

Effects of different types of exercise interventions on metabolic and cardiorespiratory fitness in children and adolescents with type 1 diabetes mellitus: a systematic review and network meta-analysis

Chen Liu¹, Xiaoping Liang^{2*}

¹Department of Pediatrics, Ulanqab Central Hospital, Inner Mongolia Autonomous Region, China

²Department of Pediatrics, Inner Mongolia Autonomous Region Maternity and Child Health Care Hospital, Inner Mongolia Autonomous Region, China

Submitted: 20 March 2025; **Accepted:** 5 August 2025

Online publication: 20 September 2025

Arch Med Sci 2025; 21 (5): 1936–1955
DOI: <https://doi.org/10.5114/aoms/209000>
Copyright © 2025 Termedia & Banach

***Corresponding author:**

Xiaoping Liang
Inner Mongolia
Autonomous Region
Maternity and Child
Health Care Hospital
Inner Mongolia
Autonomous Region, China
E-mail: lxiaoping1225@163.com

Abstract

Introduction: The aim of this study is to assess the effects of various exercise interventions of differing types and intensities (high-intensity aerobic training, moderate-intensity aerobic training, low-intensity aerobic training, high-intensity aerobic training combined with anaerobic training, high-intensity aerobic training combined with resistance training, moderate-intensity aerobic training combined with resistance training, mind-body exercises, and resistance training) on metabolic and cardiorespiratory function in children and adolescents with type 1 diabetes mellitus (T1DM).

Material and methods: Through systematic searches of databases such as PubMed, Embase, Cochrane, and Web of Science, randomized controlled trials (RCTs) were gathered to examine the effects of eight different types and intensities of exercise interventions on the metabolic and cardiorespiratory functions of children and adolescents with T1DM.

Results: A total of 19 RCTs involving 738 children and adolescents with T1DM were included. The network meta-analysis (NMA) results showed that high-intensity aerobic training combined with anaerobic training and high-intensity aerobic training significantly reduced the patients' lipid profile, including total cholesterol (TC) (MD = -1.92, 95% CI = (-2.36, -1.48)), low-density lipoprotein cholesterol (LDL-C) (MD = -1.18, 95% CI = (-1.94, -0.42)), and increased high-density lipoprotein cholesterol (HDL-C) (MD = 1.63, 95% CI = (1.21, 2.05)).

Conclusions: Based on NMA and surface under the cumulative ranking curve (SUCRA) rankings, it was concluded that high-intensity aerobic training combined with anaerobic training and high-intensity aerobic training can improve the metabolic and cardiorespiratory functions of children and adolescents with T1DM, although they did not show significant effects on hemoglobin A1c (HbA1c), blood glucose (BG), peak oxygen consumption (VO₂ peak), or triglycerides (TG).

Key words: type 1 diabetes mellitus, children, adolescents, network meta-analysis, hemoglobin A1c.

Introduction

Type 1 diabetes mellitus (T1DM), as the most prevalent chronic endocrine disorder among children and adolescents, demonstrates an esca-

lating incidence rate annually. Its pathogenesis is characterized by T lymphocyte-mediated destruction of pancreatic β cells, resulting in absolute loss of islet function [1], which presents significant challenges for radical cure. Affected individuals require lifelong dependence on exogenous insulin therapy. Although insulin replacement therapy can improve patient survival rates, long-term complications still occur and severely impact quality of life. Consequently, many patients adopt non-pharmacological interventions including physical exercise, dietary control, and appropriate self-management to complement their treatment.

Exercise, as a non-pharmacological intervention, plays a significant role in improving metabolic and cardiopulmonary function in T1DM patients. Physical activity not only enhances skeletal muscle glucose uptake but also modulates insulin sensitivity and promotes glycogen synthesis, thereby improving metabolic control. Additionally, it benefits cardiopulmonary function by reducing hypertension and dyslipidemia. However, children and adolescents with T1DM still face challenges during exercise, primarily due to an increased risk of exercise-induced hypoglycemia, which may be attributed to abnormal hormonal responses or impaired glucose counterregulatory mechanisms. This contributes to exercise-related fear in some pediatric T1DM patients. Furthermore, given the unique physiological characteristics of children and adolescents, their metabolic and cardiopulmonary responses differ from those of adults, necessitating targeted research in this population.

Previous meta-analyses have only compared the effects of specific types of physical activity on hemoglobin A1c (HbA1c) in children and adolescents with T1DM [2–4]. On one hand, these studies lacked analyses of lipid profiles and cardiorespiratory function; on the other hand, they did not thoroughly investigate the differences among various exercise intensity combinations. This study fills this gap by systematically comparing the effects of different types and intensities of exercise on children and adolescents with T1DM. Not only does it focus on HbA1c control, but it also includes lipid profiles and cardiorespiratory function, providing a more comprehensive metabolic evaluation. Additionally, this study offers meaningful insights for clinicians to consider which types of physical activity may effectively reduce blood glucose (BG) and lipid profiles in T1DM patients. Network meta-analysis (NMA), also known as mixed treatment comparison or multiple treatment comparison meta-analysis, differs from traditional meta-analysis, which compares only two interventions. NMA constructs an evidence network to allow for both direct and indirect comparisons of multiple interventions, ranks the interventions to increase

statistical power, and explores sources of heterogeneity [5]. Therefore, in this study, we employed NMA to compare different types and intensities of exercise interventions, aiming to assess their therapeutic effects on T1DM patients and provide a better understanding for patients and clinicians.

Material and methods

This study strictly follows the PRISMA-NMA guidelines for reporting network meta-analysis and has been registered in PROSPERO (Registration No.: CRD42025646664).

Search strategy

The researchers conducted a comprehensive literature search from the inception of the study up to December 2024 across four electronic databases: PubMed, Embase, Cochrane, and Web of Science. Additionally, 2 articles were identified through manual search. The search strategy was structured around the PICOS framework: (P) Population: children and adolescents with T1DM; (I) Intervention: physical activity; (C) Comparison: control group engaging in routine daily activities; (O) Outcomes: HbA1c, BG, total cholesterol (TC), triglycerides (TG), peak oxygen consumption (VO_2 peak), high-density lipoprotein cholesterol (HDL-C), low-density lipoprotein cholesterol (LDL-C); (S) Study design: randomized controlled trials (RCTs). A detailed search strategy, using PubMed as an example, is provided in Supplementary Table S1.

Inclusion criteria

- (1) Diagnostic criteria: The diagnostic standards for T1DM are based on the 2018 position statement by the American Diabetes Association [6].
- (2) Age range: Children and adolescents aged 5–19 years diagnosed with T1DM were included.
- (3) Inclusion criteria: Only RCTs that have been publicly published were included.
- (4) Exercise intervention: Studies should provide detailed descriptions of the type, duration, and frequency of exercise.
- (5) Outcome measures: At least one of the following should be included: HbA1c, BG, TC, TG, VO_2 peak, HDL-C, LDL-C.

Exclusion criteria

- (1) Participants with other severe chronic diseases were excluded.
- (2) Studies involving the use of novel antidiabetic drugs or other interventions that may affect outcome measures during exercise were excluded.

- (3) Studies that included adults were excluded.
- (4) Non-randomized controlled trials (non-RCTs) were excluded.
- (5) Studies with duplicate data or those that did not undergo ethical review were excluded.
- (6) Studies with incomplete data (e.g., lacking means, standard deviations, or sample sizes for outcome measures) were excluded.

Study selection

The Endnote reference management software was used to screen and exclude studies. Two researchers initially screened the titles of the studies, excluding duplicates, non-RCTs, review articles, conference papers, protocols, and communications. Subsequently, the researchers read the abstracts to determine the eligibility of the studies for inclusion and excluded those that did not meet the criteria. Finally, the researchers read the full texts of the remaining studies and further determined which studies should be included. Throughout this process, the researchers independently screened the studies and compared the remaining ones. Studies were included if there was agreement, and discrepancies were resolved through discussion with a third researcher.

Data extraction

A seven-item standard and a pre-selected data extraction table were used to record the data included in the studies, categorized under the following headings: (1) Authors, (2) Publication year, (3) Country, (4) Study duration, (5) Sample size, (6) Mean age, and (7) Details of the exercise intervention.

Risk of bias of individual studies

Two researchers used the Cochrane tool (Review Manager 5.4) to assess the risk of bias, with any disputed issues being discussed and resolved with a third researcher. The risk of bias assessment included seven components: random sequence generation, allocation concealment, blinding of participants and trial personnel, blinding of outcome assessors, incomplete outcome data, selective reporting, and other biases. The assessment was based on the number of components that potentially indicated high risk. Each component was assessed using the following categories: high risk (≥ 5), unclear (3–4), and low risk (≤ 2) [7]. For detailed information, refer to Supplementary Figures S1 and S2.

Data analysis

The network evidence plot demonstrates that various interventions can be compared both di-

rectly and indirectly. The size of the nodes indicates the number of trials included for each intervention, and the thickness of the connecting lines is proportional to the number of trials [8]. Exercise interventions are continuous variables; therefore, the standardized mean difference (SMD) is used to evaluate the effect of the interventions [9]. The SUCRA method allows for the ranking of the interventions, thereby identifying the most effective intervention [10]. Additionally, a funnel plot was used to detect any significant publication bias. All analyses were conducted using Stata 15.1.

Results

Research and selection of literature

A total of 4,201 articles were searched from four electronic databases. After removing duplicates, 2,922 articles remained. A total of 2,476 articles were excluded in the next round of screening. Of the excluded articles, 427 were excluded due to full-text issues: 108 for not including the outcome measures of this review, 292 for not meeting the intervention criteria, and 27 for incomplete data. Ultimately, 19 articles were included in the final analysis (Figure 1).

Quality assessment of the included literature

The quality assessment of the included studies revealed that 11 were classified as low risk, 7 as moderate risk, and 1 as high risk. For detailed information, refer to Supplementary Figures S1 and S2.

Characteristics of the included studies

A total of 19 studies were included, comprising 738 children and adolescents diagnosed with T1DM. The interventions in the experimental group included high-intensity aerobic training, moderate-intensity aerobic training, low-intensity aerobic training, high-intensity aerobic training combined with resistance training, moderate-intensity aerobic training combined with resistance training, resistance training, high-intensity aerobic training combined with anaerobic training, and mind-body exercise. Of the studies, 12 used HbA1c as an outcome measure, 8 used BG, 8 used TC, 8 used TG, 8 used HDL-C, 7 used LDL-C, and 5 used VO_2 peak. Seven studies were from Europe, six from the Americas, four from Asia, one from Africa, and one from Oceania. For detailed information, refer to Table I [11–29].

NMA

The network evidence plots for each outcome measure are shown in Figures 2 A, 3 A, 4 A, 5 A, 6 A, 7 A, and 8 A.

