Impact of exercise on articular cartilage in people at risk of, or with established, knee osteoarthritis: a systematic review of randomised controlled trials

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ABSTRACT

Objective To investigate the impact of knee joint loading exercise on articular cartilage in people at risk of, or with established, knee osteoarthritis (OA) by conducting a systematic review of randomised controlled trials (RCTs).

Design We followed the Preferred Reporting Items for Systematic Reviews and Meta-analyses guidelines.

Data sources We performed a literature search with no restriction on publication year or language in MEDLINE, EMBASE, CINAHL, the Cochrane Central Register of Controlled Trials and Web of Science up to September 2017.

Eligibility criteria RCTs investigating the impact of exercise on MRI-assessed articular cartilage in people over 18 years of age.

Results We included nine trials, including a total of 14 comparisons of cartilage morphometry, morphology and composition outcomes, of which two included participants at increased risk of knee OA and 12 included participants with knee OA. In participants at increased risk, one study comparison reported no effect on cartilage defects and one had positive effects on glycosaminoglycans (GAG). In participants with OA, six study comparisons reported no effect on cartilage thickness, volume or defects; one reported a negative effect and one no effect on GAG; two reported a positive effect and two no effect on collagen.

Conclusions Knee joint loading exercise seems to not be harmful for articular cartilage in people at increased risk of, or with, knee OA. However, the quality of evidence was low, including some interventions studying activities considered outside the therapeutic loading spectrum to promote cartilage health.

INTRODUCTION

Knee osteoarthritis (OA) is the most common joint disease and a major cause of disability and pain. 1 The OA prevalence has doubled since the mid-20th century 2 with an expected higher incidence in the future. 3 The annual total medical cost per person suffering from OA is on average €11 100. 4

Articular cartilage breakdown is the hallmark of OA, with aggrecan loss being an early sign of tissue degeneration. Many factors such as age, body mass index (BMI), knee injury, inflammation, sex and family history independently, and as a result of their interaction, contribute to its development and progression. 4–6 For example, approximately every second major knee injury from sports results in OA 10–15 years later, 7–9 and it has been estimated that at least 12% of the total burden of knee OA originates from knee injury. 10 Hypothetically, interventions targeting younger patients at increased risk of OA (eg, following sports injury), or in the early stages of the disease, increase the chances of slowing down articular cartilage breakdown since the integrity of the cartilage may still be intact with little or no aggregan loss.

Therapeutic exercise is a first-line treatment in OA: it is safe 11 and effectively reduces pain and improves function. 12–14 Less is known about the effects from therapeutic exercise on knee joint articular cartilage. However, exercise at higher doses, such as playing sports at elite level, is associated with development of OA, suggesting injury and also load in itself as being a contributing factor. 15–16 The mechanical loading generated from exercise, in combination with cell biology, and in some cases inflammatory factors, may alter the function of articular cartilage. 17 While there are no conclusive studies, it has been suggested that exercise may prevent or delay OA onset. 18 In support of this, two cohort studies found that a moderate dose of physical activity could slow down cartilage degeneration in middle-aged individuals at early OA stages. 19, 20 Furthermore, initiating an accelerated and progressive weight-bearing intervention a few hours after cartilage surgery was shown to be safe for the cartilage and resulted in more favourable clinical outcomes compared with a delayed knee joint loading exercise intervention. 21 Also, in patients having had meniscectomy, therapeutic exercise increased cartilage glycosaminoglycan (GAG) content. 22 However, patients at risk of, or with, knee OA still often believe that exercise may wear down their knee joints, creating a barrier to exercise. 23

Systematic reviews of randomised controlled trials (RCTs) provide the highest quality of evidence for assessing effectiveness and harms of treatments. Current knowledge in this area of interest has not been summarised systematically. Therefore, we aimed to review the existing evidence regarding the impact of knee joint loading exercise on articular cartilage.

METHODS

Terminology

As defined by the authors of the original papers, participants at risk of knee OA are those with risk factors (eg, knee injury treated with or without surgery, or BMI (kg/m²) ≥ 25) associated with the
development or progression of the disease, while participants with OA are those with a clinical diagnosis of OA (ie, according to the American College of Rheumatology criteria) with or without radiographic signs of knee OA (Kellgren-Lawrence grade >1), in the tibiofemoral and/or patellofemoral compartments of one or both knees.24

Articular cartilage outcomes assessed by MRI were classified into morphometry (ie, thickness and volume), morphology (ie, defects) or composition (ie, GAG assessed by delayed gado-linium-enhanced MRI of cartilage (dGEMRIC) and collagen assessed with T2-mapping in seven comparisons).

