

Effect of an Intensive Exercise Intervention Strategy on Modifiable Cardiovascular Risk Factors in Subjects With Type 2 Diabetes Mellitus

A Randomized Controlled Trial: The Italian Diabetes and Exercise Study (IDES)

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Background: This study aimed to assess the efficacy of an intensive exercise intervention strategy in promoting physical activity (PA) and improving hemoglobin A_{1c} (HbA_{1c}) level and other modifiable cardiovascular risk factors in patients with type 2 diabetes mellitus (T2DM).

Methods: Of 691 eligible sedentary patients with T2DM and the metabolic syndrome, 606 were enrolled in 22 outpatient diabetes clinics across Italy and randomized by center, age, and diabetes treatment to twice-a-week supervised aerobic and resistance training plus structured exercise counseling (exercise group) vs counseling alone (control group) for 12 months. End points included HbA_{1c} level (primary) and other cardiovascular risk factors and coronary heart disease risk scores (secondary).

Results: The mean (SD) volume of PA (metabolic equivalent hours per week) was significantly higher ($P < .001$) in the exercise (total PA [nonsupervised conditioning PA + supervised PA], 20.0 [0.9], and nonsupervised, 12.4 [7.4]) vs control (10.0 [8.7]) group. Compared with the control group, supervised exercise produced significant improvements (mean difference [95% confidence inter-

val]) in physical fitness; HbA_{1c} level (−0.30% [−0.49% to −0.10%]; $P < .001$); systolic (−4.2 mm Hg [−6.9 to −1.6 mm Hg]; $P = .002$) and diastolic (−1.7 mm Hg [−3.3 to −1.1 mm Hg]; $P = .03$) blood pressure; high-density lipoprotein (3.7 mg/dL [2.2 to 5.3 mg/dL]; $P < .001$) and low-density lipoprotein (−9.6 mg/dL [−15.9 to −3.3 mg/dL]; $P = .003$) cholesterol level; waist circumference (−3.6 cm [−4.4 to −2.9 cm]; $P < .001$); body mass index; insulin resistance; inflammation; and risk scores. These parameters improved only marginally in controls.

Conclusions: This exercise intervention strategy was effective in promoting PA and improving HbA_{1c} and cardiovascular risk profile. Conversely, counseling alone, though successful in achieving the currently recommended amount of activity, was of limited efficacy on cardiovascular risk factors, suggesting the need for a larger volume of PA in these high-risk subjects.

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CARDIORESPIRATORY FITNESS is inversely related to all-cause and cardiovascular mortality, both in normal subjects and those with cardiovascular disease and cardiovascular risk factors,¹ including type 2 diabetes mellitus (T2DM).^{2,3} A low level of physical activity (PA) is also associated with increased prevalence of T2DM⁴ and

*For editorial comment
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Group Information: The IDES Investigators and Diabetes and Metabolic Fitness Centers are listed on page 1802.

the metabolic syndrome.⁵ Conversely, in patients with T2DM, a moderate-high level of PA was associated with reduced total and cardiovascular mortality,^{6,7} a lifestyle intervention to achieve and maintain weight loss through decreased ca-

loric intake and increased PA improved glycemic control and cardiovascular risk factors.⁸ Lifestyle modification programs including PA were also shown to prevent development of T2DM^{9,10} and to improve cardiovascular risk factors¹¹ in subjects with impaired glucose tolerance (IGT).

The US Department of Health and Human Services¹² and the American College of Sports Medicine¹³ recommend a minimum of 150 min/wk of moderate-intensity or, in moderately fit subjects, 60 min/wk of vigorous exercise or PA. The American Diabetes Association has extended these prescriptions also to subjects with IGT, to prevent T2DM development, and to patients with T2DM, to improve glycemic control, assist with weight maintenance, and reduce cardiovascular risk.¹⁴ However, it is debatable whether the same volume of PA

could be applied to subjects with T2DM, who have a high cardiovascular risk. It is also essential to identify effective strategies to promote an adequate amount of PA in these subjects. Counseling interventions have been recently designed and tested successfully in clinical settings¹⁵ and those focused only on exercise and PA appear to be more effective than those targeting multiple behaviors.¹⁶ Moreover, meta-analyses of small-sized studies showed that supervised exercise is effective in improving cardiorespiratory fitness,¹⁷ glycemic control,¹⁸ and other cardiovascular risk factors.¹⁹ Finally, growing evidence suggests that resistance training is beneficial also in diabetic patients, and a recent trial showed that combined aerobic and resistance exercise is more effective than either one alone.²⁰

The aim of the Italian Diabetes and Exercise Study (IDES) was to assess whether a strategy combining a prescribed and supervised mixed (aerobic and resistance) training program with structured exercise counseling is effective in promoting PA and improving hemoglobin A_{1c} (HbA_{1c}) level and other modifiable cardiovascular risk factors in a large cohort of sedentary subjects with T2DM. This combined strategy was compared with conventional disease management, including exercise counseling.

METHODS

PARTICIPANTS

This randomized controlled trial was conducted in 22 outpatient diabetes clinics across Italy, each connected with a Metabolic Fitness Center. In these gym facilities, patients trained under the supervision of an exercise specialist. The research protocol was approved by the locally appointed ethics committees, and participants gave written informed consent. To improve efficacy and safety of exercise intervention and patient adherence, a specific strategy was implemented prior to starting the IDES for training and selecting a group of diabetologists and exercise specialists to provide exercise prescription and counseling and supervise exercise sessions, respectively (eAppendix 1; <http://www.archinternmed.com>).

This study enrolled sedentary patients with T2DM fulfilling the International Diabetes Federation (IDF) criteria for the metabolic syndrome,²¹ which is almost invariably associated with T2DM and contributes significantly to the increased cardiovascular risk of these subjects.²² Patients having any condition limiting or contraindicating PA were excluded from the study. Design and methods have been detailed elsewhere.²³

RANDOMIZATION AND INTERVENTIONS

Between October 1, 2005, and March 31, 2006, of 691 eligible patients, 606 were recruited and randomized to supervised training plus structured exercise counseling (exercise [EXE] group, n=303) vs counseling alone as part of standard care (control [CON] group, n=303) for 12 months (**Figure 1**). Randomization was stratified by center and, within each center, by age (<60 vs ≥60 years) and type of diabetes treatment (diet ± oral agents vs insulin), using a permuted-block randomization software program installed in a computer at each participating center. The allocation sequence was generated by the coordinating center and was concealed until interventions were assigned. Physicians and patients were not blinded to group assignment, whereas sample blinding at central laboratory was achieved using bar codes.