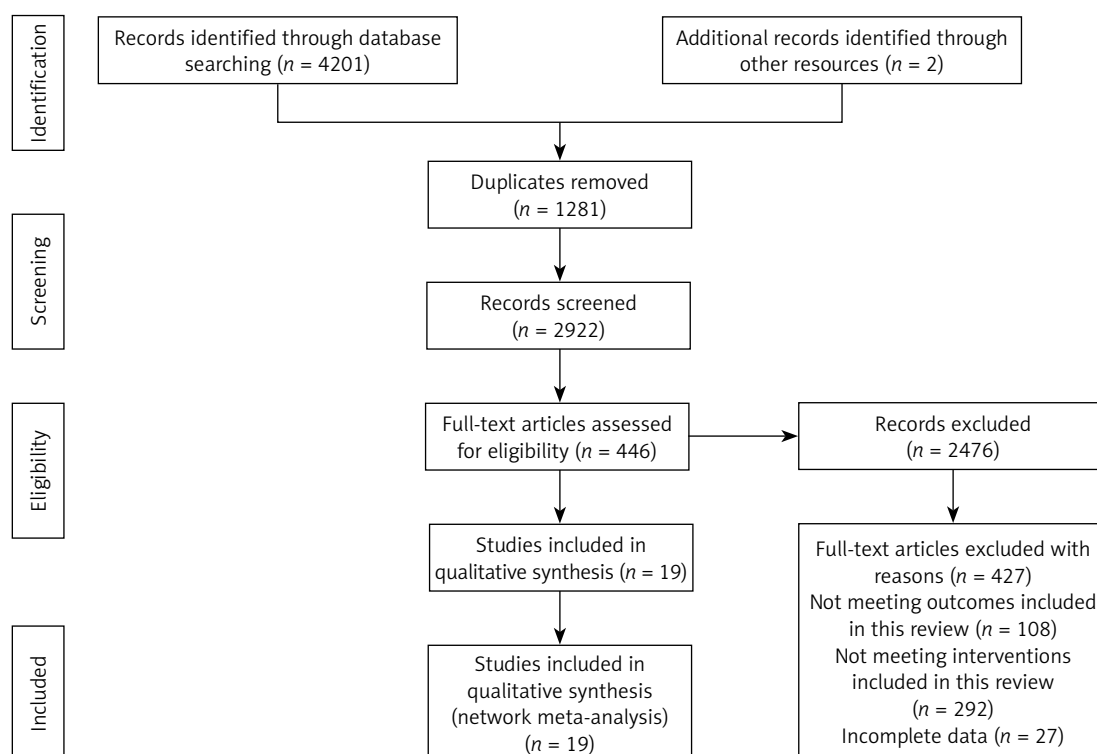


Figure 1. Flowchart of the literature selection process

HbA1c

All indirect and direct comparisons between studies were tested for consistency and inconsistency, with p -values greater than 0.05 indicating that the consistency effect across studies is acceptable. Detailed information is provided in Supplementary Table SII. The NMA results revealed that, compared to the control group's daily activity, high-intensity aerobic training (MD = -1.22, 95% CI = (-2.74, 0.31)), moderate-intensity aerobic training (MD = -0.95, 95% CI = (-2.03, 0.14)), high-intensity aerobic training combined with anaerobic training (MD = -0.93, 95% CI = (-2.99, 1.12)), high-intensity aerobic training combined with resistance training (MD = -0.94, 95% CI = (-3.22, 1.33)), resistance training (MD = -0.87, 95% CI = (-2.57, 0.82)), mind-body exercise (MD = 0.06, 95% CI = (-2.08, 2.20)), and low-intensity aerobic training (MD = 0.40, 95% CI = (-1.13, 1.94)) showed no significant differences in reducing HbA1c (details are presented in Table II A). SUCRA probability rankings for different intensities of exercise interventions showed that high-intensity aerobic training (SUCRA: 72.8%, as shown in Figure 2 B) ranked first in reducing HbA1c.

BG

All indirect and direct comparisons between studies were tested for consistency and inconsistency, with p -values greater than 0.05 indicating

that the consistency effect across studies is acceptable. Detailed information is provided in Supplementary Table SIII. The NMA results revealed that, compared to the control group's daily activity, resistance training (MD = -1.19, 95% CI = (-3.06, 0.67)), high-intensity aerobic training (MD = -0.60, 95% CI = (-1.63, 0.42)), moderate-intensity aerobic training (MD = -0.37, 95% CI = (-1.20, 0.46)), moderate-intensity aerobic training combined with resistance training (MD = 0.16, 95% CI = (-1.39, 1.71)), and low-intensity aerobic training (MD = 0.07, 95% CI = (-0.86, 0.99)) showed no significant differences in reducing BG (details are presented in Table II B). SUCRA probability rankings for different intensities of exercise interventions showed that resistance training (SUCRA: 83.7%, as shown in Figure 3 B) ranked first in reducing BG.

VO₂ peak

All indirect and direct comparisons between studies were tested for consistency and inconsistency, with p -values greater than 0.05 indicating that the consistency effect across studies is acceptable. Detailed information is provided in Supplementary Table SIV. The NMA results revealed that, compared to the control group's daily activity, high-intensity aerobic training (MD = 0.55, 95% CI = (-0.21, 1.32)), moderate-intensity aerobic training (MD = 0.48, 95% CI = (-0.44, 1.40)), high-intensity aerobic training combined with resistance training

Table 1. Specific content of the included studies

Author	Country	Year	Population	Age (mean ± SD)	Total	Intervention	Control	Outcome
Pemberton [11]	Britain	2023	T1DM	12.3 (±3.7)	125	High-intensity aerobic training Length of intervention: 12 weeks Freq: - Duration: 5–40 min	CON	HbA1c
Mohammed [12]	Saudi Arabia	2019	T1DM	12–17	20	High-intensity aerobic training Length of intervention: 12 weeks Freq: 3 times a week Duration: 50 min	CON	HbA1c BG TC TG LDL-C HDL-C
Wong [13]	Taiwan	2010	T1DM	12.34 (±2.07)	28	Moderate-intensity aerobic training Length of intervention: 12 weeks Freq: 3 times a week Duration: 30 min	CON	HbA1c
D'hooge [14]	Belgium	2010	T1DM	10–18	16	High-intensity aerobic training combined with resistance training Length of intervention: 20 weeks Freq: twice a week Duration: 70 min	CON	HbA1c BG VO ₂ peak
Ramalho [15]	Brazil	2005	T1DM	19.8 (±5.1)	13	Moderate-intensity aerobic training Length of intervention: 12 weeks Freq: 3 times a week Duration: 40 min	Resistance training	HbA1c BG TC TG LDL-C HDL-C
Huttunen [16]	Finland	1989	T1DM	8.2–16.9	32	Low-intensity aerobic training Length of intervention: 13 weeks Freq: once a week Duration: 60 min	CON	HbA1c BG VO ₂ peak
Stratton [17]	USA	1988	T1DM	15.1 (±1.2)	130	High-intensity aerobic training Length of intervention: 8 weeks Freq: twice a week Duration: 30 min	CON	BG
Stratton [18]	USA	1987	T1DM	T: 15.1 (±1.2) C: 15.5 (±0.9)	16	Moderate-intensity aerobic training Length of intervention: 8 weeks Freq: 3 times a week Duration: 30–45 min	CON	BG TC TG HDL-C

Table 1. Cont.

Author	Country	Year	Population	Age (mean ± SD)	Total	Intervention	Control	Outcome
Landt [19]	USA	1985	T1DM	T: 16.1 (±0.8) C: 15.9 (±0.3)	15	High-intensity aerobic training Length of intervention: 12 weeks Freq: 3 times a week Duration: 45 min	CON	VO ₂ peak
Campaigne [20]	USA	1985	T1DM	T: 16 (±3) C: 15 (±0.9)	14	High-intensity aerobic training Length of intervention: 12 weeks Freq: 3 times a week Duration: 45 min	CON	VO ₂ peak TC TG LDL-C HDL-C
Adolfsson [21]	Sweden	2011	T1DM	14–19	59	Moderate-intensity aerobic training Low-intensity aerobic training Length of intervention: 3 d Freq: twice a day Duration: 3 h, 2.8 h	CON	BG
Campaigne [22]	USA	1984	T1DM	T: 9 (±0.47) C: 8.5 (±0.57)	19	Moderate-intensity aerobic training Length of intervention: 12 weeks Freq: 3 times a week Duration: 30 min	CON	HbA1c BG VO ₂ peak
Dahl-Jorgensen [23]	Norway	1980	T1DM	T: 9–15 C: 9–13	22	Low-intensity aerobic training Length of intervention: 20 weeks Freq: twice a week Duration: 60 min	CON	HbA1c
Heyman [24]	France	2007	T1DM	T: 15.9 (±1.5) C: 16.3 (±1.2)	16	Moderate-intensity aerobic + resistance training Length of intervention: 24 weeks Freq: once a week Duration: 2 h	CON	TC TG LDL-C HDL-C
Salem [25]	Egypt	2010	T1DM	T: 14.5 (±2.4) C: 15 (±2.35)	121	High-intensity aerobic training combined with anaerobic training Length of intervention: 24 weeks Freq: 3 times a week Duration: 30 min	CON	TC TG LDL-C HDL-C
Tunar [26]	Turkey	2012	T1DM	12–17	31	Mind-body exercise Length of intervention: 12 weeks Freq: 3 times a week Duration: 45 min	CON	HbA1c TC TG LDL-C HDL-C

Table I. Cont.

Author	Country	Year	Population	Age (mean ± SD)	Total	Intervention	Control	Outcome
Aouadi [27]	UK	2011	T1DM	12.4 (±1.5)	22	Moderate-intensity aerobic training Length of intervention: 24 weeks Freq: 4 times a week Duration: 60 min	CON	HbA1c TC TG LDL-C HDL-C
Marrero [28]	India	1988	T1DM	12–14	18	Moderate-intensity aerobic training Length of intervention: 12 weeks Freq: 3 times a week Duration: 45 min	CON	HbA1c
Petschnig [29]	Austria	2020	T1DM	T: 11 (±0.8) C: 11.3 (±0.7)	21	Resistance training Length of intervention: 32 weeks Freq: twice a week Duration: 50 min	CON	HbA1c

(MD = 0.39, 95% CI = (−0.60, 1.38)), and low-intensity aerobic training (MD = 0.13, 95% CI = (−0.56, 0.82)) showed no significant differences in increasing VO₂ Peak (details are presented in Table II C). SUCRA probability rankings for different intensities of exercise interventions showed that high-intensity aerobic training (SUCRA: 71.6%, as shown in Figure 4 B) ranked first in increasing VO₂ peak.

TC

All indirect and direct comparisons between studies were tested for consistency and inconsistency, with *p*-values greater than 0.05 indicating that the consistency effect across studies is acceptable. Detailed information is provided in Supplementary Table SV. The NMA results revealed that, compared to the control group’s daily activity, high-intensity aerobic training combined with anaerobic training (MD = −1.92, 95% CI = (−2.36, −1.48)) and high-intensity aerobic training (MD = −0.94, 95% CI = (−1.67, −0.21)) were superior in reducing TC (details are shown in Table II D). SUCRA probability rankings for different intensities of exercise interventions showed that high-intensity aerobic training combined with anaerobic training (SUCRA: 98.9%, as shown in Figure 5 B) ranked first in reducing TC.

TG

All indirect and direct comparisons between studies underwent consistency and inconsistency tests, with *p*-values greater than 0.05 indicating that the consistency effect across studies is acceptable. Detailed information is provided in Supplementary Table SVI. The NMA results revealed that, compared to the control group’s daily activity, moderate-intensity aerobic training (MD = −1.32, 95% CI = (−3.23, 0.59)), resistance training (MD = −1.18, 95% CI = (−4.51, 2.16)), high-intensity aerobic training combined with anaerobic training (MD = −0.55, 95% CI = (−3.08, 1.98)), mind-body exercise (MD = −0.10, 95% CI = (−2.70, 2.50)), moderate-intensity aerobic training combined with resistance training (MD = −0.01, 95% CI = (−2.70, 2.68)), and high-intensity aerobic training (MD = 0.29, 95% CI = (−1.64, 2.23)) showed no significant differences in reducing TG (details are provided in Table II E). SUCRA probability rankings for different intensities of exercise interventions indicated that moderate-intensity aerobic training (SUCRA: 76.3%, as shown in Figure 6 B) ranked first in reducing TG.