The term ‘knee joint loading exercise’ refers to the stimuli applied to the knee joint from ‘exercise’ or ‘exercise therapy’. The term ‘exercise therapy’ refers to ‘physical activities, which are usually done on a regular basis with the intention of improving or maintaining physical fitness or health’ and ‘physical activity’ refers to ‘any bodily movement produced by skeletal muscles that requires energy expenditure’. The term ‘exercise therapy’ refers to ‘a regimen or plan of physical activities designed and prescribed for specific therapeutic goals with the purpose to restore normal musculoskeletal function or to reduce pain caused by diseases or injuries’.23

Protocol
This systematic review is reported according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines (online supplementary appendix A). Study selection, eligibility criteria, data extraction and statistical analysis were performed according to the Cochrane Collaboration guidelines23 and published in a protocol in the PROSPERO database (CRD42016039536).

Eligibility criteria
We included RCTs investigating the impact of knee joint loading exercise on articular cartilage in people over 18 years of age. Studies were excluded when no full text was available and when treatment arms involved interventions other than knee joint loading exercise that might have impacted on the articular cartilage.

Literature search
A systematic literature search was performed with no restric-
tion on publication year or language in MEDLINE via PubMed, EMBASE via Ovid, CINAHL (including preCINAHL) via EBSCO, the Cochrane Central Register of Controlled Trials (CENTRAL) and Web of Science (WoS) up to May 2016. The search was repeated for the period from May 2016 to September 2017 in these databases to identify additional studies published before manuscript submission.

Search methods and study selection
The search was first performed in MEDLINE (online supplemen-
tary appendix B) and then customised for EMBASE, CENTRAL, WoS and CINAHL. All terms were searched, if possible, both as keywords (MeSH) and as text words in titles and abstracts (TIAB). In MEDLINE and EMBASE, animal studies were identified and removed before screening all the studies, using a validated animal filter.26 27 Initially, two reviewers (AB and CBJ) independently screened titles and abstracts, and all studies deemed eligible by at least one of the reviewers were checked independently in full text by the same two reviewers. In addition, reference lists from retrieved publications and systematic reviews published after January 2010 were screened. Disagreements between the two reviewers in inclusion were discussed until consensus was reached.

Data collection
A customised data extraction form was developed for each of the articular cartilage outcome categories: morphometry (ie, thickness and volume), morphology (ie, defects) or composition (ie, GAG and collagen). These outcomes were estimated from the combination of different cartilage compartments (ie, medial and lateral) when data were available. Otherwise, values from the medial and lateral values of the tibia, femur and the patella were used. Data were extracted by the first and second authors (AB and CBJ) from tables and graphs of published manuscripts. The following information was mandatory: authors of the study, year of publication, design of the trial, intervention characteristics, location of the trial (in the case of multicentre studies, primary investigator affiliation was applied), number of participants allocated (to the exercise and control groups, respectively), the participants’ average age, average body mass index (BMI, kg/m²), the duration of the study (presented in weeks) and the MRI characteristics. When several intervention groups were included in a study, the between-group difference was reported for each possible comparison. For example, when a study had two intervention groups (A and B) and one control group (C), we compared A versus C and B versus C, and reported the results as two separate study comparisons. This procedure is in accordance with the Cochrane handbook.23

Narrative synthesis of results
Between-group difference
We assessed the effect of knee joint loading exercise as positive (‘+’) or negative (‘−’) when a statistically significant (p<0.05) improvement or decline in the outcome of interest was reported for the overall cartilage or at least one of the cartilage compartments assessed in the intervention group compared with the control group. If none of the compartments showed an increase or a decrease in the outcome of interest, we reported this finding as no effect (‘=’).

Increased T2 values have been associated with deteriorated collagen orientation and increased hydration,28 29 which is considered to have a negative impact on the cartilage. There-
fore, we reported increased T2 values as negative (‘−’) and decreased T2 values as positive (‘+’) for the cartilage. A decrease in cartilage thickness/volume was interpreted as negative for the cartilage. Accordingly, an increase in cartilage thickness/volume was interpreted as potentially beneficial. However, the proof of a positive effect on cartilage volume/thickness would need additional information since increased cartilage volume/thickness may also be related to the growth of the subchondral bone for example.

