

Interferential current therapy

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Introduction
Therapists often use transcutaneous electrical stimulation to treat their patients. They can select alternating current of various frequencies or direct current applied continuously or as a train of pulses. Each type of current has both advantages and disadvantages when used therapeutically.

Direct current and low-frequency alternating currents (>1 kHz) encounter a high electrical resistance in the outer layers of the skin. This makes the treatment of deep structures painful because a large transcutaneous current must flow so that adequate current passes deeply. Alternating currents of medium (>1 kHz to <10 kHz) or high frequency (>10 kHz) meet little resistance (due to a marked reduction in the effects of skin capacitance upon current flow) and penetrate the tissues easily, although such currents generally oscillate too rapidly to stimulate the tissues directly1-3.

These difficulties were overcome in the early 1950s with the development of interferential current therapy. The equipment produces two alternating currents of slightly differing medium frequency and is used widely to induce analgesia, elicit muscle contraction, modify the activity of the autonomic system, promote healing, and reduce oedema3-5.

Use of interference effects in therapy
When two or more sinusoidal currents alternate at the same frequency, rising and falling at exactly the same time, they are said to be in phase. Waves become out of phase when they are a half wavelength out of step and the rising segment of one coincides with the falling segment of the other. Waves in phase interfere constructively to produce a resultant wave with an amplitude greater than that of either of the originals. Waves out of phase interact in a similar way but interfere destructively to cancel each other out (Figure 1).

Interference also occurs between waves of slightly differing frequency. As one wave peak ‘catches up’ with the other, constructive interference causes an increase in the amplitude of the resultant wave, which declines subsequently as the waves again drift out of phase and interfere destructively. The rate at which the amplitude of the resultant rises and falls is equal to the difference in frequency present between the two original waves and is called a ‘beat frequency’. This process is an example of amplitude modulation.

Interferential current therapy exploits this principle of interference to maximize the current permeating the tissues whilst reducing to a minimum unwanted stimulation of cutaneous nerves. The principal components of an interferential unit, illustrated in Figure 2, are a pair of signal generators, the output of one oscillating at the fixed frequency of 4000 Hz whilst the other is variable in frequency between 4000 and 4250 Hz. These signals are then amplified to a therapeutically useful intensity. The

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0306-4179/90/02087-06

Figure 1. Amplitude modulation of alternating currents by interference

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Figure 2. An interferential therapy unit with vacuum and flexible carbon rubber electrodes

A variable-frequency oscillator can sweep automatically between one pre-set frequency and another, thus producing a range of beat frequencies that yield several therapeutic effects, all of which may be obtained with a single application.4

Two pairs of electrodes, conveying separately the amplified output of the oscillators, are aligned on the skin so that the currents flowing between each pair intersect and interfere within the structure to be treated. A resultant current of low frequency is generated that alternates at 0–250 Hz. The precise frequency will depend upon the difference that exists between the frequencies of the original currents. The beat frequency current flows maximally in the region of maximum interference that develops along diagonals extending at 45° to the direct paths between the two sets of electrodes (Figure 3). A snowflake-shaped field is created because one current flows laterally from its direct path to interact with the adjacent current. This region of maximal therapeutic effect is usually static and situated deep within the tissues.3

Static fields are used to treat small, well defined lesions but may miss sites of more diffuse damage. This difficulty is overcome by scanning the region of maximum interference systematically through the tissues. A voltage (and hence a current) applied to one of the pairs of electrodes, varying rhythmically in intensity with respect to the other, will influence an area that expands and recedes regularly. This causes the region of maximum interference to pan through the tissue.5 Most interferential units offer this as an automated facility, although all such automatic functions have a manual over-ride.

