Effects of weight bearing and non-weight bearing exercises on bone properties using calcaneal quantitative ultrasound

P S Yung, Y M Lai, P Y Tung, H T Tsui, C K Wong, V W Y Hung, L Qin

Objective: This study was designed to investigate bone properties using heel quantitative ultrasound (QUS) in young adults participating in various sports.

Methods: A cross sectional study was performed on Chinese male students (n = 55), aged 18–22 years. Subjects with previous fractures or suffering from any diseases known to affect bone metabolism or taking any medication with such an effect, were not included. The subjects were categorised according to their main sporting activities, including soccer (n = 15) (high impact, weight bearing exercise), dancing (n = 10) (a low impact, weight bearing exercise), and swimming (n = 15) (non-weight bearing exercise). A sedentary group acted as controls (n = 15). A reproducibility study of the velocity of sound (VOS) and the broadband ultrasound attenuation (BUA) measurement was performed and analysed using the intraclass correlation coefficient (ICC).

Results: There was good intra-investigator and inter-investigator agreement (ICC > 0.8; p < 0.05) in the measurement of BUA and VOS. No significant differences in BUA and VOS (p > 0.05) were found between the dominant and non-dominant heel. Soccer players (137 ± 4.3 dB/MHz; 1575 ± 56 m/s; 544.1 ± 48.4) and dancers (134.6 ± 3.7 dB/MHz; 1538 ± 46 m/s; 503.0 ± 37.0) had significantly higher BUA, VOS, and stiffness index (SI) scores (p < 0.05), respectively, than swimmers (124.1 ± 5.1 dB/MHz; 1495 ± 42 m/s; 423.3 ± 46.9) and the sedentary control group (119.9 ± 6.1 dB/MHz; 1452 ± 41 m/s; 369.9 ± 46.4). A trend of a significant linear increase with the weight bearing and high impact exercise was revealed in all QUS parameters (p < 0.05).

Conclusion: This cross sectional study indicated that regular participation in weight bearing exercise in young people might be beneficial for accruing peak bone mass and optimising bone structure.

Bone strength is determined by both bone mass and bone structure, while “osteoporosis is characterised by low bone mass and structural deterioration of bone tissue, leading to bone fragility and an increase in susceptibility to fractures, especially for hip, spine and wrist.” The current understanding is that maximising peak bone mass is key to preventing osteoporosis and osteoporotic fractures.

Although genetic factors appear to have the greatest impact, exercise, hormonal status, and nutrition can modify the modelling and remodelling of the bone to optimise and maintain peak bone mass. The desired outcome of all treatment regimens is to improve bone strength. Physical exercise, especially weight bearing activity, has been reported to have beneficial effects on the skeleton in both adolescents and the elderly.

Many studies have shown that weight bearing exercise can increase bone mineral density (BMD), particularly at a young age. It has been widely accepted that engaging in weight bearing activity can elicit significant positive bone mass adaptation. Groups that engaged in such exercise were compared with a non-weight bearing exercise group and a sedentary control group using dual energy x-ray absorptiometry (DXA) for BMD measurements, which indicate the site specific effects of osteogenesis induced by mechanical stimuli.

DXA used for the above studies is a common technique for diagnosing osteoporosis. However, DXA only measures bone status in terms of BMD, not bone structure. Techniques such as bone histomorphometry and microCT are used for quantitative studies of bone structure, but they are invasive. In recent years, non-radiation quantitative ultrasound (QUS) has been introduced for assessing skeletal status related to bone structure and mechanical properties in osteoporosis.
Questionnaire
Health and food frequency questionnaires were administered to collect information for each individual on calcium intake, age, history of lower limb fractures, family history of osteoporosis, diseases, medications, and treatments known to affect bone metabolism. The individual’s usual calcium intake in milligrams per day was obtained using a food list on which the individual was asked to indicate his food intake for the previous 7 days. Compiled from the Dietetic Information Center of the Hong Kong Hospital Authority, 33 food items commonly consumed in Hong Kong were listed. For each food item, the participants were asked to indicate their usual consumption in terms of frequency. Their calcium intake was calculated using the method published by the Hong Kong Center of the Hong Kong Hospital Authority.

