Assessment of a New Lateral Cushioned Casting Orthosis

Effects on Peroneus Longus Muscle Electromyographic Activity During Running

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Background: Classical medial wedge (CMW) orthoses have been prescribed to treat overpronation foot pathologies in runners. The effects of a novel supination orthosis (NSO) on the surface electromyography (EMG) activity of the peroneus longus (PL) muscle during a complete cycle of running have yet to be tested.

Purpose/Hypothesis: The purpose of this study was to compare the EMG activity of the PL in participants wearing CMW orthoses and NSOs versus neutral running shoes (NRS) during a full cycle of running gait. It was hypothesized that the PL muscle activity would be lower for the NSO compared with CMW or NRS.

Study Design: Controlled laboratory study.

Methods: Included were 31 healthy recreational runners of both sexes (14 male and 17 female; mean age, 38.58 ± 4.02 years) with a neutral Foot Posture Index and standard rearfoot-strike pattern. Participants ran on a treadmill at 9 km/h while wearing NSO (3-, 6-, and 9-mm thicknesses), CMW (3-, 6-, and 9-mm thicknesses), and NRS, for a total of 7 different conditions randomly selected, while the EMG signal activity of the PL was recorded for 30 seconds. Each trial was recorded 3 times, and the intraclass correlation coefficient (ICC) to test reliability of the measurements was calculated. The Wilcoxon pair to pair nonparametric test with Bonferroni correction was performed to analyze differences among the conditions.

Results: The reliability of all assessments was almost perfect (ICC, >0.81). For both the CMW and NSO, regardless of thickness, the PL activity was statistically significantly lower compared with the NRS (P < .05 for all). For all CMW thicknesses, the PL activity was lower compared with the respective NSO thicknesses, with the 3-mm thickness having the largest difference (CMW3mm, 18.63 ± 4.64 vs NSO3mm, 20.78 ± 4.99 mV; P < .001).

Conclusion: Both CMW and NSO produced reduced EMG activity of the PL muscle; therefore, they can be prescribed to treat overpronation pathologies without associated PL strain concerns. In addition, the NSO saved the enhancement material placed on the medial-rear side of CMW, making it easier to wear sports shoes.

Clinical Relevance: Knowing the safety of CMW and NSO will aid in understanding treatments for overpronation pathologies.

Keywords: orthosis; peroneus longus; supination; surface electromyography

During running activity, the neuromuscular coactivation of the different muscles of the lower limb plays an important part in achieving maximal strength to perform the exercise efficiently and to prevent injuries. A malalignment of this equilibrium could cause alterations in either the foot or locomotor apparatus. Foot overpronation has been identified as one of the most important factors of overuse of the lower limb during running, and the prescription of foot orthoses is accepted as a valid tool to prevent and treat this condition and other medialized foot pathologies.

Foot orthoses are often designed using enhancement material on the medial side, such as a medial heel skive or classical medial wedge (CMW), or an inverted orthosis. The goal is to stop the total amount of the overpronation moment, to decrease the medial acceleration of the foot.
during the initial-contact and full-contact phases of gait,\textsuperscript{18} or even to correct a valgus heel.\textsuperscript{13} However, the lower limbs can be affected by kinetic and kinematic reactions to foot orthoses, for example, by changing the pulling activity of the muscles.\textsuperscript{25} The use of traditional foot orthoses could affect the lever arm of the leg muscles and therefore affect ankle balance.\textsuperscript{26}

Ankle instability is described as the condition of the foot moving away from the normal range of motion.\textsuperscript{6} The peroneus muscles, involved in lateral ankle control movements, have been shown to be affected by supination moments of the hindfoot caused by classical orthoses,\textsuperscript{42} and foot orthoses have led to increased muscle activity of the peroneus longus (PL) as measured using electromyography (EMG).\textsuperscript{22,24,28}

To reduce the strain on the PL, we have developed a novel supination orthosis (NSO) with no medial enhancement material and with a lateral cushioned casting. The purpose of the present study was to compare the EMG effects of 2 kinds of orthoses on PL activity, a CMW and an NSO, with respect to a nonorthotic condition (neutral running shoes [NRS]) during a running test performed on a treadmill. It was hypothesized that the NSO would decrease PL activity more than the CMW or NRS would during running gait.

