**Cardiovascular Effects of Doping Substances, Commonly Prescribed Medications and Ergogenic Aids in relation to sports. A position statement of the Sport Cardiology and Exercise Nucleus of the European Association of Preventive Cardiology**

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Word count: 9299 (9460 including tables)

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**Abstract**

The use of substances and medications with potential cardiovascular effects among those practicing sports and physical activity has progressively increased in recent years. This is also connected to the promotion of physical activity and exercise as core aspects of a healthy lifestyle, that has led also to an increase in sport participation across all ages. In this context, three main users’ categories can be identified, 1) professional and amateur athletes using substances to enhance their performance, 2) people with chronic conditions, that include physical activity and sport in their therapeutic plan, in association with prescribed medications, 3) athletes and young individuals using supplements or ergogenic aids to integrate their diet or obtaining a cognitive enhancement effect. All the substances used for these purposes have been reported to have side effects, among whom the cardiovascular consequences are the most dangerous and could lead to cardiac events. The cardiovascular effect depends on the type of substance, the amount, the duration of use and the individual response to the substances, considering the great variability in responses. This Position Paper reviews the recent literature and represents an update to the previously published Position Paper published in 2006. The objective is to inform physicians, athletes, coaches and those participating in sport for a health enhancement purpose, about the adverse cardiovascular effects of doping substances, commonly prescribed medications and ergogenic aids, when associated with sport and exercise.

**Word count:** 231

**Keywords**: cardiovascular side effects; doping; ergogenic aids; energy drinks; medications

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| Abbreviations | |
| AAS | Anabolic Androgenic Steroids |
| ADHD | Attention-Deficit Hyperactivity Disorder |
| ADT | Anti-Depressant Tricyclic |
| AF | Atrial Fibrillation |
| AR | Androgen Receptor |
| AV | Atrioventricular |
| BRS | Baroreflex Sensitivity |
| CMR | Cardiac Magnetic Resonance imaging |
| COX | Cyclooxygenase |
| CRISPR | Clustered Regularly Interspaced Short Palindromic Repeats |
| CV | Cardiovascular |
| CYP | Cytochrome |
| EAPC | European Association of Preventive Cardiology |
| ECG | Electrocardiogram |
| EHRA | European Heart Rhythm Association |
| ESC | European Society of Cardiology |
| Hb | Hemoglobin |
| hGH | Human Growth Hormone |
| HIF | Hypoxia Inducible Factor |
| IF | International Federation |
| IGF | Insulin-like Growth Factor |
| INR | International Normalized Ratio |
| IOC | International Olympic Committee |
| IPC | International Paralympic Committee |
| LA | Left Atrium |
| LQTS | Long QT Syndrome |
| LV | Left Ventricle |
| LVH | Left Ventricular Hypertrophy |
| NADO | National Anti-Doping Organization |
| NOAC | New Oral Anti-Coagulant |
| NSAID | Non-Steroidal Anti-Inflammatory Drug |
| PDE | Phosphodiesterase |
| PHD | Proly Hydroxylase |
| RADO | Regional Anti-Doping Organization |
| rhEPO | Recombinant Human Erythropoietin |
| RSR | Right Shifting Reagent |
| RV | Right Ventricle |
| SARMs | Selective Androgen Receptor Modulators |
| SCD | Sudden Cardiac Death |
| TUE | Therapeutic Use Exemption |
| VKA | Vitamin K Antagonists |
| VMS | Vitamin/Mineral Supplements |
| VO2max | Maximal Oxygen Uptake |
| WADA | World Anti-Doping Agency |

**Introduction**

Doping is defined as the use of a substance or method, which is potentially dangerous to athletes’ health or capable of enhancing their performance.1 In order to lead a collaborative worldwide movement for doping-free sport, the World Anti-Doping Agency (WADA), an international independent agency, composed and funded equally by the sport movement and governments of the world, was established in 1999. In 2004 the WADA Code was introduced (latest revision in 2021), and up to date, it has been accepted by approximately 700 sport organizations, including the International Olympic Committee (IOC), the International Paralympic Committee (IPC), International Federations (IFs), National Olympic and Paralympic Committees, as well as National and Regional Anti-Doping Organizations (NADOs and RADOs). Moreover, the WADA updates yearly the List of Prohibited Substances and Methods.2 Nevertheless, the use of novel and unclassified agents or off-label use of prescription medications continues to pose a problem in terms of safety, equity and regulation. This is due to the lag between the time athletes start experimenting with novel substances, to the time when authorities become aware of these agents and are able to track them.3 Based on a recent systematic review 4, the prevalence of doping in competitive sport ranged from 0% to 73%, with most falling under 5% and it impacts all levels of sport, from elite to amateur levels, with an increasing use in recreational athletes, who have less health surveillance.5 Furthermore, yearly WADA reports confirm that most accredited doping control laboratories have an Adverse Analytical Findings of approximately 2%.6 A retrospective re-analysis of anti-doping rule violations of all samples collected at Summer Olympics Games from 1968 to 2012 revealed that the majority of positive re-tested samples contained metabolites of exogenous Anabolic Androgenic Steroids (AAS) 7, but the list of the WADA banned drugs is extensive. The prevalence of the reported adverse analytical findings by doping category is presented in Table 1. Moreover, it is worthy to distinguish between the substances and methods prohibited at all times (In- and Out-of-Competition) and those prohibited in-competition only.

This paper is an update of the 2006 adverse cardiovascular effects of doping in athletes position paper published by the European Society of Cardiology sports cardiology study group.8 The objective of this position paper is to raise awareness and to inform cardiologists, physicians and sport enthusiasts of the adverse cardiovascular effects of doping substances, performance-enhancing drugs, substances of abuse and most frequently prescribed medication, with particular emphasis on their cardiovascular effects during sport participation and exercise. Authors undertook a comprehensive review of the published evidence. A critical evaluation of all substances implicated in doping, commonly prescribed medication and ergogenic aids athletes may use was performed, including assessment of pharmacological and pathophysiological mechanisms, impact on the cardiovascular system, impact on exercise performance and the risk benefit ratio.

***Doping substances***

**Anabolic agents**

AAS are widely used not only by athletes competing in power or strength sports, but also in endurance sports to aid in recovery and strength. The simultaneous use of AAS and erythropoietin is common both in strength and endurance athletes.9 AAS act by activating androgen receptor (AR) signaling. Moreover, increased testosterone levels inhibit glucocorticoid action and protein catabolism. These mechanisms in combination with the stimulation of growth-hormone and IGF-1 axis cause muscle protein formation.10 These effects are enhanced when combined with regular training, leading to increased muscle mass and strength and reduced fat body mass.11-13 Significant increases in physical performance and strength have been observed in double-blinded randomized trials comparing AAS vs placebo.14,15

Mortality amongst athletes doping with AAS is estimated to be 6-20 times higher than in clean athletes, and around 30% of these deaths can be attributed to cardiovascular causes.16 Four principal mechanisms responsible for sudden cardiac death (SCD) have been proposed in AAS abusers: 1) the atherogenic model, 2) the thrombosis model, 3) the nitric-oxide mediated vasospasm model, and 4) the direct myocardial injury model.17 Attempting to study the cardiovascular side effects of AAS comes with inherent limitations as ethical and legal considerations prohibit their administration in athletes even for research purposes. Accordingly, AAS preparations, dosage and duration of AAS use are based on athlete self-reporting in most studies. Additionally, the majority of studies included a small population size and most athletes use combination of different substances, prohibited or legal, such that results cannot be solely attributed to AAS use.18 Despite these limitations, the results of 49 studies over the last 10 years in 1467 athletes taking AAS show that the most common disorders attributable to their use include early onset of coronary heart disease, hypertension, myocardial infarction and heart failure, arrhythmias, and SCD.19

AAS and coronary atherosclerosis

Regarding atherosclerotic heart disease, Baggish et al. found that there was an increase in coronary artery plaque volume in AAS users when compared to non-using weight-lifters, leading to rapidly progressive coronary artery disease.20 Numerous studies have shown that otherwise healthy young AAS-using athletes have elevated levels of low-density lipoprotein, markedly reduced levels of high-density lipoprotein, and increased arterial blood pressure.16,21 Impaired coagulation leading to thrombotic complications and myocardial infarction have also been described.19 Chang et al. suggested that AAS use may reduce synthesis of coagulation factors, inhibitors, and fibrinolytic proteins, causing a procoagulant state that may lead to myocardial infarction and other thrombotic complications.22 On the contrary, Corona et al. in a systematic review and meta-analysis, reported no increased cardiovascular risk in 1448 patients receiving testosterone over a mean duration of 34 weeks.23

AAS and cardiomyopathies

Numerous studies have shown that AAS users are at increased risk for cardiomyopathy and left ventricular dysfunction. The existence of AAS-induced cardiomyopathy has been confirmed by data derived from post-mortem examination, echocardiography and cardiac magnetic resonance imaging (CMR).24-26 Indeed, AAS use has been shown to change the physiological cardiac remodelling typical of athletes to a pathophysiological cardiac hypertrophy with an increased risk of life-threatening arrhythmias. The condition shares similar characteristics with hypertrophic cardiomyopathy, showing greater cardiac mass, left ventricular wall thickness / hypertrophy (LVH), prevalence of cardiac fibrosis and impairment of systolic and diastolic left ventricular function.25,27-30 LVH was attributed to either arterial hypertension or to the direct binding of AAS to the ARs on the myocardium.20,31 Even in cases with normal standard echocardiogram, tissue Doppler, strain, and strain rate echocardiography have been used to detect early regional myocardial dysfunction after AAS abuse. Mean dosage and duration of AAS use were found to be strongly associated with a subclinical reduction of both systolic and diastolic LV function.29 Even past illicit AAS use was found to be associated with impaired LV global longitudinal strain, suggesting cardiac systolic dysfunction years after AAS cessation.32 To explain early ventricular dysfunction in AAS users, it was suggested that high blood pressure may have a negative effect.33 Montisci et al. supported that AAS can directly damage myocardial cells, causing a subsequent focal repair process and a disproportionate increase in the connective tissue content of the damaged area. Cecchi et al. described a direct apoptotic cardiac and endothelial change in the heart tissue in patients with heart failure who had a history of AAS abuse.34 Additionally, peak systolic right ventricle (RV) free wall strain and strain rate were found to be reduced in bodybuilders AAS users compared with nonusers.35 D'Andrea et al. reported a more impaired left atrial (LA) deformation and LA systolic dysfunction with the use of speckle echocardiography in AAS users.31 LA enlargement has been proposed as a predictor of common cardiovascular outcomes such as atrial fibrillation, stroke and death.36 Many case reports described episodes of SCD in anabolic abuse, linked AAS to potentially life-threatening arrhythmias.17,19 Hypertrophy, fibrosis, and necrosis represent a substrate for arrhythmias, especially when combined with exercise. Neto et al. found a marked cardiac autonomic alteration in AAS users, with a shift toward sympathetic modulation predominance and vagal attenuation.37 In a recent study, Kouidi et al. found that long-term AAS in strength-trained athletes decreases baroreflex sensitivity (BRS) and short-term heart rate variability indices due to sympathetic overestimation. Moreover, a positive correlation between the reduced BRS and early left ventricular diastolic dysfunction, which was mentioned in AAS users, was determined.38 An association between nandrolone use and life-threatening ventricular arrhythmias was also supported in an experimental study.39 Moreover, Marocolo et al. reported that anabolic administration in rats associated with cardiac autonomic dysfunction and ventricular repolarization and reflected an increase in QT interval.40

**Human Growth Hormone**

Human Growth Hormone (hGH) is an endogenous neurohormone considered to have anabolic effects when used in supra-physiologic doses. There is little evidence that recombinant hGH improves performance although it may aid more rapid recovery from soft tissue damage.9 Little is known about the direct cardiovascular effects of excessive hGH administration in athletes; however, excess of endogenous hGH in patients with acromegaly may result in hypertension, congestive cardiac failure and cardiomyopathy.9 It has been suggested that hGH causes myocardial hypertrophy due to concentric remodelling 41, and hGH may lead to increases in myocardial collagen deposition, fibrosis, cellular inflammation and necrosis.8,42 These alterations may be underlying mechanisms for malignant arrhythmias and the development of heart failure.43 Finally, limited data suggest that hGH abuse can cause dose-dependent increase in cholesterol levels.44

**Selective Androgen Receptor Modulators**

Selective androgen receptor modulators(SARMs, e.g. thymosin beta-4) are a new class of substances designed to isolate the androgenic and anabolic effects of AAS. Limited information is available on the cardiovascular side effects of the several artificially designed SARMs that are used among athletes. Experimental data suggest that thymosin beta-4 can inhibit myocardial cell death, stimulate vessel growth, and activate endogenous cardiac progenitors.45 At present, SARMs are considered experimental in humans with potential side effects including carcinogenicity and cardiovascular problems and their performance enhancing potential incompletely understood.

