The effect of six weeks of sling exercise training on
trunk muscular strength and endurance for clients
with low back pain

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Abstract. [Purpose] The purpose of this study was to investigate the effects of 6 weeks sling exercise training for clients with low back pain on the levels of pain, disability, muscular strength and endurance. [Subjects and Methods] Twelve chronic LBP subjects participated in this study. Subjects were randomly divided into a control group and a training group. Subjects in the training group performed sling exercise training for six weeks, and participants in the control group did not perform any exercise. [Results] Pain, disability levels and muscular strength significantly improved in the training group, but not in the control group. The left multifidus showed a significant improvement in muscular endurance, measured as the slope of the median frequency after training. [Conclusion] Six weeks of sling exercise training was effective at reducing pain intensity, and improving the disability level and trunk muscular strength of subjects with low back pain.

Key words: Chronic low back pain, Sling exercise training, Slope of median frequency

INTRODUCTION

Lumbar instability is a common symptom and also one of the causes of low back pain. It is usually caused by a neuromuscular control disorder rather than structural instability1,2. The definition of lumbar segmental instability is decreased stiffness of the spinal motion segments3. Previous studies have indicated that lumbar instability is associated with pain possibly3; and it may be due to a defect in spinal segment movement control, leading to compression of the neural structure4,5.

Trunk muscular strength may protect the spine during daily activities6–8. Weakness of the trunk muscles and poor muscular endurance are also characteristics of LBP9). The severity of trunk muscular weakness or fatigability may be examined using isokinetic or isometric tests10–12; Numerous studies have investigated the difference in trunk muscular strength and endurance between chronic LBP patients and healthy subjects13, 14. Some reported subjects with LBP have significantly less muscular strength and endurance than healthy subjects13, 14). This may be explained by LBP clients being unwilling to make maximal effort during the muscular strength test due to pain or fear of injuries15, 16).

Previous studies have investigated the trunk muscular activation and muscle fatigue of LBP patients using electromyography (EMG) and compared the results with those of healthy adults. The most frequent site showing pathologic changes is the 4th and 5th lumbar vertebrae, where the multifidus muscles are located17). The median frequency of EMG has been used as a fatigue index to compare the back muscular fatigability of the left and right sides between 40% maximal voluntary contraction (MVC) and 80% MVC, and the median frequency imbalance was significantly larger in LBP than in healthy subjects18).

Regarding exercise training, numerous exercise types have been developed as exercise therapy for clients with LBP, such as hip joint exercises, trunk muscular strengthening exercises, and aquatic exercise19). Lumbar segmental stabilization training is the most popular LBP treatment. It aims to train injured and healthy supporting tissue, facilitate tissue repair and prevent structural weakness from excessive loading19, 20). Exercise training for LBP is not only concerned with positional correctness, but also deep muscle and neuromuscular control training. Previous studies have demonstrated that exercise on an unstable surface, such as exercises on a Swiss ball and sling exercise training (S.E.T),
increases muscular activation levels. The activation levels of the internal and external oblique muscles increased during bridge exercise with vibration training on an unstable surface. Exercise on an unstable surface challenges the motor control system, increasing the speed and intensity of lumbar stabilizers, contraction and the activation ratio as well as improving muscle activation synergy.

A S.E.T system provides an unstable training condition that increases exercise difficulty. Postnatal women with pelvic pain reported significantly reduced pain, improved physical function and better quality of life after 20 weeks of S.E.T training. Baseball players with LBP participated in 12 weeks of exercise training, using ultrasound biofeedback training or S.E.T training. The ultrasound biofeedback training comprised stretching and general trunk muscle strengthening under ultrasound monitoring. The ultrasound biofeedback training helped subjects practice and realize how the deep muscles work. The results showed S.E.T training could improve pain, physical function and lumbar instability more significantly than ultrasound biofeedback training. In general, subjects who suffer from LBP show improved trunk proprioception, physical function and trunk stability after six weeks of S.E.T.

To the best of our knowledge, most studies have measured the effects of interventions for LBP using functional fitness or a subjective questionnaire. Few studies have measured the effects of exercise intervention on muscular strength and endurance. In addition, due to the possible influence of psychological factors, using the slope of the median frequency may be a relatively objective way of measuring muscular endurance compared to using maintenance time only. Thus, the purpose of this study was to examine the effects of 6 weeks S.E.T for clients with LBP on pain, disability, muscular strength and muscular endurance.

