Neovascularisation and pain in jumper’s knee: a prospective clinical and sonographic study in elite junior volleyball players

K Gisslén, H Alfredson

Background: The nature of tendon neovascularisation associated with pain over time has not been studied. Objective: To prospectively study the patellar tendons in elite junior volleyball players. Methods: The patellar tendons in all students at the Swedish National Centre for high school volleyball were evaluated clinically and by ultrasonography (US) and Power Doppler (PD) sonography. Results: Altogether 120 patellar tendons were followed for 7 months. At inclusion, jumper’s knee was diagnosed clinically in 17 patellar tendons. There were structural changes on US in 14 tendons, in 13 of which PD sonography showed neovascularisation. There were 70 clinically normal tendons with normal US and PD sonography, 24 clinically normal tendons with abnormal US but normal PD sonography, and nine clinically normal tendons with abnormal US and neovascularisation on PD sonography. At 7 month follow up, jumper’s knee was diagnosed clinically and by US in 19 patellar tendons, in 17 of which there was neovascularisation. Three of nine clinically normal tendons with structural changes and neovascularisation at inclusion developed jumper’s knee. Two of 24 tendons clinically normal at inclusion, with abnormal US but normal PD sonography, developed jumper’s knee with abnormal US and neovascularisation on PD sonography. A total of 20 clinically normal tendons with normal US and PD sonography at inclusion developed structural tendon changes and 12 of these also developed neovascularisation. Conclusions: The clinical diagnosis of jumper’s knee is most often associated with neovascularisation in the area with structural tendon changes. The finding of neovessels might indicate a deterioration of the condition.

Jumper’s knee (chronic patellar tendinosis) is a troublesome condition with unknown aetiology and pathogenesis. The condition is mainly seen in athletes engaged in explosive jumping sports, and is likely associated with overloading of the knee extensor mechanism. Jumper’s knee is the most common overuse injury in volleyball (28%), and 40% of professional players have experienced symptoms of jumper’s knee during their careers.

Clinically, jumper’s knee is characterised by activity related pain and/or soreness at the patellar tendon attachment to the patella. The condition is difficult to treat and there is no treatment of choice, conservative or surgical. Several studies report unpredictable results with surgical treatment. Interestingly, it is not yet known where the pain comes from in this condition. Ultrasonography (US) is a good method to study the tendon structure. In both adolescent and adult patients with a long history of pain from the patellar tendon, examination usually shows a local widening, irregular collagen fibre structure, and hypoechoegenic areas in the patellar tendon insertion into the patella. However, these changes can also be seen in asymptomatic athletes. Power Doppler (PD) and colour Doppler techniques can be used to study blood flow in the tendon. However, only high flow rates can be registered with these techniques as normal blood flow in the tendon does not register due to its relatively low flow rate. Recent studies on chronic painful Achilles tendon have indicated an association between pain during tendon loading activity and the occurrence of neovascularisation in the area with tendon changes.

The aim of this prospective study was to clinically, and by grey scale US and PD sonography, follow the patellar tendons in elite junior volleyball players (15–19 years) at the Swedish National Centre for volleyball during one season (30 weeks) of high intensity training and playing. We were particularly interested in the occurrence of neovascularisation and pain.

METHODS

Subjects

The most talented junior volleyball players in Sweden are recruited to the Swedish National Centre for high school volleyball. General physical tests and sport specific tests are undertaken regularly. During their 3 years at the Swedish National Centre for high school volleyball, the players consistently train and play 15 h/week throughout the season. Most of the volleyball players are members of the Swedish Junior National Team and participate in international tournaments. Four teams represent the high school in the Swedish Volleyball Federation leagues, from the women’s top elite division to the first and second divisions for men and women.

After permission from the Educational Board of the Swedish National Centre for volleyball, all 60 players (29 male and 31 female) in first, second, and third grades (15–19 years old) were invited to participate in the study.

The study was approved by the Ethical Committee of the Medical Faculty at the University of Gothenburg, Sweden. All volleyball players provided written informed consent.