Some units allow for both currents to be applied in one circuit using a single pair of electrodes. Interference current will affect all the tissues between the electrodes and allow poorly localized lesions to be treated adequately. This area of maximum interference is, however, dispersed widely, thus reducing the therapeutic effect. The behaviour of interference currents in fluid media is considered in greater detail elsewhere.6

Some manufacturers offer equipment that can also operate at a base frequency of 2 kHz. The interference currents so generated are of similar frequency to those produced by the interaction of currents alternating at 4 kHz, although clinical practice suggests that the lower base frequency is able to stimulate muscles more effectively.1

Recent advances in electronic design enable manufacturers to supply units that generate three-dimensional, or stereodynamic interference fields. Three currents of slightly differing medium frequency are applied via three separate electrode pairs. These interact to affect a greater volume of tissue than is possible with the more common twin-current quadripolar application.7

Techniques, contraindications and safety

The area of skin to be treated is cleaned with soap and water to reduce linear electrical resistance (reactance arising from capacitance is unchanged) and the electrodes are fixed to the skin with tape. Some apparatus is supplied with electrodes that are held in place by suction cups evacuated using a vacuum pump. This facility is useful when treating regions such as the trunk where it is difficult to strap an electrode. The electrodes are orientated so that the two currents intersect within the target structure. Alternatively, the therapist may wear one electrode of each pair as a glove and vary the site of maximum interference during the treatment. Some units incorporate four electrodes into a single small applicator, thus facilitating the effective treatment if superficial and localized lesions.

The intensity of the current is increased gradually until the patient reports that a further rise would cause discomfort. Cutaneous nerves accommodate rapidly to this stimulus and after a few seconds a larger current can be applied. This procedure is
repeated until no further accommodation is observed. Most patients tolerate interferential therapy well. Further explanation of the practical aspects of treatment are available in various authoritative texts.2,4,5,8-10

Contraindications are few, although the prudent would not treat patients presenting with very acute inflammation, fever, tumour, thrombosis, those who are pregnant, have a marked aversion to this type of therapy, or persons wearing a cardiac pacemaker. Concern that interferential therapy might promote the aggregation of platelets and induce thrombosis appears unfounded.11

This apparatus should not be used within five metres of an operational short-wave diathermy unit because the cables may act as antennae and conduct a dangerous quantity of RF energy to the patient.6

Physiological and therapeutic effects of interferential currents

The current flowing between each pair of electrodes is insufficient to stimulate nerve and muscle directly until amplitude is modulated by interference. Interferential therapy thus reduces the stimulation of cutaneous sensory nerves near the electrodes whilst promoting the effect upon deep tissues.

The physiological effect of an amplitude-modulated suprathreshold current depends upon frequency. Neurons exhibit a maximum rate at which action potentials are conducted and this is a function of the degree of myelination and the diameter of the axon. Repetitive stimulation at any frequency up to its maximum (1 kHz for a large motor neuron) will cause action potentials to flow in the axon at the same rate. As the rate of stimulation increases above this value, successive stimuli fall within the relative, and eventually the absolute refractory period of the preceding action potential. A larger than normal flow of current is necessary to stimulate a refractory neuronal membrane and thus the sensitivity of the nerve decreases. This effect is termed Wedensky inhibition. Prolonged stimulation at a supramaximal frequency will eventually cause the axon to cease conducting. Accommodation of the neuron is responsible for this effect, caused by an increased threshold and synaptic fatigue.12 Some sources report that these effects occur in large neurons stimulated at frequencies as low as 40 Hz.13 Small or unmyelinated neurons have a slower conduction velocity and longer refractory period than large neurons and will show a stimulus-induced block to conduction at a lower frequency.

Stimulation of muscle

A neurone showing the reduced sensitivity associated with Wedensky inhibition will also have a rate of firing independent of the frequency of the applied stimulus. This rate is dictated instead by the duration of the refractory period. Known as the Gildemeister effect, rapid stimulation of a motor nerve with large although comfortable interferential currents will result in an asynchronous depolarization of individual motor units. This mimics the pattern observed during a normal voluntary contraction. Traditional low-frequency neuromuscular stimulation tends to recruit only the large axon motor neurons, which have a lower threshold than small fibres, and innervate muscle fibres that fatigue readily. This pattern of discharge is synchronous and unlike a normal contraction.

