Timing of Muscle Activation Is Altered During Single-Leg Landing Tasks After Anterior Cruciate Ligament Reconstruction at the Time of Return to Sport

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Abstract

Objectives: It is well known that alterations in landing mechanics persist for years after anterior cruciate ligament reconstruction (ACL-R). Nevertheless, existing literature is controversial in reporting successful or unsuccessful recovery of prelanding muscle activation timing after ACL-R. The study aimed at comparing myoelectric and kinematic patterns during landing tasks between ACL-R and healthy subjects. Design: Cross-sectional study. Setting: Institutional research laboratory. Patients and Intervention: Fifteen male athletes after ACL-R using patellar tendon and 11 using hamstrings autograft at the time of return to sport were recruited. Fifteen healthy athletes served as control group. Participants performed 4 different single-leg landing tasks arriving onto a force plate. Main Outcome Measures: Electromyographic (EMG) activity of knee extensors and flexors, normalized vertical ground reaction force (vGRF), and knee angular displacement were recorded. Results: In all the tasks, preimpact EMG duration was longer in ACL-R (112 ± 28 ms in the knee extensors; 200 ± 34 ms in the knee flexors) compared with healthy participants (74 ± 19 ms in the knee extensors; 153 ± 29 ms in the knee flexors; P < 0.05). Initial contact (IC) and maximum postimpact knee angle were lower in ACL-R (9 ± 7 degrees at IC; 39 ± 12 degrees at maximum flexion) compared with healthy participants (17 ± 9 degrees at IC; 52 ± 15 degrees at maximum flexion; P < 0.05). Normalized vGRF was higher in ACL-R compared with healthy participants (3.4 ± 0.5 and 2.7 ± 0.6; P < 0.05). Conclusions: At the time of return to sport, ACL-R subjects showed altered motor control strategies of single-leg landings. These alterations may lead to uncoordinated movement, hence increasing the risk of reinjury.

Key Words: neuromuscular control, return to play, knee injury, EMG duration, motor programming, knee flexion, GRF

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INTRODUCTION

Noncontact anterior cruciate ligament (ACL) injury is one of the most common knee injuries in cutting and pivoting sports such as soccer, basketball, and volleyball. The ACL tears occur soon after the initial ground contact and too quickly for reflexive muscular activation (>100 ms) to prevent injuries. Zebis et al showed that abnormal coactivation of thigh muscles performing side-cutting tasks predisposes for future ACL injury, therefore, modulating muscle activity before landing seems to be crucial to avoid excessive joint rotations and to protect ACL from dangerous loading.

When ACL surgery is required, the reconstruction can be performed by using either autograft or allograft tissue. It has been shown that autograft is superior to irradiated allograft with regards to knee functional outcomes and laxity. The standard surgical autogenous harvest sites are patellar and hamstrings tendons, and it has been recently pointed out that the short- and long-term outcomes of these grafts are similar in providing stability and function.

Considering the electromyographic (EMG) activity before landing in anterior cruciate ligament reconstructed (ACL-R) subjects, results are controversial in reporting successful or abnormal neuromuscular strategies performing jump-landing tasks. A recent review of Theisen et al describes in detail prelanding muscle activity in ACL injured and reconstructed subjects reviewing the literature from 1980 to 2015. The review underlines the weakness of current evidences on this topic recognizing clinical and methodological heterogeneity, such as the type of graft, time from surgery, and level of physical activity as main weak points of existing studies.

The aim of this study is to compare timing and magnitude of activation of knee extensor and flexor muscles between nonprofessional competitive athletes who underwent ACL reconstruction with bone–patellar tendon-bone (B-PT-B) and semitendinosus and gracilis (ST GR) autograft, with respect to healthy individuals, performing single-leg landing tasks, 6 months after surgery (return to sport).
MATERIALS AND METHODS

Participants

This investigation was conducted as a cross-sectional study. An eligibility investigation was conducted on 108 ACL-R subjects operated by the same surgeon undergoing the fifth postsurgical time-scheduled medical examination between August and December 2015 (Figure 1).