Standard care consisted of a treatment regimen aimed at achieving optimal glycemic, lipid, blood pressure (BP), and body

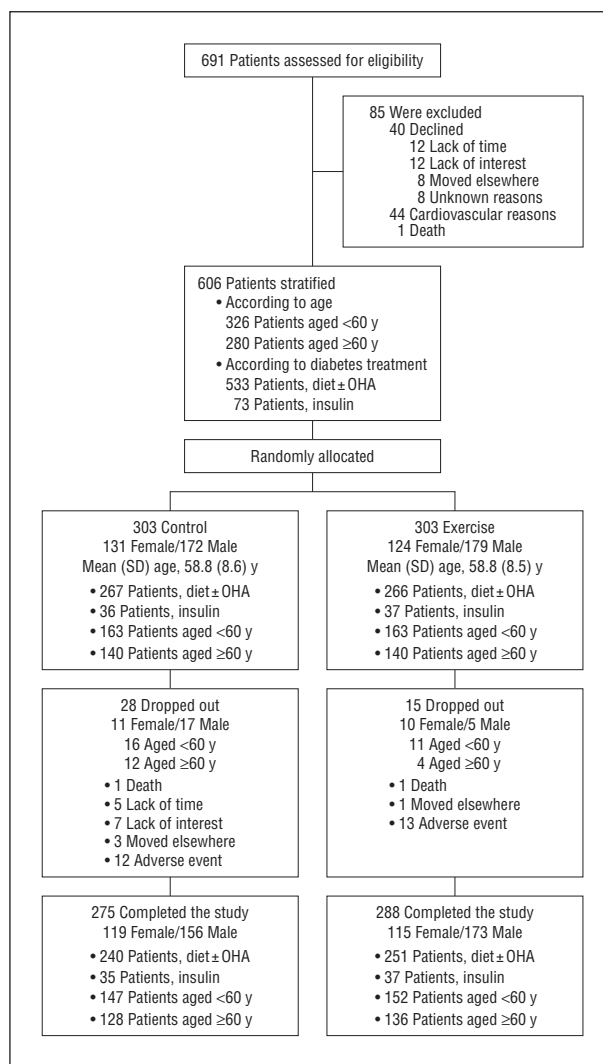


Figure 1. Study flow diagram. OHA indicates oral hypoglycemic agent.

weight targets, as established by current guidelines, and included glucose-, lipid-, and BP-lowering agents as needed.²³ For ethical reasons, drugs were also adjusted throughout the study to attain target levels and to account for reduced needs. Since all patients were overweight or obese, caloric intake (55% complex carbohydrates, 30% fat, and 15% protein) was reduced to obtain a negative balance of 500 kcal/d against energy expended. Requirements were calculated by adding the estimated energy expenditure from PA to basal metabolism.²³ Adherence to diet was verified by the use of food diaries, and dietary prescriptions were adjusted at each intermediate visit.

Subjects from both groups received a structured individualized counseling,¹⁵ aimed at achieving the currently recommended amount of PA by encouraging any type of commuting, occupational, home, and leisure time PA. Counseling was reinforced every 3 months.

The training program for the EXE group consisted of 150 min/wk in 2 supervised sessions of progressive mixed (aerobic and resistance) training.²³ Aerobic training was performed using treadmill, step, elliptical, arm, or cycle ergometer. Exercise load for each equipment was calculated to achieve prescribed exercise intensity, expressed as percentage of maximal oxygen consumption ($\dot{V}O_{2max}$), by the use of standard equations.²⁴ Resistance training consisted of 4 resistance exercises, ie, thrust movement on the transverse plane (chest press or

Table 1. Volume of Physical Activity (PA), Fitness, Anthropometric, and Biochemical Parameters and Medications at Baseline and at the End of the 12-Month Study Period^a