Within-group difference
Additionally, we investigated within-group differences assessing the effect of knee joint loading exercise as positive (‘+’) or negative (‘−’) when an improvement or a decline in the outcome of interest was reported between preintervention and postinterven-
tion, and as no effect (‘=’) if none of the compartments showed an increase or a decrease in the outcome of interest.

Overall quality of evidence
Risk of bias
Study quality was assessed by rating the risk of selection bias, performance bias, detection bias, attrition bias, reporting bias,
Knee joint loading exercise quality assessment
Based on a combination of theoretical and clinical considerations, two of the authors (CBJ and EMR) independently assessed the anticipated impact of the knee joint loading interventions on cartilage (low, moderate or high) and if the dose was considered adequate to presume positive cartilage modifications were possible. High-impact activities (eg, jumping) and participation in sports is associated with cartilage deformation and increased risk of radiographic OA. Similarly, lack of knee joint loading in the form of knee immobilisation or sedentary behaviour is associated with detrimental cartilage changes. Therefore, interventions including activities being considered outside the therapeutic loading spectrum were assessed as inadequate to promote cartilage health. Accordingly, the anticipated impact was considered to be too high in interventions focusing on jumping and too low in aquatic exercise.

GRADE assessment
The overall quality of evidence for the estimates was evaluated using the GRADE (Grading of Recommendations Assessment, Development and Evaluation) approach. The GRADE is a systematic approach to rate the quality of evidence across studies for specific outcomes. It is based on five domains that involve the methodological flaws of the studies (ie, risk of bias), the heterogeneity of results across studies (ie, inconsistency), the generalisability of the findings to the target population (ie, indirectness), the precision of the estimates and the risk of publication bias.

RESULTS
Study selection and characteristics
The literature search identified a total of 2868 unique publications, of which 21 individual RCTs were identified as potentially eligible. Ultimately, we included nine papers, involving 14 study comparisons (figure 1). MRI-assessed cartilage morphometry was investigated in four, cartilage morphology in three and cartilage composition in seven comparisons. One study was reported in two different papers. Multanen et al reported findings in the tibiofemoral compartment and Koli et al in the patellofemoral compartment of the same participants following the same exercise intervention. We included both papers and counted them as one study with two study comparisons, as suggested in the Cochrane guidelines.

Figure 1 Flow chart of the included studies in the systematic reviews.
Two study comparisons investigated the effect of knee joint loading exercise in participants at increased risk of developing OA: one in participants having had arthroscopic partial meniscectomy28 and the other in overweight or obese participants.36 Twelve study comparisons focused on participants with OA.32–35 37–40

Participant characteristics

The overall number of participants in the included studies was 702, with a mean age (SD) of 57.7 years (6.5) and a mean BMI (kg/m²) (SD) of 29.5 (4.4). The overall percentage of women was 81.7% (table 1).

Outcome measures

In the two study comparisons including participants at risk of OA, articular cartilage was assessed as cartilage morphology using the semiquantitative MRI Osteoarthritis Knee Score (MOAKS) scoring system,36 and cartilage composition as GAG via dGEMRIC index.22

In the 12 study comparisons focusing on participants with established OA, articular cartilage was assessed using cartilage morphology in four12 and morphology with semiquantitative scoring systems in three.33–35 Cartilage composition was assessed in seven comparisons as GAG via dGEMRIC37 38 or collagen via T2 mapping.39–40

Detailed characteristics of participants and outcome measure characteristics are reported in table 2.

Knee joint loading exercise interventions

Knee joint loading exercise interventions differ substantially among studies. All but one of the included trials tested the effect of a therapeutic exercise programme. One trial tested the effect from a general physical activity programme in which participants were encouraged to take part in physical activity classes, for example, Nordic walking, volleyball or modern dance.36 Furthermore, all the included studies compared a knee joint loading exercise intervention to a non-exercising control group treatment such as local heat or oral glucosamine. Detailed characteristics of knee joint loading exercise interventions are reported in table 2.

