Effects of adding load to the gait of children with cerebral palsy: a three-case report

Efeitos da adição de carga na marcha de crianças com paralisia cerebral: relato de três casos

Efectos de la adición de carga sobre la marcha de niños con parálisis cerebral: relato de tres casos

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ABSTRACT | Our purpose in this study was to analyze the immediate effects of locomotor gait training with different loads on a treadmill on the kinematic parameters of gait in children with Spastic Hemiparetic Cerebral Palsy (SHCP), as well as investigating which load prompted the most adequate motor responses to promote the propulsion of the Paretic Lower Limb (PLL). This case report included 3 children of both sexes, aged 8–12 years. The children walked on the treadmill with loads on their ankles that corresponded to 40, 50 and 60% of the weight of the Lower Limb (LL), on 3 different non-consecutive days. The kinematic parameters were assessed during the pre-training phase (PTP) and immediately after training (PH). The spatiotemporal variables did not change immediately after gait training with the aforementioned loads. On the other hand, we observed wider joint angles in the hip and knee during the swing phase immediately after training, especially with a load of 60% of the weight of the lower limb. These findings indicate that the 60% load is the most appropriate to prompt immediate changes in the joint kinematics of the PLL. These alterations can be important in improving propulsion during the swing phase of gait in children with SHCP.

Keywords | Cerebral Palsy; Rehabilitation; Gait; Weight-Bearing.

RESUMO | O objetivo deste estudo foi analisar os efeitos imediatos do treino locomotor na esteira com diferentes cargas, sobre os parâmetros cinemáticos da marcha de crianças com Paralisia Cerebral Hemiparética Espástica (PCHE), e investigar qual carga promove repostas motoras mais adequadas para favorecer a propulsão do Membro Inferior Parético (MIP). Participaram deste relato de caso 3 crianças de ambos os sexos, com idades de 8-12 anos. As crianças realizaram treino na esteira com carga nos tornozelos equivalentes a 40, 50 e 60% do peso do Membro Inferior (MI), em 3 dias diferentes e não consecutivos. Os parâmetros cinemáticos foram avaliados nas fases pré-treinamento ($F_{PT}$) e imediatamente após o treino ($F_{PH}$). As variáveis espaço-temporais não sofreram alterações imediatamente após o treino de marcha com carga. Por outro lado, foi observado aumento dos ângulos articulares de quadril e joelho durante a fase de balanço imediatamente após o treino, principalmente com carga de 60% do peso do membro inferior. Estes achados indicam que a carga de 60% seja a mais apropriada para solicitar alterações imediatas na cinemática articular do MIP. Tais alterações podem ser importantes para favorecer a propulsão durante a fase de balanço da marcha de crianças com PCHE.

Descritores | Paralisia Cerebral; Reabilitação; Marcha; Suporte de Carga.

RESUMEN | El objetivo de este estudio fue analizar los efectos inmediatos del entrenamiento locomotor en la estera con diferentes cargas, sobre los parámetros cinemáticos de la marcha de niños con parálisis cerebral hemipléjica...
INTRODUCTION

Children with Spastic Hemiparetic Cerebral Palsy (SHCP) present gait patterns characterized by predictable kinematic and kinetic alterations1,2, such as slow progression speed, shorter step length, larger base of support3, and longer duration of the phase of support on the non-paretic leg4. Decreased dorsiflexion during the swing phase and lower amplitudes of knee and hip flexion and extension are also observed1. Along with the diminished capability of the flexor plantar muscles to generate propulsion force, these kinematic alterations result in inefficiencies to lift an individual’s foot off the surface5,6, thus leading to a pattern of “dragging” the Paretic Lower Limb (PLL) during propulsion7.

With the purpose of improving the gait efficiency of children with SHCP, techniques of intervention have been suggested and utilized to increase the generation of force by specific muscle groups at the ideal time within the gait cycle. Considering that changes at the moment of force generation can favor the system's dynamic reorganization and promote alterations in motor behavior4, it is suggested that the physical therapy treatments administered to the gait of children with SHCP must be based on muscle strengthening and aimed at producing hip flexion strength7.