METHODS

The study protocol was approved by the institutional review board at Hospital Universitario Nuestra Señora de Valme, and the study was conducted according to the guidelines of the Declaration of Helsinki; all participants provided informed consent before the start of the study. The STROBE (Strengthening the Reporting of Observational Studies in Epidemiology)\textsuperscript{41} criteria and randomly consecutive examination techniques were followed to perform the present research.

Participants

All participants were recruited from a biomechanical clinic in Madrid, Spain, over a 3-month period (between September and November 2020). The following inclusion criteria were used to choose the participants: (1) healthy participants between 18 and 30 years of age, (2) recreational runners with a rearfoot-strike pattern who had been training for 3 to 4 hours per week for at least the past year, (3) neutral Foot Posture Index (FPI) (ie, values between 0 and +5 points\textsuperscript{27}), and no lower limb injuries for at least 1 year before study enrollment. The exclusion criteria were (1) any pain during the test, (2) any drug use at the time of the assessments, and (3) not having joint mobility on the feet and lower limbs to allow for typical biomechanical behavior.\textsuperscript{31,32} Body mass index (BMI) was taken into account to select a homogeneous sample in order to avoid hypothetical influences on the obtained results.

Materials

The NSOs and CMWs used in the current study were custom-made in an external orthopaedics laboratory that was blinded to the present research. The NSOs were made from a flat sheet of ethylene-vinyl acetate (EVA) of high hardness. Three versions with different EVA thicknesses were created: 3 mm (NSO\textsubscript{3mm}), 6 mm (NSO\textsubscript{6mm}), and 9 mm (NSO\textsubscript{9mm}). In all versions, a lateral cushioning casting was placed from the bisectrix of the rear part of the orthosis to its lateral edge, which was filled with viscoelastic rubber of Poron (Microban).\textsuperscript{40} Finally, a low-hardness layer of EVA, 1 mm thick, was used to cover the upper layer of the orthosis (Figure 1).

The CMW was made using a flat sheet of EVA of high hardness and 1-mm thickness, with posting wedges made of EVA on the medial and rear sides.
Figure 2. Classical medial wedge orthosis with 3 mm–thick medial ethylene-vinyl acetate enhancement on the rear side.

with different EVA thicknesses for the medial wedge posting: 3 mm (CMW3mm), 6 mm (CMW6mm), and 9 mm (CMW9mm) (Figure 2).

To avoid other alterations to the normal foot biomechanical behavior, no further orthotic modifications were added. For both the NSOs and CMWs, the right and left feet had the same described characteristics. The NRS used in the study were Newfeel PW 100 M medium gray (model No. 2018022).

Instruments and Assessments

The NeuroTrac Simplex Plus (Verity Medical Ltd) EMG device with USB Bluetooth33 was used to study the superficial EMG activity of the PL during running trials; 0.2 to 2000 mV was the range of record of the device, with a sensitivity of 0.1-mV root mean square, 10 m of free wireless (Bluetooth) connection range, and an accuracy of 4% of the reading from ±0.3 mV to 200 Hz, with a bandpass filter of 18 ± 4 Hz to 370 Hz ± 10% for readings <235 mV. The assessment of the signals was done via self-adhesive circular surface electrodes of 30-mm diameter made on high-quality hydrogel and conductive carbon film to detect the electrical action of the muscle fibers. The signal from each electrode was captured by the receiver module and filtered automatically via the NeuroTrac software (Verity Medical Ltd). It was sent via a unidirectional radioelectric secure Bluetooth33 connection to a computer, which digitally transformed it to generate the activity pattern data of each electrode.

An experienced podiatric clinician and researcher (R.S.G.) took the assessments of the participants. In order to localize the muscle belly and set the correct place of location of the sensors, he requested that each participant perform a foot eversion movement of the tested leg against clinician resistance for a few seconds; then, surface electrodes were placed on the most prominent bulge of the PL muscle, according to the European Recommendations for Surface EMG.11 After that, maximal eversion force against hand resistance of the clinician was applied for 5 seconds to set the maximal voluntary isometric contraction needed to calibrate the device and normalize EMG data amplitudes of each trial.

