup>-1</sup>) men completed at 2-wk intervals a resting control session and three randomized double-blind exercise trials after the oral administration of a placebo, the PG inhibitor indomethacin (75 mg/day for 5 days), or naltrexone (reported elsewhere). Circulating CD<sup>3</sup>·CD<sup>16</sup>·CD<sup>56</sup> NK cell counts, PGE<sub>2</sub>, cortisol, and NKCA were measured before, at 0.5-h intervals during, and at 2 and 24 h after a 2-h bout of cycle ergometer exercise (65% peak O<sub>2</sub> consumption). During placebo and indomethacin conditions, exercise induced significant (P < 0.0001) elevations of NKCA (>100%) and circulating NK cell counts (>350%) compared with corresponding control values. With placebo treatment, total NKCA was suppressed (28%; P = 0.05) 2 h after exercise, and a postexercise elevation (36%; P = 0.02) of circulating PGE<sub>2</sub> was negatively correlated (r = 0.475, P = 0.03) with K-562 tumor cell lysis. NK counts were unchanged in the postexercise period, but at this stage CD14<sup>+</sup> monocyte numbers were elevated (P < 0.0001). Indomethacin treatment eliminated the postexercise increase in PGE<sub>2</sub> concentration and completely reversed the suppression of total and per CD16<sup>+</sup>·CD<sup>56</sup> NKCA 2 h after exercise. These data support the hypothesis that the postexercise reduction in NKCA reflects changes in circulating PGE<sub>2</sub> rather than a differential lymphocyte redistribution.

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strenuous 2-h bout of cycle ergometer exercise would induce increased circulating PGE₂ concentrations and postexercise suppression of NKCA and that these responses would be reversed by 5 days of oral indomethacin treatment.

METHODS

Subjects. Ten untrained, but recreationally active [peak O₂ consumption (V₀₂peak) = 44.0 ± 3.5 (SD) ml·kg⁻¹·min⁻¹], nonsmoking (men ± SD: 26.8 ± 5.4 yr of age, 79.2 ± 10.3 kg body mass, 1.78 ± 0.07 m height) volunteered to participate in the study under conditions approved by the University of Toronto and Defence and Civil Institute of Environmental Medicine Human Experimentation Committees. At preliminary medical examination, subjects were excluded if they had a history of gastrointestinal ulcers or other known forms of sensitivity to nonsteroidal anti-inflammatory drugs. Other specific criteria for exclusion included a history of allergies and acute or chronic infection.

Experimental design. The study consisted of five laboratory visits: 1) clinical, physical, and anthropometric assessment, 2) one nonexercise, resting control condition, and 3) three double-blinded exercise tests ordered according to a randomized block design (placebo, indomethacin, and naltrexone). For the purposes of this study, only the resting control, placebo, and indomethacin trials are considered. A separate component of the study involving administration of the opioid antagonist naltrexone is described elsewhere (18).

Physical assessment. After medical approval, but ≥1 wk before the control condition, V₀₂peak and heart rate were determined on a mechanically braked cycle ergometer (Ergomedic 818E, Monark, Stockholm, Sweden). Subjects performed a progressive test at a pedal cadence of 70 rpm (an initial loading of 60 W, with 25 W/min increments). Volitional exhaustion was reached in 8–12 min. Expired gas, collected breath-by-breath, was analyzed for respiratory minute volume and O₂ consumption with use of a metabolic measurement cart (model 2900C, SensorMedics, Yorba Linda, CA). A heart rate monitor (Vantage XL, Polar, Port Washington, NY) was used to record heart rates at 5-s intervals. The work rate needed to elicit 65% V₀₂peak was determined for each subject from a plot of work rate vs. O₂ consumption.

Control and experimental trials. Within 2 wk of the physical assessment, subjects underwent resting control observations followed by three randomized, counterbalanced exercise trials at intervals of ≥2 wk. This design allowed for a systemic clearance of drug metabolites and ensured that a subject’s metabolic status was not compromised from previous blood sampling. On each test day, subjects reported to the laboratory at 0700–0730, having fasted overnight and abstained from strenuous physical activity for 36 h. They were immediately instrumented with a heart rate monitor and a 21-gauge intravenous catheter (Insyte Vascular Access, Becton-Dickinson, Sandy, UT). To standardize metabolic conditions, each subject consumed 1.1 MJ (250 kcal) of a clinical nutritional supplement (Ensure Plus, Abbott Laboratories, Saint-Laurent, PQ, Canada) immediately after collection of the initial blood sample.

The control session served to familiarize subjects with personnel, protocol, equipment, and the laboratory environment used for exercise testing. Beginning at 0700–0800, after ∼30 min of seated rest, serial blood samples were collected according to the same schedule as in exercise trials.