**Narcotics**

The WADA Prohibited List includes a number of narcotic analgesic drugs including buprenorphine, dextromoramide, diamorphine (heroin), fentanyl and its derivatives, hydromorphone, methadone, morphine, nicomorphine, oxycodone, oxymorphone, pentazocine and pethidine. Narcotics may be used in athletes for treatment of pain due to sports-related injury, and post-traumatic pain syndrome in conjunction with an approved therapeutic use exemption. Oxycodone, a strong opioid analgesic, is increasingly used among young students and athletes for nonmedical and recreational use.46 Narcotics can cause dependency, a reduction in the perception of pain and a dangerous false sense of well-being. Several narcotics such as methadone and levomethadyl can also cause QT-lengthening and increase the risk of polymorphic ventricular tachycardia.47 Other potential adverse effects include changes in QT dispersion, Takotsubo syndrome (stress cardiomyopathy), Brugada-like syndrome, and coronary artery diseases.48

**Stimulants**

Stimulants include mainly amphetamines and methylphenidate, which are commonly prescribed for the treatment of Attention-Deficit Hyperactivity Disorder (ADHD), a common condition in athletes in some regions of the world.49 ADHD treatment typically relies on methylphenidate or its derivatives. These substances are prohibited according to the WADA Prohibited List.2 Amphetamine-based treatment is contraindicated in people with familial or personal history of arrhythmic diseases, in particular those with a genetic basis. The use of amphetamines and methylphenidate in athletes is only allowed upon acceptance of a Therapeutic Use Exemption (TUE) application. More recently, another psychoactive substance known as captagon (fenethylline), became widely popular for its addictive properties and its use as a powerful physiological and psychostimulant factor. Captagon can promote high physical performance and endurance, cognitive enhancement, and reduction of sleep and food requirements.50

Stimulants have profound effects on the cerebrovascular and cardiovascular system, leading to congestive heart failure, acute myocardial infarction, cardiac chambers and valvular fibrosis, pulmonary hypertension, cerebral infarction and haemorrhage.51,52 Additionally, a drug-induced cardiomyopathy has also been described.53 Pathologic mechanisms of amphetamine-related cardiomyopathy may include: direct toxic effects, neurohormonal activation, alteration of calcium homoeostasis, oxidative stress, modulation of cardiac gene expression, and apoptosis.54 The histology of this cardiomyopathy is characterised by concentric LVH, atypical nuclei, interstitial and perivascular fibrosis, vacuolation of the cardiomyocytes and hypertrophy of the middle layer of small intramyocardial vessels.55 It is well known that amphetamines stimulate the release of norepinephrine affecting both alpha (α) and beta (β) adrenergic receptor sites. Alpha-adrenergic stimulation causes vasoconstriction and an increase in total peripheral resistance, while β-adrenergic receptor stimulation leads to an increase in heart rate, stroke volume and skeletal muscle blood flow. These adverse reactions lead to tachycardia, increased body temperature, respiratory frequency and blood pressure. Furthermore, amphetamine and other nervous system stimulants lead to indirect stimulation of the autonomic nervous system through the release of catecholamines, dopamine, and serotonin in nerve terminals of the central and peripheral nervous systems, leading to cardiac arrhythmias.56 The anatomical and functional changes derived from amphetamine abuse could act as substrates of SCD.57 Beside the arrhythmogenic effect of amphetamine-derived substances, these drugs have also shown to increase the risk of *heat-related illnesses*. In particular, amphetamines could potentially mask or delay fatigue by slowing the exercise-induced internal temperature rise. This could also impact the thermoregulatory system potentially resulting in muscle overheating.58 The use of dopamine reuptake inhibitors has shown to improve performance but also to cause hyperthermia without any change in the perception of effort or thermal stress, potentially increasing the risk of exertional heat injuries.59 A similar effect is known for ephedrine-containing compounds, due to the sympathomimetic effect, impairing the body's ability to dissipate heat properly.60 Ephedrine can be found in many over-the-counter preparations available from pharmacies.

**Metabolic modulators**

Meldonium (Mildronate)is licenced for clinical use in some Eastern European countries as an anti-anginal with a mechanism of action that is believed to be modulated, at least in part, by lowering of L-carnitine availability and a reduction in mitochondrial energy production.61 Rare adverse effects were reported in athletes, including allergic reactions (redness and itchy skin, urticaria, rash, and/or angioedema), dyspepsia, tachycardia, and alterations (increase or decrease) in blood pressure.62 After anecdotal reports of widespread use at the London 2012 Olympics, meldonium was detected in the urine of 9% of athletes at the 2015 European Games 63, and was subsequently included in the WADA Prohibited List in January 2016.

**Beta 2 agonists**

Beta-2 agonists such as salbutamol and clenbuterol are commonly prescribed as treatment for asthma, given their broncho-dilatory effects on the smooth muscles of the lung. In 2011, Pluim et al. performed a meta-analysis of randomised controlled trials comparing inhaled or systemic beta-2 agonists to placebo and concluded that there are no data to support a positive effect on maximal oxygen uptake (VO2max), peak power output, strength or endurance performance with inhaled beta-2 agonists (salbutamol, albuterol or terbutaline).64 There was some weak evidence in support of high dose, oral salbutamol having a positive anaerobic capacity and strength 64, however the doses used would be expected to produce adverse side effects such as tachycardia, ventricular ectopy, tremor and hypokalaemia.65 However, clenbuterol has recently emerged as a drug of misuse in both elite and recreational athletic circles, due to its effect on beta-3 receptors in adipocytes, resulting in lipolysis and weight loss, a desirable side effect in sports where being lean and/or light weight is desirable.66 The doses required to achieve these effects are 120-160 µg daily, which is 3-4 times higher than the doses that are generally prescribed for the treatment of reactive airway disease.66 Not surprisingly, side effects such as tachycardia, gastrointestinal disturbances and tremor are common in individuals using clenbuterol in these doses.67 Additionally, supraventricular and ventricular arrhythmias, myocardial ischemia, sudden cardiac failure, and cardiac arrest have been reported.68,69 The arrhythmogenic effect of the drugs is related both to their direct beta-2 stimulant action (particularly when inhaled).70 Moreover, evidence of myocardial damage indicated by increased troponin concentrations was reported.71 Clenbuterol is noted as an anabolic agent on the WADA Prohibited List.

**Glucocorticoids**

Glucocorticoids are classified as doping substances and they are prohibited in-competition when administered by oral, intravenous, intramuscular or rectal route.72 It has been suggested that they may increase the availability of metabolic substrates and improve the use of energy sources during exercise.73 The major cardiovascular side effects include hypertension and dyslipidemia. Arterial hypertension is attributed to fluid retention, increased systemic vascular resistance mainly due to reduced nitric oxide availability, and enhanced myocardial contractility.73 Dyslipidemia is mediated by impaired lipid metabolism and elevated levels of total plasma cholesterol, triglycerides and low density lipoprotein cholesterol have been reported.18

***Methods to Increase Skeletal Muscle Oxygen delivery***

**Blood doping**

Usually involving transfusion of autologous blood collected some time earlier to increase red blood cell mass, has been used for decades. There are small, blinded trials which support the notion that oxygen carrying capacity and hence performance are improved with blood doping.74,75

* Berglund et al. performed a single blinded study on 6 cross country skiers and observed a mean 6% reduction in 15 km race time both 3 and 14 days after reinfusion of 1,350 mL of autologous blood.74
* Similar results were observed by Brien at al., who performed a double blinded cross-over study on 6 high level amateur 10 km runners, where hematocrit increased by 5% and 10 km race time was reduced by an average of one minute after reinfusion of 400 ml of packed red blood cells, but not after infusion of saline.75

**Oxygen-carrying modulators**

Agents that can increase oxygen availability to the working muscles, either by

1. increasing oxygen content in the blood,
2. improving cardiac output, or
3. improving peripheral oxygen extraction

are theorized to improve endurance performance; however, the evidence for a positive effect on performance for many of these agents (e.g. perfluocarbons) is limited.76

Recombinant human erythropoietin

Recombinant human erythropoietin (rhEPO) triggers an increase in red blood cell mass and hemoglobin concentration similar to that of blood doping, as well as an improvement in maximal oxygen consumption. However systematic evidence that this translates into a positive effect on performance is limited.77,78

* Birkeland et al. demonstrated an increase in both hematocrit and VO2max following administration of rhEPO over 4 weeks in a double-blind placebo-controlled study with only a small cohort of trained cyclists (n=10). This period was needed to demonstrate a large treatment effect (42.7 vs. 50.8% (p<0.0001), and 63.6 vs. 68.1 ml/kg/min (p<0.0001) for hematocrit and VO2max, respectively).79 Although this study did not have a direct performance measure, time to exhaustion was increased significantly in the EPO group from 12.8 to 14 minutes (p<0.0001) as compared to 13.1 to 13.3 minutes (p=0.04) in the control group who were exposed to the same training effect.79
* Similar effects on VO2max have been demonstrated in other placebo-controlled, double blind studies of rhEPO administration.78,80-82 However, in the study of Heuberger et al., no improvement in a cycling race to Mont Ventoux with regards to time was observed despite a 5% improvement in VO2max.78

Nevertheless, it is not surprising that different EPO formulations, direct EPO receptor agonists and micro-dosing techniques are used by athletes with the aim of improving performance with minimal risk of being detected.

* The potential negative cardiovascular consequences of such practices are underlined by a prospective cross-sectional study of 3,000 healthy senior adults, which found that each doubling in serum EPO level was independently associated with a 25% increase in risk of incident heart failure over a mean follow up of 10 years.83 Cardiac side effects occurring in athletes with “hematologic doping” (especially if they are dehydrated and exposed to strenuous exercise) are secondary to the circulatory overload, induced by the increased erythroid mass, increased blood viscosity, and altered endothelial and platelet function with possible thromboembolic events and hypertension during effort.70,77 Additionally, it increases blood viscosity, coagulation and platelet reactivity leading to an increased risk of thrombosis.84 Some case reports of thromboembolic events as well as acute coronary syndrome with intraventricular thrombus in athletes following rhEpo doping have been reported.85

Rather than increasing the blood oxygen content (like rhEPO), theoretically the same effect may be achieved by increasing the amount of O2 that hemoglobin can deliver to the surrounding tissues. A number of agents with these properties have been reportedly used by athletes to aid performance:

* **Cobalt chloride** is a water soluble compound that can stimulate erythropoiesis and angiogenesis, presumably due to activation of hypoxia inducible factor (HIF-1) signaling.86 Although the direct cardiovascular effects in humans have not been prospectively studied, unintentional ingestion of cobalt has been associated with the development of a dilated cardiomyopathy.87,88
* **Efaproxiral** (right shifting reagent 13, RSR 13 or Efaproxiral) is a synthetic modifier of Hb, with *in vivo* studies demonstrating a shift in the Hb/O2 dissociation curve to the right, thereby increasing the dissociation of O2 in the peripheral muscles. RSR13 has been shown to increase oxygen consumption in stimulated canine skeletal muscle 89, when inspired O2 was supplemented. However, in humans breathing sea level air, the right-shift of the O2 curve induced by RSR13 causes significant hypoxemia under resting conditions 90 that is likely to be further exacerbated by exercise. The side effects associated with exercising in a hypoxemic state are not known and it is unlikely that the athletes in whom it is being used are aware of the physiology and potential risks.

There have also been attempts to improve muscle oxygen delivery by improving cardiac output. Specific pulmonary vasodilators such as **Sildenafil** are rumored to be widely used amongst some endurance athletes. The rationale would seem that by reducing pulmonary vascular resistance it may be possible to reduce cardiac work, particularly of the RV, thereby enabling the heart to maintain a high level of function for longer.91 This is especially relevant given that exercise seems to place a disproportionate load on the pulmonary circulation and RV.92 In patients with preexisting cardiovascular risk factors some cardiovascular, cerebrovascular, and vascular events, have been reported in the past, in temporal association with the use of sildenafil 93, nevertheless more recent data on phosphodiesterase-5 (PDE5) inhibitors confirm the safety of the pharmacological class even in patients with CV risk factors and suggest a potential cardio-protective role of these molecules.94 However, no complications have been reported in healthy athletes. Several studies have assessed whether pulmonary vasodilators can improve exercise performance in healthy volunteers and athletes.

* Ghofrani et al. documented improvements in exercise capacity in a randomized, double-blind placebo-controlled trial in 14 healthy subjects during normobaric hypoxia (10% O2) and at altitude (Mount Everest base camp, 5245 m above sea level).95

However, whilst studies using both phosphodiesterase type 5 (PDE5) inhibitors and endothelin antagonists have consistently demonstrated improvements in hemodynamics and exercise performance in *hypoxic* conditions, they have failed to show any benefit in *normoxia.*96-98 These agents are thus currently not banned by the WADA.

