Eccentric decline squat protocol offers superior results at 12 months compared with traditional eccentric protocol for patellar tendinopathy in volleyball players

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Background: Conservative treatment of patellar tendinopathy has been minimally investigated. Effective validated treatment protocols are required.

Objectives: To investigate the immediate (12 weeks) and long term (12 months) efficacy of two eccentric exercise programmes for the treatment of patellar tendinopathy.

Methods: This was a prospective randomised controlled trial of 17 elite volleyball players with clinically diagnosed and imaging confirmed patellar tendinopathy. Participants were randomly assigned to one of two treatment groups: a decline group and a step group. The decline group were required to perform single leg squats on a 25° decline board, exercising into tendon pain and progressing their exercises with load. The step group performed single leg squats on a 10 cm step, exercising without tendon pain and progressing their exercises with speed then load. All participants completed a 12 week intervention programme during their preseason. Outcome measures used were the Victorian Institute of Sport Assessment (VISA) score for knee function and 100 mm visual analogue scale (VAS) for tendon pain with activity. Measures were taken throughout the intervention period and at 12 months.

Results: Both groups had improved significantly from baseline at 12 weeks and 12 months. Analysis of the likelihood of a 20 point improvement in VISA score at 12 months revealed a greater likelihood of clinical improvements in the decline group than the step group. VAS scores at 12 months did not differ between the groups.

Conclusions: Both exercise protocols improved pain and sporting function in volleyball players over 12 months. This study indicates that the decline squat protocol offers greater clinical gains during a rehabilitation programme for patellar tendinopathy in athletes who continue to train and play with pain.

Patellar tendinopathy (jumper’s knee) occurs in several sports, with jumping athletes being the most susceptible. For example, the prevalence of jumper’s knee is 40–50% among elite volleyball players. This often recurrent condition can severely limit or even end an athlete's career, and recovery from each episode can be prolonged. Importantly, the condition is not self limiting, and, although rest may offer symptomatic relief, pain often recurs on resumption of activity. Surgical options have provided limited success, with a retrospective study finding that only half of all athletes who had either open or arthroscopic patellar tenotomy were competing at their former sporting level at a four year follow up.

Tendinopathy research to date has concentrated on the morphology and aetiology of this condition, with little focus on conservative treatment options. Although testing the efficacy of clinical intervention protocols does not identify the underlying pathomechanics, it does provide invaluable clinical information on the usefulness of these protocols.

Conservative treatment of patellar tendinopathy is empirically and clinically based, with progressive eccentric strengthening forming the cornerstone of most rehabilitation programmes. Despite this, there is little clinically relevant research on which to base an eccentric training programme, as there are few randomised controlled trials that have compared exercise based protocols for this condition. Although speed based eccentric exercise programmes proposed by Curwin and Stanish are in widespread use, the efficacy of these programmes for patellar tendinopathy has not been fully investigated.

The success of a pain based eccentric exercise programme has been demonstrated in the treatment of Achilles tendinopathy, but the effect of painful eccentric training during the rehabilitation of patellar tendinopathy is unknown. Furthermore, recent investigations have shown that squats performed on a 25° decline board target the knee extensor mechanism more specifically than the standard squat, and it has been suggested that this may be relevant in the management of patellar tendinopathy. Given these findings, a combination of squatting on a decline board and into tendon pain would theoretically provide an effective conservative treatment protocol for patellar tendinopathy.

The purpose of this study was to investigate the short and long term efficacy of two exercise programmes, one based on a traditional eccentric protocol (step group) and one based on more contemporary treatment options (decline group), for the treatment of patellar tendinopathy in volleyball players throughout a competitive season.