LDL-C

All indirect and direct comparisons between studies underwent consistency and inconsistency tests, with *p*-values greater than 0.05 indicating that the consistency effect across studies is acceptable. Detailed information is provided in Sup-

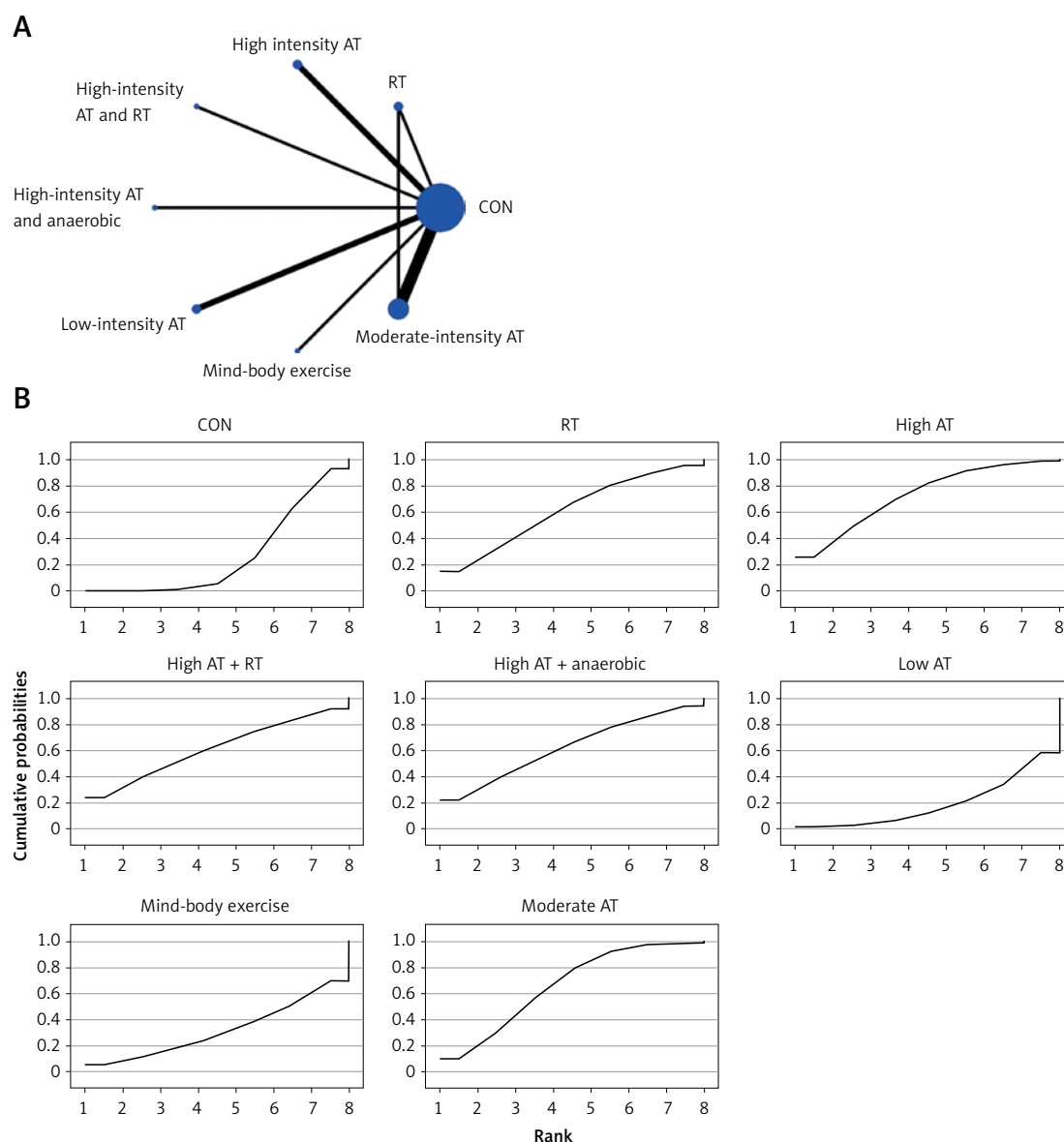


Figure 2. A – NMA figure for HbA1c. B – SUCRA plot for HbA1c

plementary Table SVII. The NMA results revealed that, compared to the control group's daily activity, high-intensity aerobic training (MD = -1.18 , 95% CI = $(-1.94, -0.42)$) was superior in reducing LDL-C (details are provided in Table II F). SUCRA probability rankings for different intensities of exercise interventions indicated that high-intensity aerobic training (SUCRA: 94.2%, as shown in Figure 7 B) ranked first in reducing LDL-C.

HDL-C

All indirect and direct comparisons between studies were subjected to consistency and inconsistency tests, with p -values greater than 0.05 indicating that the consistency effect across studies is acceptable. Detailed information is presented in Supplementary Table SVIII. The NMA

results demonstrated that, compared to the control group's daily activity, high-intensity aerobic training combined with anaerobic training (MD = 1.63 , 95% CI = $(1.21, 2.05)$) was more effective in increasing HDL-C (further details are presented in Table II G). SUCRA probability rankings for various exercise intensities indicated that high-intensity aerobic training combined with anaerobic training (SUCRA: 100%, as shown in Figure 8 B) was the most effective intervention for increasing HDL-C.

Publication bias test

To evaluate the potential for publication bias, funnel plots were generated for each outcome indicator. The plots did not demonstrate any significant publication bias (further details are provided in Figures 9 A–G).

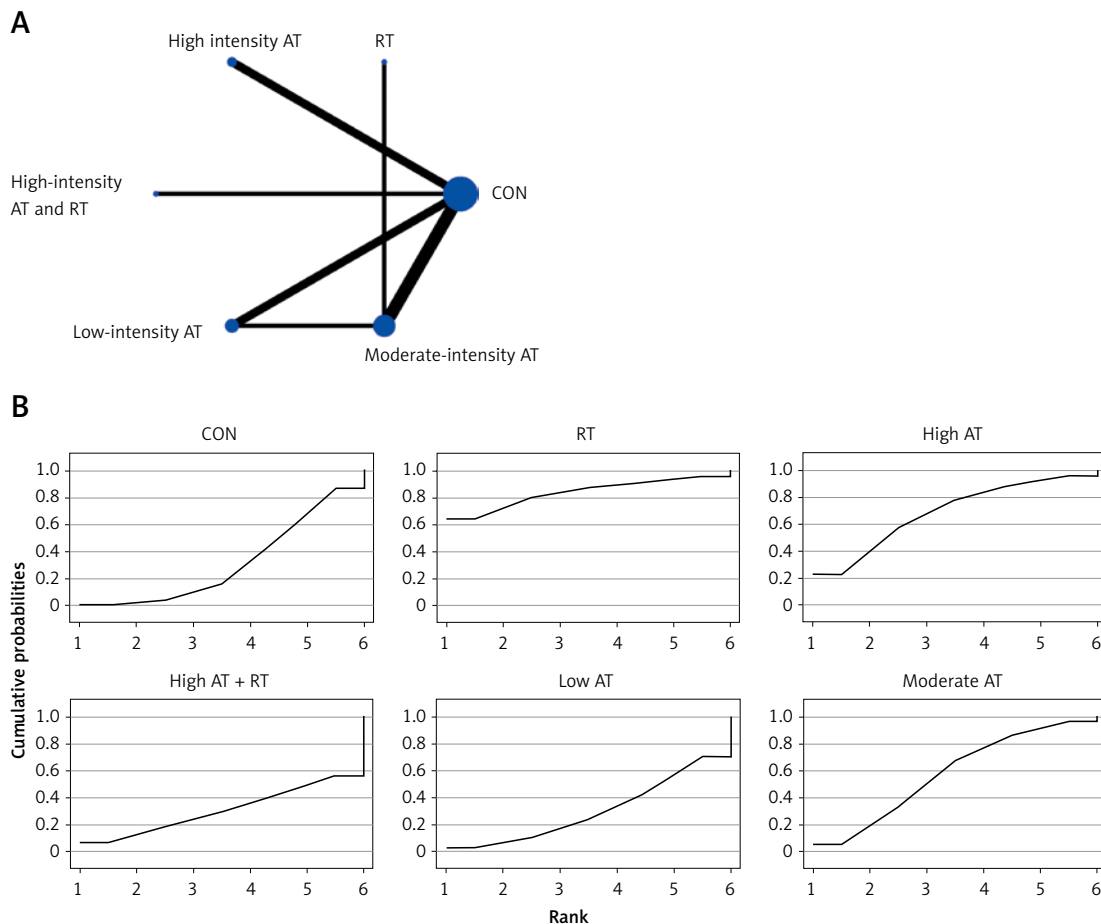


Figure 3. A – NMA figure for BG. B – SUCRA plot for BG

Discussion

In this study, we compared the effectiveness of various types and intensities of exercise interventions on the improvement of metabolic and cardiopulmonary functions in children and adolescents diagnosed with T1DM. We conducted both direct and indirect comparisons of 19 studies, involving 738 children and adolescents diagnosed with T1DM, with 8 distinct types of exercise interventions. Our findings indicate that exercise did not have a significant effect on BG levels and HbA1c control. However, significant improvements were observed in TC, LDL-C, and HDL-C. Specifically, we found that high-intensity aerobic training combined with anaerobic training and high-intensity aerobic training were effective in lowering TC, with high-intensity aerobic training combined with anaerobic training proving to be the most effective intervention for reducing TC. High-intensity aerobic training was identified as the most effective intervention for lowering LDL-C. Additionally, high-intensity aerobic training combined with anaerobic training emerged as the most effective intervention for improving HDL-C. Overall, we conclude that high-intensity aerobic

training combined with anaerobic training and high-intensity aerobic training are the most effective interventions for improving the metabolic function of children with T1DM.