Variable	CON Baseline	CON 12 mo	P Value, 0-12 mo ^b	EXE Baseline	EXE 12 mo	P Value, 0-12 mo ^b	Mean Difference (95% CI)	P Value, EXE vs CON ^c
Nonsupervised PA, MET-h/wk								
Conditioning	0.76 (1.5)	10.0 (8.7)	<.001	0.73 (1.8)	12.5 (7.4)	<.001	2.47 (1.1 to 3.8)	<.001
Nonconditioning	NA	6.7 (4.2)	NA	NA	6.6 (3.8)	NA	-0.16 (-0.82 to 0.50)	.60
Supervised PA, MET-h/wk	NA	NA	NA	NA	7.6 (2.8)	NA	NA	NA
Total PA, MET-h/wk ^d	0.76 (1.5)	10.0 (8.7)	<.001	0.73 (1.8)	20.0 (9.0)	<.001	10.0 (8.6 to 11.5)	<.001
Estimated $\dot{V}O_{2max}$, mL/kg/min	25.9 (7.0)	27.5 (6.8)	<.001	25.9 (5.4)	30.4 (5.8)	<.001	2.8 (2.1 to 3.5)	<.001
Upper body strength, kg	39.7 (15.7)	39.1 (15.6)	.94	40.2 (16.3)	51.0 (19.0)	<.001	11.0 (9.5 to 12.5)	<.001
Lower body strength, kg	104.0 (69.5)	102.3 (65.9)	.12	108.0 (64.5)	139.8 (72.8)	<.001	30.8 (25.1 to 35.6)	<.001
Bending, cm	11.2 (9.6)	10.1 (10.3)	<.001	12.5 (9.9)	6.7 (9.4)	<.001	-4.6 (-5.7 to -3.6)	<.001
HbA _{1c} , %	7.15 (1.4)	7.02 (1.2)	.48	7.12 (1.4)	6.70 (1.1)	<.001	-0.30 (-0.49 to -0.10)	<.001
Fasting blood glucose, mg/dL	150 (52)	140 (47)	.005	145 (49)	135 (42)	<.001	-0.68 (-9.4 to 8.1)	.88
Serum insulin, μ U/mL	12.8 (8.6)	12.9 (6.9)	.06	12.4 (8.1)	11.3 (7.4)	.001	-1.18 (-2.36 to 0.0)	<.001
HOMA-IR	4.8 (3.9)	4.5 (3.1)	.29	4.5 (3.6)	3.8 (2.9)	<.001	-0.36 (-0.94 to 0.22)	.047
SBP, mm Hg	142 (18)	138 (16)	.001	140 (18)	132 (14)	<.001	-4.2 (-6.9 to -1.6)	.002
DBP, mm Hg	85 (10)	83 (9)	.02	84 (10)	80 (8)	<.001	-1.7 (-3.3 to -1.1)	.03
TG, mg/dL	139 (81)	141 (74)	.11	131 (97)	132 (82)	.20	-6.7 (-14.4 to 11.8)	.85
TC, mg/dL	201 (34)	188 (36)	<.001	199 (32)	181 (35)	<.001	-5.3 (-12.0 to 1.4)	.12
HDL-C, mg/dL	45.8 (10.5)	45.6 (10.0)	.65	44.9 (11.4)	48.4 (11.9)	<.001	3.7 (-2.2 to 5.3)	<.001
LDL-C, mg/dL	128 (34)	114 (33)	<.001	129 (31)	106 (29)	<.001	-9.6 (-15.9 to -3.3)	.003
Waist circumference, cm	105.1 (11.0)	104.8 (10.9)	.04	105.2 (11.8)	101.3 (11.4)	<.001	-3.6 (-4.4 to -2.9)	<.001
BMI	31.9 (4.6)	31.7 (4.5)	.20	31.2 (4.6)	30.3 (4.4)	<.001	-0.78 (-1.07 to -0.49)	<.001
hs-CRP, mg/L	2.6 (2.0)	2.8 (2.2)	.20	2.8 (2.2)	2.0 (1.9)	<.001	-1.0 (-1.4 to -0.7)	<.001
10-y CHD UKPDS risk score	18.5 (12.2)	17.8 (12.0)	.08	19.5 (13.3)	15.8 (10.4)	<.001	-3.1 (-4.2 to -2.0)	<.001
10-y fatal CHD UKPDS risk score	12.1 (10.3)	11.9 (10.2)	.82	12.8 (11.1)	10.2 (8.5)	<.001	-2.4 (-3.3 to -1.5)	.01
Diet alone, No. (%)	22 (8.0)	18 (6.5)	.13	25 (8.7)	21 (7.3)	.22		.85
Medications, No. (%)								
OHAs	230 (83.6)	232 (84.4)	.82	236 (81.9)	240 (83.3)	.42	NA	.85
Sulfonylureas	86 (31.3)	85 (30.9)	>.99	72 (26.7)	72 (25.0)	.36	NA	.12
Meglitinides	27 (9.8)	38 (13.8)	.007	29 (10.1)	31 (10.8)	.69	NA	.047
Metformin	200 (72.7)	207 (75.3)	.17	213 (74.0)	216 (75.0)	.61	NA	.98
Thiazolidinediones	24 (8.7)	40 (14.5)	.001	28 (9.7)	47 (16.3)	<.001	NA	.88
Acarbose	4 (1.5)	4 (1.5)	>.99	5 (1.7)	5 (1.7)	>.99	NA	.95
Insulin	13 (4.7)	16 (5.8)	.45	18 (6.3)	18 (6.3)	>.99	NA	.51
Combined (OHA + insulin)	22 (8.0)	32 (11.6)	.006	19 (6.6)	25 (8.7)	.11	NA	.30
Antihypertensive agents	167 (60.7)	181 (65.8)	.001	194 (67.4)	191 (66.3)	.51	NA	.004
ACE inhibitors	79 (28.7)	85 (30.9)	.21	98 (34.0)	93 (32.3)	.18	NA	.06
Angiotensin II receptor antagonists	82 (29.8)	93 (33.8)	.02	75 (26.0)	75 (26.0)	>.99	NA	.03
Diuretics	63 (22.9)	71 (25.8)	.04	73 (25.3)	67 (23.3)	.11	NA	.007
Calcium channel blockers	32 (11.6)	35 (12.7)	.25	51 (17.7)	55 (19.1)	.29	NA	.64
β -Blockers	37 (13.5)	48 (17.5)	.003	50 (17.4)	56 (19.4)	.11	NA	.35
α_1 -Blockers	10 (3.6)	10 (3.6)	>.99	13 (4.5)	13 (4.5)	>.99	NA	.91
Lipid-lowering agents	117 (42.5)	148 (53.8)	<.001	116 (40.3)	130 (45.1)	.003	NA	.42
Statins	102 (37.1)	130 (47.3)	.001	92 (31.9)	107 (37.2)	<.001	NA	.04
Fibrates	13 (4.7)	17 (6.2)	.42	16 (5.6)	18 (6.3)	.69	NA	.72
Omega-3	18 (6.5)	21 (7.6)	.61	18 (6.3)	20 (6.9)	.75	NA	.77

Abbreviations: ACE, angiotensin-converting enzyme; BMI, body mass index (calculated as weight in kilograms divided by height in meters squared); CHD, coronary heart disease; CI, confidence interval; CON, control group; DBP, diastolic blood pressure; EXE, exercise group; HbA_{1c}, hemoglobin A_{1c}; HDL-C, high-density lipoprotein cholesterol; HOMA-IR, Homeostasis Model Assessment-Insulin Resistance; hs-CRP, high-sensitivity C-reactive protein; LDL-C, low-density lipoprotein cholesterol; MET-h/wk, metabolic equivalent hours per week; NA, not applicable; OHAs, oral hypoglycemic agents; SBP, systolic blood pressure; TC, total cholesterol; TG, triglycerides; UKPDS, United Kingdom Prospective Diabetes Study; $\dot{V}O_{2max}$, maximal oxygen consumption.