SUBJECTS AND METHODS

This study recruited chronic LBP patients. They were randomly divided into a control group and a training group. The pain area was located between the lower ribs and gluteus muscles, and the pain duration had persisted for at least three months. Subjects who were diagnosed with spondylolisthesis or disc herniation were excluded. The investigators explained the purposes and procedures of the assessment and obtained basic personal information and informed consent before conducting the experiment. The participants provided their written consent to participation and the study was approved by the Kaohsiung Medical University Ethics Committees.

Participants’ subjective parameters (pain intensity and disability levels), and objective parameters (muscular strength and endurance) were assessed. Participants in the training group performed stabilization exercise using a S.E.T system for six weeks. Participants in the control group did not perform any exercise intervention. After six weeks, participants, subjective and objective parameters were measured again.

A 10-centimeter visual analog scale was used to measure pain intensity. Low scores represented low pain intensity, and high scores represented high pain intensity.

The Chinese version of the Oswestry disability scale for LBP was used to measure the disability level. This questionnaire has 10 items assessing pain and disability. Each item is scored from 0 to 5, with higher the scores indicating greater disability. The maximum score for this questionnaire is 50 points, and the raw scores are converted to percentages. According to Fairbank, 0–20% represents mild disability, 21–40% represents moderate disability, 41–60% represents severe disability, 61–80% means most physical functions are impaired by back pain, and it is classified as disabled, and 81–100% means the subject is bed-bound.

The muscular strength assessment was measured by a custom-designed muscular strength dynamometer. Subjects were instructed to carry out the trunk extension and rotation to the left and right in a sitting position. For each movement they aimed to exert maximal voluntary isometric contraction for 5 seconds in three trials (Fig. 1). During the trunk flexion and extension test, the torque sensor was placed on the left of the body with its height parallel to the iliac crest.

For the trunk extension test, a fixed bar was set on the spine at the height of the scapula to fix the trunk, and an investigator applied a strength with force along the femoral bone. The torque sensor was placed on the head to measure trunk rotation the fixed bar set at the height of the sternal notch. Velcro was used to fix the pelvis during all tests.

Subjects rested for ten minutes after the maximal muscular strength test, and then carried out the endurance test at about 52% MVIC test in one trial. Subjects performed trunk extension and sustained the contraction until they could not maintain the standard testing posture, their hand touched the bed, or the posture was sustained for 240 seconds. The investigators recorded the time the subject sustained the posture, and the change in the median frequency slope was used as an index of fatigue. Each subject performed this test one time.

Participants in the training group attended an exercise course of three sessions a week with each session comprising 30 minutes of training and 10 minutes of warm up.

In the training program, participants had to hold the end position for 8–10 seconds in 12–15 repetitions of each exercise. The exercise intensity was adjusted by the distance from the point of sling suspension and the distance between the slings and the bed. The repetitions and intensity of exercise were gradually increased. Investigators considered...
the fitness levels differed between the participants, thus, the exercise prescriptions were individually decided with different exercise maintenance times and repetitions in the initial training session. Investigators instructed participants to perform a pelvic backward tilt and keep their back straight during exercise to prevent injury through excessive loading of the lumbar spine during exercise.

Exercise (1): participants were instructed to flex the elbow to 90 degrees and kneel on the bed under the sling point. The forearms were put in straps and the body was extended. Participants lay supine on the bed with their ankles in the slings, and executed a bridging exercise.

Exercise (2): participants stood with their hands in the slings and gradually extended their arms while keeping their backs straight.

Exercise (3): participants lay on the bed with their ankles in the slings and executed a bridging exercise.

Exercise (4): participants lay prone on the bed and the ankles were under the sling point. Straps were set as high as the participants’ upper arm to make the body parallel to the bed during exercise. The participants supported their body with their forearms and ankles. Exercise (5): participants lay prone on the bed and the ankles were under the sling point. Straps were set at the height of the participants’ upper arm to make the body parallel to the bed during exercise. The participants supported their body with their forearms and ankles. Exercise (6): participants lay prone on the bed and the ankles were under the sling point. Straps were set as high as the participants’ upper arm to make the body parallel to the bed during exercise. The participants supported their body with their forearms and ankles.

Investigators calculated the mean of maximal torque of 10 consecutive data minus the mean baseline torque for 10 consecutive data to calibrate the error. The 10 consecutive data of maximal torque were chosen as the 5 data before the maximal value and the 5 data after maximal value. The value divided by the lever arm was used to obtain the force value. Muscular strength was normalized to subjects’ body weight.

The trunk muscular endurance was measured during extension, and the effects of S.E.T on trunk muscular endurance. Fatigue was assessed using the slope of each back muscle.