Anthropometry
Body weight and body height of the participants were recorded and body mass index (BMI) was calculated. The maximum transverse and longitudinal diameters (MTD and MLD) of their feet were also recorded.

Ultrasound measurement
The bilateral calcanei of each subject were measured using a heel ultrasound densitometer (Paris, Norland Medical System, Fort Atkinson, WI, USA). Quality assurance was performed using a dedicated phantom (supplied by the manufacturer) before the first measurement of the day. The dominant foot was determined by the foot used to kick a ball. Ultrasound gel was applied as a coupling medium to ensure good contact. The velocity of sound (VOS) and broadband ultrasound attenuation (BUA) were measured. A stiffness index (SI) was then derived from both the VOS and BUA, where, as defined by the manufacturer, SI = (0.8471 × VOS) + (4.1034 × BUA) − 1352.2. Each subject had three measurements without repositioning to calculate mean value.

Reproducibility of QUS measurement
The dominant heel of 15 control group subjects was used to evaluate the intra-investigator and inter-investigator reliability of the QUS measurement. The measurement was repeated three times with repositioning.

Statistical analysis
One way ANOVA was used to test if there was a difference among the groups in terms of anthropometric parameters, calcium intake, and QUS parameters. A Tukey post hoc test was employed to determine the pairwise difference if the one way ANOVA was significant. A paired t test was used to examine the significance of the differences in the QUS parameters between the dominant and non-dominant heels. The level of significance was set at p<0.05. In the intraclass correlation coefficient (ICC) measurement, a two way ANOVA mixed test model with 95% confidence intervals (CI) and absolute agreement was employed, with a test value of 0.8, to calculate the intra-investigator and inter-investigator variability. All the statistical analyses were performed using SPSS 10.0 for Windows. The results are expressed as mean ± standard deviation (SD), unless stated otherwise.

RESULTS
Subject characteristics
There was no significant difference (p>0.05) in age, body weight, body height, BMI, calcium intake, MTD, and MLD among all the groups (table 1).

Reproducibility of QUS measurement
Agreement between the investigators who measured the same QUS parameters on three occasions in 15 subjects with repositioning, was assessed by ICC. Intra-investigator ICC values were 0.949 (95% CI: 0.921–0.968), 0.866 (95% CI: 0.795–0.916), and 0.954 (95% CI: 0.930–0.971) for VOS, BUA, and SI, respectively. Inter-investigator ICC values were 0.944 (95% CI: 0.878–0.979), 0.953 (95% CI: 0.858–0.975), and 0.949 (95% CI: 0.889–0.981) for VOS, BUA, and SI, respectively. All ICC values were compared with the test value, 0.8 (p<0.05).

Site specificity of exercise effect: dominant and non-dominant foot
No significant differences were found in VOS, BUA, and SI in the QUS measurements of the dominant and non-dominant sides in each study group (p>0.05) (table 2).

Comparison of QUS parameters among exercising and non-exercising control groups
One way ANOVA showed that there were significant differences (p<0.001) in VOS, BUA, and SI among the four groups in both feet (table 2). The BUA of both the dominant and non-dominant sites are shown in fig 1. The mean BUA value at the dominant site of the soccer group was 14.3% (p<0.001) and 5.3% (p<0.001) higher than the value for the control and swimming groups, respectively. The mean BUA of the dancing group was 12.2% (p<0.001) and 8.5% (p<0.001) higher than that of the control and swimming groups, respectively. The mean BUA value obtained from the non-dominant site of the soccer group was 16.6% (p<0.001) and 10.4% (p<0.001) higher than that of the control and swimming groups, respectively. The mean BUA obtained from the non-dominant site of the dancing group was 14.4% (p<0.001) and 8.3% (p<0.001) higher than for the control and swimming groups, respectively. The mean BUA of the swimming group was 5.7% (p<0.01) higher than that of the control and swimming groups.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Subject characteristics (mean ± SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parameter</td>
<td>Control (n = 15)</td>
</tr>
<tr>
<td>Age (years)</td>
<td>21.3 ± 1.2</td>
</tr>
<tr>
<td>Body height (cm)</td>
<td>174.4 ± 5.4</td>
</tr>
<tr>
<td>Body weight (kg)</td>
<td>64.8 ± 8.3</td>
</tr>
<tr>
<td>BMI (kg/m²)</td>
<td>21.3 ± 2.3</td>
</tr>
<tr>
<td>Calcium intake (mg/day)</td>
<td>274.3 ± 190.7</td>
</tr>
<tr>
<td>Frequency (times/week)</td>
<td>–</td>
</tr>
<tr>
<td>Duration (h/time)</td>
<td>–</td>
</tr>
<tr>
<td>MTD (dominant, cm)</td>
<td>9.4 ± 0.6</td>
</tr>
<tr>
<td>MTD (dominant, cm)</td>
<td>9.2 ± 0.5</td>
</tr>
<tr>
<td>MTD (non-dominant, cm)</td>
<td>25.3 ± 1.2</td>
</tr>
<tr>
<td>MLD (dominant, cm)</td>
<td>25.1 ± 1.4</td>
</tr>
<tr>
<td>MLD (non-dominant, cm)</td>
<td>–</td>
</tr>
</tbody>
</table>