In this study, among the eight exercise interventions, the high-intensity aerobic training group showed reduced HbA1c, although it was not statistically significant. However, a systematic review published in 2024 indicated that multi-component exercise could significantly reduce HbA1c [2]. A 2023 systematic review found that high-intensity concurrent training had the most significant effect in reducing HbA1c [3]. An RCT published in 2006 [15] divided T1DM adolescents into two groups: one group performed aerobic training, and the other performed resistance training. After 12 weeks, neither group showed significant improvements in HbA1c. Additionally, Kennedy *et al.* [4] reported that both aerobic training and aerobic training combined with resistance training did not significantly impact the control of HbA1c or BG. The results of various studies exhibit certain degrees of variability. Several factors may contribute to the observed heterogeneity: First, differences in the inclusion and exclusion criteria among the studies could lead to inconsistent outcomes. Sec-

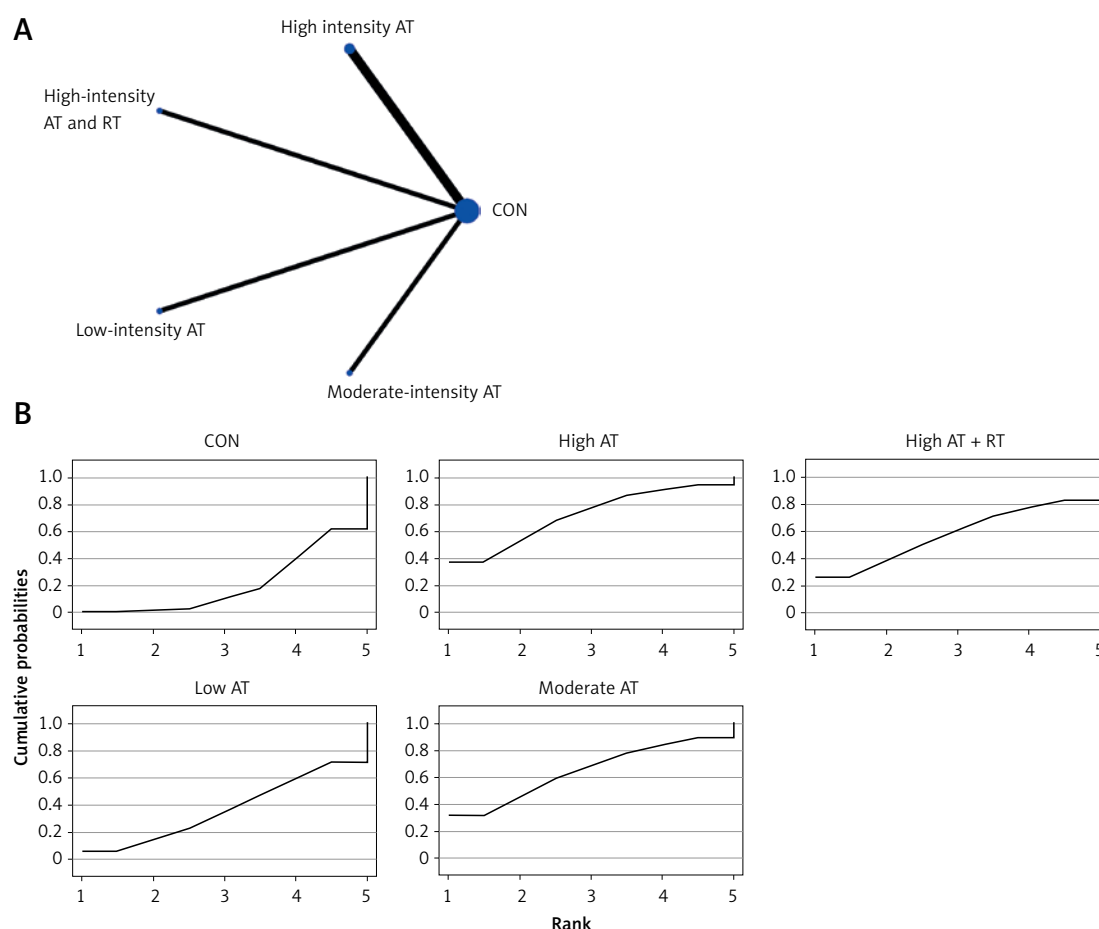


Figure 4. A – NMA figure for VO_2 peak. B – SUCRA plot for VO_2 peak

ond, variations in the type, intensity, and duration of exercise across studies may also contribute to the heterogeneity. Finally, HbA1c has lower sensitivity than BG and reflects BG control over the past 2–3 months, which may not accurately represent the current metabolic status of the body [4]. Furthermore, increases in caloric intake and reductions in insulin dosage prior to exercise could also lead to variations in results. This study suggests that high-intensity aerobic training may reduce HbA1c due to the excessive expression of GLUT4 in skeletal muscle during exercise. As a key glucose transporter protein, GLUT4 is typically associated with enhanced glucose processing and insulin action. Some researchers have observed increased GLUT4 expression in skeletal muscle during high-intensity aerobic training, which may improve insulin sensitivity, glucose processing, and glycogen storage [30]. Additionally, high-intensity aerobic training can activate AMP-activated protein kinase, which reduces hepatic gluconeogenesis and improves HbA1c [31]. However, in children and adolescents with T1DM, some researchers have observed that the secretion of glucagon and epinephrine during exercise is significantly lower than that in healthy children

and adult patients, which leads to insufficient hepatic glycogen output [32]; in addition, compared with adults, children and adolescents had low expression of GLUT4 transporter and insufficient glycogen synthase activity [33]. Therefore, the lack of statistical significance may be related to variations in exercise interventions, follow-up duration, insufficient secretion of counter-regulatory hormones, low efficiency of muscle glycogen metabolism, and baseline metabolic status. This study suggests that resistance training may potentially reduce BG in children and adolescents with T1DM, although the effect was not statistically significant. In other studies [34], resistance training is typically combined with other forms of exercise interventions, making it unclear whether isolated resistance training has the potential to reduce BG; furthermore, researchers often focus on HbA1c as the primary outcome measure, without investigating BG [35]. A previously published RCTs [29] found that isolated resistance training can significantly reduce BG both before and after exercise, which is consistent with the findings of this study. This study examined the effects of different exercise types on BG levels and found, according to SUCRA rankings, that resistance training had the

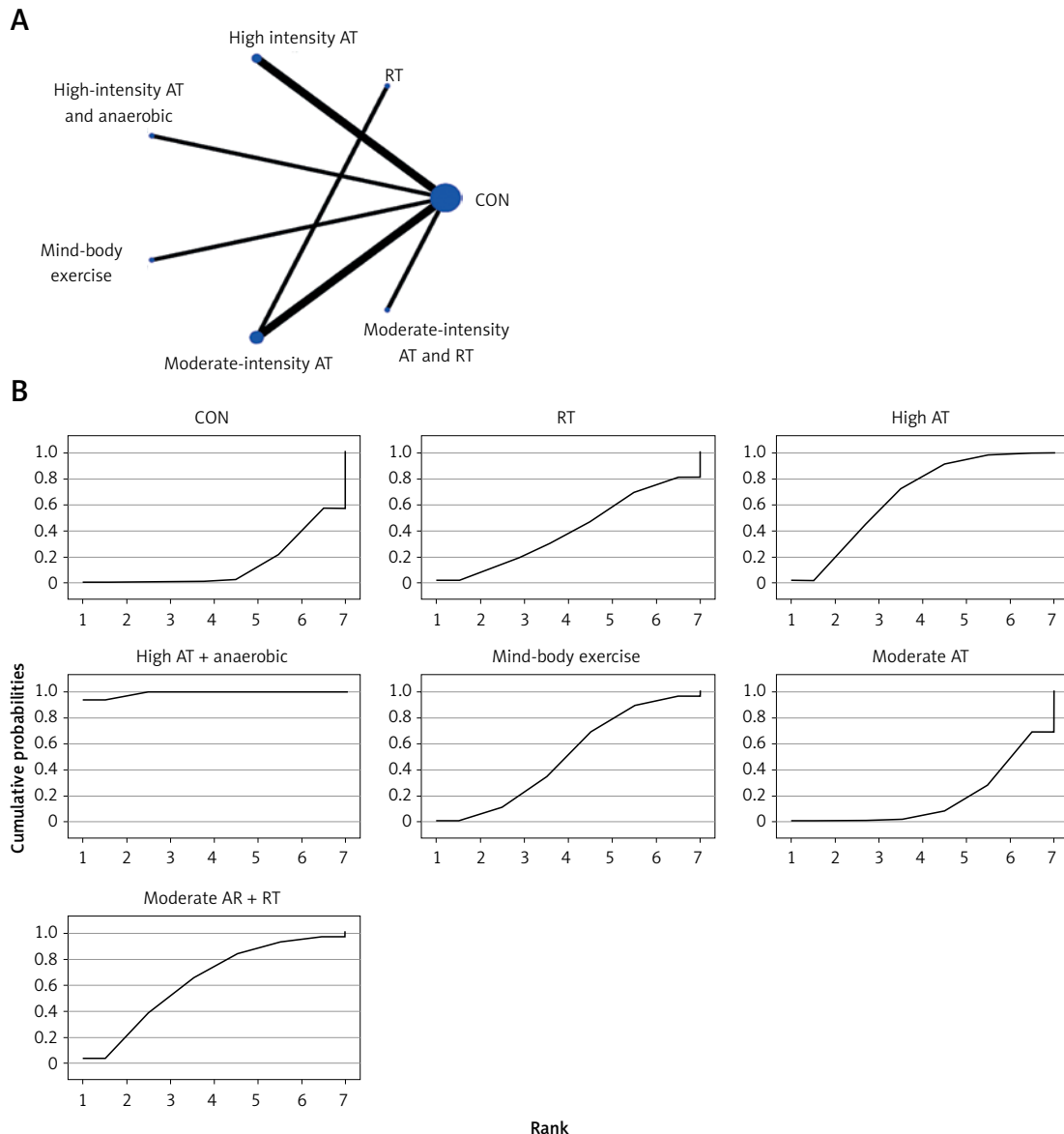


Figure 5. A – NMA figure for TC. B – SUCRA plot for TC

most significant effect, followed by high-intensity aerobic training. This is because resistance training can increase muscle mass and improve glucose tolerance, as muscle tissue is the optimal area for utilizing residual energy substrates and insulin [35]. While BG may not decrease significantly during exercise, it remains lower for an extended period afterward [36]. In contrast, although aerobic training can significantly reduce immediate BG levels, the reduction is less noticeable unless performed consistently over the long term.

This study suggests that high-intensity aerobic training is the most effective exercise modality for increasing VO_2 peak, which is consistent with previous research findings [19, 20]. Additionally, some scholars argue that high-intensity interval training (HIIT) is more effective than moderate-intensity continuous training (MICT) in improving

VO_2 peak [37]. This is because high-intensity aerobic training can increase left ventricular volume and myocardial contractility, thereby enhancing stroke volume [38]. It also promotes coronary angiogenesis, improving myocardial metabolism and oxygen supply. Furthermore, high-intensity aerobic training stimulates erythropoietin secretion, increasing red blood cell count and enhancing oxygen transport capacity. It also facilitates a decrease in blood pH, causing a rightward shift in the oxygen dissociation curve, which releases more oxygen [39]. Moreover, studies have shown that 6 weeks of high-intensity aerobic training can induce mitochondrial proliferation in skeletal muscles, significantly improving VO_2 peak [38].

