Clinical availability of the deep tendon reflex test using a novel apparatus in healthy subjects

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Abstract. [Purpose] The aim of this study was to investigate the clinical usefulness of a novel apparatus intended to improve the consistency and reliability of the deep tendon reflex (DTR) test. [Subjects] The participants included 50 healthy adults (25 male and 25 female) between 20 and 31 years of age who showed no knee abnormalities upon physical examination. [Methods] The intraclass correlation coefficient (ICC) was used to verify inter-rater reliability for two parameters examined in the DTR test using a newly designed apparatus. These parameters were the patellar reflex amplitude and first knee extension angle. Pearson’s product correlation coefficient was then used to examine the correlation between these two parameters. [Results] The inter-rater reliability analysis showed a high correlation between the examiners for both DTR parameters (ICCs = 0.91–0.96). In addition, a significant positive correlation was observed between the two parameters (r = 0.91). [Conclusion] The results show that it is possible to use the novel apparatus described herein to obtain reliable results in the DTR test.

Key words: Deep tendon reflex, First knee extension angle, Reliability

INTRODUCTION

The deep tendon reflex (DTR) test is widely used as an initial exam to identify the presence of potential neurological problems and to assess the severity of neurological disease1, 2). In addition, the DTR test is one of many methods that can be used to diagnose upper and lower motor neuronal disorders3). This test is widely used in clinical practice because it is simple and can be performed quickly and easily to assess a patient’s neurological condition. However, concerns regarding its consistency have been raised due to the fact that it shows wide variation among human subjects4, 5). Therefore, improved techniques and tools are required to ensure quantitative consistency among measurements obtained in the DTR test.

Many previous studies have sought to identify quantitative and objective measures for the DTR test6–8). Kuruoglu and Oh9) conducted an electrophysiological study using an electric hammer as a more quantitative means of conducting the DTR test. However, limitations in terms of inter-rater reliability and validity remain, given that the examiners must directly handle the reflex hammer and may unintentionally vary the percussion intensity, direction, and position6, 10). Indeed, DTR results obtained using an electric hammer in 25 healthy subjects showed very low inter-rater reliability for the various measurements, with intraclass coefficients as low as r = 0.28010). The authors attributed this low correlation coefficient to differences among examiners when striking a given part of the tendon10). In more recent studies, quantitative trials of the DTR test have been carried out using motion analysis, which examines angular velocity and acceleration of the relative joints8, 11).

The reproducibility of measurements is very important for developing objective and quantitative assessment tools for various biological signals measured in the body12). Experimental efforts have identified the controllable variation in DTR measurements, but reliability studies are rarely published due to the technical difficulty of performing the measurements in a consistent manner. Therefore, the development of objective and quantitative DTR test tools, as well as studies examining the reliability and validity of these tools, are needed.

The purpose of this study was to investigate inter-rater reliability for the amplitude of compound muscle action potentials and first knee extension angle (FKEA) in the DTR test and to assess the clinical utility of a novel DTR apparatus attached to an electric hammer.

SUBJECTS AND METHODS

Subjects

This study was conducted in a silent laboratory environment physically isolated from outside disturbances. The subjects included 50 healthy adults (25 male and 25 female) between 20 and 31 years of age, who had no previous history of neurological disease or knee abnormality upon physical...
examination. The average age, height, and weight of the male subjects were 27.1 ± 2.7 years, 173.5 ± 5.1 cm, and 69.7 ± 8.1 kg, respectively; the average age, height, and weight of the female subjects were 23.6 ± 3.1 years, 163.8 ± 3.5 cm, and 52.7 ± 3.4 kg, respectively. The subjects were given a detailed explanation of the study procedure by the researcher and then provided informed consent prior to participation in this study. This study complied with the ethical standards of the Declaration of Helsinki, and the Local Research Ethics Committee approved the study and measurement protocol.