The study started at the beginning of the semester in September 2002 with a lecture on jumper’s knee (patellar tendinosis) for all students. Thereafter, all students filled out a questionnaire (see below) with investigator (KG) assistance.

Abbreviations: PD, power Doppler; US, ultrasonography
Jumper’s knee in volleyball players (n = 60) at baseline and at 7 month follow up

<table>
<thead>
<tr>
<th>Variable</th>
<th>Grade 1</th>
<th></th>
<th>Grade 2</th>
<th></th>
<th>Grade 3</th>
<th></th>
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<tbody>
<tr>
<td></td>
<td>Male (n = 11)</td>
<td>Female (n = 11)</td>
<td>Male (n = 8)</td>
<td>Female (n = 8)</td>
<td>Male (n = 10)</td>
<td>Female (n = 12)</td>
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<tr>
<td>Age (years)</td>
<td>16.3 (0.4)</td>
<td>16.1 (0.6)</td>
<td>17.0 (0.7)</td>
<td>17.1 (0.5)</td>
<td>18.3 (0.4)</td>
<td>17.9 (0.6)</td>
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<tr>
<td>Weight (kg)</td>
<td>80.6 (12.1)</td>
<td>65.9 (5.7)</td>
<td>77.6 (9.6)</td>
<td>67.7 (7.2)</td>
<td>79.5 (8.5)</td>
<td>68.6 (7.8)</td>
</tr>
<tr>
<td>Volleyball played (years)</td>
<td>3.7 (2.5)</td>
<td>4.1 (1.4)</td>
<td>4.6 (2.8)</td>
<td>4.1 (2.0)</td>
<td>7.2 (2.3)</td>
<td>6.2 (1.7)</td>
</tr>
</tbody>
</table>

Data are means (SD).

Jumper’s knee 446520304341

<table>
<thead>
<tr>
<th>Jumper’s knee</th>
<th>Baseline</th>
<th>Follow up</th>
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<tbody>
<tr>
<td>Male (n = 22)</td>
<td>Female (n = 22)</td>
<td>Male (n = 16)</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>6</td>
</tr>
</tbody>
</table>

120 tendons were investigated.
these there were also structural tendon changes on US and neovascularisation on PD sonography (fig 1; tables 2 and 3). During the 7 month period of observation, three (two male and one female) of the nine asymptomatic tendons with structural changes and neovascularisation at inclusion developed clinical symptoms of jumper’s knee, and had abnormal US and neovascularisation on PD sonography. Of the remaining six tendons in this category at inclusion, three

<table>
<thead>
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<th>Follow up</th>
<th>Baseline</th>
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</thead>
<tbody>
<tr>
<td>Normal US/clinically n = 50</td>
<td>Normal US/clinically n = 70</td>
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<td>Abnormal US and normal clinically n = 20</td>
</tr>
<tr>
<td>Abnormal US and normal clinically n = 1</td>
<td>Abnormal US and normal clinically n = 20</td>
</tr>
<tr>
<td>Normal US clinical jumper’s knee n = 1</td>
<td>Abnormal US clinical jumper’s knee n = 2</td>
</tr>
<tr>
<td>Abnormal US and normal clinically n = 3</td>
<td>Normal US/clinically n = 1</td>
</tr>
<tr>
<td>Abnormal US and normal clinically n = 5</td>
<td>Abnormal US and normal clinically n = 24</td>
</tr>
<tr>
<td>Normal US clinical jumper’s knee n = 1</td>
<td>Normal US/clinically n = 1</td>
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<tr>
<td>Abnormal US and normal clinically n = 3</td>
<td>Normal US clinical jumper’s knee n = 3</td>
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<td>Abnormal US and normal clinically n = 9</td>
<td>Abnormal US clinical jumper’s knee n = 3</td>
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<td>Normal US clinical jumper’s knee n = 1</td>
</tr>
<tr>
<td>Abnormal US and normal clinically n = 2</td>
<td>Normal US and clinical jumper’s knee n = 2</td>
</tr>
<tr>
<td>Abnormal US and normal clinically n = 12</td>
<td>Abnormal US and clinical jumper’s knee n = 1</td>
</tr>
<tr>
<td>Abnormal US and normal clinically n = 13</td>
<td>Abnormal US and clinical jumper’s knee n = 14</td>
</tr>
</tbody>
</table>