This study suggests that high-intensity aerobic training combined with anaerobic training is the most effective exercise intervention for lowering

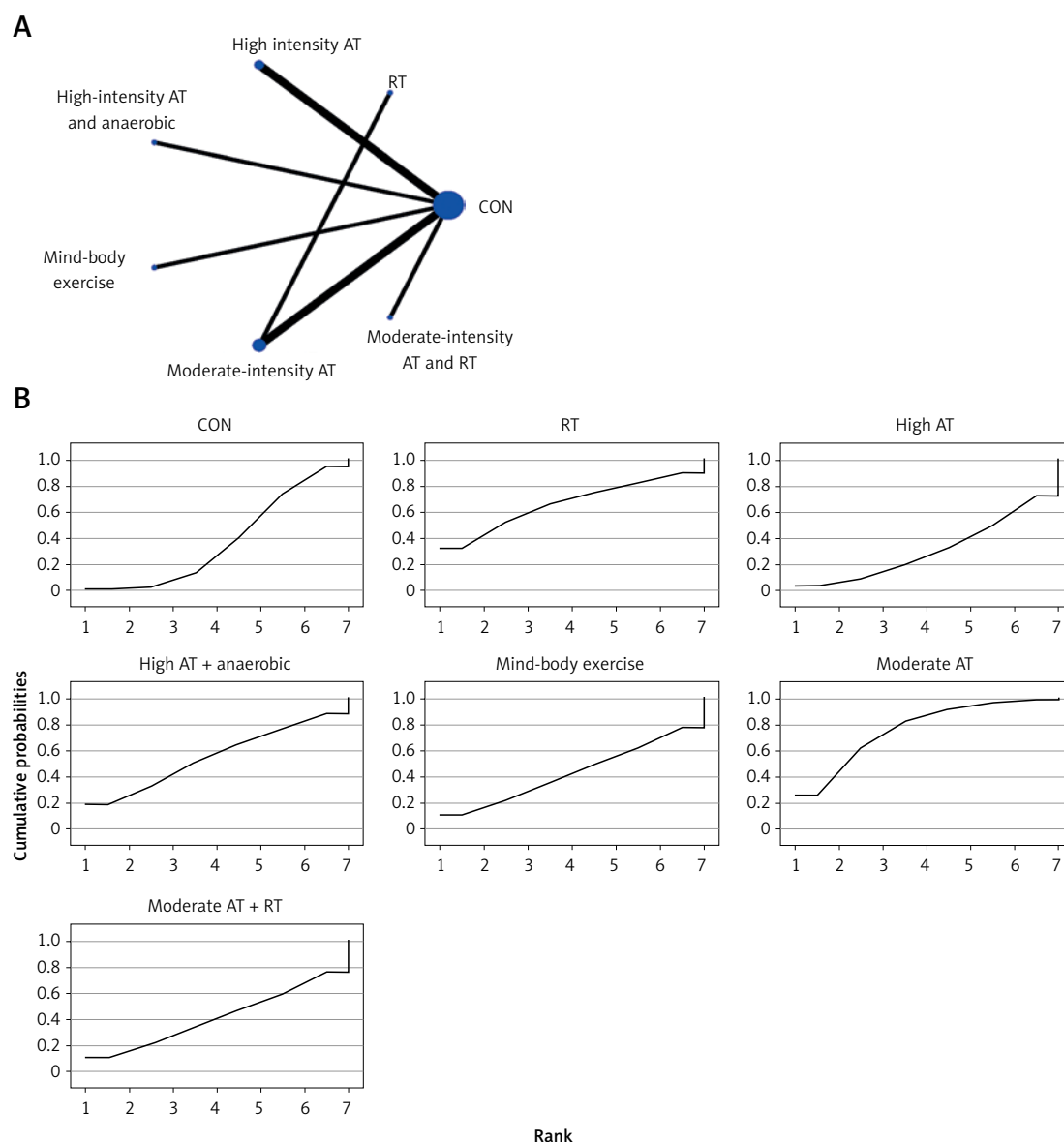


Figure 6. A – NMA figure for TG. B – SUCRA plot for TG

TC and increasing HDL-C, while high-intensity aerobic training is the best intervention for reducing LDL-C, and moderate-intensity aerobic training is the most effective for TG. High-intensity aerobic training activates AMP-activated protein kinase in skeletal muscles, enhancing mitochondrial fatty acid oxidation, accelerating the clearance of free fatty acids, inhibiting very-low-density lipoprotein (VLDL-C) synthesis, and ultimately lowering TC. Additionally, high-intensity aerobic training can downregulate the activity of HMG-CoA reductase, reducing endogenous cholesterol synthesis [30, 40, 41]. Anaerobic training increases muscle mass, which influences lipoprotein metabolism and regulates lipid receptor pathways to reduce blood lipids [42]. Furthermore, HDL-C is responsible for reverse cholesterol transport [43]; the enhanced reverse cholesterol transport can upregulate HDL-C syn-

thesis [37, 40]. These findings confirm the synergistic effect of high-intensity aerobic training combined with anaerobic training in improving TC and HDL-C. Studies published in 2008 and 2012 suggested that moderate-intensity aerobic training is more effective than high-intensity aerobic training in lowering TG [44, 45]. These findings align with the results of this study. Possible reasons are as follows: high-intensity aerobic training provides energy through glycogen breakdown, which leads to lactate accumulation and temporary insulin resistance, potentially reducing the mobilization of TG [46]. On the other hand, moderate-intensity aerobic training can provide energy through fat oxidation, with adipose tissue releasing free fatty acids into the bloodstream. Skeletal muscles then take up these free fatty acids, enhancing lipoprotein lipase activity to hydrolyze TG, which

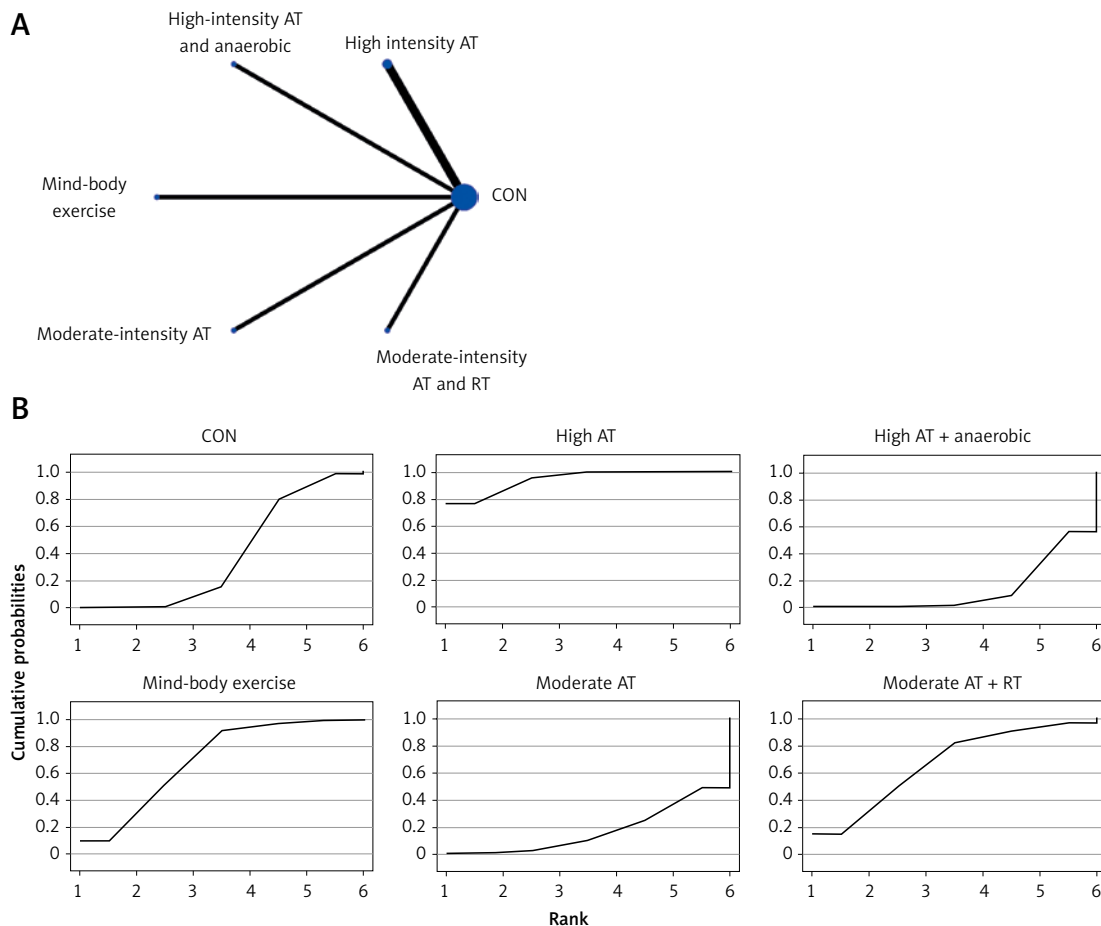


Figure 7. A – NMA figure for LDL-C. B – SUCRA plot for LDL-C

results in a decrease in TG levels [47]. Additionally, moderate-intensity aerobic training can activate AMP-activated protein kinase, promote mitochondrial biogenesis, improve insulin sensitivity, and reduce TG synthesis [46]. High-intensity aerobic training lowers VLDL, promotes the transfer of TC to HDL-C, and increases LDL-C receptor activity, thereby indirectly lowering LDL-C levels [31]. This study suggests that high-intensity aerobic training is the best intervention for improving LDL-C levels. In comparison, high-intensity aerobic training combined with anaerobic training yields slightly less favorable results, which may be due to the combination of different exercise forms and increased metabolic stress, possibly suppressing LDL-C receptor expression or increasing VLDL secretion, ultimately leading to variations in energy expenditure or metabolic adaptation [48]. Some researchers believe that both intense and moderate-intensity exercise can reduce TC, TG, and LDL-C [41, 49]. A systematic review published in 2025 [50] suggested that combined exercise is more effective than aerobic training alone in significantly lowering TC. Both combined exercise and aerobic training can reduce TG and LDL-C. The differences in study outcomes may be attributed

to confounding factors such as sample size, intervention duration, whether participants strictly controlled their diet, and personal lifestyle factors.

Beyond the aforementioned exercise regimens, the total daily physical activity volume (e.g., daily step count) and its quality (e.g., movement rhythm/step frequency) may also exert significant influences on metabolic and cardiopulmonary outcomes in children and adolescents with T1DM. Recent research indicates that in adults, a significant nonlinear inverse association exists between daily step count and all-cause and cardiovascular disease mortality, where accumulating as few as 4,000 steps per day significantly reduces all-cause mortality, with progressively greater mortality reduction observed at higher step volumes [51]. Although direct data for children and adolescents remain limited, extrapolating these findings to the youth population suggests that setting step-based activity goals (especially for sedentary individuals) could serve as a beneficial adjunct to structured exercise interventions. Furthermore, movement rhythm or step frequency (cadence, steps/minute) can function as a practical indicator for assessing exercise intensity. Higher cadence (e.g., during brisk walking or running) is strongly associated