Running Test

A motorized treadmill (Domys T520) was used for the running test. Participants performed a trial run for 3 minutes at 5.7 km/h to become acclimatized to the treadmill34 and to minimize external variables (eg, different floor slopes or running speeds). Then, the running test was performed at 9 km/h36 under each of the 7 conditions (NRS, NSO3mm, NSO6mm, NSO9mm, CMW3mm, CMW6mm, and CMW9mm), randomly performed on the same day. The mean EMG peroneus muscle activity pattern of the right leg was recorded 3 times (ie, a total of 21 trials per participant) for 30 seconds each, leaving 5 minutes of rest between each test.9 To avoid a possible imbalance of the musculoskeletal system, the same conditions for each trial were performed on the contralateral foot.

Statistical Analysis

To assess the reliability of the present study, the within-day trial-to-trial intraclass correlation coefficient (ICC) and standard error of measurement (SEM) were calculated for all participants under the 7 running conditions. The ICCs were interpreted according to Landis and Koch16 (<0.20, slight; 0.20-0.40, fair; 0.41-0.60, moderate; 0.61-0.80, substantial; 0.81-1.00, almost perfect agreement). To reach enough scientific validity, we considered ICCs >0.81 to be appropriate to support the present study. The SEM was calculated to assess the minimum detectable change (MDC) for all measurements. The Shapiro-Wilk test was used to assess the normality of the sample, with normal distribution considered P > .05. Participant variables were reported as means and standard deviations.

The nonparametric paired Friedman test was used to verify differences between conditions, and the Wilcoxon pair to pair nonparametric test with Bonferroni correction was performed to analyze differences between the conditions. Statistically significant differences were indicated when P < .05.

Sample size estimations to carry out the present study were assessed by the statistics unit at the Complutense University of Madrid, which used SPSS Version19.0 (IBM Corp) software to compare the EMG changes in PL activity during running among the 7 different study conditions. Data on the gastrocnemius lateralis in a previous study34 showed a mean EMG value of 25.96 ± 4.68 mV for a novel orthosis compared with 22.27 ± 2.51 mV (P < .05) for typical running shoes. Considering a statistical power of 80%, β = 20%, a 95% confidence interval, and α = .05, a total of 30 participants were needed to perform this study.
RESULTS

The Shapiro-Wilk test showed a nonnormal distribution of the sample, and the Friedman test showed that values were different among the conditions. Of 51 participants initially assessed for eligibility, 16 participants did not meet the inclusion criteria, leading to 31 participants (14 male and 17 female) being ultimately enrolled in the study. The characteristics of the participants are shown in Table 1.

The reliability of the EMG muscle data during the 7 running conditions is shown in Table 2. ICCs for all recollected data were >0.81, indicating that the values had almost perfect reliability. The SEM and MDC data also showed excellent reliability.

The mean EMG activity of the PL during the 7 running conditions is shown in Table 3. All EMG values for CMW and NSO underwent a statistically significant reduction with respect to NRS (23.08 ± 6.67 mV; CMW3mm, 18.63 ± 4.64 mV (P < .001); CMW6mm, 18.462 ± 4.5 mV (P < .001); CMW9mm, 18.78 ± 4.74 mV (P < .001); NSO3mm, 20.78 ± 4.99 mV (P < .001); NSO6mm, 19.844 ± 5.34 mV (P < .001); and NSO9mm, 19.55 ± 4.14 mV (P < .001). When comparing the 2orthoses, significant differences were seen across all 3 thicknesses: CMW3mm, 18.63 ± 4.64 versus NSO3mm, 20.78 ± 4.99 mV (P < .001); CMW6mm, 18.462 ± 4.5 versus NSO6mm, 19.844 ± 5.34 mV (P < .05); and CMW9mm, 18.78 ± 4.74 versus NSO9mm, 19.55 ± 4.14 mV (P < .05).

DISCUSSION

The purpose of the present study was to assess the effects of NSO with a special supination design on mean PL muscle activity during a full running cycle in comparison with NRS and CMW. The EMG values for both CMW and NSO were lower than those for NRS during the running test. The wide variability among related studies in sample size and type (eg, poor participant recruitment8,15,30 or participants with pathology3,31-33 vs healthy participants) and experimental conditions (eg, walking8,30,34-36 vs running2,14,21 and intramuscular electrode32,34 vs surface electrode2,17,22,39 assessments of PL activity) renders any meaningful comparison between results difficult.