**Figure 1**

***Commonly prescribed medications***

**Beta-blockers and antiarrhythmics**

According to the List of Prohibited Substances and Methods 2, beta-blockersare banned drugs in certain skill-based sports such as shooting and archery, due to the performance benefit offered by lowering heart rate and reducing anxiety and tremor. Conversely, there is a general reluctance amongst athletes and prescribers to use beta-blockers in athletes with cardiovascular disease, due to the potentially detrimental effects of lowering the heart rate during exercise and reducing performance.99 This is particularly true for endurance athletes and those requiring high cardiac output.

* In a small group of healthy, untrained volunteers, nebivolol (a beta-1 selective beta blocker), at a dose of 5 mg daily, was found to result in no significant reduction in peak power output or VO2max as compared to placebo, despite a 14% reduction in peak heart rate.99
* In the same study, 100 mg of atenolol (also a beta-1 selective blocker) was shown to result in a 25% reduction in maximum heart rate, and 5% reduction in both peak power output and VO2max, leading the authors to conclude that the lack of impact on performance of nebivolol may have been due to the lesser impact on peak heart rate at the prescribed dose, or perhaps the vasodilatory effects of nebivolol.
* At a dose of 240 mg/day, chronic administration of propranolol (a non-selective beta blocker) in untrained healthy subjects has been shown to reduce peak heart rate by 25%, VO2max by 7.5% and maximum work load by 5%.100
* Sotalol (non-selective beta blocker) has been shown to have a dose-dependent reduction on maximum heart rate, with the reduction ranging from a 4% at a dose of 160 mg/24 hours to 25% at 640 mg/24hr.101
* A similar dose dependent relationship with heart rate reduction has also been demonstrated for propranolol (another non-selective agent), with marked individual variability.102

Flecainide

Flecainide is a Class 1c antiarrhythmic used for the suppression of supraventricular and ventricular arrhythmias. It is commonly prescribed preferentially in athletic populations over beta-blockers due to the commonly held notion that it does not affect resting heart rate nor exercise performance, and also by the fact that it is an alternative treatment option not prohibited according to the WADA Prohibited List. Flecainide may be used regularly or as a “pill in the pocket” for athletes with sympathetic- and vagal-mediated paroxysmal atrial fibrillation in the absence of structural heart disease.103

* Whilst flecainide does not lower resting heart rate, it’s effect on exercise heart rate was documented in a placebo double-blinded trial of 24 non-athletes, in whom exercise heart rate was reduced even at low intensity exercise levels on a dose of 200 mg/day, with a difference of around 15 bpm (9%) at peak exercise, despite no significant reduction in exercise time.104

Although maximum heart rate is not a surrogate for exercise capacity, there does appear to be a threshold of around 15% heart rate reduction beyond which exercise performance would be expected to be reduced, and individual variability in the dose-heart rate response. Therefore, when prescribing beta-blockers and antiarrhythmics in athletes a TUE is needed in certain type of sports and, it is prudent to perform maximal exercise tests before prescription and during up-titration of therapy to guide exercise prescription and expectations. For more specific recommendations on anti-arrhythmic prescription and use in exercising individuals, the reader is suggested to refer to the “Recommendations for participation in leisure-time physical activity and competitive sports of patients with arrhythmias and potentially arrhythmogenic conditions. A position statement of the Section of Sports Cardiology and Exercise from the European Association of Preventive Cardiology (EAPC) and the European Heart Rhythm Association (EHRA), both associations of the European Society of Cardiology”.105,106

**Anti-coagulants and antiplatelets**

One of the most important topics in the management of the athlete in treatment with anti-coagulants is the haemorrhagic risk during physical activity caused by traumas or collision with opponents, thus mostly in team sports and sports with a high intrinsic traumatic risk.

* It is worth reminding that in subjects treated with Vitamin K antagonists (VKA), like acenocoumarin (Sintrom®) and warfarin (Coumadin®), an increase in the training intensity or volume can affect the international normalized ratio (INR) values.

VKA achieve their anticoagulant effect by interfering with several coagulative factors like II, V, VII and IX. Their metabolism is significantly affected by substances acting on cytochrome (CYP) P450. VKA require periodic INR control and have a delayed and prolonged effect that lasts even after suspension.

Another class of anti-coagulants is made of New Oral Anti-Coagulants (NOAC). NOACs are thrombin selective inhibitors (Dabigratan) or of the activated X Factor (Rivaroxaban, Apixaban, Edoxaban).

* It is still unknown if the NOAC’s effect is influenced by exercise intensity and volume.
* NOACs have a short half-life and they are metabolized mostly through renal and hepatic excretion, therefore have a better and safer efficacy profile.
* Given their pharmacokinetics, bioavailability, efficacy and safety NOACs should be preferably prescribed in physically active and exercising subjects.
* Furthermore, NOACs have very mild interactions with cardiovascular drugs, like atorvastatin, verapamil, diltiazem, quinidine, amiodarone and dronedarone.

Having only recently been introduced, long-term therapy effects still require further investigation, in particular for the possible drug-drug interactions and the inhibiting or promoting effect on CYP3/A/4, which is directly involved in the hepatic clearance, for example, of rivaroxaban and apixaban. There is a paucity of long-term data about NOAC’s risk/benefit profile in the clinical management of athletes.

The most commonly used antiplatelet drugs include, aspirin, clopidogrel (Plavix®), prasugrel (Efient®) and ticagrelor (Brilique®). Just like anti-coagulants, antiplatelet medications increase the haemorrhagic risk, particularly in physically active individuals that might be involved in contact sports or sports with a higher intrinsic risk of injury.

When establishing the individual risk, it is important to consider also other age-related cardiovascular diseases that might increase the likeliness of cardiovascular events such as coronary-artery disease, hypertension and atrial fibrillation. In this group of patients, anticoagulants and antiplatelet drugs reduce the risk of cardiovascular events but at the same time increase the risk of exercise-related and spontaneous haemorrhagic events. Thus, when prescribing this drug category to the exercising subject, several factors need to be addressed:

1. age,
2. sex,
3. coexisting cardiovascular disease (in case of AF the CHA2DS2-VASc score),
4. type and intensity of the physical activity practiced.

More detailed information on intensity and exercises prescription can be found in the recently published "2020 ESC Guidelines on sports cardiology and exercise in patients with cardiovascular disease”.107

### Psychoactive drugs

Benzodiazepines

Benzodiazepines differ among one another for kinetics, metabolic path, and active metabolites and should not be taken for a period exceeding 3-4 weeks because of the risk of tachyphylaxis and addiction. Chronic use can cause nocturnal hypoventilation, with a decrease in tissue oxygenation and clinical consequences. Particular attention should be paid to symptoms occurring after withdrawal of the agents (withdrawal syndrome):

* In drugs with a short/medium half-life (t1/2) like triazolam, the withdrawal syndrome is more likely to occur once the treatment is interrupted while it rarely appears after cessation of drugs with a long t1/2.
* Withdrawal syndrome is virtually absent with molecules such as zolpidem and zopiclone.
* Symptoms arise proportionally to t1/2 (e.g. 24 h for lorazepam, 3-7 days for diazepam).
* Withdrawal syndrome can cause
* arrhythmic episodes such as

1. sinus tachycardia,
2. atrial fibrillation and atrial flutter,
3. supra- and ventricular cardiac ectopy, and

* atrial pressure abnormalities such as

1. systolic hypertension,
2. orthostatic hypotension,
3. symptoms of sympathetic hyperactivity with diaphoresis, agitation, anxiety, tremors and delirium.

* A beta-blocker treatment is common in case of withdrawal syndrome.108

Antidepressants and antipsychotics

Classic anti-depressant **tricyclics** (ADT) are nonselective inhibitors of serotonin and noradrenaline reuptake. They can cause cardiotoxicity through different mechanisms, leading to impaired cardiac contractility and arrhythmias.109

* The most common effects, usually depending on the dose, are QRS enlargement, AV blocks to different extents, QT lengthening, and negative inotropic effect with a reduction in the ejection fraction.
* They can also cause, especially in older athletes, Raynaud’s phenomenon, orthostatic hypotension and sinus tachycardia and bradycardia.
* Some antidepressants and antipsychotics might cause: QT lengthening with the torsadogenic risk of producing LQTS, ventricular arrhythmias and sudden death.
* The risk is intended on the base of the single drug or attendant factors such as: age, underlying pathology, hypokalemia and drugs coadministration.
* These drugs are ADT: amitriptyline, amoxapine, clomipramine, desipramine, doxepin, imipramine, nortriptyline, trimipramine and other antidepressants such as: citalopram, fluoxetine, sertraline (see following section on SSRIs), amoxapine, venlafaxine and doxepin.

Not all antidepressants cause QT lengthening, and the torsadogenic risk increases with higher doses or when drugs are co-administered (e.g. antiarrhythmics, antihistamines, stimulants, antibiotics and antimycotics). It might be also due to familial aggregation, as in 10% of cases.110 Typical antipsychotics (chlorpromazine, pimozide, thioridazine, perphenazine, trifluoperazine, haloperidol and droperidol) and atypical antipsychotics (clozapine, quetiapine, risperidone, sultopride, ziprasidone and loxapine) are more likely to cause QT lengthening and torsade des pointes. However, the group of atypical antipsychotics is actually less hazardous.

Electrocardiograms show that some ADTs (amitriptyline, desipramine and nortriptyline), other antidepressants (maprotiline and lithium) and some antipsychotic drugs (trifluoperazine and loxapine), might cause even highly arrhythmic Brugada like type 1 and coved type syndrome. This is more frequent in familial aggregation cases (associated with Na channel mutation, SCN5A).110,111

The choice, initiation and continuation of an antidepressant and antipsychotic therapy require a careful ECG evaluation (PR, QRS, QTc, ventricular repolarization specific and nonspecific alterations, bradycardia and supra- and ventricular arrhythmias).

Anti-epileptic drugs

Athletes might need prolonged anti-epileptics drug treatment and these drugs might have pharmacokinetic interactions with other drugs. The list of anti-epileptic drugs includes sodium valproate, phenytoin, gabapentin, lamotrigine, levetiracetam, oxcarbazepine, tiagabine, topiramate, vigabatrin, zonisamide and carbamazepine. Treatment with anti-epileptic drugs in athletes should be always reported and plasma levels measured. Serial ECGs are necessary to verify tolerance to therapy and, as asymptomatic bradyarrhythmia and nocturnal AV block can occur, Holter monitor might be needed.

***Commonly used over-the-counter medications***

**Anti-inflammatory drugs**

The use of non-steroidal anti-inflammatories (NSAID) is more common in elite athletes than in non-athlete peers and this is mostly for pain and inflammation control reasons.112,113 These drugs may cause:

1. delayed tissue regeneration,
2. gastrointestinal complications (gastralgia, heartburn, haemorrhage, alvus disorders),
3. disorders of the central nervous system (fatigue, headache, decreased perception of muscle strength),
4. decreased renal blood flow resulting in decreased kidney function (indomethacin, celecoxib), and
5. cardiovascular risks (cyclooxygenase inhibitor, Cox-2). There is evidence that the COX-2 inhibitors may increase cardiovascular risk, like hypertension and atherosclerotic lesions. However, the mechanisms for this potentially adverse cardiovascular effect are unknown.114,115

***Legal ergogenic supplements***

The use of legal ergogenic aids is widespread in athletic populations and varies between 40% and 100% of athletes of both sexes, depending on the sport discipline and the level of competition. These supplements are intended to enhance performance and give a competitive edge. Many elite athletes consume a combination of supplements per day and various forms of sports supplements as well as vitamin/mineral supplements (VMS), which are generally the most used legal ergogenic aids.116 Among VMS consumers, the most frequent types are multivitamins/multiminerals, vitamin C, vitamin D, and iron, with considerable variations in frequency according to countries. The reasons leading athletes to consume VMS also vary according to country, gender and the type of sports performed. The most common reasons are to optimize or enhance performance (most frequent in males) or to compensate for possible deficiencies (most frequent in females); other reasons include improvement of immune status, general health maintenance, or to reduce cold symptoms.117

Numerous factors may be responsible for manifestation of adverse effects in athletes using nutritional aids, such as the safety and composition of the supplement *per se* and the used protocols of intake. Often, athletes take simultaneously various products without regard to optimal dose schemes and total dosage of some ingredients or synergic and antagonistic interactions between them.116 Thus, some commonly used nutritional aids may lead to health disorders and in limited cases to adverse cardiovascular side effects (Table 2).

The legal nutritional supplements which are permitted by WADA and that are supported by reliable evidence of promoting athletes’ physical performance include caffeine, creatine, carbohydrate drinks/gels/bars, β-alanine, bicarbonate, nitrate (beetroot juice) and proteins.117,118

**Caffeine**

Coffee with its ergogenic ingredient caffeine, a trimethylxanthine, is probably the most often consumed beverage worldwide. Caffeine is an adenosine antagonist, acts as a nonselective phosphodiesterase inhibitor and prompts the secretion of catecholamines 18,119. Caffeine acts as a sympathetic stimulus during exercise and has been shown to attenuate autonomic recovery post-exercise. It was suggested that this effect is dose-dependent 120.

