

**1 Title**

2 Montmorency tart cherry (*Prunus cerasus* L.) supplementation accelerates recovery from  
3 exercise-induced muscle damage in females.

**4 Running head**

5 Tart cherry juice and recovery in females.

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**22 Abstract**

23 Tart Montmorency cherry concentrate (MC) has been reported to attenuate the symptoms of  
24 exercise-induced muscle damage (EIMD) and to accelerate exercise recovery, which has been  
25 attributed to its high anti-inflammatory and antioxidant properties. Although these data are  
26 promising, there are no data regarding exclusively female populations. Therefore, the aim of  
27 this investigation was to examine the efficacy of MC on recovery following EIMD in females.  
28 In a randomised, double-blind, placebo-controlled study, twenty physically active females  
29 (mean  $\pm$  SD age  $19 \pm 1$  y; stature  $167 \pm 6$  cm; body mass  $61.4 \pm 5.7$  kg) consumed MC or a  
30 placebo (PL) for eight days (30 mL twice per day). Following four days of supplementation,  
31 participants completed a repeated-sprint protocol and measures of muscle soreness (DOMS),  
32 pain pressure threshold (PPT), limb girth, flexibility, muscle function, and systemic indices of  
33 muscle damage and inflammation were collected pre, immediately post (0 h) and 24, 48 and  
34 72 h post-exercise. Time effects were observed for all dependent variables ( $p < 0.05$ ) except  
35 limb girth and high sensitivity C-reactive protein. Recovery of countermovement jump height  
36 was improved in the MC group compared to PL ( $p = 0.016$ ). There was also a trend for lower  
37 DOMS ( $p = 0.070$ ) and for higher PPT in the MC group at the rectus femoris ( $p = 0.071$ ). The  
38 data demonstrate that MC supplementation may be a practical nutritional intervention to help  
39 attenuate the symptoms of muscle damage and improve recovery on subsequent days in  
40 females.

**41 Key words**

42 Repeated sprint, muscle soreness, algometry, muscle function, sour cherry

## 43 **Introduction**

44 Initial muscle damage is thought to be caused by a combination of mechanical disruption to  
45 the myofibrils and oxidative stress; the latter owing to an increase in the production of reactive  
46 oxygen and nitrogen species (RONS) and nitric oxide (NO) derivatives which may exceed  
47 antioxidant capacity (Powers & Jackson, 2008). Moreover, the secondary inflammatory  
48 response to muscle injury involves the degradation of damaged muscle by immune cells which  
49 release pro-inflammatory cytokines and further RONS and NO derivatives; exacerbating  
50 muscle damage (Clarkson & Hubal, 2002). The role of RONS and NO derivatives in the  
51 oxidative stress, inflammatory, and muscle damage responses which manifest during and  
52 following exercise has raised substantial interest in antioxidant supplementation. Of particular  
53 interest is tart Montmorency cherry concentrate (MC), which has been proposed to be an  
54 effective recovery aid due to its high anti-inflammatory and antioxidant properties (Bell et al.,  
55 2014; Bell et al., 2015; Keane et al., 2015a; Kirakosyan et al., 2015; Seeram et al., 2001; Wang  
56 et al., 1999). Montmorency tart cherries and their derivatives contain numerous polyphenols  
57 that include flavonoids; for example, the flavonol quercetin and anthocyanins (Kim et al., 2005;  
58 Kirakosyan et al., 2009). Certainly, the polyphenolic compounds that MC contain result in  
59 higher oxygen radical absorbance capacity (ORAC) values compared to several other  
60 antioxidant beverages such as Concord grape, acai, and blueberry juice (Bell et al., 2013;  
61 Howatson et al., 2010; Seeram et al., 2008).

62 To date, research in exercise and recovery paradigms has demonstrated that MC can improve  
63 recovery from damaging bouts of exercise in isolated muscle groups by attenuating decrements  
64 in muscle strength and/or soreness and pain (Bowtell et al., 2011; Connolly et al., 2006; Levers  
65 et al., 2015). Additionally, following damaging running activity, research has identified MC to  
66 be beneficial in reducing pain (Kuehl et al., 2010) and improving indices of inflammation,  
67 oxidative stress, antioxidant status and muscle function (Howatson et al., 2010). More recently,

68 MC has also been shown to facilitate recovery following cycling (Bell et al., 2014; Bell et al.,  
69 2015) and an adapted Loughborough Intermittent Shuttle Test (LIST) protocol (Bell et al.,  
70 2016).