Volleyball players n = 60 Patellar tendons n = 120

Figure 1 Flow chart summarising the longitudinal outcomes.
tendons (three male) did not change in any respect, in two tendons (two male) the neovascularisation disappeared on PD sonography, and in one tendon (one female) the US normalised (that is, vessels also disappeared).

Two of 24 clinically normal tendons (one male and one female) which had abnormal US but no neovascularisation on PD sonography at inclusion, developed clinical jumper’s knee, together with abnormal US and neovascularisation on PD sonography.

A total of 20 pain free and ultrasonographically normal tendons developed structural tendon changes on US, and 12 of these (nine male and three female) also developed neovascularisation on PD sonography.

At inclusion, three tendons (three female) were diagnosed clinically as having jumper’s knee but had normal US and no neovascularisation on PD sonography. At follow up, two of these were now clinically normal and still had normal US and no neovascularisation on PD sonography. The other was still diagnosed as jumper’s knee, but had normal US and no neovascularisation on PD sonography.

**DISCUSSION**

This longitudinal study provides novel cross sectional and longitudinal data regarding structural changes on US, neovessels seen on PD sonography, and clinical correlation in jumper’s knee.

**Prevalence and structural abnormality on US**

Jumper’s knee is a common problem among senior volleyball players. This investigation shows that jumper’s knee is already relatively common (14%) among high level volleyball players at a relatively young age. This is higher than the 7% reported by Lian et al in a group of male and female basketball players (14–18 years of age), but lower than the 36% reported by Lian et al in a group of 47 male senior professional volleyball players.

The absence of an association between structural tendon changes and symptoms of jumper’s knee has previously been reported. In our study, we found grey scale structural tendon changes at baseline, but no pain, in 15/98 tendons (15%) at follow up.33 In 3/18 tendons with persistent structural tendon changes, symptoms characterised as jumper’s knee had developed.

**Association between neovessels and tendon pain**

The possible relationship between chronic tendon pain and neovascularisation has recently been highlighted in the Achilles tendon. In patients with chronic painful mid-portion Achilles tendinosis and chronic insertional Achilles tendon pain, we demonstrated an association between the occurrence of neovascularisation and pain during tendon loading activity. Also, Terslev et al reported an association between neovessels and pain in a small sample of elite male basketball players with jumper’s knee. In the present study, the majority of patients, especially the males, who had a clinical diagnosis of jumper’s knee also had structural tendon changes and neovascularisation. These findings indicate a possible relationship between the combination of structural tendon changes plus neovascularisation, and pain during patellar tendon loading activity. It is noteworthy that at inclusion there were nine clinically normal tendons that had structural tendon changes plus neovascularisation, but no pain.

### Table 3 Jumper’s knee symptoms and sonographic findings at baseline and at 7 month follow up

<table>
<thead>
<tr>
<th>Hypoechic regions</th>
<th>Chronic symptomatic tendons</th>
<th>Asymptomatic tendons</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
<td>Follow up</td>
</tr>
<tr>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>Hypoechic regions</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hypoechic regions and PD flow 1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hypoechic regions and PD flow 2–3</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>No changes on US</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>
Neovascularisation and pain in jumper’s knee

What is already known on this topic

Jumper’s knee (chronic patellar tendinosis) is a troublesome condition mainly seen in athletes engaged in explosive jumping sports, such as volleyball, and is likely associated with overloading of the knee extensor mechanism.

with the findings reported by Cook et al in a similar group of junior basketball players. Structural tendon changes have previously been suggested to increase the risk of developing symptoms of jumper’s knee in junior basketball players.