Caffeine alone has been shown to be effective for the improvement of aerobic capacity in endurance athletes 119 but the ‘more is better’ philosophy, when applied to caffeine use in sports, may result in side effects that outweigh the performance benefits. Optimal performance benefits are usually achieved with intakes of 3–6 mg/kg (approximately 2-4 cups) and side effects become more common with caffeine doses over 9 mg/kg of body mass. Overdose may lead to cardiotoxicity with significant cardiovascular side effects such as tachycardia, coronary and peripheral vasoconstriction, and elevated blood pressure especially in caffeine-naive recreational athletes.121 Hypertensive episodes, hypokalaemia, paroxysmal arrhythmias, and SCD have also been reported.122,123 Additionally, vigorous exercise may exacerbate the known pharmacodynamic effects of caffeine 18,121,124.

**Creatine**

Creatine has become the most popular non-stimulant legal ergogenic supplement in sports since early 1990s and it first gained popularity after the Barcelona Olympic Games in 1992, where medal winners in sprint and power disciplines publicly announced that they believed their performance had benefitted from its use.125 Creatine is found predominantly (95%) in skeletal muscle tissue, and it is also synthesized in the liver, pancreas, and kidneys. It is reported that supplementation increases performance in anaerobic activities, delays muscle fatigue for short periods of time and contributes to the rapid resynthesis of adenosine triphosphate particularly in repeated short sprints of maximal intensity.123 Creatine can be an effective legal ergogenic aid mostly when used for simple anaerobic exercise bouts of short-duration and maximal effort.119,123 Adverse effects are few and dose-dependent, including weight gain (1.6 to 2.4 kg), muscle cramps, gastrointestinal discomfort and dehydration. There have been two case reports of transient renal function compromise referring to a significant loss of glomerular filtration rate and an interstitial nephritis, respectively.125 To date, there are no well-established adverse cardiovascular effects or major cardiovascular toxicities. However, case reports have associated creatine supplementation with the presentation of deep-vein thromboses, atrial ﬁbrillation, cardiac arrhythmia, chest pain, and even sudden death.126 In the absence of definitive data, its use should be monitored carefully since relevant studies were mostly short-term and pertained to healthy individuals. The long-term effects of creatine supplementation, or any possible effects on other creatine-containing tissues such as the cardiac muscle have not yet been clarified.125

**Carbohydrates**

The increased total thermal load determined by the environmental temperature and evaporative power as well as by the exercise intensity and duration justify the appropriate use of fluid carbohydrate supplements for energy intake, water and electrolyte replacement in continuous efforts predominantly lasting over 1hr. Carbohydrates as supplements usually refer to multiple transportable carbohydrates (such as glucose and fructose) and are often consumed in the form of isotonic sport drinks, gels or energy bars. Health disorders include mainly gastrointestinal discomfort and no adverse cardiovascular effects have been reported.127 Interestingly, the excessive consumption of grapefruit juice may lead to QT prolongation, which can cause arrhythmias, especially after the simultaneous administration of drugs that cause a prolongation of repolarization.18

**β-Alanine**

β-alanine as a supplement leads to enhanced intracellular muscle-buffering capacity increasing the level of carnosine by 40 to 80% in skeletal muscle. Carnosine is considered as a pH regulator in sarcoplasm delaying muscle fatigue, and β-alanine is reported to present an ergogenic effect in efforts lasting 1 to 4 minutes of maximal intensity.128

Several studies and meta-analyses have shown that oral supplementation with β-alanine can improve human performance of high intensity and intermittent exercise patterns.129-131 Beta‐alanine supplementation has been shown to increase carnosine levels in brain and cardiac tissue.132 Moreover, β-alanine may increase heart rate training threshold.

Studies of adverse cardiovascular effects in humans taking oral β-alanine supplements are lacking. However, neurotoxicity, myotonia, transient paresthesia (numbing in the skin) 133 and respiratory discomfort are clinical symptoms in humans with mitochondrial disorders associated with β-alanine plethora, and *in vitro* studies in which rat cardiomyocytes and fibroblasts were directly exposed to β-alanine, oxidative stress and cell apoptosis were reported.134 Therefore, it seems plausible that increased supplementation may have unfavourable cardiovascular effects.

Currently, β-alanine supplementation is legal under the WADA code and its use among athletes is widespread, with a self-reported usage of 60% in some sports.135

**Sodium Bicarbonate**

Sodium bicarbonate (NaHCO3) has been suggested as a performance enhancing nutritional supplement by reducing acidosis during exercise of moderate duration and high intensity. Bicarbonate may cause gastrointestinal disorders when ingested. This can impair rather than improve sports performance and may counteract the benefits of other supplements taken at the same time. No cardiovascular side effects have been reported.136

**Nitrates**

Oral supplementation with inorganic nitrate results in increased levels of nitric oxide thus promoting vasodilation and oxygen supply to the skeletal muscles and enhanced mitochondrial enzyme activity in endurance efforts. Thus, it is reported that intake of sodium nitrate or beetroot juice shows ergogenic effects on cardiorespiratory endurance that would benefit aerobic performance.137,138 Moreover, it is noted that it may be also significantly effective in patients with cardiovascular diseases, and it should not only be addressed in healthy populations.139 The lowering effect on blood pressure has led to the suggestion that beetroot juice could potentially be used in medical settings as an alternative to conventional anti-hypertensive drugs.140 In sport populations, no cardiovascular side effects of nitrate supplementation have been reported although nitrates may be associated with a rapid and significant lowering of blood pressure, including syncope. Besides, further research should be conducted regarding the long-term effects since there are joint biochemical pathways in the metabolism of nitrates and the malignant nitrites.

**Proteins**

High-quality whey protein supplementation (approximately 0.4-0.5 g/kg of lean body mass) increases muscle mass and strength during resistance-type exercise training when ingested both pre-and post-exercise within about 4 to 6 hrs of each other, depending on meal size.141,142 No cardiovascular side effects have been reported in athletes. Nevertheless, the need for appropriate water intake during periods of protein consumption should be encouraged to counteract any risk of dehydration.

***Recreational drugs and energy drinks***

**Alcohol**

Alcohol is the oldest social beverage and is unlikely to have any ergogenic effect on human performance. Therefore, it is currently not listed on the WADA Prohibited List although is banned in some sports according to the rules of the sport for safety reasons, such as in motor racing. Initially, alcohol consumption may lead to an increase of heart rate, respiratory frequency, and blood pressure as well as to minimal vasodilation with a dose-response pattern.8 In cases of heavy drinkers, hypertension, stroke, alcoholic cardiomyopathy, coronary events, cardiac arrhythmias such as atrial fibrillation have been reported.143 Moreover, in chronic heavy-drinking, occurrence of hypertriglyceridemia, tachycardia and coronary spasm can increase the risk for ischemic heart disease and SCD.8,143

**Nicotine and tobacco products**

The use of numerous tobacco products and diverse smokeless alternatives in sports is increasing. Nicotine is a naturally occurring alkaloid and one of the most widely used psychostimulants. Athletes use nicotine either in a smokable form or during a sporting event in the form of gum (smokeless tobacco), chewable tobacco or oral-dispersible nicotine strips or pouches, because of its psychokinetic effect.144 Nicotine is not typically a truly ergogenic aid in terms of maximizing sports performance. However, it is reported that nicotine may improve time to exhaustion even in anaerobic bouts of exercise 144 while it seems to exert similar effects in endurance efforts as caffeine.145 Nevertheless, it is well known that nicotine causes intense adrenergic stimulation and vasoconstriction of coronary artery segments and abuse may lead to atherosclerosis, dyslipidemia and cardiovascular events.8,18,124 It also decreases cardiac contractility and output, possibly alter coronary blood flow, and may contribute to endothelial dysfunction that precipitates acute ischaemic events.146 Moreover, nicotine has thrombogenic actions resulting in augmented coagulability.145 Thus, tobacco use should be clearly discouraged and certainly avoided for 2 hours before and after a sports event or training practice.8

**Figure 2**

**Energy drinks**

The World Health Organization has named the use of energy drinks as a public health concern.147 Energy drinks are non-alcoholic beverages containing predominantly caffeine in combination with other presumed energy enhancing ingredients that act mainly as stimulants and they are commonly consumed particularly by adolescents and young adults.121,148 The most common ingredients are caffeine, guarana, taurine, glucuronolactone, ginseng and bitter orange. Energy drinks and energy shots (concentrated form of energy drink) contain higher quantities of caffeine than conventional beverages and coffee products, and their caffeine concentration can range from 9 to 250 mg/oz.121 Consumption of a caffeine, taurine, and glucuronolactone formulation may increase arterial blood pressure, act as a platelet aggregation enhancing factor and compromise endothelial function in healthy individuals.148 Furthermore, it is reported that *in vitro*, taurine acts as a triggering factor for enhanced hemodynamic outcomes presenting both a positive inotropic effect and potentiated caffeine-induced cardiac muscle contraction.149 Combination with alcohol is common, with many consumers self-mixing energy drinks or energy shots with alcohol. This usage does not counteract alcohol-induced motor coordination deficits and individuals who mix energy drinks with alcohol may underestimate their true level of impairment.150 Depending on the product and the number of units imbibed, ingested caffeine dose can easily rise over 1000mg. In healthy adults, a caffeine intake of less than 400 mg per day is typically safe. Acute toxicity-derived effects begin at 1000mg, and 5000 to 10,000mg can be lethal.121

Numerous environmental, genetic, and medical settings may predispose individuals to the toxic caffeine effects of energy drinks or shots.121 Moreover, energy shots may be more hazardous since significant increases in both systolic and diastolic blood pressure, lasting up to 6 hours after intake have been noted.151 According to the International Society of Sports Nutrition, the action and the side effects of energy drinks should be clarified since there is a variety of ingredients. The intake of more than a can may lead to side effects and patients should consume only under medical advice.152 Energy drinks put individuals with genetic heart condition at risk and it is suggested that drinking two cans of an energy drink increases risk of cardiac arrest by 20% in people with an underlying heart condition such as in patients with long QT syndrome.153 Cardiovascular side effects of energy drink use include increased blood pressure, coronary disease, heart failure, cardiac arrhythmias, abnormal exercise test, increased risk of atrial fibrillation, narrow complex tachycardia, prolonged QT interval, ventricular tachycardia, ventricular fibrillation, torsade des pointes, supraventricular arrhythmias, ST segment elevation, hypokinesia with or without a reduced left ventricular ejection fraction and aortic dissection.154 Furthermore, the mixture of alcohol with energy drinks may lead to severe cardiovascular disorders.147,155,156 Children or adolescents should only consider using energy drinks with parental approval, and parents should be aware of potential adverse effects. The younger brain is more susceptible to excessive energy drink consumption and a high risk for disturbed neurodevelopment in children and adolescents has also been reported.157 Additionally, individuals with underlying cardiovascular pathology should avoid energy drinks unless approved by their physician.

***New trends of doping***

**Synthetic peptides**

Modern performance enhancing drugs can be designer synthetic peptides triggering stimulation of natural anabolic hormone secretion. However, of possibly far greater potential risk than using AAS or other prohibited drugs is athletes’ desire and consent to use experimental drugs that have not been proven safe in humans.158 The ongoing use of SARMs like ostarine, ligandrol, andarine, and cardarine claiming anabolic to androgenic ratios high up to 90:1 or peptides like ipamorelin (growth hormone secretagogue) carry a substantial risk for long term detrimental health consequences, which are usually understated by their promoters. Little is known about the cardiovascular side effects of the many peptides designed to modulate AR activity as it was previously reported in this paper. It is likely that side effects are less than AAS, but it is very difficult to know for certain.3 Thus, in some respect, confirmation of biomedical side effects is always going to be one step behind use and not surprisingly, no cardiovascular side effects have been reported so far.

Furthermore, the hypoxia inducible factor-proly hydroxylase (HIF-PHD) inhibitors (i.e. cobalt, daprodustat, molidustat, roxadustat, enarodustat, vadadustat, xenon) are basically modern erythropoiesis-triggering agents and they are used in sports alternatively to injectable erythropoietin. The study of their cardiovascular effects is still ongoing mainly in vitro.159 Besides, natural compounds like phytoekdysteroids or phosphodiesterase type 5 (PDE5) inhibitors are also used in sports and PDE5 inhibitors are alleged to be frequently misused by healthy athletes to improve sporting performance.160 Finally, the implementation of gene doping constitutes a great threat of major concern about the future of human performance manipulation.