71 Collectively, these lines of investigation have application to athletic populations that would  
72 benefit from reduced symptoms of muscle damage following strenuous activity. However, the  
73 effects of MC beyond isolated muscle, running and cycling activity are limited, and  
74 conceptually other sports and activities could benefit from this intervention. In addition, whilst  
75 females have been included in mixed-sex populations (Howatson et al., 2010; Kuehl et al.,  
76 2010), there are no data regarding exclusively female populations, largely due to the potential  
77 for oestrogen to influence outcome variables (Kendall & Eston, 2002). A growing body of  
78 evidence suggests that oestrogen has antioxidant properties (Tiidus et al., 2005; Wolf et al.,  
79 2012) and may help to maintain muscle membrane integrity consequent to muscle damage. As  
80 a result, the initial physiological stress and ensuing recovery associated with exercise-induced  
81 muscle damage (EIMD) in females is likely to differ compared to male populations. Indeed,  
82 recent evidence suggests that EIMD and recovery may differ between menstrual cycle phases  
83 given the fluctuating oestrogen concentrations (Markofski & Braun, 2014). Moreover, given  
84 their structural similarities to oestrogen, polyphenolic secondary plant metabolites (including  
85 the flavonoids that MC contains) appear to exert oestrogenic effects (Miksicek, 1995), and thus  
86 modulate and affect the bioavailability of endogenous oestrogens (Ward & Kuhnle, 2010). As  
87 such, since oestrogen is thought to play a key role in the observed sex differences in EIMD,  
88 currently the lack of studies investigating the supplementation of MC in a female only  
89 population is surprising and warrants research.

90 Therefore, the aim of this investigation was to examine the efficacy of MC on recovery from  
91 EIMD in females. It was hypothesised that indices of EIMD would be attenuated by the  
92 consumption of MC.

## 93 **Methods**

### 94 **Participants**

95 Twenty physically active females (mean  $\pm$  SD age  $19 \pm 1$  y; stature  $167 \pm 6$  cm; body mass  
96  $61.4 \pm 5.7$  kg; BMI  $22.1 \pm 1.9$  kg·m<sup>-2</sup>) were recruited from a university dance team and gave  
97 written informed consent. The sample size was determined by completing a power analysis  
98 (power=0.8,  $\alpha$ =0.05) based on isometric strength data from Bowtell et al. (2011). This  
99 determined a sample size of five in each group would provide statistical power above 80%,  
100 with an alpha level of 0.05. Exclusion criteria were; epilepsy, bronchitis, severe asthma, cardiac  
101 complaints, bacterial or viral infection in the 2 weeks preceding, injury or recovering from an  
102 injury sustained in the preceding 4 weeks, pregnancy, food allergy relating to the study  
103 supplements (as discussed with the investigator), or anything that may prevent them from  
104 successfully completing the study that was described. Participants had been training in dance  
105 regularly for  $13 \pm 4$  years and were currently exercising for  $8.3 \pm 5$  h per week; with no  
106 significant differences between groups (independent samples *t*-test  $p=0.567$  and  $p=0.598$ ,  
107 respectively). A single self-reported menstrual cycle questionnaire (as used previously by  
108 Brown et al., 2016a) identified the current contraceptive use of participants; nine were using  
109 an oral combination pill (all monophasic;  $n=6$  in Montmorency cherry concentrate (MC) group  
110 and  $n=3$  in placebo (PL) group), six were using a progesterone only pill/implant/injection ( $n=3$   
111 in both MC and PL groups), and five were menstruating normally ( $n=1$  in MC group and  $n=4$   
112 in PL group). This also estimated menstrual cycle phase and allowed testing days to be  
113 assigned; all data collection took place during the early to mid-luteal phase, or where applicable  
114 in the 14 days before a withdrawal bleed. For 24 h prior to, and for each of the testing days,  
115 participants were asked to avoid strenuous exercise, alcohol, caffeine, nutritional supplements,  
116 and any anti-inflammatory drugs or alternative treatments. Participants completed a weighed  
117 food diary (analysed using dietary analysis software (Nutritics Ltd, Swords, Ireland)) and

118 activity log throughout all trial periods. Aside from the restrictions outlined previously,  
119 participants were not restricted in their consumption of polyphenolic rich foods and were  
120 instructed to consume their habitual diets. However, portions of foods thought to contain  
121 antioxidants were totalled for each day and averaged across the experimental period (Howatson  
122 et al., 2012; Howatson et al., 2010). The study was conducted according to the guidelines of  
123 the Declaration of Helsinki and all experimental procedures were approved by the Faculty of  
124 Health and Life Sciences Ethics Committee at the University of Northumbria.