METHODS
This prospective randomised controlled trial used a parallel group, repeated measures design with an intervention period of 12 weeks and follow up at 12 months. Participants were recruited from the elite Victorian State League Volleyball (Australia) competition and clinically assessed (JC) on the last weekend of the regular season (2001). The La Trobe
University Human Ethics Committee approved the project, and all participants provided written informed consent. Participants had to be aged 18–35 years and present with proximal patellar tendon pain that limited sporting function. To be included, they had to have tendon pain on palpation, symptom reproduction on jumping, squatting, and/or step-squatting, absence of referred pain outside the tendon, a Victorian Institute of Sport Assessment (VISA) score less than 80 points, and an abnormal (hypoechoic) ultrasound. Participants were excluded if they had undergone any knee surgery in the preceding 12 months, patellar tendon surgery, corticosteroid injection into the tendon, or anterior cruciate ligament reconstruction (patellar tendon), presented with patellofemoral pain, or were receiving adjunct treatment for knee pain. Participants with bilateral knee pain were asked to select the most symptomatic knee for the purposes of the study.

**Outcome measures**

The primary outcome measure used was the VISA score, designed specifically to quantify knee function in athletes with patellar tendinopathy. Ranging from 0 to 100, the VISA score consists of eight questions assessing symptoms and simple tests of function and ability to play sport. A maximum score of 100 points represents full pain free function. Competing athletes with patellar tendinopathy commonly record a score of 50–80 points. The 100 mm visual analogue scale (VAS) was used as a secondary outcome measure for average tendon pain during weekly activity. Both measures have been shown to be valid and reliable.

To assess the stability of initial scores, participants were assessed before and after an eight week control period between recruitment and baseline testing (fig 1). After baseline testing, participants assigned themselves to a group by randomly drawing from a batch of sealed, shuffled envelopes. VISA and VAS scores were recorded every four weeks during the intervention period and at 12 months. Investigators were blinded to all VAS and VISA measurements throughout the study. Participants were required to complete a daily training diary during the intervention period. This diary was used to monitor compliance, additional activity, and any drugs used.

**Intervention**

Participants were required to complete their exercises twice a day for 12 weeks. Both groups completed three sets of 15 repetitions during a session. All exercises were completed on a single (affected) leg to about 60° of knee flexion, with participants being taught 60° of knee flexion during their initial session. Both groups progressed load by adding weight to a backpack in 5 kg increments.

The decline group used a 25° decline board to perform their squats (fig 2A). They completed the downward component (eccentric phase) of the squat on the symptomatic leg, and the upward component (concentric phase) on the asymptomatic leg. They were instructed to exercise into moderate tendon pain and to progress by increasing load if this pain eased. Participants in the step group used a 10 cm step to perform their squats (fig 2B). They completed both components of the squat on the symptomatic leg. They were instructed to exercise with minimal tendon pain only and progress their speed from slow to fast, as outlined in the program.
positive change, as with the VISA scores. Clinical significance was calculated by considering the probabilities that the effect was clinically significant rather than a more artificial, short term period, or negative (less than −10 points) for each participant. To provide case of interpretation, VAS scores were inverted for this analysis so that an improvement was signalled by a positive change, as with the VISA scores.

RESULTS All participants (13 men, 4 women) completed the 12 week intervention and 12 month follow-up (fig 1). There were no differences between the groups for subject age (mean (SD) 27.3 (18) years) or weight (82.5 (11.5) kg). There was a significant ($p = 0.01$) difference in height between the groups (decline group 178.3 (8.3) cm; step group 191.4 (9.1) cm). This is probably because three women were randomised to the decline group and one to the step group. There was no difference between groups for exercise compliance, with a mean compliance of 72 (18)% of total possible sessions.

Statistical analysis revealed no change in outcome measures between or within groups over the eight week control period from recruitment to baseline testing (fig 3). Both groups had improved significantly ($p<0.05$) from baseline in both outcome measures at 12 weeks and 12 months, but there was no difference between groups for either outcome measure at any time.

Analysis of the likelihood of obtaining a clinical improvement in VISA scores at 12 weeks revealed no difference between groups. At 12 months, however, the decline group displayed a considerable difference in the likelihood of improvement in VISA scores (fig 4A). With the smallest practically important increase in VISA score set at 20 points, there was a 94% chance that the decline group would have a positive result at 12 months, compared with a 41% chance in the step group. Analysis of VAS score improvements revealed that the step group had an increased likelihood of reduced pain on VAS scores at 12 weeks compared with the decline group (fig 4B). There was no difference in improvement between the groups at 12 months.