Twenty-six ACL-R male subjects, 15 using B-PT-B [age, 21 ± 3 years (mean ± SD); stature, 1.78 ± 0.07 m; body mass, 75 ± 10 kg] and 11 using ST GR autograft (age, 21 ± 5 years; stature, 1.74 ± 0.08 m; body mass, 72 ± 12 kg) were admitted in the study at 6.0 ± 1.2 months from surgery. Inclusion criteria were (1) previous history of practicing pivoting and cutting sport for at least 5 years, (2) same standardized postoperative rehabilitation protocol (Table 1), (3) participation in competitive sport activities (Tegner level scale of 7-9 at the time of ACL injury), and (4) postsurgical between limb difference in anterior knee laxity <3 mm measured by an arthrometer (Genourob, Laval, France).

All ACL-R subjects were released to unrestricted sport activities by a physiatrist who attested side-to-side isometric strength of knee extensors and flexors as well as side-to-side peak vertical ground-reaction force (vGRF) in the loading phase of a maximal vertical countermovement jump with an impairment of the surgical leg performance within 15% of the nonsurgical leg. Subjects with concurrent meniscal damage treated with partial meniscectomy were included. Exclusion criteria were (1) knee pain measured by the Visual Analog Scale ≥4, (2) injuries of lower limb muscles during the rehabilitation process, and (3) previous knee surgery. Fifteen healthy male subjects (age, 23 ± 2 years; stature, 1.75 ± 0.07 m; mass, 72 ± 12 kg), with no history of previous injury of muscles or joints in lower limbs and with an International Knee Documentation Committee score of 100, were matched with ACL-R participants according to their Tegner activity level and to their experience in pivoting/cutting sports, and served as control group. The study was approved by the Ethics Committee of the University of Rome “La Sapienza.” Informed consent was obtained from the participants, and all the procedures were conducted in accordance with the Declaration of Helsinki.

Experimental Setup

All the subjects performed 4 different single-leg landing tasks from a 20-cm height platform and at ground level arriving onto a force plate (model 9281 B; KISTLER, Winterthur, Switzerland). The examined limb was the operated knee for ACL-R group and the dominant leg for control group. The dominant leg was defined as the leg the subject would use to kick a ball as far as possible. Wireless bipolar surface EMG electrodes were applied on the vastus medialis (VM), rectus femoris (RF), vastus lateralis (VL), biceps femoris (BF), and semitendinosus (ST) muscles of the examined limb. Electrode position was identified between the motor point and the distal tendon, in a direction parallel to the muscle fibers in accordance with SENIAM guidelines. The electrodes were applied after careful skin cleaning with ethyl alcohol. The signal was preamplified (×1000), amplified (×1 for BF and ST and ×2 for VL, RF, and VM), band-pass filtered (5 Hz-1 kHz), and high-pass filtered with a zerolag second-order Butterworth filter with 10-Hz cutoff frequency by means of a wireless, portable EMG system (FreeEMG; BTS Bioengineering, Milan, Italy). Angular displacement of the knee joint on the sagittal plane was recorded by an electrogoniometer (EGN).

Figure 1. Flowchart showing patient recruitment. VAS, Visual Analog Scale.
Experimental Procedures

Before data collection, each subject was given 10 minutes to warm-up and practice each of the 4 single-leg landing tasks until comfortable. The warm-up and practice regimen was standardized to mitigate the possible variability deriving from such tasks. The takeoff platform was placed 30 cm away from the rear edge of the force plate.

The subjects were asked to stand on the takeoff platform with the reference leg, to jump forward, and land with the same leg onto the force plate. Four different landing tasks were performed. In the first, the participants were asked to land holding a bent knee position for 3 seconds [stop landing (STL)]; in the second, the participants were instructed to land as naturally as possible smoothly absorbing the impact and ending the movement in full extension [smooth landing (SML)]; and in the third, the participants were asked to land and immediately perform a rebound, stopping the second landing as in the first task [rebound landing (RBL)]. The fourth task was the single-leg hop for distance (SLHD), in which the subjects were asked to hold the single-leg standing position on the ground with the hands placed on their iliac crests and to jump forward a distance equal to the limb length, arriving onto the force plate.

Each subject performed 3 trials for each task keeping the hands on their hips and wearing their own sport shoes, resulting in a total of 12 trials. The task order was randomized to reduce learning effects.

Data Management

The mean values of the 3 trials for each task were averaged, and the average was used for subsequent analysis.

The interval of interest was the initial landing phase of each jump, in particular the 200 ms around the initial contact (IC). Initial contact was identified when the vGRF first exceeded 10 N.

Muscle activity onset was agreed on after visual inspection by 2 blinded assessors.