### 125 **Experimental protocol**

126 Participants were allocated to either tart Montmorency cherry concentrate (MC;  $n=10$ ) or  
127 placebo (PL;  $n=10$ ) supplementation in a double-blind manner using stratified randomisation  
128 to ensure that groups were matched and counterbalanced for muscle function. A pre-  
129 supplementation blood sample (baseline) was taken in order to detect any changes in total  
130 creatine kinase (CK) and high sensitivity C-reactive protein (hsCRP) with preload  
131 supplementation. Participants fasted for  $\geq 10$  h prior to each visit, except for water (consumed  
132 *ad libitum*) and the morning supplement. On arrival at the laboratory, baseline measures of  
133 dependant variables were recorded. Participants completed the exercise protocol, and after a 2  
134 min rest, measurement of dependent variables was repeated. Before leaving the laboratory,  
135 participants were reminded to consume a supplement prior to their evening meal.  
136 Supplementation and measurement of dependent variables were then repeated at the same time  
137 of day ( $\pm 1$  h) for the following 3 days (24, 48 and 72 h post EIMD).

### 138 **Supplementation**

139 Participants consumed their habitual diets during all trial periods. Participants were provided  
140 with eight days of supplementation along with instructions on ingestion frequency and timing.  
141 This period was for four days prior to muscle-damaging exercise, the day of exercise, and for

142 three days of recovery. The daily dose was two servings of the MC or PL; one dose taken prior  
143 to breakfast (or 1-2 h prior to laboratory visits), and one dose prior to evening meal (except for  
144 the final day where only one supplement was consumed before the final visit). This is based on  
145 previous work showing a positive effect on recovery following strenuous exercise (Bell et al.,  
146 2016; Bell et al., 2014; Bell et al., 2015).

147 The MC beverage was prepared with 30 mL of concentrate (CherryActive, Sunbury, UK)  
148 diluted in 100 mL of water. According to the manufacturer's information, a 30 mL dose of  
149 concentrate is equivalent to approximately 90 whole cherries and has been previously reported  
150 to contain a total anthocyanin content of  $73.5 \text{ mg} \cdot \text{L}^{-1}$  of cyanidin-3-glucoside, a total phenolic  
151 content of  $178.8 \text{ gallic acid equivalent} \cdot \text{L}^{-1}$  and an antioxidant capacity (TEAC) of  $0.58 \text{ trolox}$   
152  $\text{equivalents} \cdot \text{L}^{-1}$  (Keane et al., 2016). The PL was prepared with 25 mL of a synthetically  
153 derived fruit flavoured concentrate with negligible phytochemical content (Kia-Ora, Uxbridge,  
154 UK) in 100 mL of water and was fortified with flavourless maltodextrin (Myprotein,  
155 Manchester, UK) and flavourless whey protein powder (Arla Foods, Amba, Denmark). This  
156 was in order to match test beverages as closely as possible for volume (130 ml), consistency,  
157 colour, and macronutrient (24.5 g carbohydrate and 1.1 g protein) and energy content (102 kcal  
158 and 103 kcal for the MC and PL beverages, respectively).

### 159 **Exercise protocol**

160 Following a standardised warm up, participants completed a repeated-sprint protocol which  
161 comprised 15 x 30 m maximal sprints with a rapid 10 m deceleration phase, each separated by  
162 60 s rest (Brown et al., 2016a; Brown et al., 2016b; Howatson & Milak, 2009; Keane et al.,  
163 2015b). Rate of perceived exertion (RPE; Borg, (1982)) and heart rate (HR; Model RS-400,  
164 Polar, Kempele, Finland) were collected after each sprint effort. Sprint times were recorded

165 using timing gates (Brower telemetric timers, Brower timing systems, Draper, USA) to  
166 determine total sprint time, mean sprint time, and rate of fatigue (Fitzsimons et al., 1993).

167

## 168 **Dependant variables**

### 169 *Muscle soreness*

170 Subjective ratings of muscle soreness (DOMS) were measured using a 200 mm visual analogue  
171 scale. Participants were required to indicate the level of perceived active lower limb soreness  
172 felt during a 90<sup>0</sup> squat. Pain pressure threshold (PPT) was measured with a digital algometer  
173 (Model FDX, Wagner Instruments, Greenwich, USA) at three muscle locations on the right  
174 leg; the rectus femoris (RF), the vastus lateralis (VL), and medial head of the gastrocnemius  
175 (GM) (Clifford et al., 2016). To determine PPT, participants were asked to verbally indicate  
176 when the pressure applied to the muscle (at an approximate rate of 5 N·s<sup>-1</sup>) became too  
177 uncomfortable to tolerate. Intra-trial and inter-trial percentage coefficient of variation (%CV)  
178 were <8% for all locations.