SI conversion factors: To convert glucose to millimoles per liter, multiply by 0.0555; insulin to picomoles per liter, multiply by 6.945; TG to millimoles per liter, multiply by 0.0113; cholesterol to millimoles per liter, multiply by 0.0259; and hs-CRP to nanomoles per liter, multiply by 9.524.

^aValues are given as mean (SD) unless otherwise specified.

^bWilcoxon signed rank test for continuous variables and the McNemar test for categorical variables (medication use).

^cUnpaired *t* test or Mann-Whitney test for continuous variables and logistic regression adjusted for baseline for categorical variables (medication use).

^dTotal PA = nonsupervised conditioning PA + supervised PA.

equivalent), traction movement on the frontal plane (lateral pull down or equivalent), squat movement (leg press or equivalent), trunk flexion for the abdominals, and 3 stretching positions. Intensity was adjusted according to improvements in predicted $\dot{V}O_{2max}$ and 1-repetition maximum, as recorded throughout the study. In addition, caloric expenditure was increased progressively by 0.1-kcal/kg body weight per session every month.

OUTCOMES

The primary outcome was HbA_{1c} level reduction. Secondary outcomes included other modifiable risk factors, dosage of glucose-, lipid-, and BP-lowering drugs, and global coronary heart disease (CHD) 10-year risk.²³

Table 2. Percentage of Subjects On-Target for Traditional Cardiovascular Risk Factors at Baseline and at the End of the 12-Month Study Period and Probability of Reaching These Targets and Percentage of Subjects According to the Number of Targets Reached at 12 Months

Target	CON, Baseline, %	CON, 12 mo, %	P Value, 0-12 mo ^a	EXE, Baseline, %	EXE, 12 mo, %	P Value, 0-12 mo ^a	OR (95% CI), ^b EXE vs CON
HbA _{1c} <6.5%	37.8	37.1	.89	39.2	49.7	.001	2.0 (1.3-3.1)
TG <150 mg/dL	69.1	66.2	.39	76.4	72.9	.30	1.2 (0.8-1.8)
TC <175 mg/dL	25.5	37.1	.002	25.3	40.3	<.001	1.2 (0.8-1.6)
HDL-C >40 mg/dL	62.2	66.9	.111	59.0	76.0	<.001	2.0 (1.3-3.0)
LDL-C <100 mg/dL	21.2	34.1	<.001	16.2	41.5	<.001	1.5 (1.1-2.2)
SBP <130 mm Hg	18.2	26.5	.005	22.0	37.3	<.001	1.6 (1.1-2.4)
DBP <80 mm Hg	16.7	22.5	.072	18.1	26.5	.002	1.2 (0.8-1.9)
No. of Targets^c	0	1	2	3	4	5	
CON, %	10.6	29.9	31.0	21.5	4.7	2.2	
EXE, %	3.9	20.1	36.7	21.9	15.5	1.8	

Abbreviations: CI, confidence interval; CON, control group; DBP, diastolic blood pressure; EXE, exercise group; HbA_{1c}, hemoglobin A_{1c}; HDL-C, high-density lipoprotein cholesterol; LDL-C, low-density lipoprotein cholesterol; NA, not applicable; OR, odds ratio; SBP, systolic blood pressure; TC, total cholesterol; TG, triglycerides.

SI conversion factors: To convert glucose to millimoles per liter, multiply by 0.0555; to convert TG to millimoles per liter, multiply by 0.0113; and to convert cholesterol to millimoles per liter, multiply by 0.0259.

^aMcNemar test.

^bAdjusted for baseline status (on target vs not on target), treatment at baseline, and change during the study.

^cTargets considered: HbA_{1c} level lower than 6.5%, HDL-C level higher than 40 mg/dL, LDL-C level lower than 100 mg/dL, SBP lower than 130 mm Hg, and DBP lower than 80 mm Hg.

MEASUREMENTS

Volume of PA

At baseline, the volume of PA was assessed retrospectively using the Minnesota leisure time PA questionnaire. The amount of non-supervised PA was prospectively evaluated throughout the study by asking patients to fill in a daily diary, which was preliminarily validated by test-retest reliability. This diary considered the list of PAs coded in the Minnesota questionnaire; these activities were divided in conditioning or voluntary (corresponding to leisure time PA) and nonconditioning or nonvoluntary (including commuting, occupational, and home activities),²⁵ since conditioning PA consisted mainly of walking, running, and biking, for which estimates of metabolic equivalents (METs) are reliable, unlike nonconditioning PA. Volume was calculated by multiplying the MET scores corresponding to each Minnesota code²⁶ by time spent in each activity. For aerobic exercise, energy expenditure during supervised sessions was calculated automatically by the machines from workload using standard equations.²⁴ For resistance exercise, a conservative estimate of 3 MET-hours was established, based on direct measurements in subjects with T2DM not participating in this study.²⁷

Cardiovascular Risk Factors

The following modifiable cardiovascular risk factors were evaluated at baseline and end of study: HbA_{1c}, fasting blood glucose, and serum insulin levels; Homeostasis Model Assessment-Insulin Resistance (HOMA-IR) index; waist circumference; body mass index (BMI); BP; and triglyceride, total cholesterol (TC), high-density lipoprotein cholesterol (HDL-C), low-density lipoprotein cholesterol (LDL-C), and high-sensitivity C-reactive protein (hs-CRP) levels. Biochemical tests were performed at the central laboratory (at baseline and end of study) and locally (during the study period) to adjust treatment regimen.²³ Global CHD 10-year risk scores were calculated using the United Kingdom Prospective Diabetes Study (UKPDS) risk engine.²⁸

Physical Fitness and Adverse Events

Cardiorespiratory fitness, strength, and flexibility (see eAppendix 2) were evaluated at baseline and end of study and also, in the EXE group, during the study period, to adjust training loads.²³ Assessment of cardiorespiratory fitness consisted of a submaximal $\dot{V}O_{2max}$ evaluation, ie, at 80% of the predicted maximal heart rate. All patients performed the test at the treadmill, using a modified Balke and Ware protocol (eTable 1), with direct measurement of oxygen consumption using the gas exchange analyzer FitMate (Cosmed, Rome, Italy) and concurrent assessment of heart rate. For strength assessment, though the 1-repetition maximum is the most reliable test, we used a maximal repetition (or 5- to 8-repetition maximum) test, which is preferable in patients with a low-fitness profile for safety reasons, and then predicted 1-repetition maximum using the Brzycki formula.²⁹ For hip and trunk flexibility assessment, a standard bending test was performed.