Motor excitation using interferential currents is considered by many to represent an advance over the other low-frequency methods of stimulation. The optimum frequency of stimulation for most voluntary muscle appears to be 40-80 Hz,14 whilst visceral muscle, supplied by the autonomic nervous system, is stimulated optimally at 10-50 Hz.15

Interferential therapy can produce a torque in the quadriceps femoris greater than 50% of that achieved during a maximal voluntary contraction.16 This performance certainly equals that of the other methods of electrical muscle stimulation.14 A favourable clinical outcome was also reported in the treatment of muscular paralysis arising from degeneration of the facial nerve17 and radial epicondylitis.18

Control of pain

The analgesic effect of interferential therapy can be explained in part by Wedensky inhibition of Type C nociceptive fibres, although other mechanisms are certainly involved. ‘Pain gate’ theory, proposed by Malzack and Wall9 and much modified subsequently,20 remains central to this explanation. Briefly, this theory proposes that action potentials travelling in large-diameter myelinated afferent nerves from cutaneous receptors compete for access to the central ascending sensory tracts in the dorsal horn of the spinal cord with those of small-diameter unmyelinated sensory fibres carrying pain information. Activity in the large fibres takes precedence over that in small fibres, ‘closing the gate’ to pain information entering the central nervous system and preventing it from reaching a conscious level. Pain is thus reduced. Large-diameter myelinated fibres are stimulated optimally at 100 Hz.20,21 and clinical experience indicates that interferential therapy at this frequency reduces pain markedly, especially when applied to acupuncture points. Pain will also reduce as motor stimulation increases the circulation of body fluid and promotes an efflux of pain-inducing chemicals from the site of damage.

Another system that helps to reduce pain is the ‘descending pain suppression mechanism’, which is mediated by the endogenous opiates. Nociceptive information that enters the spinal cord travels to the thalamus and will interact in the mid-brain with many structures. The raphe nuclei are amongst the most important of these, and increased activity in fibres descending from the raphe nuclei to the spinal segment at which the pain information entered will release inhibitory neurotransmitters that block further conduction.22 Interferential current with a frequency of 15 Hz affects these fibres maximally.5,21 A beat frequency varying rhythmically within a narrow range about this optimum value avoids the problem of accommodation to the stimulus.4,5,2. Pain
will initially intensify as this mechanism is activated by transcutaneous stimulation of Type Aδ and C fibres, although the analgesia induced subsequently appears more enduring than that achieved by recruiting the ‘pain gate’ system.

Interferential therapy is often applied clinically to control pain but few rigorous studies are reported that justify this use. Taylor et al. noted that jaw pain was not controlled adequately by interferential therapy, although pain induced deliberately by immersion of a limb in iced water was rated as less severe, compared to the experience of the controls, by subjects treated previously with interferential current at 100 Hz (Goats et al. 1989 unpublished findings). Pain arising from sprained joints was reduced markedly by a 15 minute application of interferential therapy at a frequency varying between 0 and 100 Hz and classical migraine responded well to treatment at 90–100 Hz for 10 minutes applied to the zygomatic arch.

The placebo effect is a potent factor in the use of an interferential therapy unit.

### Autonomic effects and the control of incontinence

Type Aδ and C fibres, and those of the autonomic nervous system, are generally small and poorly myelinated. Clinical evidence suggests that these small neurons of the peripheral nervous system fail to conduct when stimulated at frequencies exceeding 40 and 15 Hz respectively. When extrapolated to the autonomic nervous system, this behaviour can be exploited therapeutically by using the stimulus of an interferential current to reproduce by non-invasive means the vasodilatation caused by chemical sympathectomy in peripheral vascular disease and reflex sympathetic dystrophy. There is some disagreement regarding the precise frequency at which this inhibitory response occurs.

Several authors report confidently that low-frequency currents can also be used to stimulate the autonomic system selectively.

Interferential therapy can benefit patients with both stress and urge incontinence although the causes of each differ. Stress incontinence results from an incompetent urethral sphincter mechanism, whilst urge incontinence arises from a disinhibition of the detrusor muscle. Patients showing stress incontinence, urge incontinence, or both, and treated with interferential therapy at 0–100 Hz for 15 minutes on three days per week reported decreased frequency of micturition. Extensive studies conducted by Laycock and Green were designed to identify precisely the optimum frequency of stimulation, and position of the electrodes, for the treatment of incontinence. Drawing upon results obtained using animals, they concluded that stress incontinence should be treated at 10–50 Hz for 15 minutes. Initially such stimulation should cause the external urethral sphincter to close by a direct action upon the slowly conducting pelvic sympathetic nerves. An additional treatment at the higher frequency excites maximally the perineal branch of the pudendal nerve (which has a conduction velocity that lies in the slow to medium range, depending upon the twitch speed of the muscle fibre that it innervates) and hence recruits all elements of levator ani.