Narrative synthesis of results

Meta-analysis was not considered appropriate because of the substantial heterogeneity between study interventions, patient characteristics and outcome variables.41 Instead, we summarised the results of these studies narratively to provide a clear critical appraisal of the evidence, as recommended by the guidelines on the conduct of narrative synthesis in systematic reviews.42

Between-group difference in participants at risk of OA

In the participants at risk of OA, one study comparison in overweight women with a mean age of 56 years reported no effect on cartilage defects (MOAKS)39 and one in mostly men with a mean age of 46 years, having had arthroscopic partial meniscectomy, reported positive cartilage composition changes on GAG as assessed from dGEMRIC.22

Between-group difference in participants with established OA

In participants with established OA, six study comparisons found no effect of knee joint loading exercise on cartilage thickness, volume or defects,32–35 one study comparison reported no effect37 on GAG and one reported a negative effect on the cartilage composition of the medial condyle of the femur, both assessing GAG via dGEMRIC.38 On the contrary, the same knee joint loading exercise intervention that reported negative effects on GAG also reported a positive effect on collagen assessed using T2 mapping in the cartilage of the posterior medial femoral condyle and central medial tibial condyle.38 Two publications from the same RCT reported a positive effect on collagen T2–mapping in the patellar cartilage40 and no effect on the cartilage of the medial condyle of the femur.37 Lastly, one study comparison reported no effect39 on collagen T2 mapping39 (table 3).

Within-group difference

The within-group differences analysis investigating articular cartilage changes preintervention to postintervention (within-group findings) showed that knee joint loading exercise increased cartilage volume32 and had a positive effect on cartilage defects in the medial femoral condyle32 and on GAG in the medial and lateral compartment of the femur and lateral compartment of the tibia.22 37 Furthermore, positive effects were also reported

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**Table 1** Studies included in the qualitative synthesis

<table>
<thead>
<tr>
<th>Study characteristics</th>
<th>Participant characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author and year</td>
<td>Participants included (IG/CG)</td>
</tr>
<tr>
<td>Armagan et al34 2015</td>
<td>Eskisehir, Turkey</td>
</tr>
<tr>
<td>Dincer et al36 2016</td>
<td>Istanbul, Turkey</td>
</tr>
<tr>
<td>Henriksen et al37 2014</td>
<td>Copenhagen, Denmark</td>
</tr>
<tr>
<td>Hunter et al38 39 2015</td>
<td>North Carolina, USA</td>
</tr>
<tr>
<td>Landsmeer et al36 2016</td>
<td>Rotterdam, Holland</td>
</tr>
<tr>
<td>Multanen et al37 38 2014 and Koli et al39 2015</td>
<td>Jyväskyla, Finland</td>
</tr>
<tr>
<td>Munukka et al37 38 2016</td>
<td>Jyväskyla, Finland</td>
</tr>
<tr>
<td>Ochiah et al40 2014</td>
<td>Chiba, Japan</td>
</tr>
<tr>
<td>Roos and Dahlberg6 2005</td>
<td>Malmö, Sweden</td>
</tr>
</tbody>
</table>

ACR, American College of Rheumatology; BMI, body mass index; CG, control group; IG, intervention group; KL, Kellgren-Lawrence scale; OA, osteoarthritis; P, patella; RKOA, radiographic knee osteoarthritis.
### Table 2  Exercise therapy and outcome characteristics of included studies