According to our results, PL muscle activity for both CMW and NSO values decreased with respect to that of the NRS. These surprising results are in agreement with the findings of other authors, who detected a decrease in PL muscle activity with a similar supination element to that used in our study, pronation-control sports shoes during running30; this could suggest that the tendinous portion of the PL muscle could undertake the mechanical responsibility of excess supination caused by CMW and NSO, as a passive tissue structure, allowing the muscle to not show any change in its electric signal pattern (Figure 3). In addition, the muscle belly of the PL is far from the force application point, which is placed on the medial rearfoot, and the longitudinal strain to the PL caused by CMW or NSO could be assumed by its own tendon before affecting the muscle belly.

On the other hand, the medial arch support present in sports shoes of previous study30 could also discharge PL activity because the structure sustains the fibers of the muscle that cross beneath the midfoot, which inserts on the base of the first metatarsal bone and therefore could prevent plantarflexion. For some authors, the increasing activity has been detected only during the preactivation phase using a foot orthosis compared with control status2; in contrast to our results, this is likely due to the assessment of each phase of running gait, whereas we recorded the full
cycle or running gait with total amount of EMG activity. In addition, this is the first study reporting isolated supination orthosis effects, without any interference piece effect (eg, medial longitudinal arch or custom orthosis) that could infer some load under the navicular bone or first ray and promote some changes on PL activity, providing benefits in the midstance and push-off phases when the Windlass mechanism is activated.

Moreover, increasing rearfoot supination moments via medial wedging in runners with overpronation foot pathology may increase the amount of the lateral ground-reaction force and thus increase PL EMG activity to dampen leg impact vibrations. Studies have shown no changes during walking, just as our results comparing CMWs between themselves during running. However, some authors have found higher PL muscle activity during walking: Murley and Bird and Murley et al tested foot orthoses on pronated and flat feet and found higher EMG activity on the PL, but the current spasticity of PL in pes planus foot is known; therefore, it is likely that antipronation orthoses could promote more tightness on PL muscle fibers and enhanced signal values. In addition, it is important to take into account that the amplitude of an EMG signal between healthy participants and those with pathology could change due to there being less recruitment of the fast and slow tired fibers of the muscle motor units.

### TABLE 3
Comparison of EMG Signal Amplitudes of the Mean Peroneus Longus Muscle Activity Between Different Study Situations

|                | EMG Activity, mV | P (vs NRS) | P (Within Orthotic Group) | P (Across Groups) |
|----------------|------------------|------------|--------------------------|-------------------|
| NRS            | 23.08 ± 6.67 (20.63-25.53) | —          | —                        | —                 |
| CMW3mm         | 18.63 ± 4.64 (16.93-20.34) | <.001c     | —                        | —                 |
| CMW6mm         | 18.46 ± 4.5 (16.8-20.12)   | <.001c     | .481 vs CMW3mm           | —                 |
| CMW9mm         | 18.78 ± 4.74 (17.05-20.53) | <.001c     | .875 vs CMW3mm           | —                 |
| NSO3mm         | 20.78 ± 4.99 (18.95-22.61) | <.05d      | —                        | <.001d vs CMW3mm  |
| NSO6mm         | 19.84 ± 5.34 (17.88-21.08) | <.001c     | <.05d vs NSO3mm          | <.05d vs CMW6mm   |
| NSO9mm         | 19.55 ± 4.14 (18.03-21.07) | <.001c     | <.05d vs NSO3mm          | <.05d vs CMW9mm   | .430 vs NSO6mm |

*CMW, classical medial wedge; mm, millimeters; NRS, neutral running shoes; NSO, novel supination orthosis. Dashes indicate not applicable.

*Data are presented as mean ± SD (95% CI).

*Statistically significant difference (P < .001).

*Statistically significant difference (P < .05).