### 179 *Limb girth*

180 An anthropometric tape measure (Bodycare Products, Warwickshire, United Kingdom) was  
181 used to determine calf (measured at its largest girth at baseline) and mid-thigh (located as  
182 midway between the inguinal fold and the superior border of the patella) girths of the right leg.  
183 Calf and mid-thigh girth intra-examiner %CVs were <1%.

### 184 *Flexibility*

185 Hamstring stiffness and flexibility was measured using the sit and reach test. The knees were  
186 fully extended with the feet together against the sit and reach box. Participants were instructed



187 to stretch as far as possible (but not to the point of pain) and to hold their ‘best stretch’ for  
188 approximately 2 s (American College of Sports Medicine, 2013) (recorded to the nearest 0.5  
189 cm). Intra-trial and inter-trial %CV were <5%.

190

### 191 *Muscle function*

192 Participants completed three countermovement jumps (CMJ) and three drop jumps (for  
193 measurement of reactive strength index (RSI)) using a light timing system (Optojump,  
194 Microgate, Bolzano, Italy), keeping their hands on their hips throughout. For CMJ, participants  
195 were asked to squat down and jump vertically and maximally. For RSI (jump height (cm) ÷  
196 ground contact time (s)), participants were instructed to drop from a height of 30 cm and upon  
197 landing, to perform a two-footed jump maximally with minimum contact time. Each effort was  
198 separated by 60 s rest and the peak CMJ and RSI were used for analysis. Intra-trial and inter-  
199 trial %CV were both <4% and <12% for CMJ and RSI respectively.

200 Maximum voluntary isometric contraction (MVC) of the right knee extensors was measured  
201 using a strain gauge (MIE Digital Myometer, MIE Medical Research Ltd, Leeds, UK). While  
202 in a seated position, the knee joint angle was standardised at 90° of flexion before each  
203 contraction. The peak force (Newtons, N) of three MVCs (of 3 s duration interspersed with 30  
204 s rest) was used for analysis. Intra-trial and inter-trial %CV were <4%.

205 Participants completed a single maximal effort 30 m sprint, and sprint time was recorded  
206 (Brower telemetric timers, Brower timing systems, Draper, USA). Both intra-trial and inter-  
207 trial %CV were <2%.

### 208 *Blood sampling and analysis*

209 Blood samples (10 mL) were collected via venepuncture from the antecubital fossa area into  
210 serum gel vacutainers. Samples were rested at room temperature for 20 min, and centrifuged  
211 for 15 min (4°C) at 3000 RCF (Allegra X-22 Centrifuge, Beckman Coulter, Bucks, UK).  
212 Aliquots of serum were stored at -80°C for later analysis of CK and hsCRP; determined  
213 spectrophotometrically using an automated system (Roche Modular, Roche Diagnostics,  
214 Burgess Hill, UK). Due to technical issues, 5 blood samples (<5%) were not collected. When  
215 lower detection limits were not reached for hsCRP, the lowest detectable concentration was  
216 used (0.15 mg·L<sup>-1</sup>). Inter-assay and intra-assay %CV for both total CK and hsCRP were <9%.

### 217 **Statistical analysis**

218 For the purpose of data analysis, all dependant variables except for DOMS, CK and hsCRP are  
219 expressed as a percentage relative to pre muscle damage values to account for inter-individual  
220 variability. Statistical software (IBM Statistical Package for Social Sciences (SPSS) V22 IBM,  
221 Armonk, USA) was used for inferential analysis and statistical significance accepted at the  
222  $p \leq 0.05$  level *a priori*. Mixed factor repeated-measures analysis of variance were performed for  
223 each dependent variable. Mauchly's test assessed the sphericity of the data and, where  
224 appropriate, violations were corrected using the Greenhouse–Geisser correction. Significant  
225 main effects were analysed using the Least Significant Difference test for adjustment for  
226 multiple comparisons. Paired samples *t*-tests were conducted to assess differences between  
227 total CK and hsCRP levels pre-supplementation (baseline) and pre-exercise, in order to detect  
228 any changes in systemic indices with preload supplementation. Independent samples *t*-tests  
229 were conducted on peak HR, peak RPE, fatigue, and total and mean sprint time to examine  
230 differences in exercise intensity during the repeated-sprint protocol between groups. Where  
231 appropriate, Cohen's *d* effect sizes (ES) were calculated with the magnitude of effects  
232 considered small (0.2), moderate (0.5) and large (>0.8).