DISCUSSION Both the decline and step protocols were effective in the treatment of tendon pain and sporting function in athletes with patellar tendinopathy. Clinicians can confidently use both conservative protocols investigated in this study to positively affect pain and, more importantly, the ability to play sport in jumping athletes. However, over a 12 month period, the decline protocol gave a considerably greater likelihood of a 20 point or more improvement in VISA score.

A more contemporary analysis was used to determine the likelihood of obtaining a clinically worthwhile outcome. The smallest clinically important change in VISA and VAS scores was set at 20 points for both outcomes, as a 20 point improvement was considered to reflect a significant change in functional capacity. Clinical significance was calculated by considering the probabilities that the effect was clinically positive (greater than 20 points), trivial (20 to −10 points), or negative (less than −10 points) for each participant. To provide case of interpretation, VAS scores were inverted for this analysis so that an improvement was signalled by a positive change, as with the VISA scores.

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and both groups completed the season with similar reductions in pain.

The purpose of this study was to compare contemporary treatment options (decline protocol) with a traditional eccentric programme (step protocol). Our ability to specify which component of the protocols was responsible for differences in improvement between treatment groups is limited because there was more than one variable between groups in this study design. Differences between groups were: squatting on a decline board or level ground, loading the eccentric phase only or both phases, exercising into tendon pain or short of pain, and progressing with speed then load or simply load. Comment on which aspect of the decline protocol was most effective in causing change in sporting function and tendon pain is reserved for more specific studies with greater numbers.

CONCLUSIONS
In active jumping athletes with patellar tendinopathy, both exercise protocols improved pain and sporting function. This study shows that the decline squat protocol presents a much greater chance of clinical improvement in VISA scores over a 12 month season than the step protocol. Therefore we recommend the use of the decline squat protocol during a rehabilitation programme for patellar tendinopathy in athletes who continue to train and play with pain. Further studies with larger numbers are required to confirm and further explore these findings.

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Patient consent has been obtained for figure 2

Competing interests: none declared

REFERENCES
The book was difficult to access as it was very broad based and general and tended to be repetitive. It was difficult to identify the most suitable audience. Although it contained examples from research studies, no referencing to source material was included.

The goal of obtaining reliable and valid measurement of joint range of motion continues to present a challenge to the clinician and researcher alike. Multiple possible sources of error remain to be overcome. Overall, the authors have attempted to minimise measurement variability by providing standardised measurement processes. Unfortunately, improved reproducibility may not always guarantee the validity of the measurement, which is relevant when the patient’s range of motion is compared with normative data for evaluation of impairment. It is recognised that it is difficult to develop a standardised measurement technique that adequately addresses all issues and can be applied to all joints and regions. Nevertheless, this book represents another step in the right direction.


The editors are to be congratulated for their work in the field over the years represented in this text which has arisen from a series of World Congresses of Science and Football which began in 1987 in Liverpool. Unfortunately, this also reveals a weakness in the limited pool of authors from which the text draws, the majority of whom list their professional addresses as Liverpool. As an Aussie with an AFL background, it may be a bit presumptuous of me to criticise those from the birthplace of the game (and the current home of a champion Australian player). However, bearing in mind recent international results, it is fair to assume that some sports science knowledge in soccer may
exist in places such as South America, Asia, Africa, and possibly Greece! And what was the score at Upton Park in 2003 anyway!

This text is certainly comprehensive in the areas it covers and easily read from the first whistle to the full 90 minutes. As stated, it covers every key facet of the game including players’ anatomy, physiology, biomechanics and psychology, coaching and training methods, nutrition, injury prevention and rehabilitation, surfaces and equipment, match analysis, growth and development of younger players, and talent identification. The allocation of space given to each area perhaps fairly reflects the strengths and areas of interest of the contributors. If readers of this journal such as team doctors and physiotherapists are after detail on sports medicine and injuries in soccer, they will be disappointed particularly by the 10 page chapter on injury prevention and rehabilitation.