<table>
<thead>
<tr>
<th>Study comparisons</th>
<th>Type</th>
<th>Frequency and duration</th>
<th>Exercise sessions attended/scheduled sessions (n and %)</th>
<th>Non-serious adverse events in the intervention group</th>
<th>Outcomes characteristics</th>
<th>Anticipated impact on cartilage</th>
<th>Exercise quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home exercise therapy vs oral glucosamine sulfate</td>
<td>WB and non-WB (quadriceps and hamstring strengthening and dynamic stains very exercises)</td>
<td>24 weeks</td>
<td>—</td>
<td>—</td>
<td>TFML</td>
<td>Morphology (semiquantitative scoring)</td>
<td>Low to moderate</td>
</tr>
<tr>
<td>Supervised and home exercise, TENS and hot pack vs TENS and hot pack</td>
<td>WB (closed kinetic chain exercises, transcutaneous electrical nerve stimulation (TENS) and hot pack)</td>
<td>5/7/12 weeks 30/12 min</td>
<td>—</td>
<td>n=2 (increase knee pain), n=1 (increase blood pressure)</td>
<td>TFML and P</td>
<td>Morphometry (thickness and volume)</td>
<td>Low to moderate</td>
</tr>
<tr>
<td>Supervised and exercise vs non-exposed group</td>
<td>WB (circuit training) 1</td>
<td>3/12/24 weeks 60/12/16 weeks</td>
<td>n=7/47 15%</td>
<td>—</td>
<td>TFML</td>
<td>Morphometry (semiquantitative scoring)</td>
<td>Moderate</td>
</tr>
<tr>
<td>Supervised and home exercise and diet vs diet only</td>
<td>WB (aerobic walking, strength training)</td>
<td>3/12/24 weeks 60/12/16 weeks</td>
<td>n=142/216 64%</td>
<td>n=1 (muscle strain), n=2 (trip/ fall)</td>
<td>TFM</td>
<td>Morphometry (thickness and volume)</td>
<td>Low to moderate</td>
</tr>
<tr>
<td>Supervised exercise and diet vs oral placebo supplementation</td>
<td>WB (Nordic walking, volleyball, bowling, salsa dancing, tai chi, softball, belly dance and modern dance)</td>
<td>1/7/12 weeks 60/20 weeks</td>
<td>n=7/20 35%</td>
<td>n=2 (side effects non-specified)</td>
<td>TFML and P</td>
<td>Morphometry (semiquantitative scoring)</td>
<td>Low</td>
</tr>
<tr>
<td>Supervised exercise therapy vs non-exposed group</td>
<td>WB (aerobic, step aerobics and jumping exercise)</td>
<td>3/12/24 weeks 60/48 weeks</td>
<td>n=98/144 68%</td>
<td>—</td>
<td>TF anterior posterior central</td>
<td>Composition (collagen via T2 mapping)</td>
<td>High</td>
</tr>
<tr>
<td>Supervised individually progressed exercise therapy vs non-exposed group</td>
<td>Non-WB (aerobic exercise therapy)</td>
<td>3/12/24 weeks 60/24 weeks</td>
<td>n=42/48 88%</td>
<td>n=2 (bilateral knee pain and dyspnoeic)</td>
<td>TF anterior posterior central</td>
<td>Composition (collagen via T2 mapping)</td>
<td>Low</td>
</tr>
<tr>
<td>Home exercise therapy vs local heat treatment</td>
<td>Non-WB (2 sets of straight leg raise, adductor training and adductor training (20 reps per set) in the morning and evening every day)</td>
<td>1/7/12 weeks 14/12/24 weeks</td>
<td>—</td>
<td>n=1 (dizziness during exercise therapy)</td>
<td>TFML</td>
<td>Composition (collagen via T2 mapping)</td>
<td>Low</td>
</tr>
<tr>
<td>Supervised individually progressed exercise therapy vs non-exposed group</td>
<td>WB (weight-bearing neuromuscular exercises)</td>
<td>1–5/week 60/12 weeks</td>
<td>n=31/54 54%</td>
<td>—</td>
<td>F anterior posterior central</td>
<td>Composition (collagen via T2 mapping)</td>
<td>Moderate</td>
</tr>
</tbody>
</table>

*Too little information available.
†No serious adverse events were reported. Adequate/inadequate—the anticipated mechanical stimuli to the cartilage generated from the knee joint exercise intervention was considered of adequate (moderate) impact or too high or too low impact to promote beneficial cartilage health.
GAG, glycosaminoglycans; L, lateral; M, medial; P, patella; ROI, region of interest; TF, tibiofemoral; WB, weightbearing; W/W, per week.
### Table 3  Synthesis of nine studies for the effect of knee joint loading exercise on articular cartilage