**Gene doping**

Gene doping (WADA prohibited method) includes the use of normal or genetically modified cells as well as gene transfer, gene silencing and gene editing technologies. There are not yet any data about complications, as might be expected considering that officially there are no confirmed adverse analytical findings of gene doping in sports. Gene doping abuses the legitimate approach of gene therapy in analogue medical protocols. Over 200 genes are associated to human performance and play a role in muscle development, oxygen delivery to tissues, neuromuscular coordination, or even pain control, and are thus candidates for gene dopers.161 The expected severe health side effects include lethal immunodeficiency and leukemia.162 Health risks may also result from gene overexpression, a common problem in gene therapy. Insulin-like growth factor (IGF) gene doping may be used for muscle repair and muscle performance. IGF-overexpression may cause cardiac hypertrophy, heart valve disease, and heart failure.162-164 Additionally, increasing EPO levels may increase viscosity and the risk for heart attack.165 Moreover, it is highly anticipated that genes for strength, analgesia, oxygen delivery, and tissue repair may be transferred simultaneously to the same athlete. Clearly, there will be hazardous side effects and probably severe gene interactions. Contrary to therapeutic gene protocols that are conducted under strict regulations and approval procedures, gene doping is expected to occur behind the scenes with limited protective actions and consequently increased health risks. Furthermore, since 2018, the WADA list also includes gene editing as *agents designed to alter genome sequences and/or the transcriptional or epigenetic regulation of gene expression*. Gene editing with genome editing tools such as CRISPR (clustered regularly interspaced short palindromic repeats) 166 involves tweaking existing genes, rather than adding completely new ones to the athlete’s body. Gene editing should make it possible to make tiny alterations to DNA in existing genes, or to just temporarily boost or switch off the activity of particular genes. Additionally, these effects could be oriented to specific tissues such as muscle, meaning the changes may not show up in blood anti-doping tests. However, it seems that there will always be the increased risk of mutation genesis and formation of malignant cells as well as unexpected side effects due to atypical regulation of cell growth and toxicity based on chronic hyper-expressions of growth factors and cytokines even affecting the cardiovascular function.167

***Aspects for non-medics***

The indiscriminate use of nutritional supplements and legal ergogenic aids in sports is a cause for concern. Nutritional supplements are commonly viewed as risk-free substances that may improve performance. Nutritional supplements, however, that have the potential to enhance human performance may also have biomedical side effects. Some nutritional supplements, including various plant and “natural” extracts, may pose a serious health risk and athletes may even risk contravening anti-doping rules. Moreover, contamination of supplements with unknown or prohibited substances remains a significant issue, with contamination rates reported between 12 to 58%.116,168 Supplements widely available like fat-burners or products based on plant extracts may trigger cardiovascular disorders if contaminated with ephedra or ephedra-like compounds, which is also a common cause of unintended anti-doping rule violations.

Athletes who use supplements often have no knowledge regarding their effects on sports performance and overall health. It is reported that most athletes get nutritional advice from coaches, fellow athletes, family members and friends 169, suggesting that more wide reaching educational interventions, at an early age, are necessary. Athletes, particularly at the higher echelons of sport, should consider consulting nutritional experts who will consider the need, potential benefits, as well as side-effects of supplements and provide an individually tailored prescription.116 Examples when nutritional supplements may be indicated include i.) specific nutrient deficiencies; ii.) clinical manifestations due to chronic inadequate nutrient intake; iii.) low calorie diets or diets excluding a group of nutrients either voluntarily e.g., vegetarians/vegans or due to allergies or food intolerance; iv.) regular traveling with uncertain/insufficient food supply or quality; v). periods of extreme training loads and increased energy expenditure.

|  |
| --- |
| ***Key-points for athletes using nutritional supplements*** |
| * A natural supplement is not necessarily a safe supplement * Use supplements if needed for known deficiencies and recommended by nutrition experts * Use products by established manufacturers with known good quality standards * Athletes are personally responsible for any substances they consume * Ignorance is not accepted as an excuse in relation to a positive doping test * Athletes with established heart disease should be even more vigilant and consult with their physician prior to using any supplements or ergogenic aids |

***Ethical considerations***

The basis of using doping substances is like that of nutritional supplements used as ergogenic aids in sports, since in both cases the objective is to improve physical performance. Athletes should be aware that supplement use exposes them to a risk of ingesting prohibited substances or prohormones and precursors of prohibited substances. Supplements are regulated as food ingredients and are not subject to the stringent regulations applied to pharmaceutical products.116 The greatest risk to athletes’ health is the use of “cocktails” and transference of effects of several substances, which might interact to the worse or the use of designer peptides produced in laboratories without rigorous safety standards. Unfortunately, it is common practice for athletes to ignore dosing recommendations and use multiple drugs simultaneously. Another aspect of consideration about ergogenic aids in sports is that when using nutritional ergogenic supplements to push physiological adaptations beyond normal under an extreme training load, supra-physiological structural and functional changes may be apparent. In this case, the induced stress reaction with high catecholamines release triggering cardiovascular response may lead to cardiovascular disorders such as atrial fibrillation or even more threatening arrhythmias.3

Anti-doping authorities may claim that they increase the penalties for anti-doping rule violations or have developed new anti-doping strategies based on increased number of anti-doping tests and sophisticated reliable methods for detection of doping substances. Besides, regarding the claims that underestimate the health side effects and mention that doping will always exist in sports and it could be eventually allowed, we should foresee that i). clinical trials establishing a safe level of intake would not exist for all probable dosage schemes, and ii.) the concept of sporting fairness would be challenged due to financial burden. Furthermore, the core of sports culture should always be the athlete and not the pharmacist or the geneticist.

Prescribing physicians should familiarize themselves with the status of a prescribed medication under the WADA anti-doping code, although the majority of the supporting information sources provides information about the prohibited drugs based on the current WADA Prohibited List, but does not provide the status of nutritional substances due to the fact many are unregulated and unlicensed.158 Usually, these tools (electronic databases and official websites) provide specific information on products sold in just a limited number of countries. Undoubtedly, it needs to be recognized that physicians should be actively part of the fight against doping and should only prescribe or recommend supplements where a clinical need can be demonstrated, such as in vitamin deficiency syndromes.170 Moreover, physicians should always discuss with the athletes to inform them about the potential risks of taking supplements. The important role of athletic coaches, equally or even more than dieticians and physicians, in providing nutritional information should be also noted. Therefore, there is a considerable need for well-educated coaches in collaboration with dieticians and doctors to provide an adequate nutritional support for athletes. Regarding young athletes, it should be noted that pediatricians are the primary contact for most young athletes and pediatric cardiologists are in a position to develop long-lasting relationships with their patients. Therefore, it is of great importance for pediatric physicians to be aware that drug use in sports is not only an adult problem.

An athlete guided by a strong “will to win” may be vulnerable to cheating practices to satisfy his goals and society’s expectations. Doping within this pursuit of sports success is a multi-dimensional issue and the fight against arbitrary use of ergogenic aids in professional and recreational sports should involve all stakeholders of the modern sport system: athletes, clubs, scientists, spectators, sponsors, media, family and official authorities 170. Physicians need to become more educated about the drugs that are being used in sports and their side effects. It is essential to have a physician who will be perceptive to the potential for drugs abuse, well informed and able to discuss openly the ergogenic and the adverse effects of nutritional supplements and drugs.125 Athletes with established heart disease should be even more vigilant and regularly consult with their physician prior to using any supplements or ergogenic aids. More research studies on biomedical side effects and educational campaigns particularly aiming at physicians, children and athletes of developmental ages can have a significant influence on drug use in sports and may act as the most powerful tools for an effective fight against the indiscriminate use of ergogenic aids.

Author contribution

Authorship: PEA, NK, and MP contributed to the conception or design of the work. PEA, NK, AD and EK contributed to the acquisition, analysis, or interpretation of data for the work. PEA and NK drafted the manuscript. PEA, NK, EC, AB, SB, AD, FF, EK, PMV, JN, EES, MS, SS and AP critically revised the manuscript. All gave final approval and agree to be accountable for all aspects of work ensuring integrity and accuracy.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

**References**

1. Kent. M. The Oxford Dictionary of Sports Science & Medicine (3 ed.). In: Oxford University Press; 2007.

2. WADA World Anti-Doping Agency. *World Anti-Doping Code International Standard Prohibited List 2021*. <https://www.wada-ama.org/sites/default/files/resources/files/2021list_en.pdf>. Montreal, Quebec, Canada: World Anti-Doping Agency; 2020.

3. La Gerche A, Brosnan MJ. Cardiovascular Effects of Performance-Enhancing Drugs. Circulation 2017;**135**(1):89-99.

4. Gleaves J, Petróczi A, Folkerts D, De Hon O, Macedo E, Saugy M, Cruyff M. Doping prevalence in competitive sport: Evidence synthesis with “best practice” recommendations and reporting guidelines from the WADA Working Group on Doping Prevalence. Sports Medicine 2021:1-26.

5. Bojsen‐Møller J, Christiansen AV. Use of performance‐and image‐enhancing substances among recreational athletes: a quantitative analysis of inquiries submitted to the Danish anti‐doping authorities. Scandinavian journal of medicine & science in sports 2010;**20**(6):861-867.

6. WADA World Anti-Doping Agency. *World Anti-Doping Agency Testing Figures Report*. <https://www.wada-ama.org/en> (01/07/2021 2021).

7. Kolliari-Turner A, Lima G, Hamilton B, Pitsiladis Y, Guppy FM. Analysis of Anti-Doping Rule Violations That Have Impacted Medal Results at the Summer Olympic Games 1968–2012. Sports Medicine 2021:1-9.

8. Deligiannis A, Bjornstad H, Carre F, Heidbuchel H, Kouidi E, Panhuyzen-Goedkoop NM, Pigozzi F, Schanzer W, Vanhees L. ESC study group of sports cardiology position paper on adverse cardiovascular effects of doping in athletes. Eur J Cardiovasc Prev Rehabil 2006;**13**(5):687-94.

9. Pope HG, Jr., Wood RI, Rogol A, Nyberg F, Bowers L, Bhasin S. Adverse health consequences of performance-enhancing drugs: an Endocrine Society scientific statement. Endocr Rev 2014;**35**(3):341-75.

10. Albano GD, Amico F, Cocimano G, Liberto A, Maglietta F, Esposito M, Rosi GL, Di Nunno N, Salerno M, Montana A. Adverse Effects of Anabolic-Androgenic Steroids: A Literature Review. In: *Healthcare*. *2021*: Abstract 9, p. 97. Multidisciplinary Digital Publishing Institute.

11. Bhasin S, Storer TW, Berman N, Callegari C, Clevenger B, Phillips J, Bunnell TJ, Tricker R, Shirazi A, Casaburi R. The effects of supraphysiologic doses of testosterone on muscle size and strength in normal men. N Engl J Med 1996;**335**(1):1-7.

12. Forbes GB, Porta CR, Herr BE, Griggs RC. Sequence of changes in body composition induced by testosterone and reversal of changes after drug is stopped. Jama 1992;**267**(3):397-9.

13. Cardinale DA, Horwath O, Elings-Knutsson J, Helge T, Godhe M, Bermon S, Moberg M, Flockhart M, Larsen FJ, Hirschberg AL, Ekblom B. Enhanced Skeletal Muscle Oxidative Capacity and Capillary-to-Fiber Ratio Following Moderately Increased Testosterone Exposure in Young Healthy Women. Front Physiol 2020;**11**:585490.

14. Giorgi A, Weatherby RP, Murphy PW. Muscular strength, body composition and health responses to the use of testosterone enanthate: a double blind study. J Sci Med Sport 1999;**2**(4):341-55.

15. Hirschberg AL, Elings Knutsson J, Helge T, Godhe M, Ekblom M, Bermon S, Ekblom B. Effects of moderately increased testosterone concentration on physical performance in young women: a double blind, randomised, placebo controlled study. Br J Sports Med 2020;**54**(10):599-604.

16. Achar S, Rostamian A, Narayan SM. Cardiac and metabolic effects of anabolic-androgenic steroid abuse on lipids, blood pressure, left ventricular dimensions, and rhythm. Am J Cardiol 2010;**106**(6):893-901.

17. Torrisi M, Pennisi G, Russo I, Amico F, Esposito M, Liberto A, Cocimano G, Salerno M, Li Rosi G, Di Nunno N. Sudden Cardiac Death in Anabolic-Androgenic Steroid Users: A Literature Review. Medicina 2020;**56**(11):587.

18. Deligiannis AP, Kouidi EI. Cardiovascular adverse effects of doping in sports. Hellenic J Cardiol 2012;**53**(6):447-57.

19. Perry JC, Schuetz TM, Memon MD, Faiz S, Cancarevic I. Anabolic steroids and cardiovascular outcomes: the controversy. Cureus 2020;**12**(7).

20. Baggish AL, Weiner RB, Kanayama G, Hudson JI, Lu MT, Hoffmann U, Pope Jr HG. Cardiovascular toxicity of illicit anabolic-androgenic steroid use. Circulation 2017;**135**(21):1991-2002.

21. Liu JD, Wu YQ. Anabolic-androgenic steroids and cardiovascular risk. Chin Med J (Engl) 2019;**132**(18):2229-2236.

22. Chang S, Münster AB, Gram J, Sidelmann JJ. Anabolic Androgenic Steroid Abuse: The Effects on Thrombosis Risk, Coagulation, and Fibrinolysis. Semin Thromb Hemost 2018;**44**(8):734-746.