Some authors have investigated adaptive changes in human locomotor behavior in response to external perturbations and showed that interferences with the system weaken the previous stability of the motor pattern and increase the possibilities of an individual modifying motor strategies in order to perform the same task more efficiently8-10. The literature on the topic describes that the imposition of resistance during the swing phase of gait — by adding load onto the Lower Limb (LL) — results in compensatory motor responses in the gait of healthy babies and adults, and of adults with neurological pathologies11-18. The main locomotor adjustments presented by these populations immediately after the removal of the imposed resistance are increases in gait speed15,16,18, flexor muscle torque14,17, flexor muscle activity11,13,14,17 and height of steps11,13,14, as well as an increase in the angle of hip and knee flexion during the swing phase11,13,15.

Considering that adding load onto the LL overloads flexor muscles during the swing phase, resulting in increased activities and amplitudes of hip and knee flexion during the swing phase of human gait11-17, we hypothesized that the presence of such locomotor adjustments would be adequate to improve the propulsion efficiency of the PLL during the swing phase of children with SHCP.

We did not find, in the current literature, clinical studies that investigated the locomotor behavior of children with SHCP in response to training with addition of load to the ankles. It is not known whether this population is able to adapt locomotor patterns and what are the motor strategies adopted by them. Moreover, there is no consensus regarding the most adequate load to be used in order to favor PLL propulsion during swing phase. Thus, in this study, we proposed to observe the behavior of kinematic variables in children with SHCP immediately after gait training on a treadmill with loads on their ankles, in addition to investigating which percentage is more appropriate to enable efficient PLL propulsion.

METHODOLOGY

Participants

This is a case report in which the participants were 3 children with SHCP who were 8, 9, and 12 years of age.
age, of both sexes, and able to walk without aid devices. Their clinical and demographic characteristics are displayed on Table 1.

This study was approved by UFRN’s Ethics Committee (report number 76.519), and the parents and/or legal guardians signed the Informed Consent.

Measurement instruments

We used the D and E dimensions of the Gross Motor Function Classification System (GMFCS) to characterize and assess the children’s functional performances. This scale describes the functional abilities of children with cerebral palsy in five levels\(^19\). The children included in this study were classified in Level I (independent gait, without restrictions).

In order to characterize and assess the participants’ gross motor function, we examined the D and E dimensions of the Gross Motor Function Measure (GMFM-66), a standardized test that quantifies the gross motor function of children with neuromotor disorders. In this study we assessed mobility, maintenance and transition of postures based on the D and E dimensions of the GMFM-66 test\(^20,21\).

The spasticity was assessed through the Modified Ashworth Scale, which consists of a subjective assessment of the degree of muscle resistance during passive joint movement, where a score 0 corresponds to the absence of increase in muscle tonus, and 4 represents rigid joints in positions of rest\(^22\). In the present study we assessed the ischiotibial, gastrocnemius, and soleus muscles of the PLL during movements of knee extension and ankle dorsiflexion with the knee extended and flexed, respectively.

The assessment of gait was performed by the Qualysis – ProReflex MCU Movement Analysis System, a video-based photogrammetry system that reconstructs passive reflective markers located in specific bone prominences in three dimensions (3D). It is composed of eight cameras that emit infrared light, captured and reflected by the passive markers. The data were captured by the Qualysis Track Manager 1.6.0.x – QTM acquisition software at a frequency of 120 Hz and exported to the Visual 3D processing software for the reconstruction of the segments and creation of the biomechanical model.