<table>
<thead>
<tr>
<th>Stage</th>
<th>Author and year of study</th>
<th>Between-group difference Morphometry</th>
<th>Within-group difference Morphometry</th>
<th>Risk of bias summary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Thickness</td>
<td>Volume</td>
<td>Defects</td>
</tr>
<tr>
<td>Increased OA risk</td>
<td>Landsmeer et al(^{36}) 2016</td>
<td>=</td>
<td>=</td>
<td>=</td>
</tr>
<tr>
<td></td>
<td>Roos and Dahlberg(^{22}) 2005</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>OA</td>
<td>Armagan et al(^{33}) 2015</td>
<td>=</td>
<td>=</td>
<td>=</td>
</tr>
<tr>
<td></td>
<td>Dincer et al(^{32}) 2016</td>
<td>=</td>
<td>=</td>
<td>=</td>
</tr>
<tr>
<td></td>
<td>Henriksen et al(^{35}) 2014</td>
<td>=</td>
<td>=</td>
<td>=</td>
</tr>
<tr>
<td></td>
<td>Hunter et al(^{33}) 2015</td>
<td>=</td>
<td>=</td>
<td>=</td>
</tr>
<tr>
<td></td>
<td>Multanen et al(^{37}) 2014</td>
<td>=</td>
<td>=</td>
<td>=</td>
</tr>
<tr>
<td></td>
<td>Kol et al(^{34}) 2015</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>Munukka et al(^{38}) 2016</td>
<td>=</td>
<td>=</td>
<td>=</td>
</tr>
<tr>
<td></td>
<td>Ochiai et al(^{39}) 2014</td>
<td>=</td>
<td>=</td>
<td>=</td>
</tr>
</tbody>
</table>

'\(^+\)’, Positive effect of exercise on cartilage; ‘\(^-\)’, negative effect of exercise on cartilage; ‘\(^\_\)’, no effect of exercise on cartilage; A, random sequence generation (selection bias); B, allocation concealment (selection bias); C, blinding of participants and personnel (performance bias); D, blinding of outcome data (detection bias); E, incomplete outcome data (attrition bias); F, selective reporting (reporting bias); G, other bias. GAG, glycosaminoglycans; OA, osteoarthritis.
on the patellar cartilage \(^{40}\) and on the posterior medial femoral condyle and central medial tibial condyle. \(^{38}\) There was only one negative within-group finding out of 14 comparisons.

**Subgroup analysis on cartilage compartment**

Three out of nine studies assessed the effect of knee joint loading exercise on the patellar compartment in addition to the tibiofemoral compartment. \(^{32},^{36},^{40}\) In one study, \(^{36}\) the patellar and tibiofemoral compartments were combined for the assessment of exercise on cartilage health, not allowing for comparisons of different cartilage compartments. In contrast, two studies\(^{2},^{32}\) \(^{40}\) analysed the patellar and tibiofemoral compartments separately. One study reported a beneficial effect on the collagen matrix of the patellar cartilage \(^{40}\) and on the posterior medial femoral condyle. \(^{38}\) There was only one negative within-group finding out of 14 comparisons.

**Impact of sex on cartilage health**

We found no indication of difference in the effect of exercise on cartilage health between the sexes. Four studies, seven study comparisons, included only women, of which two study comparisons reported a positive effect on collagen. \(^{38},^{40}\) one reported a negative effect on GAG, \(^{38}\) and four reported no effect of knee joint loading exercise on cartilage health. \(^{36},^{37},^{39}\)

Five studies, seven study comparisons, included both men and women, of which one reported a beneficial effect on GAG \(^{22}\) and six reported no effect of knee joint loading exercise on cartilage health \(^{32},^{34},^{35}\).

**Quality of evidence**

**Risk of bias**

Overall, the majority of the studies applied proper randomisation, allocation and blinding of the outcome assessment. In contrast, all the studies failed to clearly report, or inadequately addressed, dropouts of participants in the analyses (attrition bias, \(^{32},^{34},^{35}\)).

Knee joint loading exercise quality

When evaluated and rated independently by two of the coauthors (CBJ and EMR), some of the exercise interventions were assessed as including activities being considered outside the therapeutic loading spectrum and therefore not necessarily adequate to promote positive articular cartilage \(^{32}\) (table 2). This classification was purely done for descriptive purposes, and the number of studies did not allow for subgroup analyses.

**GRADE assessment**

The inadequacy of some knee joint loading interventions, the small number of studies and the few participants involved limit the generalisability of our findings. Therefore, due to this indirectness and imprecision, the overall quality of evidence was deemed low (online supplementary appendix C).

**DISCUSSION**

Our findings suggest that knee joint loading exercise seems not to be harmful for articular cartilage in people at increased risk of, or with, knee OA. However, the quality of evidence was low.