23. Corona G, Maseroli E, Rastrelli G, Isidori AM, Sforza A, Mannucci E, Maggi M. Cardiovascular risk associated with testosterone-boosting medications: a systematic review and meta-analysis. Expert Opin Drug Saf 2014;**13**(10):1327-51.

24. Deligiannis AP, Mandroukas K. Noninvasive cardiac evaluation of weight-lifters using anabolic steroids. Scandinavian Journal of Medicine & Science in Sports 1993;**3**(1):37-40.

25. Far HR, Ågren G, Thiblin I. Cardiac hypertrophy in deceased users of anabolic androgenic steroids: an investigation of autopsy findings. Cardiovasc Pathol 2012;**21**(4):312-6.

26. Montisci M, El Mazloum R, Cecchetto G, Terranova C, Ferrara SD, Thiene G, Basso C. Anabolic androgenic steroids abuse and cardiac death in athletes: morphological and toxicological findings in four fatal cases. Forensic Sci Int 2012;**217**(1-3):e13-8.

27. Baggish AL, Weiner RB, Kanayama G, Hudson JI, Picard MH, Hutter AM, Jr., Pope HG, Jr. Long-term anabolic-androgenic steroid use is associated with left ventricular dysfunction. Circ Heart Fail 2010;**3**(4):472-6.

28. Luijkx T, Velthuis BK, Backx FJ, Buckens CF, Prakken NH, Rienks R, Mali WP, Cramer MJ. Anabolic androgenic steroid use is associated with ventricular dysfunction on cardiac MRI in strength trained athletes. Int J Cardiol 2013;**167**(3):664-8.

29. D'Andrea A, Caso P, Salerno G, Scarafile R, De Corato G, Mita C, Di Salvo G, Severino S, Cuomo S, Liccardo B, Esposito N, Calabro R. Left ventricular early myocardial dysfunction after chronic misuse of anabolic androgenic steroids: a Doppler myocardial and strain imaging analysis. Br J Sports Med 2007;**41**(3):149-55.

30. Darke S, Torok M, Duflou J. Sudden or unnatural deaths involving anabolic-androgenic steroids. J Forensic Sci 2014;**59**(4):1025-8.

31. D'Andrea A, Radmilovic J, Caselli S, Carbone A, Scarafile R, Sperlongano S, Tocci G, Formisano T, Martone F, Liccardo B, D'Alto M, Bossone E, Galderisi M, Golino P. Left atrial myocardial dysfunction after chronic abuse of anabolic androgenic steroids: a speckle tracking echocardiography analysis. Int J Cardiovasc Imaging 2018;**34**(10):1549-1559.

32. Rasmussen JJ, Schou M, Madsen PL, Selmer C, Johansen ML, Ulriksen PS, Dreyer T, Kümler T, Plesner LL, Faber J, Gustafsson F, Kistorp C. Cardiac systolic dysfunction in past illicit users of anabolic androgenic steroids. Am Heart J 2018;**203**:49-56.

33. Nottin S, Nguyen LD, Terbah M, Obert P. Cardiovascular effects of androgenic anabolic steroids in male bodybuilders determined by tissue Doppler imaging. Am J Cardiol 2006;**97**(6):912-5.

34. Cecchi R, Muciaccia B, Ciallella C, Di Luca NM, Kimura A, Sestili C, Nosaka M, Kondo T. Ventricular androgenic-anabolic steroid-related remodeling: an immunohistochemical study. Int J Legal Med 2017;**131**(6):1589-1595.

35. Alizade E, Avci A, Tabakcı MM, Toprak C, Zehir R, Acar G, Kargin R, Emiroğlu MY, Akçakoyun M, Pala S. Comparison of Right Ventricle Systolic Function between Long-Term Anabolic-Androgenic Steroid User and Nonuser Bodybuilder Athletes: A Study of Two-Dimensional Speckle Tracking Echocardiography. Echocardiography 2016;**33**(8):1178-85.

36. Abhayaratna WP, Seward JB, Appleton CP, Douglas PS, Oh JK, Tajik AJ, Tsang TS. Left atrial size: physiologic determinants and clinical applications. J Am Coll Cardiol 2006;**47**(12):2357-63.

37. Barbosa Neto O, da Mota GR, De Sordi CC, Resende E, Resende L, Vieira da Silva MA, Marocolo M, Côrtes RS, de Oliveira LF, Dias da Silva VJ. Long-term anabolic steroids in male bodybuilders induce cardiovascular structural and autonomic abnormalities. Clin Auton Res 2018;**28**(2):231-244.

38. Kouidi EJ, Kaltsatou A, Anifanti MA, Deligiannis AP. Early Left Ventricular Diastolic Dysfunction, Reduced Baroreflex Sensitivity, and Cardiac Autonomic Imbalance in Anabolic–Androgenic Steroid Users. International Journal of Environmental Research and Public Health 2021;**18**(13):6974.

39. Ghorbani Baravati H, Joukar S, Fathpour H, Kordestani Z. Nandrolone Plus Moderate Exercise Increases the Susceptibility to Lethal Arrhythmias. Res Cardiovasc Med 2015;**4**(2):e26233.

40. Marocolo M, Katayama PL, Meireles A, Barbosa Neto O. Combined effects of exercise training and high doses of anabolic steroids on cardiac autonomic modulation and ventricular repolarization properties in rats. Can J Physiol Pharmacol 2019;**97**(12):1185-1192.

41. Cittadini A, Berggren A, Longobardi S, Ehrnborg C, Napoli R, Rosén T, Fazio S, Caidahl K, Bengtsson BA, Saccà L. Supraphysiological doses of GH induce rapid changes in cardiac morphology and function. J Clin Endocrinol Metab 2002;**87**(4):1654-9.

42. Colao A, Marzullo P, Di Somma C, Lombardi G. Growth hormone and the heart. Clin Endocrinol (Oxf) 2001;**54**(2):137-54.

43. Maffei P, Martini C, Milanesi A, Corfini A, Mioni R, de Carlo E, Menegazzo C, Scanarini M, Vettor R, Federspil G, Sicolo N. Late potentials and ventricular arrhythmias in acromegaly. Int J Cardiol 2005;**104**(2):197-203.

44. Crist DM, Peake GT, Loftfield RB, Kraner JC, Egan PA. Supplemental growth hormone alters body composition, muscle protein metabolism and serum lipids in fit adults: characterization of dose-dependent and response-recovery effects. Mech Ageing Dev 1991;**58**(2-3):191-205.

45. Shrivastava S, Srivastava D, Olson EN, DiMaio JM, Bock-Marquette I. Thymosin beta4 and cardiac repair. Ann N Y Acad Sci 2010;**1194**:87-96.

46. Friedman RA. The changing face of teenage drug abuse--the trend toward prescription drugs. N Engl J Med 2006;**354**(14):1448-50.

47. Fanoe S, Jensen G, Ege P. Proarrhythmic effect of methadone: an alternative explanation of sudden death in heroine addicts. PACE 2006;**29**(Suppl 1):S30.

48. Alinejad S, Kazemi T, Zamani N, Hoffman RS, Mehrpour O. A systematic review of the cardiotoxicity of methadone. Excli j 2015;**14**:577-600.

49. Polanczyk GV, Willcutt EG, Salum GA, Kieling C, Rohde LA. ADHD prevalence estimates across three decades: an updated systematic review and meta-regression analysis. Int J Epidemiol 2014;**43**(2):434-42.

50. Katselou M, Papoutsis I, Nikolaou P, Qammaz S, Spiliopoulou C, Athanaselis S. Fenethylline (Captagon) Abuse - Local Problems from an Old Drug Become Universal. Basic Clin Pharmacol Toxicol 2016;**119**(2):133-40.

51. Milroy CM, Parai JL. The histopathology of drugs of abuse. Histopathology 2011;**59**(4):579-93.

52. Hennissen L, Bakker MJ, Banaschewski T, Carucci S, Coghill D, Danckaerts M, Dittmann RW, Hollis C, Kovshoff H, McCarthy S, Nagy P, Sonuga-Barke E, Wong IC, Zuddas A, Rosenthal E, Buitelaar JK. Cardiovascular Effects of Stimulant and Non-Stimulant Medication for Children and Adolescents with ADHD: A Systematic Review and Meta-Analysis of Trials of Methylphenidate, Amphetamines and Atomoxetine. CNS Drugs 2017;**31**(3):199-215.

53. Al-Imam A. Adverse effects of amphetamines on the cardiovascular system: Review and retrospective analyses of trends. Global Journal of Health Science 2017;**9**(11):102.

54. Figueredo VM. Chemical cardiomyopathies: the negative effects of medications and nonprescribed drugs on the heart. The American journal of medicine 2011;**124**(6):480-488.

55. Cohle SD. Fatal coronary artery intimal hyperplasia due to amphetamine use. Cardiovascular Pathology 2013;**22**(3):e1-e4.

56. Fischbach P. The role of illicit drug use in sudden death in the young. Cardiology in the Young 2017;**27**:S75.

57. Morentin B, Callado LF, García-Hernández S, Bodegas A, Lucena J. The role of toxic substances in sudden cardiac death. Spanish journal of legal medicine 2018;**44**(1):13-21.

58. Roelands B, Hasegawa H, Watson P, Piacentini MF, Buyse L, De Schutter G, Meeusen RR. The effects of acute dopamine reuptake inhibition on performance. Med Sci Sports Exerc 2008;**40**(5):879-85.

59. Keisler BD, Hosey RG. Ergogenic aids: an update on ephedra. Curr Sports Med Rep 2005;**4**(4):231-5.

60. Morozova E, Yoo Y, Behrouzvaziri A, Zaretskaia M, Rusyniak D, Zaretsky D, Molkov Y. Amphetamine enhances endurance by increasing heat dissipation. Physiol Rep 2016;**4**(17).

61. Dambrova M, Makrecka-Kuka M, Vilskersts R, Makarova E, Kuka J, Liepinsh E. Pharmacological effects of meldonium: Biochemical mechanisms and biomarkers of cardiometabolic activity. Pharmacol Res 2016.

62. Schobersberger W, Dünnwald T, Gmeiner G, Blank C. Story behind meldonium–from pharmacology to performance enhancement: a narrative review. British journal of sports medicine 2017;**51**(1):22-25.

63. Stuart M, Schneider C, Steinbach K. Meldonium use by athletes at the Baku 2015 European Games. Br J Sports Med 2016;**50**(11):694-8.

64. Pluim BM, de Hon O, Staal JB, Limpens J, Kuipers H, Overbeek SE, Zwinderman AH, Scholten RJ. beta(2)-Agonists and physical performance: a systematic review and meta-analysis of randomized controlled trials. Sports Med 2011;**41**(1):39-57.

65. Sears MR. Adverse effects of beta-agonists. J Allergy Clin Immunol 2002;**110**(6 Suppl):S322-8.

66. Milano G, Chiappini S, Mattioli F, Martelli A, Schifano F. beta-2 Agonists as Misusing Drugs? Assessment of both Clenbuterol- and Salbutamol-related European Medicines Agency Pharmacovigilance Database Reports. Basic Clin Pharmacol Toxicol 2018;**123**(2):182-187.

67. Brett J, Dawson AH, Brown JA. Clenbuterol toxicity: a NSW poisons information centre experience. Med J Aust 2014;**200**(4):219-21.

68. Ferrua S, Varbella F, Conte M. Acute myocardial infarction due to coronary vasospasm and salbutamol abuse. Heart 2009;**95**(8):673-673.

69. Boucher A, Payen C, Garayt C, Ibanez H, Dieny A, Doche C, Chuniaud C, Descotes J. Salbutamol misuse or abuse with fatal outcome: A case-report. Human & experimental toxicology 2011;**30**(11):1869-1871.

70. Furlanello F, Bentivegna S, Cappato R, De Ambroggi L. Arrhythmogenic effects of illicit drugs in athletes. Ital Heart J 2003;**4**(12):829-37.

71. Ghodse A, Galea S. Opioid analgesics and narcotic antagonists. In. *Side Effects of Drugs Annual*: Elsevier; 2010, 183-224.

72. Vernec A, Slack A, Harcourt PR, Budgett R, Duclos M, Kinahan A, Mjøsund K, Strasburger CJ. Glucocorticoids in elite sport: current status, controversies and innovative management strategies-a narrative review. Br J Sports Med 2020;**54**(1):8-12.

73. Duclos M. Glucocorticoids: a doping agent? Endocrinol Metab Clin North Am 2010;**39**(1):107-26, ix-x.

74. Berglund B, Hemmingson P. Effect of reinfusion of autologous blood on exercise performance in cross-country skiers. Int J Sports Med 1987;**8**(3):231-3.

75. Brien AJ, Simon TL. The effects of red blood cell infusion on 10-km race time. Jama 1987;**257**(20):2761-5.

76. Borrione P, Mastrone A, Salvo RA, Spaccamiglio A, Grasso L, Angeli A. Oxygen delivery enhancers: past, present, and future. J Endocrinol Invest 2008;**31**(2):185-92.