Assessment procedures

Firstly, we obtained information about the diagnoses and anthropometric characteristics of the children, who were classified by the GMFCS. We then applied the D and E dimensions of the GMFM-66 test, in addition to assessing the spasticity degree of the lower limbs in order to characterize the sample. In accordance with the children’s age, we determined the mass of the LL based on the calculation proposed by Jensen\(^23\), through which we determined the masses of the foot ((0,00015xage+0,0187), leg (0,00122xage+0,3809) and thigh (0,00364xidade+0,06634). Based on this calculation, we defined the loads (corresponding to 40, 50 and 60% of the LL mass) that were utilized in the treadmill training\(^23\).

The collection of the kinematic data was conducted on three different and non-consecutive days, in two moments — static and dynamic collection. In order to carry out the kinemetry, passive markers were positioned bilaterally on specific bone prominences, namely iliac crests, greater trochanter of the femur, lateral and medial epicondyles of the femur, lateral and medial malleolus, heads of the first and fifth metatarsal bones, and base of the calcaneus. Tracking markers (Cluster) were positioned to identify the trajectories of each segment.

For the static collection, the children remained in the orthostatic position at the center of the system’s active area for three seconds. The dynamic collection, conducted as the children walked on the electric treadmill Movement® CardioFitPlus, was divided in two phases: 1) pre-training (PT\(_{\text{PH}}\)), in which we obtained kinematic data about the gait on the treadmill that referred to the baseline; 2) immediately after training (PH\(_{\text{I}}\)), when we obtained kinematic data about the gait on the treadmill immediately after the end of the training with loads attached to the participants’ ankles. At the last minute of both phases of the dynamic collection, we had obtained the kinematic data of ten cycles (Figure 1).

Table 1. Clinical and anthropometric characteristics of the sample, and loads used in the three experimental conditions

<table>
<thead>
<tr>
<th>Child</th>
<th>GMFCS</th>
<th>Sex</th>
<th>Age (years)</th>
<th>Compromised hemibody</th>
<th>Weight (kg)</th>
<th>Height (m)</th>
<th>40% Load</th>
<th>50% Load</th>
<th>60% Load</th>
<th>Orthosis (AFO)</th>
<th>GMFM</th>
<th>SDTSP</th>
<th>SDITMP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I</td>
<td>M</td>
<td>12</td>
<td>Right</td>
<td>394</td>
<td>1.55</td>
<td>2.800 kg</td>
<td>3.500 kg</td>
<td>4.200 kg</td>
<td>No</td>
<td>99.3%</td>
<td>1</td>
<td>+1</td>
</tr>
<tr>
<td>2</td>
<td>I</td>
<td>F</td>
<td>8</td>
<td>Left</td>
<td>299</td>
<td>1.30</td>
<td>1.600 kg</td>
<td>2.000 kg</td>
<td>2.500 kg</td>
<td>No</td>
<td>97.3%</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>I</td>
<td>M</td>
<td>9</td>
<td>Left</td>
<td>462</td>
<td>1.23</td>
<td>2.700 kg</td>
<td>3.400 kg</td>
<td>4.100 kg</td>
<td>Yes</td>
<td>84.6%</td>
<td>1</td>
<td>+1</td>
</tr>
</tbody>
</table>

Experimental protocol

The three children performed the training protocol on the treadmill using loads of 40, 50 and 60% of the LL weight, attached to their ankles bilaterally with shin guards. This training was conducted on three different and non-consecutive days, and the order of use of the percentages proposed was random and based on a previous draw. The collection of the kinematic data was carried out concomitantly to the training for the three experimental conditions.

The children walked at their maximum comfortable speed, defined at the moment they familiarized themselves with the treadmill. One of the children routinely used a rigid orthosis on the ankle, and kept using it during the conduction of the experimental protocol (Figure 2).

Data reduction

The data were captured by the software QTM and processed by the software Visual3D, which creates a system of coordinates for each segment and determines position and orientation based on anatomic markers. Drawing on the anatomic and tracking markers, a biomechanical model was constructed and the angles of joint movement were obtained according to the sequence proposed by Cardan24.