The sampling rate of the EMG system was 1,500 Hz. Fast Fourier transform (512 point, window processing) were used to convert the time-domain signal to the frequency domain and the median frequency was calculated. The calculated median frequency values were fitted using a first-order curve approximation to calculate the slope of the median frequency. A positive slope indicates neuromuscular fatigue did not build up; a negative slope indicates neuromuscular fatigue is present and a more negative slope indicates a higher level of neuromuscular fatigue. The median frequency slope calculation was performed using Matlab (Version R2007b MathWorks Inc., Nutwick MA, USA).

Wilcoxon’s rank test was used to compare the differences in parameters between pre-and post-intervention. The α level was chosen as 0.05, the level of significance. The statistical analyses were performed using JMP statistical software (Version 9.0.0 SAS institute Inc.).

RESULTS

This study recruited 16 LBP subjects, who were randomly assigned to the training group and the control group. Nine were in the training group and the remaining seven were in the control group. However, two subjects in the training group dropped out of the study due to their work pattern changing, which made them unable to participate in the training sessions. In addition, two subjects in the control group dropped out of the study due to personal reasons. Thus, the total number of subjects was 12, with seven in the training group and the remaining five in the control group. The characteristics of the subjects are listed in Table 1.
...and rotation to the left and right. However, there were no significant differences between the groups.

In the control group, the pain intensity had reduced after six weeks, but it did not improve significantly (Table 2). In the training group, after six weeks of training, pain intensity was reduced to 0.57 (±0.10) kg-m/BW, and it increased significantly to 0.39 (±0.15) kg-m/BW after six weeks of training (p<0.05). The muscular strength of rotation to the left was 0.27 (±0.11) kg-m/BW before training, and it increased significantly to 0.38 (±0.08) kg-m/BW after six weeks of training (p<0.05). The muscular strength of rotation to the right was 0.30 (±0.10) kg-m/BW before training, and it increased significantly to 0.41 (±0.08) kg-m/BW after six weeks of training (p<0.05). The Wilcoxon rank test was used to compare the pre-and post-training values of each group, and * significant difference (p<0.05).

Table 2. Values of the subjective parameters of each group at pre-and post-training

|                           | Control group (N=4) | Training group (N=7) |
|---------------------------|---------------------|----------------------|
| Pain intensity (cm)       | Pre training        | Post training        | Pre training        | Post training        |
|                           | 3.75 (0.87)         | 2.38 (1.03)          | 4.29 (1.44)         | 1.33 (1.17)          |
| Oswestry (%)              | 19.00 (16.20)       | 18.50 (11.82)        | 14.29 (3.90)        | 8.86 (6.41)          |

The Wilcoxon rank test was used to compare the pre-and post-training values of each group, and * significant difference (p<0.05).

Table 3. The values of muscular strength each group at pre-and post-training

|                           | Control group (N=5) | Training group (N=7) |
|---------------------------|---------------------|----------------------|
| Extension (kg-m / BW)     | Pre training        | Post training        | Pre training        | Post training        |
|                           | 0.57 (0.10)         | 0.54 (0.12)          | 0.39 (0.15)         | 0.59 (0.14)          |
| Rotation to right (kg-m / BW) | 0.37 (0.12)       | 0.35 (0.12)          | 0.30 (0.10)         | 0.41 (0.08)          |
| Rotation to left (kg-m / BW)   | 0.43 (0.12)       | 0.38 (0.04)          | 0.27 (0.11)         | 0.38 (0.08)          |

The Wilcoxon rank test was used to compare the pre-and post-training values of each group, and * significant differences (p<0.05).

This study used a visual analog scale to measure the pain intensity. Higher scores on this scale indicated higher pain intensity. The pain intensity of the control group and training group before training was 3.75 (±0.87) and 4.29 (±1.44), respectively, with no significant difference between the groups.

In the control group, the pain intensity had reduced after six weeks, but it did not improve significantly (Table 2). In the training group, after six weeks of training, pain intensity was reduced to 1.33 (±1.17) cm, and there was a significant improvement in pain intensity between pre- and post-training (p<0.05) (Table 2).

The training group showed a slightly higher disability level than the control group at the baseline assessment, but there was no statistically significant difference between the groups (Table 2).

After six weeks, there was no significant improvement in the Oswestry disability index for the control group (Table 2). The disability level in the training group before training was 14.29 (±3.90) percent, and after training, the disability level was significantly lower at 8.86 (±6.41) percent (p<0.05) (Table 2).