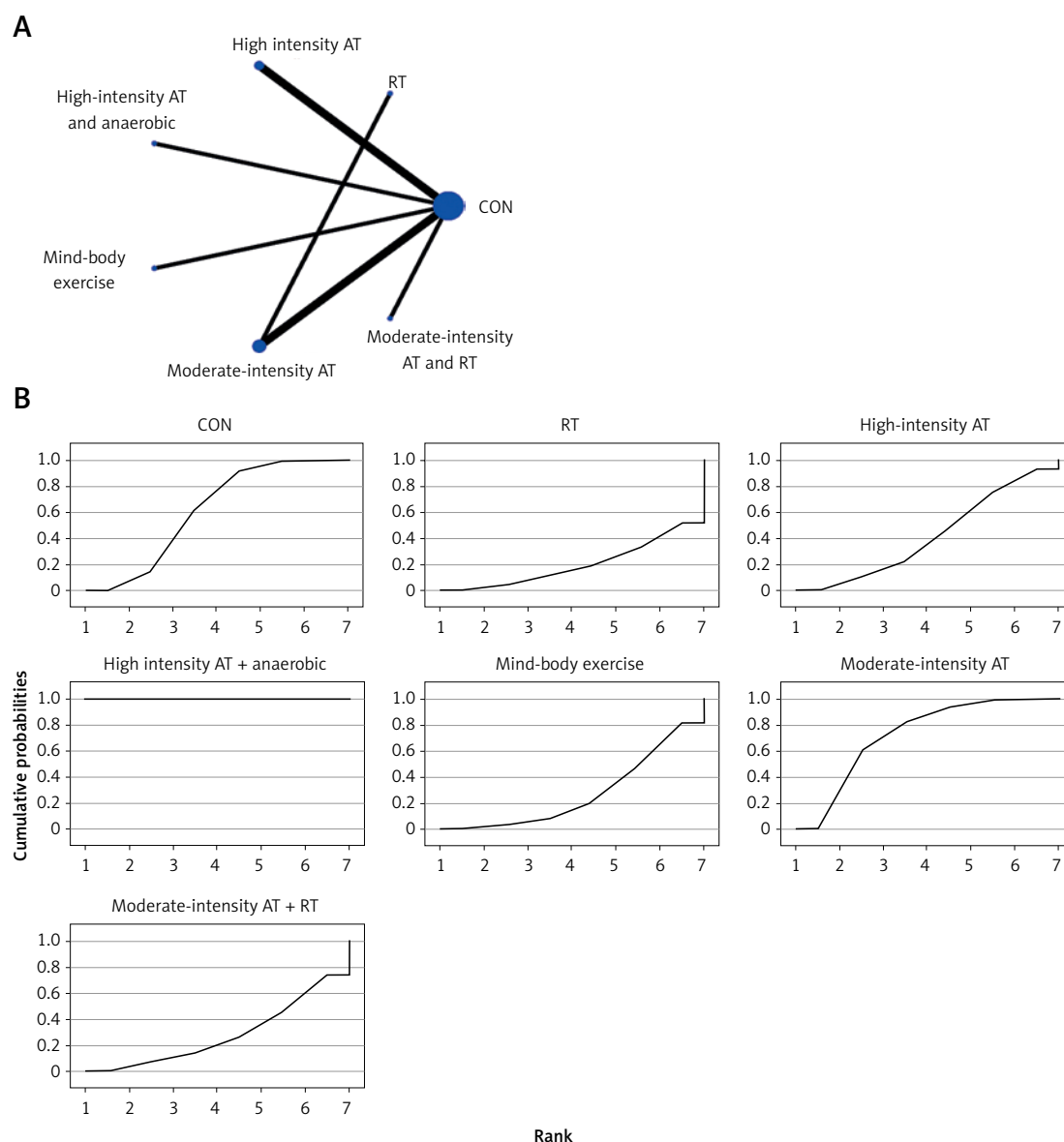


Figure 8. A – NMA figure for HDL-C. B – SUCRA plot for HDL-C

with improved cardiopulmonary fitness and metabolic health [52]. This perspective aligns well with a key finding of the present study: that high-intensity aerobic training demonstrated optimal efficacy for improving the lipid profile (e.g., reducing LDL-C), and high-intensity training is typically accompanied by a higher movement cadence. This underscores that in T1DM management, attention should extend beyond the form and intensity of exercise (as evaluated by the various regimens in this study) to also encompass the total volume (steps) and quality (cadence/intensity) of daily activities [51, 52]. The SMILE guidelines from the International Lipid Expert Panel (ILEP) also emphasize the importance of combining structured exercise with increased daily activity volume (e.g., walking), improving sleep and stress management and focusing on exercise intensity for comprehensive

improving cardiovascular health [53]. Future research should explore the feasibility and efficacy of incorporating daily step count monitoring and cadence targets into exercise prescriptions for children and adolescents with T1DM, aiming to provide more comprehensive and individualized activity recommendations.

This study is the first to quantitatively compare the benefits of eight exercise regimens on metabolic and cardiopulmonary outcomes in children and adolescents with T1DM using NMA, providing an evidence-based basis for clinical decision-making. This study identified high-intensity aerobic training combined with anaerobic training as the optimal regimen for improving lipid profile, and high-intensity aerobic training as the optimal regimen for improving cardiopulmonary fitness. However, exercise did not demonstrate statistically sig-

Table II. A – League table for: A – HbA1c, B – BG, C – VO₂ Peak, D – TC, E – TG, F – LDL-C, G – HDL-C

A

HIAT	MIAT	HIAT + A AT	HIAT + RT	RI	Mind-body exercise	CON	LIAT
HIAT	0.27 (–1.60, 2.14)	0.29 (–2.27, 2.84)	0.27 (–2.47, 3.01)	0.34 (–1.93, 2.62)	t28 (–1.35, 3.90)	1.22 (–0.31, 2.74)	1.62 (–0.54, 3.78)
–0.27 (–2.14, 1.60)	MIAT	0.02 (–2.31, 2.34)	0.00 (–2.52, 2.52)	0.08 (–1.63, 1.79)	1.01 (–1.39, 3.41)	0.95 (–0.14, 2.03)	1.35 (–0.53, 3.23)
–0.29 (–2.84, 2.27)	–0.02 (–2.34, 2.31)	HIAT + AAT	–0.01 (–3.08, 3.05)	0.06 (–2.60, 2.72)	0.99 (–1.98, 3.96)	0.93 (–1.12, 2.99)	1.33 (–1.23, 3.90)
–0.27 (–3.01, 2.47)	–0.00 (–2.52, 2.52)	0.01 (–3.05, 3.08)	HIAT + RT	0.07 (–2.76, 2.91)	1.00 (–2.12, 4.13)	0.94 (–1.33, 3.22)	1.35 (–1.39, 4.09)
–0.34 (–2.62, 1.93)	–0.08 (–1.79, 1.63)	–0.06 (–2.72, 2.60)	–0.07 (–2.91, 2.76)	RT	0.93 (–1.80, 3.66)	0.87 (–0.82, 2.57)	1.28 (–1.01, 3.56)
–1.28 (–3.90, 1.35)	–1.01 (–3.41, 1.39)	–0.99 (–3.96, 1.98)	–1.00 (–4.13, 2.12)	–0.93 (–3.66, 1.80)	Mind-body exercise	–0.06 (–2.20, 2.08)	0.34 (–2.29, 2.98)
–1.22 (–2.74, 0.31)	–0.95 (–2.03, 0.14)	–0.93 (–2.99, 1.12)	–0.94 (–3.22, 1.33)	–0.87 (–2.57, 0.82)	0.06 (–2.08, 2.20)	CON	0.40 (–1.13, 1.94)
–1.62 (–3.78, 0.54)	–1.35 (–3.23, 0.53)	–1.33 (–3.90, 1.23)	–1.35 (–4.09, 1.39)	–1.28 (–3.56, 1.01)	–0.34 (–2.98, 2.29)	–0.40 (–1.94, 1.13)	LIAT

B

RT	HIAT	MIAT	CON	HIAT + RT	LIAT
RT	0.59 (–1.53, 2.71)	0.83 (–0.84, 2.50)	1.19 (–0.67, 106)	1.36 (–1.07, 3.78)	1.26 (–0.73, 3.24)
–0.59 (–2.71, 1.53)	HIAT	0.23 (–1.07, 1.54)	0.60 (–0.42, 1.63)	0.76 (–1.09, 2.62)	0.67 (–0.71, 2.05)
–0.83 (–2.50, 0.84)	–0.23 (–1.54, 1.07)	MIAT	0.37 (–0.46, 1.20)	0.53 (–1.23, 2.29)	0.43 (–0.64, 1.51)
–1.19 (–3.06, 0.67)	–0.60 (–1.63, 0.42)	–0.37 (–1.20, 0.46)	CON	0.16 (–1.39, 1.71)	0.07 (–0.86, 0.99)
–1.36 (–3.78, 1.07)	–0.76 (–2.62, 1.09)	–0.53 (–2.29, 1.23)	–0.16 (–1.71, 1.39)	HIAT+RT	–0.10 (–1.91, 1.71)
–1.26 (–3.24, 0.73)	–0.67 (–2.05, 0.71)	–0.43 (–1.51, 0.64)	–0.07 (–0.99, 0.86)	0.10 (–1.71, 1.91)	LIAT

C

HIAT	MIAT	HIAT + RT	LIAT	CON
HIAT	–0.08 (–1.27, 1.12)	–0.17 (–1.42, 1.09)	–0.43 (–1.46, 0.61)	–0.55 (–1.32, 0.21)
0.08 (–1.12, 1.27)	MIAT	–0.09 (–1.44, 1.26)	–0.35 (–1.50, 0.80)	–0.48 (–1.40, 0.44)
0.17 (–1.09, 1.42)	0.09 (–1.26, 1.44)	HIAT + RT	–0.26 (–1.47, 0.95)	–0.39 (–1.38, 0.60)
0.43 (–0.61, 1.46)	0.35 (–0.80, 1.50)	0.26 (–0.95, 1.47)	LIAT	–0.13 (–0.82, 0.56)
0.55 (–0.21, 1.32)	0.48 (–0.44, 1.40)	0.39 (–0.60, 1.38)	0.13 (–0.56, 0.82)	CON

Table II. Cont.

D

HIAT + AAT	HIAT	MIAT + RT	Mind-body exercise	RT	MIAT	CON
HIAT + AAT	0.99 (0.13, 1.84)	1.02 (-0.12, 2.16)	1.32 (0.48, 2.17)	1.51 (0.18, 2.85)	1.88 (1.13, 2.63)	1.92 (1.48, 2.36)
-0.99 (-1.84, -0.13)	HIAT	0.03 (-1.25, 1.31)	0.34 (-0.69, 1.37)	0.53 (-0.93, 1.98)	0.89 (-0.05, 1.84)	0.94 (0.21, 1.67)
-1.02 (-2.16, 0.12)	-0.03 (-1.31, 1.25)	MIAT + RT	0.31 (-0.97, 1.58)	0.49 (-1.15, 2.13)	0.86 (-0.35, 2.08)	0.90 (-0.15, 1.95)
-1.32 (-2.17, -0.48)	-0.34 (-1.37, 0.69)	-0.31 (-1.58, 0.97)	Mind-body exercise	0.19 (-1.27, 1.64)	0.56 (-0.39, 1.50)	0.60 (-0.13, 1.32)
-1.51 (-2.85, -0.18)	-0.53 (-1.98, 0.93)	-0.49 (-2.13, 1.15)	-0.19 (-1.64, 1.27)	RT	0.37 (-0.74, 1.47)	0.41 (-0.85, 1.67)
-1.88 (-2.63, -1.13)	-0.89 (-1.84, 0.05)	-0.86 (-2.08, 0.35)	-0.56 (-1.50, 0.39)	-0.37 (-1.47, 0.74)	MIAT	0.04 (-0.56, 0.65)
-1.92 (-2.36, -1.48)	-0.94 (-1.67, -0.21)	-0.90 (-1.95, 0.15)	-0.60 (-1.32, 0.13)	-0.41 (-1.67, 0.85)	-0.04 (-0.65, 0.56)	CON