77. Heuberger JA, Cohen Tervaert JM, Schepers FM, Vliegenthart AD, Rotmans JI, Daniels JM, Burggraaf J, Cohen AF. Erythropoietin doping in cycling: lack of evidence for efficacy and a negative risk-benefit. Br J Clin Pharmacol 2013;**75**(6):1406-21.

78. Heuberger J, Rotmans JI, Gal P, Stuurman FE, van 't Westende J, Post TE, Daniels JMA, Moerland M, van Veldhoven PLJ, de Kam ML, Ram H, de Hon O, Posthuma JJ, Burggraaf J, Cohen AF. Effects of erythropoietin on cycling performance of well trained cyclists: a double-blind, randomised, placebo-controlled trial. Lancet Haematol 2017;**4**(8):e374-e386.

79. Birkeland KI, Stray-Gundersen J, Hemmersbach P, Hallen J, Haug E, Bahr R. Effect of rhEPO administration on serum levels of sTfR and cycling performance. Med Sci Sports Exerc 2000;**32**(7):1238-43.

80. Wilkerson DP, Rittweger J, Berger NJ, Naish PF, Jones AM. Influence of recombinant human erythropoietin treatment on pulmonary O2 uptake kinetics during exercise in humans. J Physiol 2005;**568**(Pt 2):639-52.

81. Connes P, Perrey S, Varray A, Prefaut C, Caillaud C. Faster oxygen uptake kinetics at the onset of submaximal cycling exercise following 4 weeks recombinant human erythropoietin (r-HuEPO) treatment. Pflugers Arch 2003;**447**(2):231-8.

82. Parisotto R, Gore CJ, Emslie KR, Ashenden MJ, Brugnara C, Howe C, Martin DT, Trout GJ, Hahn AG. A novel method utilising markers of altered erythropoiesis for the detection of recombinant human erythropoietin abuse in athletes. Haematologica 2000;**85**(6):564-72.

83. Garimella PS, Katz R, Patel KV, Kritchevsky SB, Parikh CR, Ix JH, Fried LF, Newman AB, Shlipak MG, Harris TB, Sarnak MJ, Health ABCS. Association of Serum Erythropoietin With Cardiovascular Events, Kidney Function Decline, and Mortality: The Health Aging and Body Composition Study. Circ Heart Fail 2016;**9**(1):e002124.

84. Rasmussen P, Kim YS, Krogh‐Madsen R, Lundby C, Olsen NV, Secher NH, van Lieshout JJ. Both acute and prolonged administration of EPO reduce cerebral and systemic vascular conductance in humans. The FASEB Journal 2012;**26**(3):1343-1348.

85. Jelkmann W. Erythropoietin doping: Cardiovascular effects in athletes. Ann Sports Med Res 2020;**7**(1):1142.

86. Lippi G, Franchini M, Guidi GC. Cobalt chloride administration in athletes: a new perspective in blood doping? Br J Sports Med 2005;**39**(11):872-3.

87. Alexander CS. Cobalt-beer cardiomyopathy. A clinical and pathologic study of twenty-eight cases. Am J Med 1972;**53**(4):395-417.

88. Ebert B, Jelkmann W. Intolerability of cobalt salt as erythropoietic agent. Drug Test Anal 2014;**6**(3):185-9.

89. Richardson RS, Tagore K, Haseler LJ, Jordan M, Wagner PD. Increased VO2 max with right-shifted Hb-O2 dissociation curve at a constant O2 delivery in dog muscle in situ. J Appl Physiol (1985) 1998;**84**(3):995-1002.

90. Suh JH, Stea B, Nabid A, Kresl JJ, Fortin A, Mercier JP, Senzer N, Chang EL, Boyd AP, Cagnoni PJ, Shaw E. Phase III study of efaproxiral as an adjunct to whole-brain radiation therapy for brain metastases. J Clin Oncol 2006;**24**(1):106-14.

91. La Gerche A, Claessen G. Is exercise good for the right ventricle? Concepts for health and disease. Canadian J Cardiol 2015;**[In Press]**.

92. La Gerche A, Heidbuchel H. Can intensive exercise harm the heart? You can get too much of a good thing. Circulation 2014;**130**(12):992-1002.

93. Kontaras K, Varnavas V, Kyriakides ZS. Does sildenafil cause myocardial infarction or sudden cardiac death? American Journal of Cardiovascular Drugs 2008;**8**(1):1-7.

94. Kloner RA, Goldstein I, Kirby MG, Parker JD, Sadovsky R. Cardiovascular Safety of Phosphodiesterase Type 5 Inhibitors After Nearly 2 Decades on the Market. Sex Med Rev 2018;**6**(4):583-594.

95. Ghofrani HA, Reichenberger F, Kohstall MG, Mrosek EH, Seeger T, Olschewski H, Seeger W, Grimminger F. Sildenafil increased exercise capacity during hypoxia at low altitudes and at Mount Everest base camp: a randomized, double-blind, placebo-controlled crossover trial. Ann Intern Med 2004;**141**(3):169-77.

96. Faoro V, Boldingh S, Moreels M, Martinez S, Lamotte M, Unger P, Brimioulle S, Huez S, Naeije R. Bosentan decreases pulmonary vascular resistance and improves exercise capacity in acute hypoxia. Chest 2009;**135**(5):1215-22.

97. Hsu AR, Barnholt KE, Grundmann NK, Lin JH, McCallum SW, Friedlander AL. Sildenafil improves cardiac output and exercise performance during acute hypoxia, but not normoxia. J Appl Physiol 2006;**100**(6):2031-40.

98. Guidetti L, Emerenziani GP, Gallotta MC, Pigozzi F, Di Luigi L, Baldari C. Effect of tadalafil on anaerobic performance indices in healthy athletes. Br J Sports Med 2008;**42**(2):130-3.

99. Van Bortel LMABvB, M.A. . Exercise tolerance with nebivolol and atenolol. . Cardiovasc Drug Ther 1992;**6**(239):239 - 247.

100. Gullestad L, Hallen J, Medbo JI, Gronnerod O, Holme I, Sejersted OM. The effect of acute vs chronic treatment with beta-adrenoceptor blockade on exercise performance, haemodynamic and metabolic parameters in healthy men and women. Br J Clin Pharmacol 1996;**41**(1):57-67.

101. Funck-Brentano C, Kibleur Y, Le Coz F, Poirier JM, Mallet A, Jaillon P. Rate dependence of sotalol-induced prolongation of ventricular repolarization during exercise in humans. Circulation 1991;**83**(2):536-45.

102. Coltart DJ, Shand DG. Plasma propranolol levels in the quaniitative assessment of beta-adrenergic blockade in man. Br Med J 1970;**3**(5725):731-4.

103. Turagam MK, Flaker GC, Velagapudi P, Vadali S, Alpert MA. Atrial fibrillation in athletes: Pathophysiology, clinical presentation, evaluation and management. Journal of atrial fibrillation 2015;**8**(4).

104. Wang JA, Lau CP, Tai YT, Wu BZ. Effects of flecainide on exercise hemodynamics and electrocardiography in patients without structural heart disease. Clin Cardiol 1995;**18**(3):140-4.

105. Heidbuchel H, Adami PE, Antz M, Braunschweig F, Delise P, Scherr D, Solberg EE, Wilhelm M, Pelliccia A. Recommendations for participation in leisure-time physical activity and competitive sports in patients with arrhythmias and potentially arrhythmogenic conditions: Part 1: Supraventricular arrhythmias. A position statement of the Section of Sports Cardiology and Exercise from the European Association of Preventive Cardiology (EAPC) and the European Heart Rhythm Association (EHRA), both associations of the European Society of Cardiology. Eur J Prev Cardiol 2020:2047487320925635.

106. Heidbuchel H, Arbelo E, D’Ascenzi F, Borjesson M, Boveda S, Castelletti S, Miljoen H, Mont L, Niebauer J, Papadakis M, Pelliccia A, Saenen J, Sanz de la Garza M, Schwartz PJ, Sharma S, Zeppenfeld K, Corrado D, activity EEuotRfpil-tp, arrhythmias csipw, conditions pa. Recommendations for participation in leisure-time physical activity and competitive sports of patients with arrhythmias and potentially arrhythmogenic conditions. Part 2: ventricular arrhythmias, channelopathies, and implantable defibrillators: A position statement of the Section of Sports Cardiology and Exercise from the European Association of Preventive Cardiology (EAPC) and the European Heart Rhythm Association (EHRA), both associations of the European Society of Cardiology. EP Europace 2020;**23**(1):147-148.

107. Pelliccia A, Sharma S, Gati S, Bäck M, Börjesson M, Caselli S, Collet J-P, Corrado D, Drezner JA, Halle M. 2020 ESC Guidelines on sports cardiology and exercise in patients with cardiovascular disease: The Task Force on sports cardiology and exercise in patients with cardiovascular disease of the European Society of Cardiology (ESC). European heart journal 2021;**42**(1):17-96.

108. Shader RI, Greenblatt DJ. Use of benzodiazepines in anxiety disorders. N Engl J Med 1993;**328**(19):1398-405.

109. Kassim T, Haddad TM, Rakhra A, Kabach A, Qurie A, Selim M, Nayfeh AS, Aly A, Holmberg MJ. A case of amitriptyline-induced myocarditis. Cureus 2018;**10**(6).

110. Sicouri S, Antzelevitch C. Sudden cardiac death secondary to antidepressant and antipsychotic drugs. Expert Opin Drug Saf 2008;**7**(2):181-94.

111. Yap YG, Behr ER, Camm AJ. Drug-induced Brugada syndrome. Europace 2009;**11**(8):989-94.

112. Milberg P, Hilker E, Ramtin S, Cakir Y, Stypmann J, Engelen MA, Monnig G, Osada N, Breithardt G, Haverkamp W, Eckardt L. Proarrhythmia as a class effect of quinolones: increased dispersion of repolarization and triangulation of action potential predict torsades de pointes. J Cardiovasc Electrophysiol 2007;**18**(6):647-54.

113. Tscholl P, Feddermann N, Junge A, Dvorak J. The use and abuse of painkillers in international soccer: data from 6 FIFA tournaments for female and youth players. Am J Sports Med 2009;**37**(2):260-5.

114. Howard PA, Delafontaine P. Nonsteroidal anti-inflammatory drugs and cardiovascular risk. Journal of the American College of Cardiology 2004;**43**(4):519-525.

115. Cornu C, Grange C, Regalin A, Munier J, Ounissi S, Reynaud N, Kassai-Koupai B, Sallet P, Nony P. Effect of non-steroidal anti-inflammatory drugs on sport performance indices in healthy people: A meta-analysis of randomized controlled trials. Sports medicine-open 2020;**6**:1-11.

116. Maughan RJ, Burke LM, Dvorak J, Larson-Meyer DE, Peeling P, Phillips SM, Rawson ES, Walsh NP, Garthe I, Geyer H, Meeusen R, van Loon LJC, Shirreffs SM, Spriet LL, Stuart M, Vernec A, Currell K, Ali VM, Budgett RG, Ljungqvist A, Mountjoy M, Pitsiladis YP, Soligard T, Erdener U, Engebretsen L. IOC consensus statement: dietary supplements and the high-performance athlete. Br J Sports Med 2018;**52**(7):439-455.

117. Garthe I, Maughan RJ. Athletes and Supplements: Prevalence and Perspectives. Int J Sport Nutr Exerc Metab 2018;**28**(2):126-138.

118. Schubert MM, Astorino TA. A systematic review of the efficacy of ergogenic aids for improving running performance. J Strength Cond Res 2013;**27**(6):1699-707.

119. Dhar R, Stout CW, Link MS, Homoud MK, Weinstock J, Estes NA, 3rd. Cardiovascular toxicities of performance-enhancing substances in sports. Mayo Clin Proc 2005;**80**(10):1307-15.

120. Sarshin A, Naderi A, da Cruz CJG, Feizolahi F, Forbes SC, Candow DG, Mohammadgholian E, Amiri M, Jafari N, Rahimi A. The effects of varying doses of caffeine on cardiac parasympathetic reactivation following an acute bout of anaerobic exercise in recreational athletes. Journal of the International Society of Sports Nutrition 2020;**17**(1):1-10.

121. Gurley BJ, Steelman SC, Thomas SL. Multi-ingredient, caffeine-containing dietary supplements: history, safety, and efficacy. Clin Ther 2015;**37**(2):275-301.

122. Anderson O. Creatine propels British athletes to Olympic gold medals: Is creatine the one true ergogenic aid. Running Research News 1993;**9**(1):1-5.

123. Tokish JM, Kocher MS, Hawkins RJ. Ergogenic aids: a review of basic science, performance, side effects, and status in sports. Am J Sports Med 2004;**32**(6):1543-53.

124. Angell PJ, Chester N, Sculthorpe N, Whyte G, George K, Somauroo J. Performance enhancing drug abuse and cardiovascular risk in athletes: implications for the clinician. Br J Sports Med 2012;**46 Suppl 1**:i78-84.