The two exercise trials involved administration of placebo or indomethacin before a 2-h bout of cycle ergometer exercise at a pedal cadence of 60 rpm and an intensity adjusted to elicit 65% of the individual’s V₀₂peak. O₂ consumption and heart rate were monitored at 15-min intervals during exercise, and the load was adjusted as necessary to maintain the required intensity of effort. Participants were encouraged to consume 1.0–1.5 liters of water during trials to minimize hemococoncentration. Sterile glass Vacutainers (Becton-Dickinson, Franklin Lakes, NJ) containing the necessary preservatives and anticoagulants were used to collect 45–ml blood samples at 0 (baseline), 0.5, 1, 1.5, 2, 4, and 24 h relative to the start of exercise.

Drug administration and pharmacokinetics. Beginning 5 days before the two exercise trials, subjects were given, in a double-blind fashion, four capsules of identical appearance to be taken orally each morning with breakfast; each capsule contained an inert placebo (180 mg of lactose; Novopharm, Scarborough, ON, Canada) or indomethacin (75 mg of Indocid SR, Merck Frosst, Mississauga, ON, Canada). Compliance was controlled by observation of drug ingestion on scheduled test days. Approximately 90% of orally administered Indocid is absorbed via the gastrointestinal tract within 2–4 h, and the selected dose would have yielded peak plasma concentrations of 1–2 μg/ml (1).

Hematologic analyses. Determinations of total leucocyte counts, three-cell differential counts (granulocytes, monocytes, and lymphocytes), Hb, and hematocrit were performed on K₂-EDTA-treated blood with use of an automated hematology analyzer (model JT, Coulter Electronics, Hialeah, FL). The formulas of Dill and Costill (11) were used to correct all blood cell counts and hormone concentrations to resting blood and plasma volumes, respectively.

Immunophenotyping by flow cytometry. NK cells (CD3⁻CD16⁺/66⁺) and monocytes (CD45⁺CD14⁺) were enumerated by dual-parameter immunophenotyping with use of combinations of monoclonal antibodies conjugated to FITC or phycoerythrin (PE). Briefly, 100-μl samples of EDTA-whole blood were incubated with saturating amounts of fluoro-chrome-conjugated monoclonal antibodies, as previously described (44). Stained cell suspensions were enumerated on a FACScan flow cytometer equipped with a 488-nm air-cooled argon-ion laser by using standard operating methods (Becton-Dickinson, San Jose, CA). Daily instrument calibration was performed with a mixture of monosized FITC- and PE-conjugated and unconjugated latex particles (4.8-μm Calibrite beads) and AutoCOMP software (Becton-Dickinson).

Isotopic-negative controls (anti-IgG-FITC/IgG-PE) and anti-CD4-FITC/CD8-PE double-stained whole blood samples served to optimize forward- and side-scatter gains. Electronic compensation was adjusted to eliminate spectral overlap between fluorescein (FL₁), FL₂, and FL₃ channels. Sample data were acquired on the day of collection and subsequently analyzed using CellQuest software (Becton-Dickinson).

Isolation of peripheral blood mononuclear cells. Peripheral blood mononuclear cells (PBMC) were isolated from heparinized blood samples (143 USP U/10 ml blood) by density gradient centrifugation for 30 min (20°C, 400 g) over Ficoll-Hypaque (Pharmacia, Uppsala, Sweden). The mononuclear cell band was carefully aspirated, washed, and reconstituted to a concentration of 2.0 × 10⁷ cells/ml in 10% FCS RPMI 1640.

K-562 tumor cell culture. The NK-sensitive K-562 tumor cell line (American Type Culture Collection, Rockville, MA) served as target cells for the cytolytic assays. The cell line was maintained in a continuous suspension of RPMI 1640 culture medium containing 5% FCS, 100 U/ml penicillin-streptomycin, 20 mM HEPES (pH 7.8), and 2 mM l-glutamine (GIBCO Life Technologies, Burlington, ON, Canada) in 25-cm² tissue culture flasks at 37°C in a humidified 5% CO₂
incubator (Revo Ultima, VWR Scientific, Toronto, ON, Canada). To ensure that cells were in the logarithmic phase of growth, cultures were split into 3-5 × 10⁶ cells/ml on a 24-h schedule 3 days before the experiment. Cell viability as assessed by trypan blue dye exclusion was typically >90%.