The value for many readers in this text perhaps lies in the knowledge and understanding they can gain in fields of the sports science professionals around them, rather than their own fields. An understanding of the psychology of injury, coaching, and skill acquisition is provided in some detail and will doubtless improve communication and understanding between team support staff. Other chapters such as those on nutrition and environmental issues provide excellent practical advice for team physicians planning team travel and season routines. I am not sure how the chapter on soccer hooliganism fits into the rest of its section covering coaching science—perhaps this is better in a sociological text.

As a medical professional actively working in soccer, I certainly found this text a useful read and it will retain a place on my bookshelf. It certainly improves my knowledge in the fields of the sports scientists who work with our teams and thus helps me converse from a position of understanding. And of course it will be of value to those undertaking the masters course in Liverpool. For a reference text for sports injuries and soccer, I suggest you look elsewhere.

Rating

- Presentation: 13/20
- Comprehensiveness: 13/20
- Readability: 17/20
- Relevance: 15/20
- Evidence basis: 17/20
- Total: 75/100

[PS: The score was Australia 3, England 1!]

A Jowett

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**CALENDAR OF EVENTS**

**UK Radiological Congress 2005 (UKRC 2005)**

6–8 June 2005, Manchester, UK

The UK Radiological Congress (UKRC) meeting will encompass the medical, scientific, educational, and management issues that are of interest and relevance to all those involved in the diverse fields of radiological sciences and oncology.

The UKRC provides a forum in which to bring together clinicians, scientists, radiographers, technicians, and other professionals to present and discuss the latest developments and challenges in diagnostic imaging, radiotherapy, and allied radiological sciences.

**1st World Congress on Sports Injury Prevention**

23–25 June 2005, Oslo, Norway

This congress will provide the world’s leading sports medicine experts with an opportunity to present their work to an international audience made up of physicians, therapists, scientists, and coaches. The congress will present scientific information on sports injury epidemiology, risk factors, injury mechanisms and injury prevention methods with a multidisciplinary perspective.

Panel discussions will conclude symposia in key areas providing recommendations to address the prevention issue in relation to particular injuries and sports.

**Osteosynthese International 2005**

15–17 September 2005, Curitiba, Hamburg Congress-Chairman: Johannes M. Rueger, M.D., Professor and Chair

Topics:

- Innovations in intramedullary osteosynthesis
- New frontiers in osteoporosis and fracture treatment
- Current trauma research
- Special topic: Recent development in pelvic and acetabular fractures

Abstract submission deadline: 31 March 2005

Further details: INTERCONGRESS GmbH, Martin Berndt, Düsseldorfer Str. 101, 40545 Düsseldorf-Germany. Tel: +49 211 585897-80; fax: +49 211 585897-99; email: martin.berndt@intercongress.de; website: www.osteoint2005.de

**4th European Sports Medicine Congress**

13–15 October 2005, Lemesos, Cyprus

Further details: Email: pyrgos.com@cytanet.com.cy

**BASEM Conference 2005**

10–12 November 2005, Edinburgh, Scotland

Further details: Email: BASEMInfo@aol.com

**BASEM Conference 2006**

5–7 October 2006, Oxford, UK

Further details: Email: BASEMInfo@aol.com

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**CORRECTIONS**

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Eccentric decline squat protocol offers superior results at 12 months compared with traditional eccentric protocol for patellar tendinopathy in volleyball players (Br J Sports Med 2005;39:102–5). The total percentage scores in the final line of figure 4A are incorrect; the correct totals are 6% and 94%. We apologise for this error.

doi: 10.1136/bjsm.2003.009969corr1

Kordi R, Dennick R G, Scammell B E.

Developing learning outcomes for an ideal MSc course in sports and exercise medicine (Br J Sports Med 2005;39:20–3). In table 2 of this paper the Queen Mary University of London course has been listed as an MSc in sports medicine. The course actually concerns sport and exercise medicine, and also offers diploma and certificate level qualifications. We apologise for this error.