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**Figure 3.** Schematic model showing the effect of the study orthoses. Dashed lines indicate the Helbing axis. (A) Right rearfoot without any orthosis. (B) Classical medial wedge orthosis (red shading) with medial enhancement made of ethylene-vinyl acetate on the medial-rear side. The red arrow shows the “uplift” effect of the enhancement on the right foot, the curved black double arrowhead shows the strain of the tendon portion of the peroneus longus (PL) muscle, and the curved arrow shows the supination effect of the orthosis. (C) Novel supination orthosis (red shading) with lateral cushioning casting filled with Poron (white portion). The small red arrows show the Poron depressed by the weight of the participant, the large red arrow shows the lateral “drop effect” of the right foot, the black double arrowhead shows the strain of the tendon portion of the PL muscle, and the curved arrow shows the supination effect of the orthosis.
Ludwig et al.17 also recorded an increase in PL muscle activity during walking gait; however, their participants were wearing a special orthosis with a peroneal pressure point, and they argued that this had a direct influence on the sensitivity of the foot receptors and the neuromuscular response of the PL.

According to our results, there was a statistically significant decrease in PL activity when comparing CMW versus NRS and NSO versus NRS, which was more pronounced when wearing CMW; therefore, it is presumably to think that either elevated element on the rearfoot can produce a saving muscle activity during the push-off phase that gives an advantage to the lateral-rear muscle groups, comparable to the Windlass mechanism assumption.8,12 The total amount of the decreases reported in the present work was almost the same EMG benefits.

CMW in shoes because it was made using lateral rearfoot ioning (vs hard materials) may induce more muscle activity under the same recommendations of CMW, reaching the advantage that NSO can save the enhancement material placed on the medial-rear side of the CMW, making it easier to wear sports shoes. The prescription of both NSO and CMW decreases EMG activity, which has not been studied previously.

CONCLUSION

Foot orthoses with medial corrections have been used to treat overpronation foot problems in runners. Moreover, NSOs have been designed to relieve the current CMW instability produced on the lateral muscles of the ankle. In the present study, it has been shown that PL EMG activity decreases when wearing either CMW or NSO versus NRS during a full cycle of running in healthy participants. Therefore, both can be prescribed to treat overpronation pathologies without associated PL strain precautions with the advantage that NSO can save the enhancement material placed on the medial-rear side of the CMW, making it easier to wear sports shoes. The prescription of both NSO and CMW decreases EMG activity, which has not been studied previously.

REFERENCES

1. Akuzawa H, Imai A, Iizuka S, Matsunaga N, Kaneoka K. Calf muscle activity alteration with foot orthoses insertion during walking measured by fine-wire electromyography. J Phys Ther Sci. 2016;28(12):3458-3462. doi:10.1589/jpts.28.3458
2. Baur H, Hirschmüller A, Müller S, Mayer F. Neuromuscular activity of the peroneal muscle after foot orthoses therapy in runners. Med Sci Sports Exerc. 2011;43(8):1500-1506. doi:10.1249/MSS.0b013e31820c64ae
3. Blake RL. Inverted functional orthosis. J Am Podiatr Med Assoc. 1986;76(5):275-276. doi:10.7547/87507315-76-5-275
4. Bonanno DR, Landorf KB, Munteanu SE, Murley HS, Menz HB. Effectiveness of foot orthoses and shock-absorbing insoles for the prevention of injury: a systematic review and meta-analysis. Br J Sports Med. 2017;51(2):86-96. doi:10.1136/bjsports-2016-096671
5. Burden A. Surface electromyography. In: Payton CJ, Bartlett RM, Abingdon O, eds. Biomechanical Evaluation of Movement in Sport and Exercise. British Association of Sport and Exercise Sciences Guidelines; 2008:77-102.
6. Czajka CM, Tran E, Cai AN, DiPreta JA. Ankle sprains and instability. Med Clin North Am. 2014;98(2):313-329. doi:10.1016/j.mcna.2013.11.003
7. Dananberg HJ. Functional hallux limitus and its relationship to gait efficiency. J Am Podiatr Med Assoc. 1986;76(11):648-652. doi:10.7547/87507315-76-11-648
8. Dananberg HJ. Gait style as an etiology to chronic postural pain, part I: functional hallux limitus. J Am Podiatr Med Assoc. 1993;83(8):433-441. doi:10.7547/87507315-83-8-433
9. Fleming N, Walters J, Grounds J, Fife L, Finch A. Acute response to barefoot running in habitually shod males. Hum Mov Sci. 2015;42:27-37. doi:10.1016/j.humov.2015.04.008
10. Gudur V, Dreyer MA. Talocalcaneal coalition. In: StatPearls [Internet]. StatPearls Publishing; 2021. Updated June 4, 2021. Accessed November 2. 2021. https://www.ncbi.nlm.nih.gov/books/NBK549853
11. Hermens HJ, Freriks B, Desselhorst-Klug C, Rau G. Development of recommendations for SEMG sensors and sensor placement procedures. J Electromyogr Kinesiol. 2000;10(5):361-374.
12. Hicks J. The mechanics of the foot, II: the plantar aponeurosis and the arch. J Anat. 1954;88(1):25-30.
13. Huerta JP, Moreno JMR, Kirby KA, Carmona FJG, Garcia AMO. Effect of 7-degree rearfoot varus and valgus wedging on rearfoot kinematics and kinetics during the stance phase of walking. J Am Podiatr Med Assoc. 2009;99(9):415-421. doi:10.7547/0990415
14. Kelly LA, Girard O, Racinais S. Effect of orthoses on changes in neuromuscular control and aerobic cost of a 1-h run. Med Sci Sport Exerc. 2011;43(12):2335-2343. doi:10.1249/MSS.0b013e31822037ca
16. Landis JR, Koch GG. The measurement of observer agreement for categorical data. *Biometrics*. 1977;33(1):159-174.