Adverse events were reported at intermediate visits and also, for EXE subjects, at supervised sessions, by completing a standard form.

STATISTICAL ANALYSIS

Sample size calculation considered an HbA_{1c} level reduction of at least 0.5% in EXE vs CON group with a standard deviation for baseline HbA_{1c} of 1.6 and a statistical power of 90% ($\alpha = .05$). To this end, 215 patients per arm needed to be enrolled (430 total). A sample size of 606 patients allowed for a dropout rate of up to 25%.²³

The χ^2 test for categorical variables and the unpaired, 2-tailed *t* test or the corresponding nonparametric Mann-Whitney test for continuous variables were used to compare patients' characteristics at baseline. The efficacy of intervention on primary and secondary end points was assessed using the unpaired *t* test or the Mann-Whitney test for continuous variables, by comparing between-group changes from baseline to end of study. For categorical variables (ie, medications), logistic regression

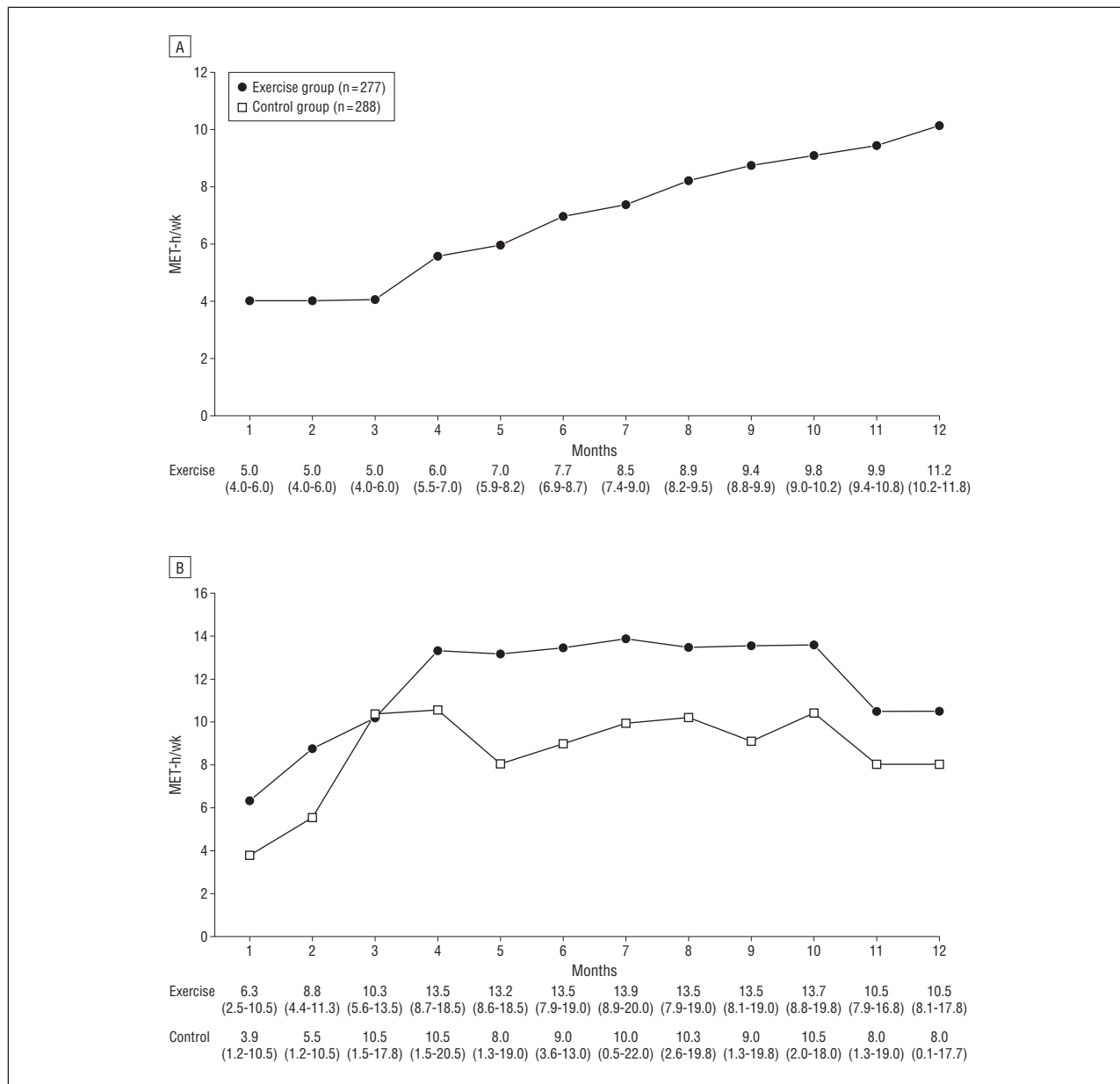


Figure 2. Average monthly energy expenditure from supervised exercise (A) and nonsupervised conditioning physical activity (B). Data are given as median (interquartile range); significantly different in exercise (EXE) vs control (CON) group at $P < .001$ by repeated-measures ANOVA (analysis of variance).

analysis was applied, with end-of-study rate of use included in the model as the dependent variable and baseline rate of use and study arm included as covariates.

To account for change in medication throughout the 12-month period, we performed both multiple regression and sensitivity analyses. In the regression models, the dependent variable was represented by baseline to end-of-study changes. Treatment at baseline and treatment initiation during the study were included in the model as dichotomous variables (yes vs no), whereas drug dosage was not taken into consideration. Sensitivity analysis was conducted for HbA_{1c} and LDL-C by comparing study arms after excluding patients in whom treatment was modified for diabetes (ie, patients previously on diet alone who started treatment with oral agents, or patients receiving oral agents who added another oral agent or started insulin treatment) or statin therapy, respectively.