**Tumor cell labeling.** K-562 tumor cells were first washed twice in 10 ml of RPMI 1640 medium without FCS and centrifuged for 5 min (20°C, 400 g). The cells were then resuspended at a concentration of 1 × 10⁶/ml and labeled using a stable lipophilic membrane dye (PKH-26, Sigma Chemical, St. Louis, MO). A volume of 0.5 ml of the target cell suspension was added rapidly to 0.5 ml of PKH-26 (4 µM) in a 12 × 75-mm polystyrene culture tube. After incubation at 25°C for 2–5 min, the reaction was stopped by the addition of 1 ml of 100% FCS for 1 min. After centrifugation (20°C, 400 g) for 5 min, cells were washed three times in 10 ml of supplemented RPMI 1640 medium and resuspended to a final concentration of 2 × 10⁶ cells/ml.

**NK cytolytic assay.** Spontaneous NKCA was assessed by a nonradioactive in vitro flow cytometric assay (42). Plasma membrane integrity of the PKH-26-labeled K-562 tumor target cells was determined using the DNA-intercalating dye propidium iodide (PI; Sigma Chemical). Briefly, 100 µl of freshly isolated PBMC (effectors, 1 × 10⁶ cells/ml) were gently mixed with 100 µl of PKH-26-labeled K-562 tumor cells (targets, 2 × 10⁶ cells/ml) and 25 µl (1 µg/ml) of PI solution at an effector-to-target ratio of 50:1. Cell mixtures were centrifuged at completed for 5 min (20°C, 50 g) to promote optimal effector-to-target cell conjugation and then incubated for 4 h at 37°C in a humid 5% CO₂ atmosphere. The assay was stopped by addition of ice cold wash to the cultures. Samples were placed on ice until same-day acquisition.

PKH-26⁺ target cells were defined flow cytometrically and gated via a histogram of FL2 fluorescence. A minimum of 5,000, 5,000 live-gated PKH-26⁺ target cell events (corresponding to ≥200,000 list mode events) were collected per sample. Dead K-562 cells were differentiated from live K-562 cells on the basis of the FL3 fluorescence of PI. Spontaneous target cell death was determined by incubating PKH-26-labeled cells with 25 µl of PI but with no effector cells. Percent specific lysis was calculated by subtracting the mean percent of spontaneously dead target cells from the percentage of target cells killed in the test sample (mean of triplicate samples). The corresponding absolute number of dead target cells was calculated by multiplying the percent lysis by the total number of target cells used in a given assay. The intra-assay coefficient of variation (CV) was consistently ≤4% among triplicate samples, and the between-trial CVs for the same subject were typically ≤5%.

**Biochemical analyses.** Venous blood samples for cortisol determination were drawn into prechilled, 3-ml heparinized glass Vacutainers (Becton-Dickinson, Oakville, ON, Canada) and placed on ice. Samples were immediately centrifuged for 15 min (4°C, 1,000 g), harvested, and frozen at −80°C for future analysis. Plasma cortisol concentrations were determined using a commercial ¹²⁵I-cortisol solid-phase RIA kit (ICN Biomedicals, Costa Mesa, CA). The intra- and interassay CVs were <10%.

Blood samples for determination of PGE₂ were collected into ice-cold 5-ml (siliconized) Vacutainers containing 10 mg/ml EDTA and indomethacin (Sigma Chemical) at 5 µg/ml blood. Solid-phase sorbent extraction of PGE₂ from indomethacin-treated plasma samples was performed using Amprep C₁₈ octadecysililic silica reverse-phase affinity chromatography minicolumns (Amersham) (24). Purified samples were eluted with ethyl acetate. The organic phase was evaporated to dryness under N₂ gas, and the residue was reconstituted in 150 µl of assay buffer. PGE₂ concentration was determined by competitive enzyme immunoassay (BIOTRAK, Amersham Life Science, Buckinghamshire, UK) with a linear range of 0-32 pg/well. The PGE₂ antiserum had a sensitivity of 0.8 pg/well (equivalent to 16 pg/ml) and the following cross-reactivities: PGE₃, 0.2%; PGB₂, 1.0%; PGD₂, 1.0%; PGE₁, 7.0%; PGF₃α, 4.3%; 6-keto-PGF₁α, 5.4%; and 13,14-dihydro-15-keto-PGE₂, <0.1%. Aliquots of 50 µl of PGE₂-specific antibody standards and unknown samples were added to 96-well microtiter plates and incubated for 3 h at 2–8°C. Optical density was read at a wavelength of 450 nm by using an automated microplate photometer (model EL-340, BIORAD Instruments, Winooski, VT). The intra- and interassay CVs were 9.8 and 14.6%, respectively.