The correlation between the occurrence of neovessels and pain is moderate in this study but better than that found using grey scale US alone in the cross sectional analysis. However, this is a prospective study, and perhaps neovessels are early signs of a deterioration of the condition, in later stages resulting in pain during tendon loading activity. Further studies should examine whether vascular effects (ingrowth, dilatation) precede neural changes (ingrowth, stimulation) in this condition. Further follow up studies will clarify the fate of these tendons.

In summary, a clinical diagnosis of jumper’s knee in junior elite volleyball players is associated with neovascularisation in the area with structural tendon changes, and neovascularisation together with structural tendon changes in asymptomatic volleyball players may indicate a risk for developing jumper’s knee. Further prospective studies over a longer period of time can possibly clarify the dynamic pattern of development of clinical symptoms and structural and vasculoneural tendon changes.

What this study adds

Neovascularisation was a common finding in adolescent elite junior volleyball players with a clinical diagnosis of jumper’s knee combined with structural tendon changes at ultrasonography. The occurrence of neovessels might possibly indicate a deterioration of the condition.

...
This clinical paper deals with the most intriguing matter of overuse related tendon changes in athletes. This study may in particular facilitate the search for the missing link between structural changes and symptoms.\(^1,^3\) The association of neovascularisation and symptoms (or increased risk for symptoms) supports earlier mentioned hypotheses of neural ingrowth accompanying neovessels and possibly causing pain in tendinopathy.\(^2\) The idea, suggested by the authors, that neovascularisation reflects a deterioration of the condition was also mentioned in connection with Achilles tendinopathy.\(^4\) However, whether the vascular ingrowth precedes the neural ingrowth in tendinopathy is thus far not substantiated and warrants further studies on this subject. Moreover, a notable observation is the existence of clinical tendinopathy without ultrasonographic changes or neovascularisation. This type of patients would not fit in the suggested pattern of symptoms and vasculoneural tendon changes. Nevertheless, much credit must be given to this very interesting clinical study that undeniably will prompt further research on tendinopathy.

K Peers
University Hospitals Leuven, Leuven, Belgium; koen.peers@uz.kuleuven.ac.be

REFERENCES

ELECTRONIC PAGES

Online case reports

Sequential avulsion of the anterior inferior iliac spine in an adolescent long jumper
C Yildiz, Y Yildiz, M T Ozdemir, et al

We present here an unusual case of a sequential avulsion fracture of the anterior inferior iliac spine (AIIS), occurring first in the right and then the left AIIS, during long jump attempts. The case of a 17 year old boy with pain around his right groin, which first occurred during a long jump attempt, is presented. Radiographic examination revealed an avulsion fracture of the right AIIS. After conservative treatment, full athletic activity was allowed 2 months after the injury. However, 4 months later the patient returned with a similar pain in the opposite side of his groin. Radiographs revealed another fracture of the left AIIS. The boy underwent the same treatment protocol; he was examined with isokinetic dynamometry. No complication or re-injury occurred during the 2 year follow up period. In the present study, we introduce the first case of a sequential bilateral AIIS avulsion fracture caused by a long jump.

(Br J Sports Med 2005;39:e31) http://bjsm.bmjjournals.com/cgi/content/full/39/7/e31

Ventricular septal defect in a world class runner
A Boraita, J Esteve-Lanao, M Perez, et al

We report the case of an elite male, East African endurance runner (18 years old) who ranked in the top 15 in the World Cross Country Championships (sub 21 year old category) despite having a ventricular septal defect (VSD; width: 0.22 cm) that was diagnosed 2 weeks after this event with echocardiographic evaluation. This athlete was a moderate altitude native (~3000 m). Cardiac dimensions were within normal limits and no significant pathological signs were observed. His VO\(_{2\text{max}}\) was relatively low given his performance level (67.9 ml kg\(^{-1}\) min\(^{-1}\)). Despite his limited training background (only 1 year), his running economy was, however, better than the values reported in our laboratory for Caucasian runners of the same age. Further cardiological follow up might confirm that the VSD causes no pathological effects or any performance detriment in future years.

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