We investigated the following spatiotemporal variables: cadence, double support, length of step, time length of support, and time length of the swing phase of the PLL. Regarding angular variables, we investigated angular movements in the hip and knee sagittal plane. For both PLL joints, we investigated maximum extension during support, maximum flexion during balance, as well as flexion and extension width, obtained through the subtraction of the maximum value by the minimum value achieved during the entire cycle.

RESULTS

We proceed to present the averages of the kinematic parameters of the three children evaluated with the use of the three load percentages, as follows:

Spatiotemporal variables

Table 2 displays the behavior of the spatial and temporal variables in response to the gait training on the treadmill with the three percentages of load during phases PT PT PH = kinematics in the 3rd minute and PHI = kinematics in the 1st minute after removal of the load. The alterations observed immediately after the removal of the load were not significant (Table 2).

Angular variables

Table 3 shows that, immediately after the removal of the load, the gait training on the treadmill with a load on the LL promoted alterations in the joint kinematics of the hip and paretic knee during the swing phase. Furthermore, we observed that 60% of the LL weight led to a more expressive increase in these variables (Table 3).
DISCUSSION

Adding a load to the ankles of children with SHCP during training on a treadmill is an unprecedented proposal for this population. It is based on concepts relating to possible mechanical and neuromuscular adjustments that can be employed as strategies for locomotor adaptation. The results of this study showed that the children with SHCP presented a tendency to modify the joint kinematics in the LL during the swing phase, thus suggesting an ability to display immediate locomotor adaptations in response to the addition of load.

Upon comparing the angular variables before (PTPH) and immediately after the gait training (PHI), we noticed that 60% of the LL weight promoted a more pronounced increase in the angular variables of hip and knee flexion, thus resulting in a multi-joint motor strategy in response to the resistance imposed during the swing phase. This strategy has also been observed in healthy individuals in response to external perturbations through increasing the height of the trajectory of the foot during the swing phase. Moreover, a strong correlation was observed between the amount of load added and the activation of hip flexor muscles.

It is suggested that physical therapy treatments for children with SHCP must be directed toward the gain of muscle strength in the hip flexors with the purpose of improving gait efficiency. The promotion and facilitation of wider angles of hip and knee flexion of the PLL during the swing phase are considered to be important compensatory strategies for this population to perform the task of walking and ensuring foot progression. Considering that adding a load of 60% of the weight of the LL to the participants’ ankles during gait training resulted in locomotor adjustments that had the purpose of favoring the propulsion of the PLL by means of a more accentuated flexion of the hip and knee during the swing phase, we suggest that this training proposal can be an appropriate tool to improve gait efficiency in this population.

Adding load to the ankles imposes resistance during the swing phase, which results in a greater activation of the flexor muscles of the LL. This response can be considered a strategy of neuromotor adaptation mediated by feedback mechanisms that occur due to changes in proprioceptive input during gait with load. Immediately after the removal of this perturbation, an increase in the flexor activity of the LL persists for some time, possibly due to anticipatory motor commands that are formed so that it can adapt to the new task demanded, in preparation for the coming perturbation. The verification of this capability to adjust to

Table 2. Average of the spatiotemporal variables for the three experimental conditions in both phases of assessment

<table>
<thead>
<tr>
<th>Spatiotemporal variables</th>
<th>40% Load</th>
<th>50% Load</th>
<th>60% Load</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speed (m/s)</td>
<td>PT_{PH} Mean±SD</td>
<td>PH Mean±SD</td>
<td>PT_{PH} Mean±SD</td>
</tr>
<tr>
<td>Cadence (steps/min)</td>
<td>0.37±0.04</td>
<td>0.37±0.03</td>
<td>0.37±0.02</td>
</tr>
<tr>
<td>Step length (m)</td>
<td>115.9±33.97</td>
<td>124.6±44.08</td>
<td>108.2±26.71</td>
</tr>
<tr>
<td>Support time (P%)</td>
<td>0.35±0.06</td>
<td>0.32±0.03</td>
<td>0.37±0.01</td>
</tr>
<tr>
<td>Double support (%)</td>
<td>0.21±0.03</td>
<td>0.21±0.03</td>
<td>0.21±0.02</td>
</tr>
<tr>
<td>PTH: pre-training phase; PHI: phase immediately after the training with load; Av: average; SD: standard deviation; P: paretic limb</td>
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</tr>
</tbody>
</table>