233

234 **Results**

235 There were no differences in the total energy intake and macronutrient intake presented as a  
236 percentage of total energy intake (all  $p>0.05$ ,  $ES>0.47$ ), and the number of portions of foods  
237 containing antioxidants consumed by participants in both treatment groups ( $6 \pm 2$  in both MC  
238 and PL groups;  $p=0.731$ ) during the supplementation period. Following all data collection  
239 periods, only  $n=4$  participants correctly identified which supplement they had consumed. There  
240 were no differences between MC and PL groups for total ( $80.74 \pm 4.02$  vs  $81.69 \pm 3.67$  s) and  
241 mean ( $5.38 \pm 0.27$  vs  $5.45 \pm 0.24$  s) sprint time, fatigue ( $5.23 \pm 2.02$  vs  $4.54 \pm 2.16\%$ ), peak  
242 HR ( $176 \pm 15$  vs  $178 \pm 8$  bpm), and peak RPE ( $17 \pm 2$  vs  $18 \pm 1$ ) during the repeated-sprint  
243 protocol (all  $p>0.05$ ); demonstrating that the exercise stimulus was comparable between  
244 groups. All raw data not illustrated in figures are presented in Table 1.

245 Muscle soreness increased post-exercise ( $p<0.001$ ), peaking at 24 h and remained elevated  
246 throughout recovery in both groups (Figure 1); however, there was a trend and moderate effect  
247 for lower DOMS in the MC group ( $p=0.070$ ,  $ES=0.58$ ). At all three locations, PPT was reduced  
248 post-exercise (all  $p<0.001$ ), reached lowest levels at 24 h and then increased throughout  
249 recovery. There were no group differences in PPT at the VL or GM, but a trend and moderate  
250 effect for higher PPT in the MC group at the RF was observed ( $p=0.071$ ,  $ES=0.59$ ).

251 Thigh and calf girths were unaffected post-exercise and there were no differences between  
252 treatment groups (all  $p>0.05$ ). Flexibility was reduced for 48 h post-exercise but returned to  
253 baseline levels at 72 h in both groups ( $p=0.022$ ) with no group differences.

254 All measures of muscle function (CMJ, RSI, MVC and 30 m sprint time) were reduced post-  
255 exercise and progressively recovered throughout recovery (all  $p<0.05$ ). While recovery of these

256 measures appeared to accelerate with MC, a group effect was only evident with CMJ ( $p=0.016$ ,  
257  $ES=0.66$ ) (Figure 2).

258 Total CK and hsCRP concentrations were not different between baseline and pre-exercise time-  
259 points for both MC and PL groups (all  $p>0.05$ ). Both groups experienced an increase in  
260 circulating CK, which peaked 24 h post-exercise and remained elevated for 72 h post-exercise  
261 ( $p<0.001$ ) with no differences between groups (Figure 3). Circulating hsCRP was unaffected  
262 by exercise and was not different between groups.

263

## 264 **Discussion**

265 This study sought to examine the efficacy of 8-day MC supplementation on recovery from  
266 EIMD in females. The data demonstrate that MC supplementation accelerated the recovery of  
267 CMJ and was associated with trends of reduced muscle soreness.

268 The clear acceleration in recovery of CMJ following MC supplementation supports a recent  
269 study demonstrating an improvement in CMJ (Bell et al., 2016), and a number of studies  
270 demonstrating an accelerated recovery in other measures of muscle function with MC  
271 consumption (Bell et al., 2015; Bowtell et al., 2011; Connolly et al., 2006; Howatson et al.,  
272 2010). The improvement of CMJ with MC may be explained by a protection against oxidative  
273 injury to the type II fibres recruited for such activity. Eccentric exercise is thought to  
274 preferentially damage type II muscle fibres (Macaluso et al., 2012) and this has implications  
275 on the muscles' force-generating capacity (Byrne et al., 2004). Interestingly, evidence suggests  
276 that mitochondrial ROS production and/or release is potentiated in type II fibres (Anderson &  
277 Neuffer, 2006) and the activity of endogenous antioxidant enzymes including superoxide  
278 dismutase (SOD) (Criswell et al., 1993; Powers et al., 1994) and glutathione peroxidase (GPX)

279 (Lawler et al., 1994; Powers et al., 1994) are lower compared with type I fibres in rodent  
280 models. During periods of increased oxidant production (for instance intense exercise), both  
281 enzymatic and non-enzymatic antioxidants collectively provide some protection to muscle  
282 fibres from oxidative injury (Powers & Jackson, 2008). Therefore, conceptually the  
283 supplementation of non-enzymatic antioxidants contributed to the free radical scavenging  
284 capacity of type II fibres and facilitated recovery of CMJ. However, the functional measures  
285 in the present investigation all require type II fibre recruitment, so intuitively, we would have  
286 expected the measures to be equally affected by MC. Indeed, the lack of an accelerated  
287 recovery of MVC with MC is in contrast to a number of previous studies (Bell et al., 2015;  
288 Bowtell et al., 2011; Connolly et al., 2006; Howatson et al., 2010). Certainly, the role of MC  
289 in accelerating the recovery of muscle function in this population following EIMD in the  
290 current study remains unclear.