Methods

To assess the reliability of DTR measurements, we examined inter-rater reliability for the patellar tendon reflex of the knee joint, one of the most widely tested parameters in clinical practice. The reflex response was measured as the amplitude of the action potential evoked in the rectus femoris muscle and the FKEA. Percussion was performed using a newly designed apparatus in which an electric reflex hammer (Medelec Corp., Germany) was suspended from a metal frame (30 × 82 cm); a goniometer was then used to modulate the tapping intensity. Surface electrodes attached to the rectus femoris muscle and the FKEA were used to measure the reflex response, and a polygraph with digital processing capability (MP150WSW polygraph, Biopac Systems Inc., Santa Barbara, CA, USA) as an accessory device to examine the correlation between the patellar reflex amplitude and FKEA in the DTR test.

Methods

Table 1. Inter-tester reliability of the amplitude and FKEA of the deep tendon reflex test according to tapping angle (N=50)

| Tapping angle | 1st tester | 2nd tester | ICC(2,k) | 95% CI |
|---------------|------------|------------|----------|--------|
|               | Mean±SD | Range | Mean±SD | Range |         |          |
| 30°           | 0.18±0.11 | 0.08–0.31 | 0.14±0.10 | 0.07–0.34 | 0.96 | 0.93–0.98 |
| 60°           | 0.29±0.13 | 0.17–0.50 | 0.38±0.16 | 0.20–0.67 | 0.91 | 0.87–0.94 |
| 90°           | 0.59±0.21 | 0.19–0.89 | 0.71±0.31 | 0.27–0.92 | 0.94 | 0.91–0.97 |
| 120°          | 0.78±0.24 | 0.31–0.92 | 0.68±0.22 | 0.31–1.14 | 0.95 | 0.92–0.98 |
| FKEA (°)      |           |          |          |        |        |          |
| 30°           | 6.84±3.21 | 3.11–9.64 | 5.74±3.44 | 2.37–10.40 | 0.92 | 0.89–0.95 |
| 60°           | 15.47±5.01 | 6.79–21.22 | 14.74±6.88 | 7.41–26.22 | 0.95 | 0.92–0.98 |
| 90°           | 24.29±10.81 | 11.47–42.55 | 28.04±9.84 | 9.71–45.77 | 0.95 | 0.91–0.98 |
| 120°          | 29.73±12.66 | 13.27–48.49 | 26.37±11.64 | 14.11–46.47 | 0.96 | 0.93–0.98 |

FKEA: first knee extension angle; SD: standard deviation; ICC: intraclass correlation coefficient; CI: confidence interval

RESULTS

Inter-rater reliabilities for patellar reflex amplitude and FKEA during the DTR test were obtained under several conditions in which the tapping angle of the electric hammer was modified (Table 1). For examiner 1, the mean amplitudes of the complex evoked potential elicited under each percussion angle were 0.18 ± 0.11 mV at 30°, 0.29 ± 0.13 mV at 60°, 0.59 ± 0.21 mV at 90°, and 0.78 ± 0.24 mV at 120°. For examiner 2, the mean amplitudes were 0.14 ± 0.10 mV at a 30° tapping angle, 0.38 ± 0.16 mV at 60°, 0.71 ± 0.31 mV at 90°, and 0.68 ± 0.22 mV at 120°. For both examiners,
greater percussion angles elicited larger mean amplitudes for the patellar reflex. For examiner 1, the mean FKEA was 6.84 ± 3.21° at 30°, 15.47 ± 5.01° at 60°, 24.29 ± 10.81° at 90°, and 29.73 ± 12.66° at 120°. For examiner 2, the mean FKEA was 5.74 ± 3.44° at 30°, 14.74 ± 6.88° at 60°, 28.04 ± 9.84° at 90°, and 26.37 ± 11.64° at 120°. As the percussion angle increased, the mean value of FKEA also increased for both examiners. ICC(2,k) values for the amplitude of the complex evoked potential ranged from 0.91–0.96 for the different percussion angles; ICC(2,k) values for FKEA ranged from 0.92–0.96 for the different percussion angles (Table 1).