E

MIAT	RT	HIAT + AAT	Mind-body exercise	MIAT + RT	CON	HIAT
MIAT	0.15 (-2.59, 2.88)	0.77 (-2.40, 3.94)	1.22 (-2.00, 4.45)	1.31 (-1.99, 4.61)	1.32 (-0.59, 3.23)	1.62 (-1.10, 4.33)
-0.15 (-2.88, 2.59)	RT	0.62 (-3.56, 4.81)	1.08 (-3.15, 5.30)	1.17 (-3.11, 5.45)	1.18 (-2.16, 4.51)	1.47 (-2.38, 5.32)
-0.77 (-3.94, 2.40)	-0.62 (-4.81, 3.56)	HIAT + AAT	0.46 (-3.17, 4.08)	0.54 (-3.15, 4.24)	0.55 (-1.98, 3.08)	0.85 (-2.34, 4.03)
-1.22 (-4.45, 2.00)	-1.08 (-5.30, 3.15)	-0.46 (-4.08, 3.17)	Mind-body exercise	0.09 (-3.65, 3.83)	0.10 (-2.50, 2.70)	0.39 (-2.85, 3.63)
-1.31 (-4.61, 1.99)	-1.17 (-5.45, 3.11)	-0.54 (-4.24, 3.15)	-0.09 (-3.83, 3.65)	MIAT + RT	0.01 (-2.68, 2.70)	0.30 (-3.01, 3.62)
-1.32 (-3.23, 0.59)	-1.18 (-4.51, 2.16)	-0.55 (-3.08, 1.98)	-0.10 (-2.70, 2.50)	-0.01 (-2.70, 2.68)	CON	0.29 (-1.64, 2.23)
-1.62 (-4.33, 1.10)	-1.47 (-5.32, 2.38)	-0.85 (-4.03, 2.34)	-0.39 (-3.63, 2.85)	-0.30 (-3.62, 3.01)	-0.29 (-2.23, 1.64)	HIAT

F

HIAT	Mind-body exercise	MIAT + RT	CON	MIAT	HIAT + AAT
HIAT	0.63 (-0.41, 1.68)	0.65 (-0.61, 1.91)	1.18 (0.42, 1.94)	1.51 (0.37, 2.64)	1.49 (0.64, 2.33)
-0.63 (-1.68, 0.41)	Mind-body exercise	0.02 (-1.23, 1.26)	0.55 (-0.17, 1.27)	0.87 (-0.24, 1.98)	0.85 (0.04, 1.66)
-0.65 (-1.91, 0.61)	-0.02 (-1.26, 1.23)	MIAT + RT	0.53 (-0.48, 1.54)	0.86 (-0.46, 2.17)	0.84 (-0.24, 1.91)
-1.18 (-1.94, -0.42)	-0.55 (-1.27, 0.17)	-0.53 (-1.54, 0.48)	CON	0.32 (-0.52, 1.17)	0.30 (-0.06, 0.67)
-1.51 (-2.64, -0.37)	-0.87 (-1.98, 0.24)	-0.86 (-2.17, 0.46)	-0.32 (-1.17, 0.52)	MIAT	-0.02 (-0.94, 0.90)
-1.49 (-2.33, -0.64)	-0.85 (-1.66, -0.04)	-0.84 (-1.91, 0.24)	-0.30 (-0.67, 0.06)	0.02 (-0.90, 0.94)	HIAT + AAT

G

HIAT + AAT	MIAT	CON	HIAT	MIAT + RT	Mind-body exercise	RT
HIAT + MT	-1.43 (-2.17, -0.69)	-1.63 (-2.05, -1.21)	-1.91 (-2.71, -1.10)	-2.18 (-3.27, -1.08)	-2.15 (-2.98, -1.31)	-2.41 (-3.81, -1.01)
1.43 (0.69, 2.17)	MIAT	-0.20 (-0.81, 0.40)	-0.47 (-1.39, 0.44)	-0.74 (-1.92, 0.43)	-0.72 (-1.66, 0.23)	-0.98 (-2.17, 0.21)
1.63 (1.21, 2.05)	0.20 (-0.40, 0.81)	CON	-0.27 (-0.96, 0.42)	-0.54 (-1.55, 0.47)	-0.51 (-1.23, 0.21)	-0.77 (-2.11, 0.56)
1.91 (1.10, 2.71)	0.47 (-0.44, 1.39)	0.27 (-0.42, 0.96)	HIAT	-0.27 (-1.49, 0.95)	-0.24 (-1.24, 0.76)	-0.50 (-2.00, 1.00)
2.18 (1.08, 3.27)	0.74 (-0.43, 1.92)	0.54 (-0.47, 1.55)	0.27 (-0.95, 1.49)	MIAT + RT	0.03 (-1.21, 1.27)	-0.23 (-1.91, 1.44)
2.15 (1.31, 2.98)	0.72 (-0.23, 1.66)	0.51 (-0.21, 1.23)	0.24 (-0.76, 1.24)	-0.03 (-1.27, 1.21)	Mind-body exercise	-0.26 (-1.78, 1.25)
2.41 (1.01, 3.81)	0.98 (-0.21, 2.17)	0.77 (-0.56, 2.11)	0.50 (-1.00, 2.00)	0.23 (-1.44, 1.91)	0.26 (-1.25, 1.78)	RT

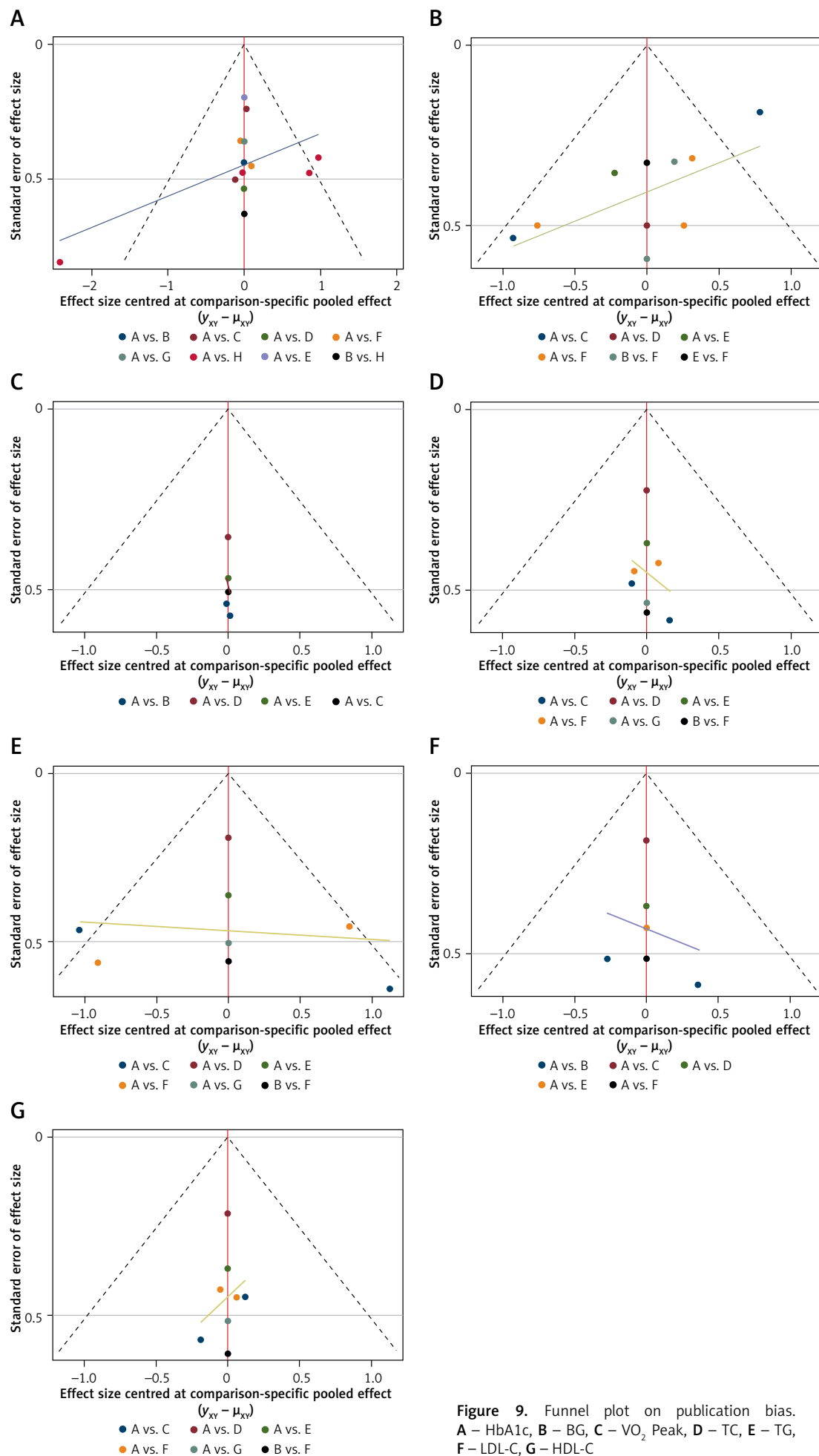


Figure 9. Funnel plot on publication bias. A – HbA1c, B – BG, C – VO₂ Peak, D – TC, E – TG, F – LDL-C, G – HDL-C

nificant improvements in BG and HbA1c, revealing the presence of distinct exercise-induced physiological responses in children and adolescents with T1DM. This finding cautions clinicians against mechanically applying treatment experiences from adults or other types of diabetes when managing children and adolescents with T1DM, emphasizing the necessity of individualized therapy. These discoveries promote a shift in clinical practice from a “glucose-centric approach” towards a “comprehensive metabolic assessment”. We recommend incorporating VO₂ peak and lipid profile alongside BG and HbA1c as core indicators for routine monitoring. Furthermore, clinicians should integrate insulin dosing, carbohydrate intake, and physical activity for the holistic management of T1DM.

First, this study focused on the effects of exercise on T1DM-related indicators in children and adolescents, as their metabolic management differs from that of adults, and research on this population is limited. Second, the study provides a detailed classification of exercise into eight types and intensity combinations, offering more intuitive recommendations for clinicians and patients. Lastly, we expanded the outcome indicators to include lipid profiles and VO₂ peak, enabling a comprehensive assessment of metabolism and cardiopulmonary function. Additionally, we applied the latest statistical method, NMA, to address the complexities of multiple intervention comparisons, enhance statistical power, and prioritize and rank interventions. However, heterogeneity is unavoidable due to publication bias in some studies, where negative results were not published. Exercise intervention parameters were not standardized, and significant differences existed across studies. Moreover, heterogeneity existed across outcome measures. For instance, while this systematic review included 19 studies, only 12 used HbA1c as an endpoint measurement. This further reduced the analyzable pediatric and adolescent sample size. Consequently, the present study ultimately incorporated a limited sample cohort. Similarly, the current findings are constrained by the aforementioned limitations. This underscores the necessity for future large-scale, multicenter clinical trials employing standardized interventions. Future prospective studies will involve larger populations to further explore the impact of exercise on metabolism and cardiopulmonary function in children and adolescents with T1DM.

In conclusion, high-intensity aerobic training combined with anaerobic training and high-intensity aerobic training can improve metabolism and cardiopulmonary function in children and adolescents with T1DM. However, the significance of improvements in BG, HbA1c, TG, and VO₂ peak was insufficient, possibly due to baseline meta-

bolic conditions, exercise duration, and follow-up time. Although the current study found no significant improvements in BG or HbA1c following exercise interventions, these results reveal unique exercise-physiological responses in children and adolescents with T1DM. This evidence suggests clinicians should develop exercise prescriptions integrating insulin dose adjustment, nutritional interventions, and continuous BG monitoring, rather than relying on standardized exercise regimens alone.

Funding

No external funding.

Ethical approval

Not applicable.

Conflict of interest

The authors declare no conflict of interest.