A comparison of baseline measurements between the groups showed the muscular strengths in extension of the control and training groups were 0.57 (±0.10) kg-m/BW and 0.39 (±0.15) kg-m/BW, that of rotation to the right was 0.37 (±0.12) kg-m/BW and 0.30 (±0.10) kg-m/BW, and that of rotation to left and 0.43 (±0.12) kg-m/BW 0.27 (±0.11) kg-m/BW, respectively. The control group had greater absolute muscular strength than the training group in extension and rotation to the left and right. However, there were no significant differences between the groups.

In the control group, extensor and rotator muscular strength had slightly decreased after six weeks without training. However, the results were not significantly different (Table 3). In the training group, muscular strength improved after six weeks training. The absolute extensor muscular strength was 0.39 (±0.15) kg-m/BW before training, and it increased to 0.59 (±0.14) kg-m/BW after six weeks of S.E.T (p<0.05) (Table 3). The results showed muscular strength of rotation to the right was 0.30 (±0.10) kg-m/BW before training, and it increased significantly to 0.41 (±0.08) kg-m/BW after six weeks of training (p<0.05). The training group before training was 3.75 (±0.87) and 4.29 (±1.44), respectively, with no significant difference between the groups.

Comparison of the slope of the median frequency between the control and training group showed no significant difference at baseline for all the muscles measured. In the control group, the slope of the median frequency for all muscle sites showed no improvement after six weeks.

The slope of median frequency in the training group showed a significant improvement on the left side of the multifidus after training (the slopes at baseline and post-training were −0.11 and −0.08, respectively) (p<0.05) (Table 4). However, the other muscle sites did not show any significant changes after training.

DISCUSSION

This study found the subjective parameters were significantly reduced by training. These findings are similar to those of previous studies. Chu reported the effects of S.E.T on baseball players who suffered from LBP. That study recruited 12 LBP baseball players, and carried out three stages of exercise training. In the first stage, ultrasound was used as a biofeedback in the training of deep muscle contraction. The second stage was the trunk muscular strengthening course, and the third stage was stabilization exercise training on slings. Pain intensity was significantly reduced after S.E.T, but it was not apparent at trunk muscular strengthening stage. That is, the S.E.T was more effective at reducing pain than the trunk muscular strengthening course for LBP patients. Chang et al. also investigated the effects of six weeks of S.E.T on LBP patients. They found that the disability level, functional fitness and trunk proprioception improved after six weeks of training. The present study found the disability level reduced after training. The
exercises combined with spinal manipulation elicited greater improvements than those of previous studies. They found that trunk strengthening exercise groups showed greater improvements in local muscular endurance. In our results, the slope of the median frequency showed a significant improvement for the training group, indicating a higher level of neuromuscular fatigue at the pre-training measurement than at the post-training measurement. The training group had a border-line significantly higher level of neuromuscular fatigue at the pre-training measurement for the right multifidus relative to the post-training measurement.

The sample size of this study was relatively small. Twelve patients participated in this study, and there were randomly allocated to the training group and the control group, with seven subjects in the training group and five subjects in the control group. A trial with 80% power and a level of significance of 5% (two tailed) was calculated to require approximately 20 patients in the training group to detect significant differences between pre- and post-training.

Further research should involve a greater number of participants. The exercise program should be prolonged for chronic LBP patients to try to achieve greater improvement. The slope of the median frequency for objectively measures neuromuscular fatigue and should be considered as a parameter for assessing the training effects.

### Table 4. Median frequency comparison of the values of each group at pre-and post-training

| Slope of MF on each muscle site | Control group (N=5) | Training group (N=7) |
|----------------------------------|---------------------|---------------------|
|                                 | Pre training        | Post training       | Pre training        | Post training       |
| L-ES                             | −0.04 (0.02)        | −0.04 (0.02)        | −0.06 (0.01)        | −0.05 (0.01)        |
| R-ES                             | −0.04 (0.01)        | −0.05 (0.03)        | −0.04 (0.01)        | −0.05 (0.02)        |
| L-MF                             | −0.06 (0.03)        | −0.06 (0.03)        | −0.11 (0.01)        | −0.08 (0.01)        |
| R-MF                             | −0.06 (0.04)        | −0.05 (0.04)        | −0.11 (0.02)        | −0.08 (0.01)        |

The Wilcoxon rank test was used to compare the pre-and post-training values of each group, and * significant differences (p<0.05).

(Units: Hz/s)

L-ES: Left side erector spinae; R-ES: Right side erector spinae; L-MF: Left side multifidus; R-MF: Right side multifidus
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