The following parameters were analyzed: (1) root mean square (RMS) EMG: magnitude of muscle activity 100 ms before and 100 ms after IC; (2) preimpact EMG duration: time interval from muscle activity onset to IC; (3) vGRF/body weight (BW): peak vGRF normalized by BW; (4) IC knee angle: knee flexion angle at IC instant; and (5) max postimpact knee angle: peak knee flexion angle reached after IC (Figure 2).

Normalization of Electromyographic Signal

Electromyographic signals from knee extensors and flexors muscles were normalized by signals recorded during a maximal voluntary isometric contraction (MVIC) and expressed as a percentage. The measurement was performed with the knee at 90 degrees of flexion in both tasks.

Electromyographic signal during MVIC was smoothed by a symmetrical moving RMS filter (30-ms time constant), and the peak was selected to normalize the RMS EMG data registered during the landing tasks in the given time intervals.

Statistical Analysis

The statistical package IBM SPSS version 21 (IBM, Chicago, IL) was used for the analysis. All data are expressed as mean ± SD. The Shapiro–Wilk test was applied before the analysis to test the normal distribution of data.

Considering vGRF/BW, IC knee angle and max postimpact knee angle parameters, 3 separate analyses of variance (ANOVAs) with repeated measures were applied, setting the 4 tasks (ie, STL, SML, RBL, and hop for distance) as within factor, and the groups (ie, B-PT-B group, ST GR group, and control group) as between factors.
For preimpact EMG duration and RMS EMG in the 5 muscles, 2 separate multivariate analysis of variance with repeated measures were applied, considering the tasks as within factor, and the groups as between factors and further univariate analysis were considered only if significant multivariate effects were detected.

When a significant interaction between task and group was observed, follow-up tests were conducted by splitting the sample into 3 groups and running separate repeated-measures ANOVAs to explore the different effect of task on the 3 groups.

Post hoc pairwise comparisons were performed by means of Fisher’s least significant difference test, and the Bonferroni alpha level correction was applied.

The significance level for all comparisons was set at $P < 0.05$.

## RESULTS

### Electromyographic Data

Root mean square EMG data analysis showed no main effects of task, group and task by group interaction.

Preimpact EMG duration multivariate analysis showed a main effect of task ($F = 14.138; P < 0.001$), group ($F = 6.858; P < 0.001$) and task by group interaction ($F = 2.126; P = 0.001$). Univariate analysis showed the same main effects for all the 5 muscles. Post hoc pairwise comparison data are shown in Figure 2. Significant differences were found between ST GR and B-PT-B groups compared with control group for all the 5 muscles in all the 4 tasks. Specifically, the preimpact EMG duration was found to be significantly longer in both ACL-R groups, as compared to the healthy controls. No differences were found between ST GR and B-PT-P groups. In the hop-for-distance task, preimpact EMG duration was significantly longer compared with the other 3 tasks for all the 5 muscles as shown in Figure 3.

### Initial Contact Knee Angle

Initial contact knee angle analysis showed a main effect of group only ($F = 10.925; P < 0.001$), while no main effect for task and task by group interaction was found. Post hoc analysis for group showed a significant difference for control group compared with ST GR group ($P = 0.006$) and B-PT-B group ($P < 0.001$). Pairwise comparison data (Table 2) showed significant differences for ST GR and B-PT-B...
compared with control group for 3 of 4 tasks except for SLHD task. In particular, ACL-R subjects demonstrated significantly lower IC angles. No differences were found between ST GR and B-PT-P groups.

**Max Postimpact Knee Angle**

Max postimpact knee angle analysis showed a main effect of group only ($F = 6.702; P = 0.004$), while no main effect for task and task by group interaction was found. Post hoc analysis for group showed a significant difference for control group compared with ST GR group ($P = 0.009$) and B-PT-B group ($P = 0.017$). Pairwise comparison data (Table 2) showed significantly lower peak knee flexion angles for ST GR and B-PT-B groups compared with control group in STL and SML tasks. No differences were found for RBL and SLHD task. No differences were found between ST GR and B-PT-P groups.