291 Supplementation with MC resulted in a moderate effect for reductions in DOMS and increases  
292 in PPT at the RF; which could have played a role in the observed improvements in CMJ. This  
293 is in line with a number of investigations reporting reduced soreness and pain with MC  
294 supplementation (Bell et al., 2016; Connolly et al., 2006; Kuehl et al., 2010; Levers et al.,  
295 2015). However, these reductions previously reported have not always been accompanied with  
296 improvements in muscle function, and vice versa (Bell et al., 2015; Bowtell et al., 2011; Levers  
297 et al., 2015), and others have found no reduction in DOMS with MC consumption (Bell et al.,  
298 2015; Bowtell et al., 2011; Howatson et al., 2010). The inconsistencies in the literature could  
299 be explained by the disparities in exercise protocol employed. Indeed, muscle soreness has  
300 been associated with increases in inflammation following exercise (Kraemer et al., 2004). In  
301 the current investigation, hsCRP was not different between groups, and limb girth (an indirect  
302 measure of inflammation, swelling and oedema (Smith, 1991)) was unaffected by the exercise.  
303 Compared to marathon running (Howatson et al., 2010) and high intensity cycling exercise

304 (Bell et al., 2015), where CRP has been shown to increase 24 and 48 h post-exercise, the  
305 repeated-sprint protocol does not appear to induce a large inflammatory response. It is  
306 conceivable that the exercise stimulus was insufficient to detect larger magnitudes of change  
307 in soreness and PPT with MC. Similarly, the CK values elicited by the exercise protocol in the  
308 current study are lower than other damaging protocols, suggesting a moderate muscle damage  
309 response, and likely influencing the ability to demonstrate differences. In addition, females  
310 have been shown to demonstrate lower basal circulating concentrations of CK, and a lower CK  
311 response following exercise compared to males (Wolf et al., 2012), owing in part to the  
312 antioxidant properties of oestrogen (Tang, Abplanalp, Ayres, & Subbiah, 1996).

313 The data which demonstrate no group differences in hsCRP and CK do not wholly support the  
314 literature which traditionally suggests attenuated symptoms of EIMD with MC is attributable  
315 to reduced muscle damage and inflammation; at least following repeated-sprint exercise in  
316 females. However, the current study was limited by a lack of measurement of oxidative stress  
317 and antioxidant capacity. Indeed, some have identified differences in oxidative stress and  
318 antioxidant status following strenuous exercise with supplementation of MC compared to PL  
319 (Bell et al., 2014; Bowtell et al., 2011; Howatson et al., 2010). It is possible that this is  
320 magnified in females given that oestrogen is also thought to have antioxidant properties (Tiidus  
321 et al., 2005; Wolf et al., 2012) as oestrogens, similar to vitamin E, display a hydroxyl group on  
322 their phenolic ring (Tiidus et al., 2001). It is thought that oestrogen donates the hydrogen atom  
323 to lipid peroxy radicals, limiting lipid peroxidation in the cell membrane (Kendall & Eston,  
324 2002). Perhaps enhanced antioxidant status and redox balance may have contributed to the  
325 improvements in CMJ and trends in reduced soreness observed with MC in this study. Future  
326 research should include measurement of a variety of systemic indices to provide greater insight  
327 into specific mechanisms influencing improved muscle function and pain with MC. Moreover,  
328 more accurate determination of menstrual cycle phase (urine ovulation prediction tests for

329 example) and measurement of concentrations of oestrogen (particularly of oestradiol) in female  
330 participants is warranted to assist with the interpretation of results.

331 This study demonstrated that 8-day MC supplementation alongside a habitual diet improved  
332 recovery of CMJ and tended to lower muscle soreness compared to PL. This research adds to  
333 the existing body of knowledge whilst providing new information for the potential application  
334 of MC to wider groups. In particular, it would appear that female populations might benefit  
335 from this nutritional intervention to help attenuate the symptoms of EIMD and improve  
336 recovery on subsequent days.