**Statistical analyses.** Values are means ± SE unless otherwise noted. To determine circadian effects, resting control data were analyzed separately for each phase of the experiment by using univariate ANOVA repeated across sampling times. Possible effects of trial order were excluded by a two-way (order × time) ANOVA. Statistical significance of changes in leukocyte and lymphocyte subsets, NKCA, cortisol, and PGE₂ concentrations was analyzed using a 3 (control, placebo, indomethacin) × 7 (sampling times) factorial design. When the F ratio showed significant interaction effects, specific post hoc pairwise multiple contrast comparisons were computed to identify sources of differences between time points. Nominal degrees of freedom are reported along with F values. An α level of 0.05 was accepted as indicating significance. The Geisser-Greenhouse adjustment of epsilon for degrees of freedom was used to minimize type I error. Linear regressions were calculated by the method of least squares. Percent change was determined intra-individually as follows: 100% × (posttest value − baseline value)/baseline value. All statistical calculations were performed using StatView and SuperANOVA microcomputer software packages (SAS Institute, Cary, NC).

**RESULTS**

**Physiological response to acute exercise.** No significant differences in metabolic measures were detected over time (P = 0.25) or between placebo and indomethacin exercise conditions (P = 0.65). Subjects worked at power outputs of 127 ± 14 and 125 ± 12 W during placebo and indomethacin trials, respectively, eliciting an average of 65% of their individual V̇O₂peak during both trials. A significant main effect of condition [F(2,18) = 85.13, P < 0.001] was apparent for heart rate; steady-state exercise heart rates during the placebo trial (157.9 ± 8.8 beats/min) were on average 11 beats/min higher than those recorded during the indomethacin trial (146.4 ± 9.33 beats/min).

**Leukocyte subset counts.** Initial resting values for total peripheral blood leukocytes and lymphocyte subset counts did not differ significantly between trials (Table 1). The concentrations of circulating leukocytes, monocytes, and granulocytes showed no significant fluctuations over time during resting control observations. A significant main effect of time [F(5,54) = 4.03, P < 0.02] was observed for lymphocyte concentration during the control condition; pairwise mean contrasts traced the source of variation to a significantly (P < 0.01) elevated lymphocyte count after 4 h (at 1200) of seated rest. Significant condition × time interaction
## Table 1. Comparison of leukocyte subset counts during control and exercise conditions

<table>
<thead>
<tr>
<th>Subset</th>
<th>Rest</th>
<th>Exercise</th>
<th>Recovery</th>
<th>P (ANOVA effect, condition × time)</th>
</tr>
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<tr>
<td></td>
<td>0</td>
<td>0.5</td>
<td>1.0</td>
<td>1.5</td>
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<tr>
<td>Leukocytes</td>
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<td></td>
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<td></td>
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<tr>
<td>Control</td>
<td>5.56 ± 1.77</td>
<td>5.85 ± 1.62</td>
<td>5.77 ± 1.72</td>
<td>5.84 ± 1.61</td>
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<td>Placebo</td>
<td>5.54 ± 0.88</td>
<td>7.92 ± 1.55*</td>
<td>8.04 ± 1.28*</td>
<td>9.57 ± 2.25*</td>
</tr>
<tr>
<td>Indomethacin</td>
<td>5.37 ± 1.34</td>
<td>7.19 ± 2.80*</td>
<td>7.88 ± 7.39*</td>
<td>9.17 ± 2.56*</td>
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<tr>
<td>Lymphocytes</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>2.10 ± 0.42</td>
<td>2.13 ± 0.41</td>
<td>2.04 ± 0.44</td>
<td>2.31 ± 0.42</td>
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<tr>
<td>Placebo</td>
<td>2.08 ± 0.39</td>
<td>3.18 ± 0.74*</td>
<td>3.16 ± 0.52*</td>
<td>3.46 ± 0.48*</td>
</tr>
<tr>
<td>Indomethacin</td>
<td>2.00 ± 0.37</td>
<td>2.88 ± 0.50*</td>
<td>3.02 ± 0.58*</td>
<td>3.48 ± 0.86*</td>
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<tr>
<td>Monocytes</td>
<td></td>
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<td></td>
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<tr>
<td>Control</td>
<td>0.38 ± 0.06</td>
<td>0.35 ± 0.05</td>
<td>0.40 ± 0.05</td>
<td>0.39 ± 0.04</td>
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<tr>
<td>Placebo</td>
<td>0.39 ± 0.07</td>
<td>0.62 ± 0.16*</td>
<td>0.62 ± 0.15†</td>
<td>0.70 ± 0.19†</td>
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<tr>
<td>Indomethacin</td>
<td>0.38 ± 0.06</td>
<td>0.52 ± 0.13†</td>
<td>0.53 ± 0.15†</td>
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<td>Granulocytes</td>
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<tr>
<td>Control</td>
<td>3.20 ± 1.47</td>
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<td>3.43 ± 1.42</td>
<td>3.45 ± 1.53</td>
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<tr>
<td>Placebo</td>
<td>3.20 ± 0.78</td>
<td>4.27 ± 1.13</td>
<td>4.48 ± 1.02</td>
<td>5.24 ± 2.05*</td>
</tr>
<tr>
<td>Indomethacin</td>
<td>3.15 ± 1.23</td>
<td>3.95 ± 1.83</td>
<td>4.25 ± 2.05</td>
<td>5.32 ± 2.12*</td>
</tr>
</tbody>
</table>

Values are means ± SD expressed as ×10^9/L; data in parentheses are percentages of total leukocytes (n = 10). Significant differences between exercise conditions vs. control: (*P < 0.05; †P < 0.0001). ‡Significant differences within control condition vs. time 0: P < 0.05.