Within-group end-of-study vs baseline values were compared using the McNemar test for categorical variables and the Wilcoxon signed rank test for continuous variables. To identify independent predictors of HbA_{1c} level changes from baseline, a multiple regression analysis was applied, with mean value of METs, baseline HbA_{1c} values, sex, age, and changes in HOMA-IR, BMI, waist circumference, and TC, LDL-C, and HDL-C, and hs-CRP levels as covariates forced in the model.

The likelihood to achieve IDF targets³⁰ after 12 months according to study group, independent of volume, was estimated using a separate logistic regression model for each target (dependent variable), with study arm, baseline status (on target vs not on target), baseline mean value, and PA volume quintiles as covariates. Additional logistic analyses were performed to evaluate the likelihood of reaching specific targets according to PA volume. In these analyses, individual targets were the dependent variable, with PA volume quintiles, baseline status, baseline mean value, treatment at baseline, and change during the study as covariates. Results of these analyses were expressed as odds ratios (ORs) with 95% confidence intervals (CIs). A test for linear trend was also applied.

All analyses were performed on individuals completing the follow-up; an analysis with baseline values carried forward was also applied.

RESULTS

The 2 study groups were similar for baseline characteristics (Figure 1 and eTable 2), including fitness, anthropometric, and biochemical parameters (Table 1), medications, and the percentage of subjects on-target for cardiovascular risk factors (Table 2). The median exercise training attendance was 80.3% (interquartile range, 75% to 99%) for aerobic and/or resistance sessions. During the 12-month period, 28 CON subjects and 15 EXE subjects dropped out (Figure 1). The results presented herein refer to patients completing the follow-up, since the baseline values carried forward analysis did not change the estimates.

According to the training program, energy expenditure during the exercise sessions increased progressively throughout the study (Figure 2A). In both groups, counseling promoted a marked increase in self-reported conditioning PA, which reached a peak at 4 months (Figure 2B) and was mainly aerobic. Energy expenditure from conditioning but not nonconditioning PA was significantly higher in EXE vs CON subjects, and the difference between the 2 groups became much larger when considering total volume of PA (nonsupervised conditioning plus supervised). This was associated with significantly more marked changes over baseline in the EXE vs CON group in cardiorespiratory fitness, upper and lower body strength, and flexibility (Table 1).

Reduction in the primary end point of HbA_{1c} level was significantly higher in EXE than in CON subjects, with a 0.42% decrease in the former vs a nonsignificant 0.13% reduction in the latter group (Table 1). At multiple regression analysis, independent predictors of HbA_{1c} level reduction were changes over baseline in waist circumference ($\beta=0.04$; $P<.001$) HOMA-IR ($\beta=0.053$; $P<.001$); male sex ($\beta=-0.17$; $P=.03$); older age ($\beta=-0.015$; $P=.001$); and higher baseline HbA_{1c} level ($\beta=-0.47$; $P<.001$). In keeping with this, when patients were stratified by baseline HbA_{1c} level, the extent of HbA_{1c} level reduction increased progressively with the initial HbA_{1c} value (eTable 3).

Changes over baseline in the EXE group were significantly more marked than in the CON group also for HOMA-IR; serum insulin level; systolic and diastolic BP; TC, HDL-C, and LDL-C levels; waist circumference; BMI, hs-CRP level; and total and fatal CHD 10-year risk scores. In fact, at 12 months, the EXE subjects exhibited significant improvements in all these parameters, whereas the CON participants showed significant decreases only in fasting blood glucose level, waist circumference, BP, and TC and LDL-C levels (Table 1).

During the study period, the percentage of patients reducing drug number and/or dosage was significantly higher in the EXE than in the CON group. In more detail, 13.5% of subjects in the EXE group vs none in the CON group stopped insulin therapy, while 5.1% in the EXE group vs 2.6% in the CON group reduced the number of oral agents without starting insulin therapy. The

Table 3. Likelihood of Reaching Specific Targets According to Study Group, Independent of Volume of Physical Activity

Target	OR (95% CI), ^a EXE vs CON
HbA _{1c} <6.5%	2.0 (1.3-3.3)
HbA _{1c} reduction ≥ 0.5	1.4 (0.9-2.3)
TG <150 mg/dL	1.1 (0.7-1.8)
TC <175 mg/dL	1.0 (0.6-1.4)
HDL-C >40 mg/dL	1.9 (1.1-3.1)
LDL-C <100 mg/dL	1.3 (0.9-2.0)
SBP <130 mm Hg	1.4 (0.9-2.2)
DBP <80 mm Hg	1.0 (0.6-1.6)
BMI reduction ≥ 1	2.0 (1.3-3.0)
Waist circumference reduction ≥ 5 cm	2.7 (1.7-4.3)

Abbreviations: BMI, body mass index (calculated as weight in kilograms divided by height in meters squared); CI, confidence interval; CON, control group; DBP, diastolic blood pressure; EXE, exercise group; HbA_{1c}, hemoglobin A_{1c}; OR, odds ratio; SBP, systolic blood pressure; TG, triglycerides.

SI conversion factors: To convert glucose to millimoles per liter, multiply by 0.0555; TG to millimoles per liter, multiply by 0.0113; and cholesterol to millimoles per liter, multiply by 0.0259.