References

1. Grzelak T, Wedrychowicz A, Grupinska J, et al. Neuropeptide B and neuropeptide W as new serum predictors of nutritional status and of clinical outcomes in pediatric patients with type 1 diabetes mellitus treated with the use of pens or insulin pumps. *Arch Med Sci* 2019; 15: 619-31.
2. Muñoz-Pardeza J, Lopez-Gil JF, Huerta-Urbe N, et al. Nonpharmacological interventions on glycated haemoglobin in youth with type 1 diabetes: a Bayesian network meta-analysis. *Cardiovasc Diabetol* 2024; 23: 230.
3. García-Hermoso A, Ezzatvar Y, Huerta-Urbe N, et al. Effects of exercise training on glycaemic control in youths with type 1 diabetes: a systematic review and meta-analysis of randomised controlled trials. *Eur J Sport Sci* 2022; 23: 1056-67.
4. Kennedy A, Nirantharakumar K, Chimen M, et al. Does exercise improve glycaemic control in type 1 diabetes? A systematic review and meta-analysis. *PLoS One* 2013; 8: e58861.
5. Bafeta A, Tringuart L, Seror R, Ravaud P. Reporting of results from network meta-analyses: methodological systematic review. *BMJ* 2014; 348: g1741.
6. Chiang JL, Maahs DM, Garvey KC, et al. Type 1 diabetes in children and adolescents: a position statement by the American Diabetes Association. *Diabetes Care* 2018; 41: 2026-44.
7. Higgins JP, Altman DG, Gotzsche PC, et al. The Cochrane Collaboration's tool for assessing risk of bias in randomised trials. *BMJ* 2011; 343: d5928.
8. Salanti G, Ades AE, Ioannidis JP. Graphical methods and numerical summaries for presenting results from multiple-treatment meta-analysis: an overview and tutorial. *J Clin Epidemiol* 2011; 64: 163-71.
9. Hao Z, Zhang X, Chen P. Effects of ten different exercise interventions on motor function in Parkinson's disease patients – a network meta-analysis of randomized controlled trials. *Brain Sci* 2022; 12: 698.
10. Owen PJ, Miller CT, Mundell NL, et al. Which specific modes of exercise training are most effective for treat-

- ing low back pain? Network meta-analysis. *Br J Sports Med* 2020; 54: 1279-87.
11. Pemberton JS, Gupta A, Lau GM, et al. Integrating physical activity strategies to lower hyperglycaemia in structured education programmes for children and young people with type 1 diabetes improves glycaemic control without augmenting the risk of hypoglycaemia. *Pediatr Diab* 2023; 2023: 2519368.
12. Mohammed MHH, Al-Qahtani MHH. Effects of 12 weeks aerobic exercise with a diet regimen on the glycemic control and cardiovascular health of boys with type 1 diabetes mellitus. *Int J Appl Exercise Physiol* 2019; 8: 2-10.
13. Wong CH, Chiang YC, Wai JPM, et al. Effects of a home-based aerobic exercise programme in children with type 1 diabetes mellitus. *J Clin Nursing* 2011; 20: 681-91.
14. D'hooge R, Hellinckx T, Christophe Van Laethem, et al. Influence of combined aerobic and resistance training on metabolic control, cardiovascular fitness and quality of life in adolescents with type 1 diabetes: a randomized controlled trial. *Clin Rehab* 2010; 25: 349-359.
15. Ramalho AC, de Lourdes Lima M, Nunes F, et al. The effect of resistance versus aerobic training on metabolic control in patients with type-1 diabetes mellitus. *Diabetes Res Clin Pract* 2006; 72: 271-6.
16. Huttunen NP, Knip M. Effect of once-a-week training program on physical fitness and metabolic control in children with IDDM. *Diabetes Care* 1989; 12: 737-40.
17. Stratton R, Wilson DP, Endres RK. Acute glycemic effects of exercise in adolescents with insulin-dependent diabetes mellitus. *Phys Sportsmed* 2016; 16: 150-7.
18. Stratton R, Wilson DP, Endres RK, Goldstein DE. Improved glycemic control after supervised 8-wk exercise program in insulin-dependent diabetic adolescents. *Diabetes Care* 1987; 10: 589-93.
19. Landt KW, Campaigne BN, James FW, Sperling MA. Effects of exercise training on insulin sensitivity in adolescents with type 1 diabetes. *Diabetes Care* 1985; 8: 461-5.
20. Campaigne BN, Landt KW, Mellies MJ, et al. The effects of physical training on blood lipid profiles in adolescents with insulin-dependent diabetes mellitus. *Phys Sportsmed* 1985; 13: 83-9.
21. Adolfsson P, Nilsson S, Lindblad B. Continuous glucose monitoring system during physical exercise in adolescents with type 1 diabetes. *Acta Paediatr* 2011; 100: 1603-9.
22. Campaigne BN, Gilliam TB, Spencer ML, et al. Effects of a physical activity program on metabolic control and cardiovascular fitness in children with insulin-dependent diabetes mellitus. *Diabetes Care* 1984; 7: 57-62.
23. Dahl-Jorgensen K, Meen HD, Hanssen KF, Aagenaes O. The effect of exercise on diabetic control and hemoglobin A1 (HbA1) in children. *Acta Paediatr* 2008; 69: 53-6.
24. Heyman E, Toutain C, Delamarche P, et al. Exercise training and cardiovascular risk factors in type 1 diabetic adolescent girls. *Pediatr Exercise Sci* 2007; 19: 408-19.
25. Salem MA, AboElAsrar MA, Elbarbary NS, et al. Is exercise a therapeutic tool for improvement of cardiovascular risk factors in adolescents with type 1 diabetes mellitus? A randomised controlled trial. *Diabetol Metabol Syndr* 2010; 2: 47.
26. Tunar M, Ozen S, Goksen D, et al. The effects of Pilates on metabolic control and physical performance in adolescents with type 1 diabetes mellitus. *J Diabetes Complications* 2012; 26: 348-51.
27. Aouadi R, Khalifa R, Aouidet A, et al. Aerobic training programs and glycemic control in diabetic children in relation to exercise frequency. *J Sports Med Phys Fitness* 2011; 51: 393-400.
28. Marrero DG, Fremion AS, Golden MP. Improving compliance with exercise in adolescents with insulin-dependent diabetes mellitus: results of a self-motivated home exercise program. *Pediatrics* 1988; 81: 519-25.
29. Petschnig R, Wagner T, Robubi A, Baron R. Effect of strength training on glycemic control and adiponectin in diabetic children. *Med Sci Sports Exerc* 2020; 52: 2172-8.
30. Richter EA, Hargreaves M. Exercise, GLUT4, and skeletal muscle glucose uptake. *Physiol Rev* 2013; 93: 993-1017.
31. Kjøbsted R, Hirst JR, Fentz J, et al. AMPK in skeletal muscle function and metabolism. *Faseb J* 2018; 32: 1741-77.
32. Alghothani N, Dungan KM. The effect of glycemic variability on counterregulatory hormone responses to hypoglycemia in young children and adolescents with type 1 diabetes. *Diabetes Technol Ther* 2011; 13: 1085-9.
33. Burke LM, van Loon LJC, Hawley JA. Postexercise muscle glycogen resynthesis in humans. *J Appl Physiol* 2017; 122: 1055-67.
34. Saki H, Nazem F, Fariba F, Sheikhsharabafan R. A High intensity Interval training (running and swimming) and resistance training intervention on heart rate variability and the selected biochemical factors in boys with type 1 diabetes. *Diabetes Res Clin Pract* 2023; 204: 110915.
35. de Abreu de Lima V, de Menezes Junior F, da Rocha Celli L. Effects of resistance training on the glycemic control of people with type 1 diabetes: a systematic review and meta-analysis. *Arch Endocrinol Metab* 2022; 66: 533-40.
36. Pauli JR, Cintra DE, de Souza CT, et al. New mechanisms by which physical exercise improves insulin resistance in the skeletal muscle. *Arq Bras Endocrinol Metabol* 2009; 53: 399-408.
37. MacInnis MJ, Gibala MJ. Physiological adaptations to interval training and the role of exercise intensity. *J Physiol* 2017; 595: 2915-30.
38. Gibala MJ, Little JP, Macdonald MJ, Hawley JA. Physiological adaptations to low-volume, high-intensity interval training in health and disease. *J Physiol* 2012; 590: 1077-84.
39. Montero D, Cathomen A, Jacobs RA, et al. Haematological rather than skeletal muscle adaptations contribute to the increase in peak oxygen uptake induced by moderate endurance training. *J Physiol* 2015; 593: 4677-88.
40. Sellami M, Almuraikhy S, Naja K, et al. Eight weeks of aerobic exercise, but not four, improves insulin sensitivity and cardiovascular performance in young women. *Sci Rep* 2025; 15: 1991.
41. Michaliszyn SF, Faulkner MS. Physical activity and sedentary behavior in adolescents with type 1 diabetes. *Res Nurs Health* 2010; 33: 441-9.
42. Strasser B, Siebert U, Schobersberger W. Resistance training in the treatment of the metabolic syndrome: a systematic review and meta-analysis of the effect of resistance training on metabolic clustering in patients with abnormal glucose metabolism. *Sports Med* 2010; 40: 397-415.
43. Cieluch A, Uruska A, Nowicki M, et al. Is it time to change the goals of lipid management in type 1 diabetes mellitus? Changes in apolipoprotein levels during the first year of type 1 diabetes mellitus. Prospective InLipoDiab1 study. *Arch Med Sci* 2022; 18: 596-603.
44. Tjønnå AE, Lee SJ, Rognmo Q, et al. Aerobic interval training versus continuous moderate exercise as a treatment for the metabolic syndrome: a pilot study. *Circulation* 2008; 118: 346-54.

45. Sijie T, Hainai Y, Fengying Y, Jianxiong W, et al. High intensity interval exercise training in overweight young women. *J Sports Med Phys Fitness* 2012; 52: 255-62.
46. Hawley JA, Hargreaves M, Joyner MJ, Zierath JR. Integrative biology of exercise. *Cell* 2014; 159: 738-49.
47. Romijn JA, Coyle EF, Sidossis LS, et al. Regulation of endogenous fat and carbohydrate metabolism in relation to exercise intensity and duration. *Am J Physiol* 1993; 265: E380-91.
48. Herbst A, Kordonouri O, Karl O Schwab KO, et al. Impact of physical activity on cardiovascular risk factors in children with type 1 diabetes: a multicenter study of 23,251 patients. *Diabetes Care* 2007; 30: 2098-100.
49. Aljawarneh YM, Wardell DW, Wood GL, Rozmus CL. A systematic review of physical activity and exercise on physiological and biochemical outcomes in children and adolescents with type 1 diabetes. *J Nurs Scholarsh* 2019; 51: 337-45.
50. Smart NA, Downes D, van der Touw T, et al. The effect of exercise training on blood lipids: a systematic review and meta-analysis. *Sports Med* 2025; 55: 67-78.
51. Banach M, Lewek J, Surma S, et al. The association between daily step count and all-cause and cardiovascular mortality: a meta-analysis. *Eur J Prev Cardiol* 2023; 30: 1975-85.
52. Ding D, Nguyen B, Nau T, et al. Daily steps and health outcomes in adults: a systematic review and dose-response meta-analysis. *Lancet Public Health* 2025; 10: e668-81.
53. Banach M, Fogacci F, Atanasov AG, et al. A 360° perspective on cardiovascular prevention: the International Lipid Expert Panel SiMple tips for the healthy hEart (ILEP-SMILE). *Arch Med Sci* 2025; 21: 711-8.