Effects were observed for absolute numbers of each of the leukocyte subsets listed in Table 1 (all variables P < 0.0001). Exercise induced a sustained mobilization of circulating leukocyte subsets during placebo and indomethacin conditions, displaying marked lymphocytosis (100%), granulocytosis (300%), and monocytosis (165%) compared with resting control values. The exercise-induced granulocytosis was significantly (P < 0.05) less pronounced during the indomethacin condition than during the placebo condition at 2 and 4 h. During the indomethacin condition, circulating lymphocyte counts fell to ~80% (P < 0.05) of the corresponding control values 2 h after exercise (Table 1). A highly significant interaction effect [F(12,108) = 18.2, P < 0.0001] emerged for CD14* monocyte counts. Pairwise contrast tests between control and placebo conditions revealed significantly elevated monocyte concentrations at all time points during (all P < 0.001) and after exercise (P < 0.05). Indomethacin treatment blunted the exercise-induced monocytosis (P < 0.05) at all time points during exercise. The 33% postexercise increase in CD14* monocyte counts under placebo conditions was completely abolished under the influence of indomethacin (see Fig. 2A).

**NK cell counts and cytolytic activity.** Circulating CD3-CD16/56* NK cell counts showed a significant main effect of time [F(6,54) = 3.16, P < 0.05] during the resting control condition. This was traced to a >20% increase in NK counts over baseline at 4 and 24 h. Cycle ergometer exercise induced significant intertrial differences in the circulating number [F(12,108) = 27.8, P < 0.0001] and percentage [F(12,108) = 30.6, P < 0.0001] of CD3-CD16/56* NK cells (Fig. 1A). After 2 h of exercise, there was a 340% increase (P < 0.0001) in NK cell counts during the indomethacin trial and a 390% (P < 0.0001) increase in the placebo trial compared with control values. At 2 h after exercise, NK cell counts were reduced 25% during the placebo trial compared with control, yet in the indomethacin condition values did not differ significantly from control (Fig. 1A).

NKCA data are summarized in Fig. 1, B and C. Figure 1B shows the total NKCA (percent lysis) per fixed number of PBMC unadjusted for changes in the proportion of circulating NK cells and monocytes. Control NKCA showed no significant main effect of time, despite a rising trend over the 4-h sample period. Total peripheral blood NKCA showed a significant interaction effect [F(12,108) = 18.9, P < 0.0001], with peak increases of 100% (P < 0.0001) during the indomethacin trial and 66% (P < 0.0001) during the placebo trial, after 1.5 h of exercise. At 2 h after exercise, NKCA was significantly (P < 0.05) reduced by 28% during the placebo trial but was unchanged in the indomethacin trial, in contrast to the corresponding control values. Pairwise contrasts revealed significantly higher NKCA, at all exercise time points, during the indomethacin trial than during the placebo trial (all P < 0.05). Moreover, in vivo indomethacin treatment eliminated the significant postexercise suppression of NKCA seen during the placebo trial.

To adjust for variations in the circulating proportion of NK cells and monocytes during exercise, NKCA was...
calculated as the number of lysed K-562 target cells per CD3−CD16+/56+ cell with use of the following formula: per NKCA = number of dead K-562 target cells/[(%CD3−CD16+/56+ PBMC) × (total PBMC count − CD14+ PBMC count)]. When NKCA was adjusted on this basis, no statistically significant main effect of time [F(6,54) = 1.52, P = 0.25] was apparent during the resting control trial, but there was a significant interaction effect [F(12,108) = 3.15, P < 0.05] between conditions. However, the exercise-induced increase in NKCA was no longer apparent. In fact, during the placebo trial the number of killed target cells was significantly (all P < 0.0001) decreased (up to 50%) relative to control at all time points during exercise, and it remained significantly (P < 0.0001) suppressed 2 h after exercise (Fig. 1C). During the indomethacin trial, per NKCA was also
significantly (all $P < 0.001$) suppressed during exercise, but the 2- and 24-h recovery values did not differ from control values. Despite an apparent trend toward higher per NKCA with exercise during the indomethacin trial, pairwise contrasts revealed that the only significant difference in per NKCA between placebo and indomethacin conditions was at 2 h after exercise ($P < 0.05$; Fig. 1C).