**Vertical Ground-Reaction Force/Body Weight**

Vertical ground-reaction force analysis showed main effects of task ($F = 6.411; P = 0.004$) and group ($F = 9.105; P = 0.001$), while no task by group interaction effect was found. Significant difference for SML task compared with the other 3 tasks (STL: $P < 0.001$; RBL: $P = 0.044$; hop for distance: $P = 0.023$) was found. Post hoc analysis for group showed a significant difference for control group compared with ST GR group ($P = 0.015$) and B-PT-B group ($P = 0.001$). Pairwise comparison data (Table 2) showed significantly higher peak vGRF/BW for ST GR and B-PT-B groups compared with control group in STL and SML Tasks.

Vertical ground-reaction force/BW was significantly higher in RBL for B-PT-P compared with control group. No differences between ST GR and control group as well as no difference between B-PT-B and ST GR was found in RBL task. No between-group differences were found in SLHD task.

**DISCUSSION**

The main finding of this study is that ACL-R subjects showed altered neuromuscular strategies for the control of single-leg landing tasks compared with healthy controls at the time of return to sport, regardless of the type of autograft (B-PT-B or ST GR) used for the reconstruction, thus clarifying an issue, which was previously controversial. In particular, they showed longer preimpact EMG duration for all the considered muscles (VM, VL, RF, BF, and ST) in all the 4 tasks compared with control group. This result is in line with Gokeler et al (2010),17 who demonstrated an earlier muscle activity onset in the involved limb of ACL-R subjects both men and women compared with uninvolved limb and healthy controls performing single-leg hop-for-distance task 6 months after surgery. Interestingly, in our study, no differences were found
in preimpact EMG duration between the 2 ACL-R groups, suggesting that graft choice does not seem to influence the impairments in neuromuscular control of landings at the time of return to sport. Labanca et al20 highlighted earlier muscle activity onset for knee extenders and flexors in ACL-R subjects compared with healthy controls after a predictable perturbation to the knee. This result is consistent with our findings, although the time elapsed from surgery (2 vs 6 months) and the type of task were considerably different.

Our findings are in contrast with Bryant et al,16 who showed no differences between ACL reconstructed male subjects (either using B-PT-B or ST GR autograft) and healthy controls in preimpact EMG duration performing single-leg hop-for-distance task 1 year after reconstruction. Because it is well established that anticipatory postural adjustments can improve with training21–23 and that timing of prelanding EMG activity can be modulated to the task constraints,24 it is likely that the findings of Bryant et al16 are biased by the fact that the authors did not take into account patients’ previous experience in jumping, pivoting, and cutting maneuvers,10 as well as the type of rehabilitation underwent by ACL-R subjects.25,26 In addition, it has been shown that overall knee function returns to values similar to the contralateral limb from 8 to 12 months after ACL reconstruction,27 therefore, differences between our findings and those of Bryant et al16 may be ascribed to the different time elapsed from surgery (6 months vs 1 year).

We found lower IC knee angle in 3 of 4 tasks except for SLHD task in ACL-R subjects compared with healthy controls. It is well known that a knee angle close to full extension (0–25 degrees of knee flexion) at toe contact in pivoting, cutting, and landing movements is a risk factor for ACL injury in noncontact situations25,28–31; therefore, this result is consistent with demonstrating a higher risk of reinjury in ACL-R subjects when returning to full sport participation. We did not find any significant differences in SLHD task, which could be due to the fact that SLHD was performed at ground level and not from a 20-cm height platform as in the other 3 landing tasks. It is possible to speculate that landing from a certain height maximally challenge single-leg landing ability of ACL-R limb.

Max postimpact knee angle was significantly lower between ACL-R subjects and healthy controls in STL and SML tasks. It has been previously shown that maximum knee flexion angle reached after the impact is an indicator of the efficiency of landing control capacity.32,33 Reduced knee flexion at landing in ACL-R subjects may be attested to a compensatory strategy related to persistent quadriceps weakness,34 in addition, limited active flexion performing landing tasks also results in lower GRF dissipation and in a “stiff” landing pattern, which may increase ACL loading.35 Therefore, we can assume that single-leg landing control strategies in ACL-R subjects are not efficient enough at the time of return to sport, 6 months after surgery. We did not find any significant difference in RBL and SLHD tasks even if there is a strong tendency for healthy subjects to have greater peak knee flexion angles.