Pearson’s correlation coefficient for the relationship between amplitude and FKEA was r = 0.91 (p < 0.01), indicating a significant positive correlation between these two parameters. Significant differences were observed between the 30° and 60° and 60° and 90° tapping angles (p < 0.01) but not between the 90° and 120° tapping angles (p > 0.05). Furthermore, in the case of FKEA, significant differences were observed between the 30° and 60° and 60° and 90° tapping angles (p < 0.01) but not between 90° and 120° (p > 0.05).

**DISCUSSION**

Although the DTR test is widely used in clinical practice, there tends to be confusion regarding its exact definition among experts, who may have difficulties conducting this test in a quantitative and consistent manner\(^4\). The previous research into DTR reliability is insufficient. Accordingly, this study used a novel test apparatus to examine inter-rater reliability for two DTR measures (patellar reflex amplitude and FKEA), as well as the correlation between these two parameters. The results indicate that this device generated highly reliable results. Regarding inter-rater reliability, the ICCs for the patellar reflex amplitude and FKEA ranged from 0.91 to 0.96 and from 0.92 to 0.96, respectively, for the different percussion angles examined (30°, 60°, 90°, and 120°).

The objective and quantitative reproducibility of the measurement tool is a very important issue\(^5,\,6\). Because of the scarcity of measurement tools that can quantitatively evaluate the DTR test, results such as these that assess the reliability and validity of the DTR test are very rare. In a recent paper, the reliability and validity of DTR data were verified through motion analysis of the patellar tendon reflex; variation in percussion speed and angle were also incorporated into that study\(^7\). Consistent with our study, the authors found that the amplitude of the response increased linearly in accordance with increased percussion angle, and a concomitant motion analysis confirmed the high reliability of the DTR data\(^8\). However, this previous work exhibited several differences in comparison with the present study. First, in the present study, DTR testing was carried out using the natural pendulum motion of a reflex hammer suspended from a metal frame, to which a goniometer was attached in order to adjust the tapping angle. Because we avoided the use of a handheld hammer, in contrast to previous studies, hammer strikes were delivered in a much more consistent and precise fashion. Second, the previous study used an indirect method to measure the amplitude of response, whereas the present study exploited the aforementioned apparatus to obtain direct reflex response measurements. Because the location, intensity, and direction of percussion were constant, our results show very high measures for inter-rater reliability for both parameters examined (patellar reflex amplitude and FKEA). Previous research has shown DTR test results to be affected by a number of factors, including the examiner’s emotional state, level of training, smoking, and respiration\(^7\). Our research suggests that variation in the stimulus applied, for whatever reason, could be minimized through the use of the device described here.

In the present study, the correlation between the patellar reflex amplitude and FKEA was r = 0.91 (p < 0.01), a strongly significant correlation. When the knee joint is free of pathology, the FKEA resulting from percussion is considered to be a quantitative and objective measurement of tendon reflex. Our novel DTR device elicited significant differences in FKEA values between the tapping angles of 30° and 60° and 60° and 90° (p < 0.01) but not between the tapping angles of 60° and 90° (p > 0.05). These results indicate that percussion angles > 90° are sufficient to induce an appropriate tendon reflex when using the equipment described in this study. In contrast, Tham et al.\(^9\) reported that an appropriate tendon reflex was only induced if a tapping angle of > 60° was used.

This study had several limitations. First, we examined only healthy subjects; the equipment was not tested on patients with neurological abnormalities who would typically be examined using the DTR test. Second, the test was conducted at four different tapping angles at intervals of 30°; therefore, quantitative changes in reflex response at more detailed percussion angles were not examined. Accordingly, additional research is necessary to examine the clinical usefulness of this apparatus for more detailed angles in patients with neurological abnormalities (e.g., spasticity), which consequently might affect the outcomes of the DTR test.

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