Table 3. Average of the angular variables for the three experimental conditions in both phases of assessment

<table>
<thead>
<tr>
<th>Angular variables</th>
<th>40% Load</th>
<th>50% Load</th>
<th>60% Load</th>
</tr>
</thead>
<tbody>
<tr>
<td>P Hip</td>
<td>PT_{PH} Mean±SD</td>
<td>PH Mean±SD</td>
<td>PT_{PH} Mean±SD</td>
</tr>
<tr>
<td>Maximum flexion - swing</td>
<td>71.80±3.88</td>
<td>72.09±6.05</td>
<td>79.51±4.38</td>
</tr>
<tr>
<td>Maximum extension-support</td>
<td>34.47±14.27</td>
<td>35.95±15.91</td>
<td>35.31±13.67</td>
</tr>
<tr>
<td>Flexion and extension amplitude</td>
<td>37.33±12.73</td>
<td>36.13±10.45</td>
<td>44.19±9.79</td>
</tr>
<tr>
<td>P Knee</td>
<td>PT_{PH} Mean±SD</td>
<td>PH Mean±SD</td>
<td>PT_{PH} Mean±SD</td>
</tr>
<tr>
<td>Maximum flexion - swing</td>
<td>81.69±4.64</td>
<td>83.73±5.20</td>
<td>84.99±4.84</td>
</tr>
<tr>
<td>Maximum extension-support</td>
<td>23.13±5.21</td>
<td>25.79±11.16</td>
<td>22.93±6.50</td>
</tr>
<tr>
<td>Flexion and extension amplitude</td>
<td>58.56±5.85</td>
<td>57.94±7.70</td>
<td>62.05±6.04</td>
</tr>
<tr>
<td>PT_{PH}: pre-training phase; PHI: phase immediately after the training with load; SD: standard deviation; P: paretic limb</td>
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</table>
a load alteration and the response pattern presented during PHI by the children in this study suggest that motor commands in children with SHCP can be adjusted in response to additional weight placed on the LL.17

Upon comparing the spatiotemporal parameters obtained in the three experimental conditions (40, 50, and 60% of the weight of the LL) during both assessment phases (PTPH and PHI), we observed that these parameters tend to not suffer any alterations immediately following gait training on a treadmill with the loads proposed, a fact justified by the use of the treadmill, which sets constant rhythm and speed.14 As gait speed directly influences spatial and temporal parameters, the steady maintenance of its values, in all phases and experimental conditions, may have influenced our findings.

With the purpose of evidencing the behavior of locomotor adjustments in children with SHCP as an immediate response to the addition of a load of 60%, we suggest the conduction of studies with larger samples, as a sample composed of 3 children is not enough to demonstrate the significance of the results obtained, and it is, therefore, a limitation of this study.

FUTURE STUDIES

The authors of the present study intend to investigate, in the future, the immediate effects of training on a treadmill with an added load of 60% of the LL’s weight in a more representative sample of children with SHCP. We consider it important to proceed with this study by analyzing whether an increase in hip and knee flexion in the DLL during the swing phase of gait on a treadmill occurs in a significant manner in this group, and whether these adaptations can be transferred to gait on the ground after the conduction of a longitudinal training protocol.

CONCLUSION

The children with SHCP demonstrated capability of locomotor adaptation by increasing the DLL’s hip and knee flexion during the swing phase in response to the addition of load to the lower limbs during gait on a treadmill. These kinematic alterations were more expressive immediately after the training with a load of 60% of the LL’s weight, which suggests that this percentage is the most adequate to prompt locomotor responses that facilitate the DLL’s propulsion during the swing phase of gait.

REFERENCES