Plasma PGE$_2$ concentrations. Figure 2 displays the kinetic changes in PGE$_2$ concentration relative to changes in CD14$^+$ monocyte counts and total NKCA. Resting plasma PGE$_2$ concentrations were within the expected normal range (3–15 pg/ml) (24) and did not differ significantly between exercise conditions, averaging $10.7 \pm 2.19$ and $9.20 \pm 3.11$ pg/ml for the placebo and indomethacin conditions, respectively. Changes in PGE$_2$ concentrations showed a significant main effect of time ($F(6,54) = 4.49, P < 0.01$). A significant interaction effect ($F(12,108) = 2.15, P < 0.05$) was traced to elevated (36%; $P < 0.02$) PGE$_2$ relative to control values in the placebo trial 2 h after exercise (Fig. 2A). No significant differences in PGE$_2$ were noted at any other time points. Postexercise differences in PGE$_2$ between conditions were eliminated during the indomethacin trial. Plasma PGE$_2$ concentrations were negatively correlated ($r = 0.45, P = 0.03$) with the number of dead K-562 tumor cells (as a dependent variable) 2 h after exercise (Fig. 3A). The kinetics of PGE$_2$ concentration paralleled changes in CD14$^+$ monocyte counts and were found to be positively related ($r = 0.56, P = 0.01$; Fig. 3B).

Plasma cortisol concentrations. Initial baseline (at 0800) levels of total cortisol (11.5–14.2 µg/dl; Fig. 4) were within the expected normal range of 5–20 µg/dl and did not differ significantly between sessions. A

![Fig. 2. Exercise-induced changes in concentration of circulating prostaglandin E$_2$ (PGE$_2$) vs. change in CD14$^+$ monocyte counts (A) and change in total NKCA (B) during placebo and indomethacin conditions. Values (means ± SE) are expressed as change relative to resting (time 0) values, as shown in insets. Significant changes in PGE$_2$ concentration, monocyte counts, and NKCA within exercise conditions vs. time 0: * $P < 0.05$; ** $P < 0.0001$; † significant ($P < 0.05$) intergroup differences between placebo and indomethacin exercise conditions ($n = 10$). Data for 24-h time points were omitted, since no significant differences in measured variables were detected.](image)

![Fig. 3. Scatterplots of relationship between circulating PGE$_2$ concentration and number of dead K-562 tumor target cells per assay tube (A) and CD14$^+$ monocyte counts (B), as measured 2 h after exercise by linear regression.](image)
significant main effect of time was seen during the control condition $[F(6,42) = 4.69, P < 0.01]$, with plasma cortisol values decreasing (37%) by 4 h of observation (from $11.5 \pm 1.8 \mu g/dl$ at 0800 to $7.0 \pm 1.3 \mu g/dl$ at 1200). A significant interaction effect $[F(12,84) = 1.85, P = 0.05]$ was also found. Relative to corresponding control values, pairwise mean contrasts showed significant ($P < 0.01$) elevations (peak value = 18.6 pg/dl) of cortisol at 1.5 and 2 h of exercise during the indomethacin trials and at 2 h during the placebo trial. No significant differences in cortisol concentration were observed between placebo and indomethacin trials, and under both conditions, cortisol levels had returned to normal by 2 h after exercise.

**DISCUSSION**

The results of this randomized, double-blind, placebo-controlled study indicate that a 5-day oral treatment with the prostaglandin inhibitor indomethacin augments the total unadjusted NKCA of the peripheral blood compartment during prolonged exercise and also reverses the suppression of NKCA 2 h after exercise. These results confirm prior exercise trials (32, 40, 53) providing new evidence that postexercise suppression of total peripheral blood NKCA and per CD3−CD16+/56+ NKCA is associated with elevated plasma concentrations of PGE2 and that the suppression is reduced if PGE2 levels are reduced by administration of indomethacin. The postexercise immunosuppression does not appear to result from NK cell redistribution or the solitary inhibitory action of cortisol, since removal of PGE2 by indomethacin treatment restores NKCA without altering NK cell counts or circulating cortisol levels.

**Modulation of circulating PGE2 and total NKCA.**

This investigation is the first to directly relate plasma PGE2 concentrations to circulating NK cell numbers and cytolysis activity during prolonged exercise. Prior evidence regarding changes in PGE2 levels during exercise is conflicting: increases in circulating PGE2 have been seen after a marathon run (10), but not after an 8-h triathlon (26). Meanwhile, others have demonstrated that moderate cycle ergometer exercise (75% $\text{VO}_{2\text{peak}}$) stimulates intramuscular PGE2 release (37), yet plasma PGE2 concentrations remain unchanged after progressive cycle ergometer exercise to exhaustion (31). Such discordant findings may reflect the inherent difficulties of isolating endogenous prostanoids and/or a lower sensitivity of earlier assay methodologies (24).