17. Ludwig O, Kelm J, Fröhlich M. The influence of insoles with a peroneal pressure point on the electromyographic activity of tibialis anterior and peroneus longus during gait. *J Foot Ankle Res*. 2016;9(1):33. doi:10.1186/s13047-016-0162-5

18. Maharaj JN, Cresswell AG, Lichtwark GA. The immediate effect of foot orthoses on subtalar joint mechanics and energetics. *Med Sci Sports Exerc*. 2018;50(7):1449-1456. doi:10.1249/MSS.0000000000002591

19. McKenzie DC, Clement DB, Taunton JE. Running shoes, orthotics, and injuries. *Sport Med*. 1985;2(5):334-347. doi:10.2165/00007256-198502050-00003

20. Menéndez C, Batalia L, Prieto A, Rodríguez MA, Crespo I, Olmedillas H. Medial tibial stress syndrome in novice and recreational runners: a systematic review. *Int J Environ Res Public Health*. 2020;17(20):1-13. doi:10.3390/ijerph17204757

21. Mündermann A, Wakeling JM, Nigg BM, Humble RN, Styfanysny DJ. Foot orthoses affect frequency components of muscle activity in the lower extremity. *Gait Posture*. 2006;23(3):295-302. doi:10.1016/j.gaitpost.2005.03.004

22. Murley GS, Bird AR. The effect of three levels of foot orthotic wedging on the surface electromyographic activity of selected lower limb muscles during gait. *Clin Biomech (Bristol, Avon)*. 2006;21(10):1074-1080. doi:10.1016/j.clinbiomech.2006.06.007

23. Murley GS, Landorf KB, Menz HB. Do foot orthoses change lower limb muscle activity in flat-arched feet towards a pattern observed in normal-arched feet? *Clin Biomech (Bristol, Avon)*. 2010;25(7):728-736. doi:10.1016/j.clinbiomech.2010.05.001

24. Murley GS, Landorf KB, Menz HB, Bird AR. Effect of foot posture, foot orthoses and footwear on lower limb muscle activity during walking and running: a systematic review. *Gait Posture*. 2009;29(2):172-187. doi:10.1016/j.gaitpost.2008.08.015

25. Nawoczenski DA, Ludwig PM. Electromyographic effects of foot orthotics on selected lower extremity muscles during running. *Arch Phys Med Rehabil*. 1999;80(5):540-544. doi:10.1016/s0003-9993(99)90196-x

26. Nigg BM. The role of impact forces and foot pronation: a new paradigm. *Clin J Sport Med*. 2001;11(1):2-9. doi:10.1097/00042752-200101000-00002

