Does post-exercise massage treatment reduce delayed onset muscle soreness? A systematic review

E Ernst

Abstract
Background—Delayed onset muscle soreness (DOMS) is a frequent problem after unaccustomed exercise. No universally accepted treatment exists. Massage therapy is often recommended for this condition but uncertainty exists about its effectiveness.

Aim—To determine whether post-exercise massage alleviates the symptoms of DOMS after a bout of strenuous exercise.

Method—Various computerised literature searches were carried out and located seven controlled trials.

Results—Most of the trials were burdened with serious methodological flaws, and their results are far from uniform. However, most suggest that post-exercise massage may alleviate symptoms of DOMS.

Conclusions—Massage therapy may be a promising treatment for DOMS. Definitive studies are warranted.

Keywords: massage treatment; delayed onset muscle soreness; muscle soreness; exercise

Delayed onset muscular soreness (DOMS) is a predictable painful condition which often occurs after unaccustomed eccentric exercise. It is a benign condition which usually subsides after 3–4 days of relative inactivity. Nevertheless it can lead to considerable suffering and handicaps athletes by temporarily impeding performance and preventing training. Thus an effective treatment has been sought for many years. Among the treatments tried are transcutaneous electrical nerve stimulation, ultrasound, and the administration of aspirin and other anti-inflammatory drugs, steroids, and vitamin C and other antioxidants. To date, none of these approaches has been fully convincing.

Muscle massage could be another candidate for an effective treatment. Recent reviews have pointed out the potential of massage to alleviate DOMS or enhance performance. Inter alia, massage therapy has been shown to increase local blood and lymph flow, decrease oedema production, reduce muscular tone, and enhance mood. None of these (mostly narrative) reviews makes a systematic attempt to summarise the controlled trials on the efficacy of post-exercise massage as a treatment for DOMS. The present systematic review aimed to fill that gap.

Methods

The following databases were searched: Medline, Embase, and the Cochrane Library, each from its institution to July 1997. In addition, the author’s own and other experts’ files were considered. A study was included if it was conducted against a control group, if it was on human subjects, and if it included outcome measures to quantify DOMS. Foreign language publications were not excluded. Data were extracted in a standardised predefined fashion (table 1). Initially, statistical pooling was considered; this plan had to be abandoned, however, when it became clear that the trials were too heterogeneous for application of meta-analytical techniques.

Results

Seven studies that met the above criteria were located. Table 1 summarises them in chronological order.

Eltze and co-workers allocated 20 volunteers to receive either three vibrational massages with a mechanical vibrator device or no massages. All volunteers had previously performed eccentric exercises to induce DOMS. There was less decline in isometric strength and more release of creatine kinase with massage. Pain due to DOMS was also numerically less; however, this failed to reach the level of statistical significance. This study was not randomised, leaving it open to selection bias. The sample size was small, rendering a Type II error a realistic possibility.

Wenos and colleagues induced DOMS in untrained seated adults by asking them to lower a weight of 75% lean body mass from knee extension to flexion. One side was subsequently massaged by a licensed massage therapist while the other served as a control. Soreness perception was evaluated by questionnaire 24, 48, and 72 hours after exercise. There was no significant difference between the massaged and control sides.

Bale and James included nine male athletes in their study. After a maximal run, all participants were either rested or massaged manually for 17 minutes, or asked to “warm down” by exercising at a moderate level. DOMS was less in the massaged individuals, who also showed a more rapid decline in lactate levels. This study is relevant for the investigation of DOMS, but the small sample size seriously limits its conclusiveness.

Ellison et al randomised 16 volunteers to receive a “retrograde massage”, a placebo massage (massage without force), or a rest after a
### Table 1  Summary of the seven trials on the effect of post-exercise massage on delayed onset muscle soreness

<table>
<thead>
<tr>
<th>First author (year)</th>
<th>Trial design</th>
<th>Sample</th>
<th>Intervention</th>
<th>Outcome measures</th>
<th>Main results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ertez (1982)</td>
<td>CCT</td>
<td>20 healthy volunteers</td>
<td>Exercise induced soreness of upper arm and leg followed by daily interventions for 3 days of (A) vibrational massage for 30 min (B) no intervention</td>
<td>Pain</td>
<td>Trend for less pain in A vs B</td>
</tr>
<tr>
<td>Wenos (1990)</td>
<td>CCT</td>
<td>9 untrained volunteers</td>
<td>Exercise induced soreness of both quadriceps muscles followed by (A) massage of one leg (B) other leg no intervention</td>
<td>Soreness perception (by questionnaire)</td>
<td>No difference between sides</td>
</tr>
<tr>
<td>Bale (1991)</td>
<td>CCT</td>
<td>9 male athletes</td>
<td>Maximal runs followed by (A) manual massage of legs (B) “warm down” (run on treadmill with heart rate at 120 beats/min)</td>
<td>Pain</td>
<td>Immediately after massage and 12 hours later significantly less soreness in A vs B or C</td>
</tr>
<tr>
<td>Smith (1995)</td>
<td>RCT</td>
<td>19 male untrained athletes</td>
<td>Isokinetic eccentric exercise of elbow flexors and extensors followed 2 hours later by (A) 30 min manual massage (B) rest</td>
<td>Pain</td>
<td>Less soreness in A vs B</td>
</tr>
<tr>
<td>Ellison (1992)</td>
<td>RCT</td>
<td>16 healthy volunteers</td>
<td>Exercise induced soreness followed by either (A) retrograde massage (B) “placebo massage” (C) rest (all applied only once)</td>
<td>Soreness perception (24 and 48 hours after exercise)</td>
<td>No significant differences between groups</td>
</tr>
<tr>
<td>Rodenburg (1994)</td>
<td>RCT</td>
<td>50 healthy volunteers</td>
<td>Isometric and eccentric exercises with forearm flexors and extensors (A) warm up + stretching before exercise plus massage after exercise (B) no such interventions</td>
<td>Pain</td>
<td>Less soreness in A vs B</td>
</tr>
<tr>
<td>Smith (1995)</td>
<td>RCT</td>
<td>19 male untrained volunteers</td>
<td>Bout of eccentric quadriceps work (A) one leg was massaged daily for 4 days (B) control leg received no massage</td>
<td>Pain</td>
<td>Pain significantly less after 48 hours</td>
</tr>
</tbody>
</table>