125. Calfee R, Fadale P. Popular ergogenic drugs and supplements in young athletes. Pediatrics 2006;**117**(3):e577-89.

126. Francaux M, Poortmans JR. Side effects of creatine supplementation in athletes. International journal of sports physiology and performance 2006;**1**(4):311-323.

127. Cermak NM, van Loon LJ. The use of carbohydrates during exercise as an ergogenic aid. Sports Med 2013;**43**(11):1139-55.

128. Trexler ET, Smith-Ryan AE, Stout JR, Hoffman JR, Wilborn CD, Sale C, Kreider RB, Jäger R, Earnest CP, Bannock L, Campbell B, Kalman D, Ziegenfuss TN, Antonio J. International society of sports nutrition position stand: Beta-Alanine. J Int Soc Sports Nutr 2015;**12**:30.

129. Quesnele JJ, Laframboise MA, Wong JJ, Kim P, Wells GD. The effects of beta-alanine supplementation on performance: a systematic review of the literature. Int J Sport Nutr Exerc Metab 2014;**24**(1):14-27.

130. Bellinger PM, Minahan CL. The effect of beta-alanine supplementation on cycling time trials of different length. Eur J Sport Sci 2015:1-8.

131. Bellinger PM, Minahan CL. Performance effects of acute beta-alanine induced paresthesia in competitive cyclists. Eur J Sport Sci 2016;**16**(1):88-95.

132. Smith‐Ryan AE, Woessner MN, Melvin MN, Wingfield HL, Hackney AC. The effects of beta‐alanine supplementation on physical working capacity at heart rate threshold. Clinical physiology and functional imaging 2014;**34**(5):397-404.

133. Hoffman JR, Varanoske A, Stout JR. Effects of β-Alanine Supplementation on Carnosine Elevation and Physiological Performance. Adv Food Nutr Res 2018;**84**:183-206.

134. Shetewy A, Shimada-Takaura K, Warner D, Jong CJ, Mehdi AB, Alexeyev M, Takahashi K, Schaffer SW. Mitochondrial defects associated with beta-alanine toxicity: relevance to hyper-beta-alaninemia. Mol Cell Biochem 2016;**416**(1-2):11-22.

135. Kelly VG, Leveritt MD, Brennan CT, Slater GJ, Jenkins DG. Prevalence, knowledge and attitudes relating to beta-alanine use among professional footballers. J Sci Med Sport 2016.

136. Hadzic M, Eckstein ML, Schugardt M. The Impact of Sodium Bicarbonate on Performance in Response to Exercise Duration in Athletes: A Systematic Review. J Sports Sci Med 2019;**18**(2):271-281.

137. Breese BC, McNarry MA, Marwood S, Blackwell JR, Bailey SJ, Jones AM. Beetroot juice supplementation speeds O2 uptake kinetics and improves exercise tolerance during severe-intensity exercise initiated from an elevated metabolic rate. Am J Physiol Regul Integr Comp Physiol 2013;**305**(12):R1441-50.

138. Domínguez R, Cuenca E, Maté-Muñoz JL, García-Fernández P, Serra-Paya N, Estevan MC, Herreros PV, Garnacho-Castaño MV. Effects of Beetroot Juice Supplementation on Cardiorespiratory Endurance in Athletes. A Systematic Review. Nutrients 2017;**9**(1).

139. Woessner MN, McIlvenna LC, Ortiz de Zevallos J, Neil CJ, Allen JD. Dietary nitrate supplementation in cardiovascular health: an ergogenic aid or exercise therapeutic? Am J Physiol Heart Circ Physiol 2018;**314**(2):H195-h212.

140. Stanaway L, Rutherfurd-Markwick K, Page R, Wong M, Jirangrat W, Teh KH, Ali A. Acute Supplementation with Nitrate-Rich Beetroot Juice Causes a Greater Increase in Plasma Nitrite and Reduction in Blood Pressure of Older Compared to Younger Adults. Nutrients 2019;**11**(7).

141. Cermak NM, Res PT, de Groot LC, Saris WH, van Loon LJ. Protein supplementation augments the adaptive response of skeletal muscle to resistance-type exercise training: a meta-analysis. Am J Clin Nutr 2012;**96**(6):1454-64.

142. Schoenfeld BJ, Aragon AA. Is There a Postworkout Anabolic Window of Opportunity for Nutrient Consumption? Clearing up Controversies. J Orthop Sports Phys Ther 2018;**48**(12):911-914.

143. Rehm J. The risks associated with alcohol use and alcoholism. Alcohol Res Health 2011;**34**(2):135-43.

144. Johnston R, Crowe M, Doma K. Effect of nicotine on repeated bouts of anaerobic exercise in nicotine naïve individuals. Eur J Appl Physiol 2018;**118**(4):681-689.

145. Pesta DH, Angadi SS, Burtscher M, Roberts CK. The effects of caffeine, nicotine, ethanol, and tetrahydrocannabinol on exercise performance. Nutr Metab (Lond) 2013;**10**(1):71.

146. Mündel T. Nicotine: sporting friend or foe? A review of athlete use, performance consequences and other considerations. Sports Medicine 2017;**47**(12):2497-2506.

147. Breda JJ, Whiting SH, Encarnação R, Norberg S, Jones R, Reinap M, Jewell J. Energy drink consumption in europe: a review of the risks, adverse health effects, and policy options to respond. Front Public Health 2014;**2**:134.

148. Gutiérrez-Hellín J, Varillas-Delgado D. Energy Drinks and Sports Performance, Cardiovascular Risk, and Genetic Associations; Future Prospects. Nutrients 2021;**13**(3):715.

149. Chaban R, Kornberger A, Branski N, Buschmann K, Stumpf N, Beiras-Fernandez A, Vahl CF. In-vitro examination of the positive inotropic effect of caffeine and taurine, the two most frequent active ingredients of energy drinks. BMC Cardiovasc Disord 2017;**17**(1):220.

150. Ruiz LD, Scherr RE. Risk of Energy Drink Consumption to Adolescent Health. Am J Lifestyle Med 2019;**13**(1):22-25.

151. Marczinski CA, Stamates AL, Ossege J, Maloney SF, Bardgett ME, Brown CJ. Subjective State, Blood Pressure, and Behavioral Control Changes Produced by an "Energy Shot". J Caffeine Res 2014;**4**(2):57-63.

152. Campbell B, Wilborn C, La Bounty P, Taylor L, Nelson MT, Greenwood M, Ziegenfuss TN, Lopez HL, Hoffman JR, Stout JR, Schmitz S, Collins R, Kalman DS, Antonio J, Kreider RB. International Society of Sports Nutrition position stand: energy drinks. J Int Soc Sports Nutr 2013;**10**(1):1.

153. Gray B, Ingles J, Medi C, Driscoll T, Semsarian C. Cardiovascular Effects of Energy Drinks in Familial Long QT Syndrome: A Randomized Cross-Over Study. Int J Cardiol 2017;**231**:150-154.

154. Mangi MA, Rehman H, Rafique M, Illovsky M. Energy Drinks and the Risk of Cardiovascular Disease: A Review of Current Literature. Cureus 2017;**9**(6):e1322.

155. Chrysant SG, Chrysant GS. Cardiovascular complications from consumption of high energy drinks: recent evidence. J Hum Hypertens 2015;**29**(2):71-6.

156. Gunja N, Brown JA. Energy drinks: health risks and toxicity. Med J Aust 2012;**196**(1):46-9.

157. Serdar M, Mordelt A, Müser K, Kempe K, Felderhoff-Müser U, Herz J, Bendix I. Detrimental Impact of Energy Drink Compounds on Developing Oligodendrocytes and Neurons. Cells 2019;**8**(11).

158. La Gerche A, Brosnan MJ. Drugs in Sport - A Change is Needed, but What? Heart Lung Circ 2018;**27**(9):1099-1104.

159. Uchida L, Tanaka T, Saito H, Sugahara M, Wakashima T, Fukui K, Nangaku M. Effects of a prolyl hydroxylase inhibitor on kidney and cardiovascular complications in a rat model of chronic kidney disease. American Journal of Physiology-Renal Physiology 2020;**318**(2):F388-F401.

160. Di Luigi L, Sansone M, Sansone A, Ceci R, Duranti G, Borrione P, Crescioli C, Sgrò P, Sabatini S. Phosphodiesterase Type 5 Inhibitors, Sport and Doping. Curr Sports Med Rep 2017;**16**(6):443-447.

161. Roth SM, Rankinen T, Hagberg JM, Loos RJ, Pérusse L, Sarzynski MA, Wolfarth B, Bouchard C. Advances in exercise, fitness, and performance genomics in 2011. Med Sci Sports Exerc 2012;**44**(5):809-17.

162. Harridge SD, Velloso CP. IGF-I and GH: potential use in gene doping. Growth Hormone & IGF Research 2009;**19**(4):378-382.

163. van der Gronde T, de Hon O, Haisma HJ, Pieters T. Gene doping: an overview and current implications for athletes. British Journal of Sports Medicine 2013;**47**(11):670-678.

164. Fischetto G, Bermon S. From gene engineering to gene modulation and manipulation: can we prevent or detect gene doping in sports? Sports Medicine 2013;**43**(10):965-977.

165. Unal M, Unal DO. Gene doping in sports. Sports Medicine 2004;**34**(6):357-362.

166. Vermersch E, Jouve C, Hulot J-S. CRISPR/Cas9 gene-editing strategies in cardiovascular cells. Cardiovascular research 2020;**116**(5):894-907.

167. Brzeziańska E, Domańska D, Jegier A. Gene doping in sport - perspectives and risks. Biol Sport 2014;**31**(4):251-9.

168. Martínez-Sanz JM, Sospedra I, Ortiz CM, Baladía E, Gil-Izquierdo A, Ortiz-Moncada R. Intended or Unintended Doping? A Review of the Presence of Doping Substances in Dietary Supplements Used in Sports. Nutrients 2017;**9**(10).

169. Denham BE. Athlete Information Sources About Dietary Supplements: A Review of Extant Research. Int J Sport Nutr Exerc Metab 2017;**27**(4):325-334.

170. Negro M, Marzullo N, Caso F, Calanni L, D'Antona G. Opinion paper: scientific, philosophical and legal consideration of doping in sports. Eur J Appl Physiol 2018;**118**(4):729-736.

**Tables**

Table 1. Prevalence of adverse analytical findings by substance category in WADA Anti-Doping Administration & Management System (ADAMS) – (WADA, 2019 Anti-Doping Testing Figures)

|  |  |
| --- | --- |
| *Substances & Methods* | *% of all ADAMS reported findings* |
| Anabolic Agents | 43.66 |
| Beta-2 Agonists | 3.66 |
| Beta-Blockers | 0.48 |
| Cannabinoids | 3.11 |
| Chemical and Physical Manipulation | 0.05 |
| Diuretics and Other Masking Agents | 16.20 |
| Enhancement of Oxygen Transfer | 0.05 |
| Glucocorticosteroids | 5.50 |
| Hormone and Metabolic Modulators | 8.66 |
| Narcotics | 0.72 |
| Peptide Hormones, Growth Factors and Related Substances | 3.30 |
| Stimulants | 14.62 |

Table 2. Adverse cardiovascular effect of common legal nutritional supplements in sports [65-70, 74, 75, 77].

|  |  |
| --- | --- |
| *Supplement* | *Cardiovascular side effects* |
| Anti-cortisol supplements (glutamine, phosphatidylserine) | unknown |
| Antioxidants | unknown |
| β-alanine | unknown |
| B-Hydroxy β-methylbutyric acid (HMB) | unknown |
| Caffeine | arrhythmias, vasoconstriction, hypertension, electrolytic disorders |
| Carbohydrates (sport drinks, energy bars) | unknown |
| Coenzyme-Q10 (ubiquinone) | unknown |
| Colostrum | unknown |
| Creatine | unknown |
| Dark chocolate | unknown |
| Joint-supporting supplements (glucosamine, chondroitin, methylsulfonylmethane) | unknown |
| L-Carnitine | unknown |
| Lipotropic factors – fat burners | When contaminated with ephedra/ephedra-like compounds: arrhythmias, vasoconstriction, hypertension |
| Multivitamins | unknown |
| Nicotine products | arrhythmias, vasoconstriction, hypertension, coagulability, thrombogenesis |
| Nitrates (beetroot juice) | unknown |
| Oxygenated water | unknown |
| Plant supplements  Guarana  Ginseng | arrhythmias, hypertension  arrhythmias, hypertension |
| Proteins - aminoacids | unknown |
| Sodium Bicarbonate | unknown |

**Figure Legend**

Figure 1. **Cardiovascular effect of doping substances and drugs**. The figure summarizes the main cardiovascular consequences of the different substance’s categories. BP, blood pressure; CAD, coronary artery disease; CMP, cardiomyopathy; LVH, left ventricular hypertrophy; SARM, selective androgen receptor modulators.

Figure 2. **Performance enhancing effects for doping substances and drugs**. The figure summarizes the main performance enhancing effects of the most relevant different substance’s categories. SARM, selective androgen receptor modulators.