^aAdjusted for baseline status (on-target vs not-on-target), baseline mean values and PA volume quintiles (conditioning + supervised PA [metabolic equivalent hours per week]).

mean (SD) dose of insulin (+11.6 [4.6] IU/d vs -2.3 [1.9] IU/d in the EXE group) and the median dose of metformin (from 1700 [interquartile range, 1200-2550] mg/d to 2000 [1500-2712] mg/d vs no change) increased only in the CON group. In addition, the percentage of subjects requiring meglitinides, combined oral plus insulin therapy, and antihypertensive treatment (particularly angiotensin II receptor antagonists and diuretics) increased only in the CON group, whereas the percentage of those receiving statins increased significantly more in the CON than in the EXE group (Table 1). Finally, adjusted multiple linear regression analysis and sensitivity analysis confirmed differences between groups. In particular, multiple regression analysis after adjusting for baseline LDL-C level and treatment at baseline and throughout study with statins (the only medication that changed significantly in both groups) showed that patients assigned to the EXE group still had significantly reduced LDL-C levels compared with the CON group (mean [SE] difference, -10.0 [2.56] mg/dL; $P<.001$). Moreover, sensitivity analysis showed results superimposable to those obtained in the whole cohort for HbA_{1c} (mean [SE] difference, -0.26% [0.10%]; $P=.03$) and LDL-C (mean [SE] difference, -10.95 [3.403] mg/dL; $P=.001$) outcomes.

At the end of the study, the percentage of subjects on-target according to the IDF Guidelines³⁰ increased significantly for TC and LDL-C levels and systolic BP in the CON group and for all cardiovascular risk factors, except triglycerides, in the EXE group. Overall, the probability of reaching all targets (except triglycerides) and the number of targets reached were higher in the EXE than in the CON subjects (Table 2). When adjusting for baseline values and volume of PA, patients assigned to the EXE arm still had a higher probability of reaching targets (Table 3).

The probability of reaching specific targets according to quintiles of PA volume showed a variable trend

Table 4. Likelihood of Reaching Specific Targets According to Physical Activity (PA) Volume Quintiles^a

Target	PA Volume Quintile ^b					P Value for Trend
	First Quintile (RC) (≤4.74)	Second Quintile (4.75-12.28)	Third Quintile (12.29-18.20)	Fourth Quintile (18.21-24.63)	Fifth Quintile (>24.63)	
HbA _{1c} <6.5%	1 [Reference]	1.3 (0.7-2.6)	2.6 (1.3-5.0)	2.1 (1.1-4.1)	1.5 (0.8-2.9)	.13
HbA _{1c} reduction ≥0.5	1 [Reference]	2.8 (1.2-6.4)	5.1 (2.3-11.3)	5.3 (2.4-11.4)	4.6 (2.1-10.0)	.02
TG <150 mg/dL	1 [Reference]	1.5 (0.8-2.9)	1.4 (0.7-2.6)	1.9 (1.0-3.6)	1.4 (0.7-2.6)	.23
TC <175 mg/dL	1 [Reference]	1.3 (0.7-2.2)	1.2 (0.7-2.0)	1.3 (0.8-2.3)	1.7 (1.0-3.0)	.93
HDL-C >40 mg/dL	1 [Reference]	1.5 (0.7-3.0)	3.0 (1.4-6.1)	2.6 (1.3-5.2)	2.9 (1.4-6.0)	.30
LDL-C <100 mg/dL	1 [Reference]	1.4 (0.8-2.5)	1.4 (0.8-2.5)	1.5 (0.8-2.6)	2.0 (1.1-3.5)	.65
SBP <130 mm Hg	1 [Reference]	2.0 (1.0-4.0)	2.4 (1.2-4.8)	3.0 (1.5-5.9)	2.2 (1.1-4.4)	.05
DBP <80 mm Hg	1 [Reference]	1.2 (0.6-2.5)	2.2 (1.1-4.3)	1.9 (1.0-3.8)	1.6 (0.8-3.1)	.33
BMI reduction ≥1	1 [Reference]	1.8 (1.0-3.2)	1.8 (1.0-3.3)	2.6 (1.4-4.7)	3.1 (1.7-5.6)	<.001
Waist circumference reduction ≥5 cm	1 [Reference]	6.5 (2.4-18.0)	9.1 (3.3-24.7)	13.2 (4.9-35.7)	15.9 (5.9-43.2)	<.001

Abbreviations: BMI, body mass index (calculated as weight in kilograms divided by height in meters squared); DBP, diastolic blood pressure; HbA_{1c}, hemoglobin A_{1c}; RC, reference category; SBP, systolic blood pressure; TC, total cholesterol; TG, triglycerides.

SI conversion factors: To convert glucose to millimoles per liter, multiply by 0.0555; TG to millimoles per liter, multiply by 0.0113; and cholesterol to millimoles per liter, multiply by 0.0259.

^aData are given as odd ratios (95% confidence intervals), adjusted for baseline status, baseline mean value, treatment at baseline, and change during the study.

^bConditioning + supervised PA (metabolic equivalent hours per week).

Table 5. Baseline to End-of-Study Changes (Δ) in Total and Fatal CHD UKPDS 10-Year Risk Scores According to Physical Activity (PA) Volume Quintiles

UKPDS Score	PA Volume Quintile ^a					P Value for Trend ^c
	First Quintile (RC) (<4.74)	Second Quintile (4.74-12.28)	Third Quintile (12.29-18.20)	Fourth Quintile (18.21-24.63)	Fifth Quintile (>24.63)	
ΔTotal CHD ^b	0.6 (-1.9 to 2.6)	-0.4 (-3.4 to 2.7)	-1.8 (-4.0 to -0.1)	-3.0 (-6.5 to -0.3)	-3.1 (-7.5 to -0.05)	<.001
P value		.11	<.001	<.001	<.001	
ΔFatal CHD ^b	0.8 (-1.2 to 2.1)	-0.1 (-1.9 to 1.7)	-0.9 (-2.6 to 0.3)	-1.6 (-4.6 to 0.0)	-1.5 (-5.2 to 0.1)	<.001
P value		.09	<.001	<.001	<.001	

Abbreviations: CHD, coronary heart disease; RC, reference category; UKPDS, United Kingdom Prospective Diabetes Study.

^aConditioning + supervised PA (metabolic equivalent hours per week).

^bMedian and interquartile range.

^cMann-Whitney test.

for the different risk factors (**Table 4**) and CHD scores (**Table 5**), without a clear dose-dependent effect, except for BMI, waist circumference, and CHD scores.

Adverse effects related to PA were more frequent, though not significantly, in EXE than in CON subjects, whereas the number of unrelated events did not differ between the 2 groups (**Table 6**). No episode of hypoglycemia was severe enough to require assistance.