27. Redmond AC, Crosbie J, Ouvrier RA. Development and validation of a novel rating system for scoring standing foot posture: the Foot Posture Index. *Clin Biomech (Bristol, Avon)*. 2006;21(1):89-98. doi:10.1016/j.clinbiomech.2005.08.002

28. Reeves J, Jones R, Liu A, Bent L, Plater E, Nester C. A systematic review of the effect of footwear, foot orthoses and taping on lower limb muscle activity during walking and running. *Prosthet Orthot Int*. 2019;43(6):576-596. doi:10.1177/0309364619870668

29. Roca-Dols A, Losa-Iglesias ME, Sánchez-Gómez R, et al. Effect of the cushioning running shoes in ground contact time phases of gait. *J Mech Behav Biomed Mater*. 2018;88:196-200. doi:10.1016/j.jmbbm.2018.08.032

30. Roca-Dols A, Losa-Iglesias ME, Sánchez-Gómez R, López-López D, Becerro-de-Bengoa-Vallejo R, Calvo-Lobo C. Electromyography comparison of the effects of various footwear in the activity patterns of the peroneus longus and brevis muscles. *J Mech Behav Biomed Mater*. 2018;82:126-132. doi:10.1016/j.jmbbm.2018.03.003

31. Root ML, Orien WP, Weed JH. Neutral Position Casting Techniques. *Biomechanics Corp*; 1971.

32. Sánchez-Gómez R, Becerro-de-Bengoa-Vallejo R, Losa-Iglesias ME, et al. Reliability study of diagnostic tests for functional hallux limitus. *Foot Ankle Int*. 2020;41(4):457-462. doi:10.1177/107110071901116

33. Sánchez-Gómez R, Becerro-de-Bengoa-Vallejo R, Romero Morales C, et al. Muscle activity of the triceps surae with novel propulsion heel-lift orthotics in recreational runners. *Orthop J Sport Med*. 2020;8(10):2325967120956914. doi:10.1177/2325967120956914

34. Sánchez-Gómez R, Romero-Morales C, Gómez-Carrion A, et al. Effects of novel inverted rocker orthoses for first metatarsophalangeal joint on gastrocnemius muscle electromyographic activity during running: a cross-sectional pilot study. *Sensors (Switzerland)*. 2020;20(11):1-12. doi:10.3390/s20113205

35. Saunders PU, Pyne DB, Telford RD, Hawley JA. Reliability and variability of running economy in elite distance runners. *Med Sci Sports Exerc*. 2004;36(11):1972-1978.

36. Shi H, Lin KL, Shang TY. Is the foot striking pattern more important than barefoot or shod conditions in running? *Gait Posture*. 2013;38(3):490-494. doi:10.1016/j.gaitpost.2013.01.030

37. Starrett CJ. Historical review and current use of the Whitman/Robert’s orthoses in biomechanical therapy. *Clin Podiatr Med Surg*. 1994;11(2):231-239.

38. Tam N, Tucker R, Santos-Concejero J, Prins D, Lambert RP. Running economy: neuromuscular and joint-stiffness contributions in trained runners. *Int J Sports Physiol Perform*. 2019;14(1):16-22. doi:10.1123/ijspp.2018-0191

39. Tomaro J, Burdett RG. The effects of foot orthotics on the EMG activity of selected leg muscles during gait. *J Orthop Sports Phys Ther*. 1993;18(4):532-536. doi:10.2519/jostpt.1993.18.4.532

40. Tong JWK, Ng EYK. Preliminary investigation on the reduction of plantar loading pressure with different insole materials (SRP – Slow Recovery Poron®, P – Poron®, PPF – Poron®-Plastazote, firm and PPS – Poron®-Plastazote, soft). *Foot*. 2010;20(1):1-6. doi:10.1016/j.foot.2009.12.004

41. von Elm E, Altman DG, Egger M, et al. The Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) statement: guidelines for reporting observational studies. *Int J Surg*. 2014;12(12):1495-1499. doi:10.1016/j.ijsu.2014.07.013

42. Williams DS, Davis IM, Baich SP. Effect of inverted orthoses on lower-extremity mechanics in runners. *Med Sci Sports Exerc*. 2003;35(12):2060-2068. doi:10.1249/01.MSS.0000098988.17182.8A