In STL and SML tasks, we found significantly higher vGRF/BW of ACL-R subjects compared with healthy controls. It is well established that high peak vGRF/BW in landing underlines scarce impact absorption capacity,34,36,37 and that high vGRF combined with decreased maximum knee flexion reached after IC can increase knee abduction moment,9,38,39 which is known to be one of the principal risk factors for ACL injury. In our study, ACL-R groups showed both less peak knee flexion and higher peak vGRF/BW; therefore, we can state that ACL-R subjects in this condition have an increased risk of reinjury at the time of return to sport.

In RBL, vGRF/BW was significantly higher in B-PT-B compared with healthy controls. This could be ascribed to a surgery-related quadriceps weakness, which is present in B-PT-B subjects30,40,41 when asked not only to land but also to perform a push-off from the ground, thus challenging power output, which results in a stiffer knee and in a greater vGRF/BW. No between-group differences were found for SLHD tasks probably because of the different execution of this task as previously mentioned.

The main limitation of this study is that kinematic and kinetic interlimb differences were not analyzed. Furthermore, because it is well established that neuromuscular alterations do affect the contralateral side after ACL reconstruction,42 including such analysis in the study would have helped in obtaining a deeper understanding of landing motor control.

| TABLE 2. Vertical Ground-Reaction Force/BW, IC Knee Angle and Max Postimpact Knee Angle Data for the 3 Groups in the 4 Tasks |
|---------------------------------------------------------------|
| **STL** | **SML** |
| **B-PT-B** | **ST GR** | **CONTROL** | **B-PT-B** | **ST GR** | **CONTROL** |
| vGRF/BW | 3.4 ± 0.8 | 3.5 ± 0.4 | 2.8 ± 0.6 | 3.0 ± 0.6 | 3.1 ± 0.5 | 2.5 ± 0.5 |
| IC knee angle (degrees) | 7.2 ± 4.5 | 10.4 ± 5.9 | 20.1 ± 11.1 | 7.7 ± 5.2 | 10.2 ± 7.0 | 18.1 ± 7.2 |
| Max postimpact knee angle (degrees) | 38.8 ± 11.2 | 36.1 ± 11.5 | 55.2 ± 14.1 | 42.2 ± 12.1 | 35.3 ± 12.5 | 57.9 ± 14.4 |
| **RBL** | **HOP for Distance** |
| **B-PT-B** | **ST GR** | **CONTROL** | **B-PT-B** | **ST GR** | **CONTROL** |
| vGRF/BW | 3.5 ± 0.4 | 3.1 ± 0.5 | 2.8 ± 0.6 | 3.5 ± 0.9 | 3.6 ± 0.7 | 2.8 ± 0.5 |
| IC knee angle (degrees) | 9.0 ± 8.1 | 10.0 ± 8.1 | 18.3 ± 8.4 | 10.1 ± 6.9 | 10.04 ± 7.3 | 13.9 ± 8.2 |
| Max postimpact knee angle (degrees) | 40.0 ± 14.4 | 39.5 ± 10.7 | 52.0 ± 13.3 | 39.2 ± 13.1 | 37.8 ± 10.5 | 44.4 ± 13.0 |

* Significantly different from B-PT-B and ST GR, P < 0.05.
† Significantly different from B-PT-B and ST GR, P < 0.01.
‡ Significantly different from B-PT-B and ST GR, P < 0.001.
§ Significantly different from CONTROL, P < 0.05.

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adaptations after ACL reconstruction. In addition, individuals of control group were not matched for limb dominance, although 19 of 26 (73.1%) ACL-R subjects underwent injury of their dominant leg. This may have biased performance toward control group. However, because the magnitude of kinematic and kinetic asymmetry between dominant and non-dominant leg during the execution of single-leg functional tasks such as side-cutting and single-leg landing has previously shown to be small, we believe that the overall magnitude of bias would be negligible.

In conclusion, ACL-R subjects who returned to unrestricted sport activities 6 months after surgery showed longer preimpact EMG duration, lower IC, and max postimpact knee angle as well as greater vGrF/BW when performing single-leg landings, which is likely to increase the potential risk of reinjury. The analysis of preimpact EMG duration performing landing tasks at the time of return to sport may be a useful tool in the decision-making process for full sport participation through the identification of subjects showing neuromuscular alterations in motor programming.

Future studies should look at which of the outcome measures that were identified as differing between ACL-R and healthy subjects are related to reinjury risk when return to sport. In addition, further investigations are needed to understand whether these neuromuscular alterations persist bilaterally over time or can be reversed by specific interventions early in the rehabilitation process.

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