COMMENT

Mortality is inversely related to cardiorespiratory fitness and its main determinant PA, both in the general population and in subjects with T2DM.¹⁻³ However, evidence of efficacy of supervised exercise intervention on modifiable cardiovascular risk factors in patients with T2DM is mainly derived from small-sized studies,^{18,19} and it is unclear which volume of exercise or PA is required to reduce cardiovascular burden and which is the best strategy for promoting PA in these high-risk individuals. The IDES showed that both the volume of PA and the extent of reduction of HbA_{1c} level and other modifiable cardiovascular risk factors were significantly higher

with the combination of structured exercise counseling and a prescribed and supervised training program than with counseling alone. Though difference in volume of PA between the 2 groups seems to explain the different outcome in terms of cardiovascular risk profile, the volume-adjusted analysis given in Table 3 suggests that the intervention strategy might have contributed to reduce modifiable cardiovascular risk factors and CHD scores. This effect might be attributed to supervision and/or type of exercise, though energy expenditure from resistance training was only a small part of total volume.

Important new information can be derived from these results. First, this study, which was multicenter and thus less dependent on local factors and of larger size and longer duration than previously published exercise intervention trials in patients with T2DM, provides definitive evidence that exercise is highly effective in improving HbA_{1c} level and cardiovascular risk profile in these subjects. Second, supervised exercise programs could represent an effective strategy for promoting lifestyle changes in subjects with sedentary habits, such as patients with T2DM. In fact, supervised training on top of structured coun-

Table 6. Adverse Events in the Control (CON) and Exercise (EXE) Groups

Events	CON	EXE	P Value ^a
Related to exercise intervention	20	34	.13
Shoulder pain/chronic tendinopathy of rotator cuff	5	9	
(Aggravation of) low back pain	2	6	
Aggravation of pre-existing osteoarthritis of hip or knee joint	2	5	
Shin splints/lower limb pain	3	7	
Other/generalized musculoskeletal discomfort	8	7	
Unrelated to exercise intervention	23	25	.90
Elective surgery	14	13	.91
Arthroscopic knee surgery	1	2	
Total thyroidectomy	1	0	
Cataract surgery	3	2	
Knee/hip joint replacement	1	2	
Inguinal hernia	2	1	
Varicose vein surgery	1	2	
Percutaneous coronary revascularization	2	2	
Mastectomy for carcinoma of the mammary gland	2	1	
Percutaneous lower limb revascularization	1	1	
Other serious medical event	8	11	.73
Atrial fibrillation	1	1	
Newly diagnosed myocardial ischemia	1	3	
Accidental bone fracture	2	3	
Bronchitis/pneumonia	3	2	
Otitis	1	2	
Death from any cause	1	1	
Death from cardiovascular causes	0	0	
Total	43	59	.26^a

^a χ^2 test.

selling was superior to counseling alone in increasing the amount of nonsupervised PA, thus suggesting that the twice-a-week sessions supervised by an exercise specialist served as continuous reinforcement to counseling. In addition, these results might imply that the amount of PA that is required to effectively reduce cardiovascular burden in these high-risk subjects could be higher than the minimum recommended. This suggestion derives from the finding that counseling alone, though almost successful in achieving the currently recommended amount of PA (ie, 150 min/wk of moderate-intensity activity corresponding to 11.25 MET-h/wk) and improving significantly cardiorespiratory fitness in previously sedentary subjects, produced limited benefits in terms of glycemic control and reduction of global cardiovascular risk, at least over 1 year. Indeed, the currently recommended level of energy expenditure was originally derived from studies in healthy subjects and extended to the diabetic or IGT population, based on the amount of exercise performed (1) in the small-sized studies included in a meta-analysis,¹⁸ which did not consider the volume of PA performed outside the exercise sessions, and (2) in the Diabetes Prevention Program (DPP),⁹ in which the intensive lifestyle intervention consisted of a combination of exercise and diet. Besides, in the DPP,¹¹ the intensive lifestyle intervention, while greatly reducing the T2DM incidence compared with placebo, produced improvements in BP and cholesterol levels that were of an order of magnitude similar to that observed in the CON group (and less than that detected in the EXE group), whereas reductions of weight and triglyceride levels were more marked, possibly reflecting the effect of diet.

The finding that the extent of HbA_{1c} level reduction was less than in previous reports^{18,20} may be explained by the lower baseline HbA_{1c} level. Indeed, a larger reduction was documented in individuals with higher baseline HbA_{1c} levels, in keeping with the observation that baseline BP levels and the extent of BP reduction were higher in our study than in the study by Sigal et al.²⁰

Potential limitations of this trial are self-reported data of nonsupervised PA, change in medication, unblinded design, and effect of diet. Provided that the use of devices is not applicable to a large multicenter study population followed for 12 months, the prospective evaluation of PA by a daily diary greatly reduces the risk of inaccuracy of self-reporting questionnaires, as compared with retrospective assessment. Moreover, changes in medication during the study attenuated, if any, differences between groups, thus ruling out the possibility that better outcome in EXE subjects was related to modification of treatment regimen. In fact, in keeping with a previous report,⁸ drug number and/or dosage was significantly reduced as a consequence of increased PA, but this effect was observed only in EXE subjects, whereas the percentage of subjects requiring an increment of treatment regimen increased solely or more markedly in CON participants. Furthermore, though it was impossible to keep assignment to supervised training hidden to both patients and physicians, sample analysis was blinded. Finally, though diet was not considered in data analysis, patients from both groups received specific dietary prescriptions, and adherence to diet was verified at intermediate visits. Future studies are needed to determine the optimal "dose" of exercise and PA in subjects with T2DM and to assess the applicability

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of this intervention strategy to clinical practice, including analysis of cost-effectiveness.

In conclusion, twice-weekly, supervised, facility-based combined aerobic and resistance exercise had significant incremental benefits beyond those of exercise counseling alone in terms of promotion of PA and improvement of HbA_{1c} level and cardiovascular risk profile in sedentary patients with T2DM.

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