Urg incontinence is treated at 5–10 Hz for 30 minutes, the lower small afferent fibres in the pudendal nerve that have a slow conduction velocity. This will produce reflex inhibition of detrusor following contraction of the slow twitch pelvic floor muscles. A clinical evaluation of these regimes is not yet available. Other workers have failed to identify a role for interferential therapy in the treatment of anorectal incontinence.

### Control of circulation and reducing oedema

Several studies investigate changes in the rate of blood flow following transcutaneous electrical nerve stimulation. Stimulation applied to the dorsal roots or spinal segment of origin of a peripheral nerve causes peripheral vasodilatation in the structures innervated by it. Sufferers from Raynaud’s syndrome treated for five minutes at 90–100 Hz in the region of the stellate ganglion in the neck showed a doubling of pulse volume in the digital vessels. Nikolova-Troeva demonstrated a similarly marked sympatholytic improvement in patients with endarteritis obliterans who failed to respond to chemical sympathectomy or medication. Supporting these findings is a report that those with a peripheral vascular disease benefit from interferential therapy at 0–100 Hz for 10 minutes, although recent investigations cast doubt on the reproducibility of these effects.

Interferential therapy at a frequency of 100 Hz is recommended for the reduction of acute oedema. Such stimulation will activate the musculoskeletal pump and inhibit sympathetic activity, thus assuring the drainage of fluid from the affected area. Interferential currents also appear to have a direct effect upon the cell membrane and reduce the escape of intracellular fluid.

Chronic oedema is treated optimally using a two-stage application. Initially the current is applied at 100 Hz to promote vasodilatation. This is followed by a treatment at 10 Hz which activates the musculoskeletal pump to remove fluid that has returned to the venous and lymph channels.

Evidence supporting the use of interferential therapy in the control of oedema appears mainly anecdotal, although in most textbooks this still appears as an indication.
interferential therapy that are as yet understood poorly, such as the acceleration of bone healing and the repair of nerves and ligaments, and improved regeneration of the liver. Further consideration of this topic is beyond the scope of the present work and the interested reader is referred elsewhere.

The use of electric currents to promote the healing of bone currently enjoys considerable interest. An extensive literature attends this topic and again the interested reader is referred to recent reviews for further information. Interferential therapy is still little used in this capacity, although good results are claimed in the treatment of acute fractures of the tibia and fibula at 20 Hz for 20 minutes on five days per week. The same author reports a beneficial effect, on the basis of empirical observations, in cases of delayed or non-healing. Interferential therapy at 20 Hz for 20 minutes improved the union of mandibular fractures, and at 100 Hz for 20 minutes accelerated the resolution of Sudeck’s atrophy and pseudoarthrosis. The rate of callus formation and subsequent mineralization resulting from fractures induced experimentally in the radius and ulna was more rapid in animals treated with interferential therapy.

Therapy in neurological impairment

Spasticity resulting from a cerebrovascular accident was suppressed by the stimulation of groups of muscles antagonistic to those in spasm. This was achieved using an interferential current alternating at 50 Hz, and although the spasticity returned after one hour, useful progress in rehabilitation was possible during this period. Chronic electrical stimulation for eight hours daily at 10 Hz helped to reverse neuroopathic changes caused by diabetes in rats, and may indicate a method by which vulnerable nerves might be protected.

Conclusion

Interferential current therapy is used widely to stimulate tissues that lie deep within the body. The effects can be local or more general depending upon the configuration of the current applied to the skin. Unlike other methods of low-frequency electrical stimulation, these currents encounter a low electrical resistance and can thus penetrate deeply without causing undue discomfort.

Several physiological effects clearly occur during interferential current therapy, although reliable clinical studies seeking to evaluate the claimed therapeutic benefits are reported infrequently.

Research suggests that interferential therapy can effectively stimulate voluntary muscle, promote peripheral blood flow, and accelerate bone healing. Empirical observations support a case for using this technique to reduce pain and control incontinence. Interferential therapy would seem to represent a valuable adjunct to the medical and physiotherapy management of the pathologies seen frequently by those specializing in sports medicine. As research continues to clarify the precise characteristics of the current required to treat these various types of lesion successfully, interferential therapy will continue to grow in importance as a versatile and effective approach to therapy.

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