The current findings of a 70–80% increase in unadjusted NKCA throughout exercise, with a 28% drop below baseline 2 h after exercise (placebo condition) are typical of the cytolytic response to prolonged cycle ergometer exercise (19). Our results confirm the findings of Pedersen et al. (40), who demonstrated that 1 h of cycle ergometer exercise (75% $\text{VO}_{2\text{peak}}$) induced a 60–70% increase in NKCA per fixed number of PBMC (50:1 effector-to-target cell ratio) followed by a 30–35% decrease 2 h after exercise. Also in accord with the current findings, this group showed that oral indomethacin treatment (50 mg, 3 times/day for 2 days) potentiates exercise-induced NKCA (>100% above rest) and abolishes the postexercise suppression of NKCA without significantly modifying NK cell numbers (40). Our results strengthen the suggestion that PGE2 is necessary and sufficient for mediating postexercise inhibition of NKCA by demonstrating an inverse relationship between circulating concentrations of this mediator and the number of lysed tumor cells. In addition, the positive association observed between increases in circulating CD14+ monocyte counts and circulating levels of PGE2 strongly supports previous indications (40, 53) that monocyte-derived PGE2 is an important physiologic downregulator of NKCA after exercise.

In contrast to the current findings and those of Pedersen et al. (40), in vivo (150 mg/day for 2 days) (5) and in vitro (1 μg/ml) (36) indomethacin treatment did not significantly attenuate the postexercise suppression of total NKCA in experienced runners after 1.0 or 2.5 h of running. Furthermore, when NKCA was expressed on a per-cell basis, the postexercise depression of NKCA was no longer apparent, even in indomethacin-free cultures (36). There seem to be several possible explanations for these disparate results. Differences in exercise mode (cycling vs. running) and duration (1 h vs. 2.5 h) are an obvious source of variance between studies.

Disagreement between studies may also relate to the choice of sample population. Well-trained subjects often display greater resting NKCA than untrained individuals (19, 41), although the concentration of circulating NK cells may be similar in trained and untrained subjects (15, 35). The mechanism of chronic training-induced enhancement of NKCA is unknown. It could reflect the removal of, or a decrease in sensitivity to, inhibitory factors such as PGE2 (44, 53). Consistent with this notion, exercise-induced increases in plasma PGE2 and the sensitivity of lymphocytes to the inhibitory action of PGE2 are significantly lower in chroni-
cally exercised rats than in sedentary animals (22, 58). Similarly, naive human subjects show a greater sensitivity to PGE₂ than do conditioned volunteers in response to various forms of physical stress (21). Furthermore, recent evidence suggests that significant postexercise suppression of NKCA may occur only when exercise exceeds the ventilatory threshold (49). Thus it can be postulated that well-conditioned runners may produce less PGE₂ or are possibly more refractory to the inhibitory actions of endogenous PGs than untrained individuals, such as those in the present investigation. Additional studies are necessary to confirm or refute this explanation, since published reports (5, 36) involving indomethacin treatment in conditioned runners did not assay PGE₂ concentrations. Alternatively, regular exercise may alter NKCA by modifying cytokine expression (19, 43).

Another potential source of variation between studies is the age of participants. The mean ages of subjects in the current study and the study of Pedersen et al. (40) were ≤ 30 yr, whereas the mean age of the marathon runners described by Nieman et al. (36) was 38.7 ± 1.5 yr, and the matched control group was even older (45.3 ± 2.3 yr). Aging may be an important discriminator, since evidence suggests that it is associated with 1) increases in total NKCA and per NKCA (38), 2) decreases in plasma PGE₂ levels (8), and 3) a reduced sensitivity of circulating lymphocytes to PGE₂-mediated inhibition (22).

**Change in NKCA per cell.** When expressed on a CD3⁺-CD16⁺/56⁺ per-cell basis, postexercise suppression of NKCA was also abolished by treatment with indomethacin. Surprisingly, per-cell activity was depressed throughout the entire exercise period under placebo and indomethacin conditions. Despite a trend toward higher per-cell activity with indomethacin treatment than with placebo, no statistically significant differences between conditions were observed during exercise. Because PGE₂ levels did not rise significantly until after exercise, the acute reduction in cytolytic capacity during exercise would appear to be mediated by PG-independent mechanisms. Such a finding reinforces the view that the regulation of NKCA is multifactorial and that a variety of mediators are likely involved in exercise-induced modulation of NK cell function (18, 39).