CCT, controlled clinical trial; RCT, randomised controlled trial.

#### Discussion

Most of the above studies are burdened with serious methodological flaws—for example, small sample size. It is therefore difficult to generate a clear picture from the available data. In one trial, a positive trend emerged. One investigation is inconclusive because two co-interventions were used in parallel. Two further investigations do not show a significant effect of massage on DOMS, and three studies do imply a positive symptomatic effect. With only one exception, these studies suffer from using very small sample sizes. The positive trials do not seem to differ from the negative ones in any systematic way.

Some—for example, but not all—for example, investigations suggest that post-exercise massage treatment can increase muscular performance. This effect may be related to the effectiveness (if any) of massage on DOMS.

Several hypotheses on the pathophysiology of DOMS exist. (1) Exercise leads to local accumulation of metabolic waste, which in turn sensitises A-delta and C fibres causing pain. (2) Exercise causes muscle ischaemia, which results in the production of a pain substance. Pain in turn produces a reflex spasm which, in a vicious cycle, prolongs ischaemia. (3) Exercise results in intramuscular oedema which activates mechanoreceptors thus causing pain. (4) Eccentric exercise leads to damage of the connective tissues in the area of the muscle and this damage is responsible for the pain. (5) Exercise leads to the release of
inflammatory byproducts, which sensitise nerve fibres thus causing pain.29 (6) Exercise leads to destruction within muscle fibres liberating muscle creatine kinase, which is the cause of pain.25 Positive effects of massage on pain caused by these mechanisms are conceivable. The hypothesis is that, through its mechanical pressure on muscle tissue, massage treatment leads to enhanced local microcirculatory blood and lymph flow. This, in turn, reduces oedema, ischaemia, or accumulation of substances that directly or indirectly cause pain. Clearly this hypothesis requires further testing in carefully designed experiments.

Thus massage may be a promising intervention for the reduction of DOMS. Its effectiveness should be investigated in a rigorous trial designed experiments. and lymph flow. This, in turn, reduces oedema, pressure on muscle tissue, massage treatment causes by these mechanisms are conceivable. The hypothesis is that, through its mechanical

Indeed statistics from the Great Britain team in Atlanta in 1996 revealed that massage formed 47% of all treatments to athletes from all sports. Despite this popular appeal, a consensus about massage from the literature is difficult to obtain because of wide variations in technique, time, area of the body, and outcome measures.1 Professor Ernst has looked specifically at the use of massage on athletes with delayed onset muscle soreness (DOMS) and has reviewed papers fulfilling certain criteria. Although he concludes that massage may have some potential for relieving DOMS, he gives some useful words of advice to future researchers in this area. Noting the limitations of the papers he has reviewed, care should be taken to avoid type II errors due to small sample size, to avoid using multiple therapeutic interventions other than massage, and to avoid using the contralateral limb as a control. The last point is particularly pertinent as many researchers may be tempted to do just this to help boost the sample size. As the author points out, the idea that the massage has only a local (unilateral) effect may not be true. This is certainly an observation in recent unpublished work of electrical stimulation of the quadriceps muscle group and in unilateral strength training.2

Commentary

Massage has been performed on athletes from the ancient right up to the modern Olympiads. Indeed statistics from the Great Britian team in Atlanta in 1996 revealed that massage formed 47% of all treatments to athletes from all sports. Despite this popular appeal, a consensus about massage from the literature is difficult to obtain because of wide variations in technique, time, area of the body, and outcome measures.1 Professor Ernst has looked specifically at the use of massage on athletes with delayed onset muscle soreness (DOMS) and has reviewed papers fulfilling certain criteria. Although he concludes that massage may have some potential for relieving DOMS, he gives some useful words of advice to future researchers in this area. Noting the limitations of the papers he has reviewed, care should be taken to avoid type II errors due to small sample size, to avoid using multiple therapeutic interventions other than massage, and to avoid using the contralateral limb as a control. The last point is particularly pertinent as many researchers may be tempted to do just this to help boost the sample size. As the author points out, the idea that the massage has only a local (unilateral) effect may not be true. This is certainly an observation in recent unpublished work of electrical stimulation of the quadriceps muscle group and in unilateral strength training.2


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