BMI, body mass index; MLD, maximum longitudinal diameter; MTD, maximum transverse diameter. There were no statistically significant differences among the four groups, so no adjustments were made for body weight and height, etc.
Effects of weight bearing and non-weight bearing exercises

Table 2 Result of QUS measurements

<table>
<thead>
<tr>
<th></th>
<th>Control</th>
<th>Swimming</th>
<th>Dancing</th>
<th>Soccer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dominant BUA</td>
<td>1452 ± 41†‡</td>
<td>1495 ± 42†</td>
<td>1538 ± 46*</td>
<td>1575 ± 56†</td>
</tr>
<tr>
<td>Non-dominant BUA</td>
<td>1454 ± 46†‡</td>
<td>1503 ± 27†</td>
<td>1521 ± 52†</td>
<td>1579 ± 60†‡</td>
</tr>
<tr>
<td>Dominant SI</td>
<td>119.9 ± 6.1†‡</td>
<td>124.1 ± 5.1†‡</td>
<td>134.6 ± 3.7†‡</td>
<td>137.0 ± 4.3†‡</td>
</tr>
<tr>
<td>Non-dominant SI</td>
<td>118.1 ± 6.2†‡</td>
<td>124.8 ± 4.1†‡</td>
<td>135.1 ± 5.1†‡</td>
<td>137.8 ± 5.3†‡</td>
</tr>
<tr>
<td>Dominant VOS</td>
<td>369.9 ± 46.4†‡</td>
<td>423.3 ± 46.9†‡</td>
<td>503.0 ± 37.0†‡</td>
<td>544.1 ± 48.4†‡</td>
</tr>
<tr>
<td>Non-dominant VOS</td>
<td>364.2 ± 54.2†‡</td>
<td>453.5 ± 23.8†‡</td>
<td>490.7 ± 55.3†‡</td>
<td>551.3 ± 63.4†‡</td>
</tr>
</tbody>
</table>

BUA, broadband ultrasound attenuation; SI, stiffness index; VOS, velocity of sound.
*Significantly different from the control group; †significantly different from the swimming group; ‡significantly different from the dancing group.

control group. In general, there was a significant ascending trend in the BUA of both sites in the following order of groups: control, swimming, dancing, and soccer (p<0.001).

The result of the VOS measurements of both the dominant and non-dominant sites is shown in fig 2. The mean VOS value at the dominant site of the soccer group was 8.5% (p<0.001) and 5.4% (p<0.001) higher than the value of the control and swimming groups, respectively. The mean VOS of the dancing group was 5.9% (p<0.001) higher than that of the control group. The mean VOS value obtained from the non-dominant site of the soccer group was 8.6% (p<0.001), 5.1% (p<0.001), and 3.8% (p<0.05) higher than that of the control group, swimming group, and dancing group, respectively. The value of the dancing group was 4.6% (p<0.05) higher than that of the control group; and that of the swimming group was 3.4% (p<0.05) higher than that of the control group. In general, there was a significant ascending trend in the VOS of both sites in the following order of groups: control, swimming, dancing, and soccer (p<0.001).