**Articular cartilage morphometry and morphology**

The inconclusive findings about knee joint loading and the impact on cartilage thickness, volume and defects may relate to the heterogeneity of the populations, the interventions studied or the outcomes used. In fact, when evaluated and rated independently by two of the coauthors (CBJ and EMR), not all the exercise interventions were assessed as adequate to promote positive articular cartilage changes. In some cases, the dose was considered too low, and in one case, the type of exercise (jumps) was considered excessive for the cartilage of older women who had mild OA. Additionally, the compliance with the exercise interventions investigating cartilage morphometry or morphology was generally poor. The resulting inadequate mechanical stimuli could potentially be at least partly responsible for the lack of effect. On the other hand, MRI-based cartilage assessments have been shown to be sensitive enough to detect between-group morphometry and morphology changes in previous randomised studies using quantitative and semi-quantitative methods. \(^{43}\) Nevertheless, in our review, the studies assessing cartilage with both quantitative and semi-quantitative methods failed to report a change for either method, suggesting the lack of positive effect was not due to poor responsiveness of the evaluation methods.

**Articular cartilage composition**

It is well known that alterations in articular cartilage composition is a marker of early OA changes. \(^{44}\) Negative changes in cartilage composition may therefore be expected to occur prior to changes in morphometry and morphology cartilage parameters. \(^{45}\) None of the studies included in our review allowed for a comparison of treatment effects on both structural and compositional changes of the cartilage. However, GAGs and collagen assessed as dGEMRIC and T2 mapping, respectively, were the only outcomes that showed a response to the treatment interventions, supporting the theory that these early OA markers are sufficiently sensitive to detect treatment effects in individuals with early or established OA. Nevertheless, six out of seven study comparisons found no effect or beneficial effect or beneficial effect on cartilage composition, highlighting that knee joint loading exercise seems to be at least safe in patients at increased risk of, or with, knee OA.

**Limitations**

This study has some limitations. The heterogeneity of the interventions, patient characteristics and outcome variables did not support the use of a meta-analysis. Instead, in accordance with the Cochrane Handbook, we described our findings narratively. \(^{23}\) Although, from a statistical point of view, there is no restriction on study number or similarity, it is important to consider the conceptual diversity of the included studies for the meta-analysis to be meaningful for researchers, clinicians and patients. \(^{41}\) Furthermore, the low compliance with the exercise interventions in studies investigating articular cartilage morphology and morphometry limits the possibility of concluding whether exercise had a positive or negative impact on these outcome measures. Additionally, the included studies did not allow for comparison of different exercise programmes and/or comparisons of specific cartilage compartments since all studies included a non-exercising control arm and only two studies reported the patellofemoral compartment separately. Thus, our findings are restricted to the effect of increased knee joint loading from therapeutic exercise compared with no change in knee joint loading, particularly in the tibiofemoral compartment. As no meta-analysis was performed, precision, inconsistency and publication bias were based on the narrative synthesis of results. Finally, one trial included the control treatment of glucosamine \(^{44}\) and another trial included a control of local heat treatment. \(^{39}\) Recent systematic reviews conclude that glucosamine does not impact cartilage...
health, and there is no evidence to suggest an effect of local heat treatment on articular cartilage.

**Implications for researchers and clinicians**

More high-quality RCTs are needed to further investigate the impact of knee joint loading exercise on articular cartilage in patients at increased risk of, or with, knee OA. To increase the possibility of finding positive effects, available results suggest future studies need to focus on interventions in the form of supervised weight-bearing exercise therapy of sufficient dose in younger subjects at risk or in early stages of the disease, allowing for evaluation of cartilage composition with measures such as dGEMRIC and T2 mapping.

**CONCLUSION**

We narratively summarised the impact of knee joint loading exercise on knee joint articular cartilage in the participants at risk of, or with, knee OA included in RCTs of exercise. Knee joint loading exercise seems not to harm articular cartilage in participants at increased risk of, or with, knee OA. However, the quality of evidence was low, including some interventions studying activities considered outside the therapeutic loading spectrum to promote cartilage health.

**What is already known?**

- Knee joint loading exercise is a cornerstone in the management of knee osteoarthritis (OA).
- Knee joint loading exercise in the form of exercise therapy has a moderate effect in reducing pain and improving physical function in patients with knee OA.

**What are the new findings?**

- Knee joint loading exercise seems not to be harmful for articular cartilage in participants at increased risk of, or with, knee OA.
- Knee joint loading exercise interventions at a dose sufficient to improve cartilage health need to be investigated.

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