NKCA is a result of a fine balance between positive and negative signals induced through distinct sets of receptors activating or inhibiting cytolytic activity (6). The inhibitory action of cAMP on NKCA is well documented (30, 59). Elevation of intracellular cAMP suppresses NKCA by impairing NK-target cell recognition (54) and by reducing effector-to-target cell conjugation (33, 45), providing an important shut-off mechanism for the NK lytic pathway. Such feedback inhibition is required for the cell to continue to function. NK cells need to replenish their stores of cytolytic molecules and to reset the receptor and enzyme systems of the cytolytic response so they can respond anew to subsequent tumor cell contacts (59). In addition to PGE₂, many agents that increase cAMP are potent regulators of cytokine release (55). For example, β₂-adrenergceptor stimulation by epinephrine elevates cAMP (27) and downregulates the synthesis of several NK cell-stimulatory cytokines, including interferon-γ, tumor necrosis factor-α, and interleukin-12, while also provoking the release of the immunosuppressive cytokine interleukin-10 (14, 15). Furthermore, acute exercise rapidly upregulates β-adrenergceptor density on circulating NK cells (2). Therefore, it can be hypothesized that exercise-elicited sympathetic activation, with the systemic release of catecholamines, contributes to the acute suppression of NKCA via enhanced cAMP production and subsequent changes in cytokine production.

The immunomodulatory properties of indomethacin are not restricted to their inhibition of the cyclooxygenase system and PG production (57). Indomethacin also interferes with a number of other physiological processes, including alteration of second-messenger pathways (55) and cytokine production (52). For example, basal or exercise-induced catecholamine secretion can be directly modified by indomethacin treatment (25), and this compound has been shown to decrease β-adrenergceptor density and sensitivity to catecholamine stimulation (17). Such an effect is supported by the decreased heart rate response observed with exercise during the indomethacin trial. Therefore, an indomethacin-induced decrease of β-adrenergic activation may have led to reduced cAMP production, resulting in the dampening of cAMP-mediated immunosuppression. In addition, indomethacin is known to upregulate production of several NK cell-stimulatory cytokines (52). Taken together, these results suggest that indomethacin-mediated immunopotentiation may provide an explanation for the trend toward higher NKCA during exercise with indomethacin treatment. Future investigations are needed to more fully elucidate the complex interactions between cAMP-enhancing agents, cytokine release, and immunoregulation by exercise.

**Circulating cortisol response and NKCA.** Exercise-induced secretion of cortisol may have contributed to the overall postexercise lymphocytopenia during placebo and indomethacin conditions. An important action of glucocorticoids is their ability to interfere with cellular adhesion and migration (2). Because we did not detect any significant differences in the number of circulating NK cells relative to the control condition during the postexercise period, cortisol does not appear to have had a major impact on NK cell mobilization. This conclusion is supported by recent demonstrations that circulating cortisol levels are unrelated to the magnitude or the duration of postexercise changes in NK cell counts, although they can reduce postexercise monocytecytosis (47, 48).

In addition to their potential effects on lymphocyte redistribution, long-term exposure to pharmacological doses of natural and synthetic glucocorticoids can inhibit NKCA directly (20, 28, 29). Similar to PGE₂-induced increases in cAMP, large doses of glucocorticoids can interfere with normal NK-target cell recognition and the triggering of lytic machinery (56), including reduced synthesis of granzyme A (60). By contrast,
physiological doses of glucocorticoids may stimulate, rather than inhibit, NKCA in rats. Although there have been suggestions that plasma cortisol levels are increased by indomethacin treatment (5, 1), the present results do not support such an effect. Nevertheless, we cannot exclude the possibility that PGE2 and cortisol act synergistically to downregulate NKCA during exercise, as in other forms of stress (16, 34). However, in the absence of PGE2, exercise-induced increases in cortisol are insufficient to suppress NKCA, since indomethacin treatment restored NKCA of exercising subjects to resting levels.

Conclusion. Our data are consistent with the hypothesis that in vivo treatment with the PG inhibitor indomethacin fully reverses the postexercise increase in PGE2 and associated suppression of NKCA. Because neither the percentage nor the concentration of circulating CD3+CD16+/56+ NK cells differed significantly between placebo and indomethacin treatments during the postexercise period, the attenuation of NK suppression observed after oral indomethacin treatment appears to be specific to single-cell activity and is not the result of differential lymphocyte redistribution. This conclusion is supported by earlier animal (12, 32) and human studies (40, 53). Increases in circulating cortisol may contribute to these inhibitory effects but appear insufficient to suppress NKCA in the absence of PGE2. The contribution of other immunoinhibitory mediators, including cytokines, to exercised-induced suppression of NKCA remains to be evaluated.

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