337

338

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- 471

472 **Tables**

473

474 Table 1. Values for dependent variables in response to muscle-damaging exercise, mean  $\pm$   
475 SD.

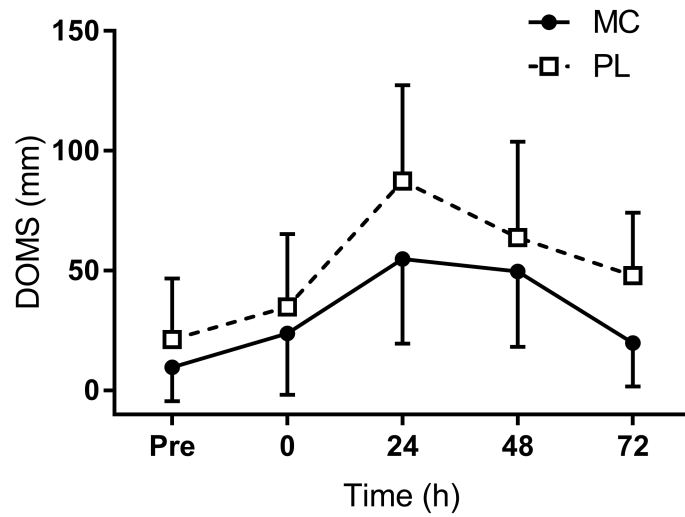
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Variable	Group	Time post muscle-damaging exercise (h)				
		Pre	0	24	48	72
RF PPT, N	MC	48.1 $\pm$ 8.8	46.9 $\pm$ 11.6	42.5 $\pm$ 10.8	48.7 $\pm$ 12.9	56.0 $\pm$ 17.5
	PL	35.2 $\pm$ 12.4	30.8 $\pm$ 10.6	25.9 $\pm$ 6.9	28.7 $\pm$ 10.0	35.1 $\pm$ 8.8
VL PPT, N	MC	42.6 $\pm$ 9.8	47.3 $\pm$ 18.0	34.9 $\pm$ 13.6	41.6 $\pm$ 12.6	53.3 $\pm$ 23.3
	PL	30.2 $\pm$ 10.1	29.7 $\pm$ 11.8	25.5 $\pm$ 7.2	28.5 $\pm$ 10.2	32.5 $\pm$ 10.5
GM PPT, N	MC	41.4 $\pm$ 11.2	42.4 $\pm$ 15.5	31.8 $\pm$ 8.8	39.4 $\pm$ 9.4	50.2 $\pm$ 12.2
	PL	27.3 $\pm$ 12.1	25.0 $\pm$ 12.1	21.9 $\pm$ 8.7	24.9 $\pm$ 10.2	30.1 $\pm$ 9.9
Thigh girth, cm	MC	50.1 $\pm$ 3.1	50.4 $\pm$ 3.0	50.3 $\pm$ 3.0	50.3 $\pm$ 3.0	50.3 $\pm$ 2.8
	PL	50.6 $\pm$ 2.2	50.9 $\pm$ 2.6	51.0 $\pm$ 2.4	51.0 $\pm$ 2.5	50.9 $\pm$ 2.4
Calf girth, cm	MC	36.1 $\pm$ 2.3	36.2 $\pm$ 2.4	36.1 $\pm$ 2.4	36.1 $\pm$ 2.3	36.2 $\pm$ 2.2
	PL	36.2 $\pm$ 2.1	36.1 $\pm$ 1.9	36.2 $\pm$ 2.0	36.2 $\pm$ 2.2	36.2 $\pm$ 2.0
Flexibility , cm	MC	29.1 $\pm$ 5.4	28.3 $\pm$ 6.4	25.0 $\pm$ 7.2	26.4 $\pm$ 9.3	29.0 $\pm$ 7.8

	PL	20.3 ± 9.0	17.7 ± 9.0	14.5 ± 6.1	17.4 ± 8.3	17.6 ± 9.0
RSI, cm·s <sup>-1</sup>	MC	102.8 ±				107.0 ±
		22.5	88.6 ± 21.5	97.2 ± 28.5	99.0 ± 22.2	27.1
	PL	81.5 ± 17.6	74.7 ± 13.7	72.0 ± 13.8	73.0 ± 14.4	80.2 ± 20.1
MVC, N	MC	394.3 ±	347.1 ±	362.7 ±	381.3 ±	376.5 ±
		59.3	82.5	87.1	87.2	73.6
	PL	392.2 ±	354.1 ±	355.4 ±	361.8 ±	375.9 ±
		89.4	72.7	73.8	70.2	63.9
30 m	MC					
sprint		5.32 ± 0.35	5.42 ± 0.36	5.39 ± 0.31	5.45 ± 0.29	5.37 ± 0.40
time, s						
	PL	5.28 ± 0.26	5.46 ± 0.30	5.37 ± 0.27	5.58 ± 0.41	5.43 ± 0.29
hsCRP, mg·L <sup>-1</sup>	MC	1.63 ± 1.99	1.79 ± 1.87	2.15 ± 0.24	2.13 ± 1.97	1.56 ± 1.35
	PL	1.81 ± 1.93	1.80 ± 1.87	1.73 ± 1.73	1.29 ± 1.14	1.71 ± 1.31