The SI values of both the dominant and non-dominant sites are shown in fig 3. For the dominant site, the mean SI value of the soccer group was 47% (p<0.001) and 28.5% (p<0.001) higher than that of the control and swimming groups, respectively. The mean SI of the dancing group was 36.0% (p<0.001) and 18.8% (p<0.001) higher than that of the control and swimming groups, respectively. The mean SI of the swimming group was 14.4% (p<0.05) higher than that of the control group. For the non-dominant site, the mean SI value of the soccer group was 51.4% (p<0.001), 27.2% (p<0.001), and 14.8% (p<0.05) higher than that of the control, swimming, and dancing groups, respectively. The mean SI of the dancing group was 34.7% (p<0.001) and 13.2% (p<0.05) higher than that of the control and swimming groups, respectively. The mean SI of the swimming group was 5.7% (p<0.05) higher than that of the control group. Moreover, significantly higher QUS parameters were measured in exercises with a greater weight bearing loading. These results concur with the present study in that the athletes generally had better bone ultrasonic properties than...
Frost, who stated that exercise has a combined effect on the relationship between loading magnitude and bone can be dominant extremities of the subject groups. The level of impact has been identified, in classified as low, moderate, and high impact exercise, respectively. The level of impact has been identified, in both animal and human studies, as an important determinant of the skeleton’s adaptive response to mechanical loading. More osteogenesis was found when bones were subjected to progressively greater magnitudes of strain through artificial loading in animal experiments. An in vivo human study also showed a significantly high correlation between level of activity and QUS parameters. The relationship between loading magnitude and bone can be explained by the bone mechanostat theory proposed by Frost, who stated that exercise has a combined effect on bone modelling and remodelling, in that bone mass is increased by modelling and the added bone is retained by remodelling. Mechanical loading is also beneficial to bone structure. If a load is imposed, the bone will accommodate and undergo an alteration in mass, external geometry, and internal micro-architecture.

Previous studies indicated the existence of a site specificity effect in volleyball players and squash players. However, site specificity between the dominant and non-dominant foot is not shown in this study. As regards biomechanics, the physical activities entailed in swimming and dancing may exert similar strains on both legs. For soccer players, the supporting leg on the ground during kicking withstands high strains that have comparable loading to the kicking leg.

Most previous studies using DXA found that swimming does not affect the acquisition of bone minerals. However, the present study is inconsistent with those previous studies. We found that the group of swimmers had higher VOS (3.0–3.4%) and BUA (3.5–5.6%) in their bilateral calcanei than the control group. There was a trend towards better QUS parameters in high impact exercise. These findings support the importance of high impact, weight

**Figure 3** Stiffness index (SI) (mean ± SE) of the dominant and non-dominant extremities of the subject groups.

---

**What is already known on this topic**

Previous exercise intervention studies using the preferred technique, dual energy x-ray absorptiometry (DXA), have demonstrated an osteogenic effect. However, DXA only measures bone status in terms of bone mineral density. There has been growing interest in using non-ionising quantitative ultrasound to demonstrate both bone density and structural changes.

**What this study adds**

The findings of this study support the importance of high impact weight bearing exercises in accruing peak bone mass. Swimming, a non-weight bearing exercise, which is believed to have an insignificant effect on bone density increase, may have favourable effects on bone properties, such as elasticity and microstructure, which are detectable in QUS but not in DXA.
bearing exercise at a young age in maximising peak bone mass with better mechanical strength. Our findings suggest that such exercises should be promoted among children to maximise and optimise their bone mass and quality and, hence, prevent osteoporosis in later life.

ACKNOWLEDGEMENTS
We would like to thank the Physical Education Section, Student Affairs Office, The Chinese University of Hong Kong Polytechnic University for support for this study.

Authors’ affiliations
P S Tung, Y M Lai, P Y Tung, H T Tsui, C K Wong, Department of Optometry and Radiography, The Hong Kong Polytechnic University, Kowloon, Hong Kong, China
V W Y Hung, L Qin, Department of Orthopaedics and Traumatology, The Chinese University of Hong Kong, Shatin, New Territories, Hong Kong, China

Competing interests: none declared

REFERENCES
21 Ng YFO, Marlane HF. Relationship of kinetic demands of athletic training and knee joint laxity. Phys Ther Sport 2001;2:66–70.

www.bjsportmed.com