477 MC, Montmorency cherry group (*n*=10); PL, placebo group (*n*=10); Pre, pre-exercise; RF,  
 478 rectus femoris; VL, vastus lateralis; GM, medial head of the gastrocnemius; PPT, pain pressure  
 479 threshold; CMJ, countermovement jump; RSI, reactive strength index; MVC, maximal  
 480 voluntary isometric contraction; hsCRP, high sensitivity C-reactive protein.

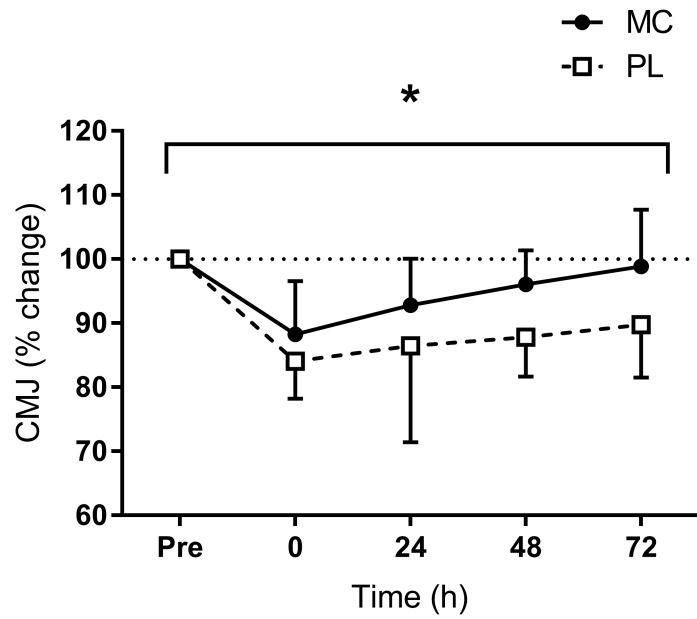
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483 Figure 1. Muscle soreness (DOMS) post exercise-induced muscle damage in the Montmorency  
484 cherry (MC) ( $n=10$ ) and placebo (PL) ( $n=10$ ) groups. Values presented as mean  $\pm$  SD.

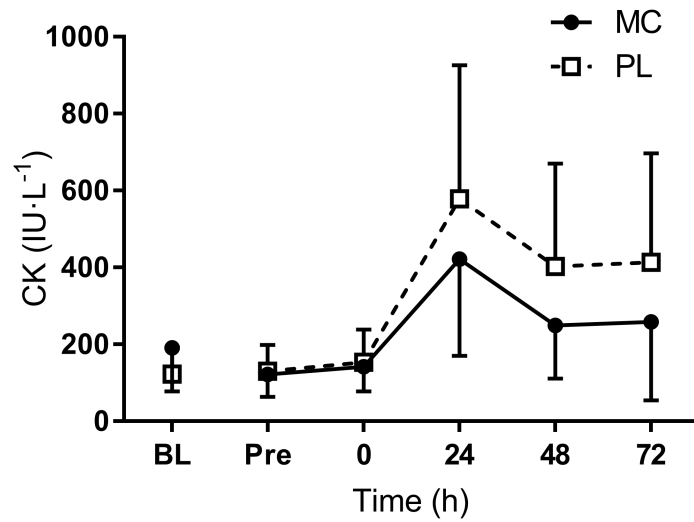




485

486 Figure 2. Percentage relative to pre-exercise (Pre) countermovement jump height (CMJ) post  
 487 exercise-induced muscle damage in the Montmorency cherry (MC) ( $n=10$ ) and placebo (PL)  
 488 ( $n=10$ ) groups. Values presented as mean  $\pm$  SD. \*denotes significantly higher CMJ in MC  
 489 group. Significance at  $p<0.05$ .

490



491

492 Figure 3. Total creatine kinase (CK) at baseline pre-supplementation (BL), before (Pre) and  
493 post exercise-induced muscle damage in the Montmorency cherry (MC) ( $n=10$ ) and placebo  
494 (PL) groups ( $n=10$ ). Values presented as mean  $\pm$  SD.