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O M Giggins, B M Fullen and G F Coughlan
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What is This?
Neuromuscular electrical stimulation in the treatment of knee osteoarthritis: a systematic review and meta-analysis

OM Giggins, BM Fullen and GF Coughlan

Abstract
Objective: To assess the effectiveness of surface neuromuscular electrical stimulation in the treatment of knee osteoarthritis.
Design: Systematic review and meta-analysis of randomized controlled and controlled clinical trials
Methods: Studies were identified from databases (MEDLINE, EMBASE, CINAHL, Sports Discus, PEDro and the Cochrane Library) searched to January 2011 using a battery of keywords. Two reviewers selected studies meeting inclusion criteria. The methodological quality of the included studies was assessed using the Thomas Test and the strength of the evidence was then graded using the Agency for Health Care Policy and Research guidelines. Data were pooled and meta-analyses were performed.
Results: Nine randomized controlled trials and one controlled clinical trial, studying a total of 409 participants (n = 395 for randomized controlled trials, and n = 14 for controlled trial) with a diagnosis of osteoarthritis were included. Inconsistent evidence (level D) was found that neuromuscular electrical stimulation has a significant impact on measures of pain, function and quadriceps femoris muscle strength in knee osteoarthritis.
Conclusion: The role of neuromuscular electrical stimulation in the treatment of knee osteoarthritis is ambiguous. Therefore, future work is needed in this field to clearly establish the role of neuromuscular electrical stimulation in this population.

Keywords
Electrical stimulation, knee osteoarthritis, rehabilitation interventions

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Introduction
Osteoarthritis is the most common form of arthritis predominantly affecting the large weight-bearing joints of the body such as the knee. Symptoms associated with knee osteoarthritis include joint instability, pain on weight-bearing and/or at rest, reduced
range of motion and disuse atrophy and weakness of
the quadriceps femoris muscle. Functional disabil-
ity arises from pain and loss of quadriceps femoris
strength, both of which reduce quality of life and
increase the risk of further morbidity and mortality. Exercise therapy aims to decrease pain and increase
quadriceps femoris strength, therefore improving
functional capacity for those with knee osteoarthri-
tis. The American College of Rheumatology has
approved regular exercise as a therapeutic approach2
with both aerobic and strengthening exercises
shown to improve pain and physical function in
patients with knee osteoarthritis.3

Neuromuscular electrical stimulation consists of
electrically stimulating muscle and/or nerves to
induce a muscle contraction. It increases the load on
the muscle using an electrically induced contraction
and can therefore be used to improve muscle
strength.4 Evidence suggests that neuromuscular
electrical stimulation can increase strength of the
quadriceps femoris muscle and decreases pain in
knee osteoarthritis,5,6 however this has not been
thoroughly investigated. A previous systematic
review published in 2000 identified strong evidence
for the beneficial application of neuromuscular
electrical stimulation in knee osteoarthritis, how-
ever the authors highlighted limitations which
included the limited number of included studies,
their small sample sizes and flawed allocation pro-
cedures.7 In addition, patients post total knee arthro-
plasty were included as was the use of transcutaneous
electrical nerve stimulation for pain relief.

Because of the expansion of research in the area
of neuromuscular electrical stimulation in the past
decade, an update on the current evidence is
required. Hence this study was undertaken to sys-
tematically review the literature to determine the
efficacy of surface neuromuscular electrical stimula-
tion as a method of improving quadriceps femoris
muscle strength, pain and function in patients with
knee osteoarthritis.

**Methodology**

The review comprised three phases. In phase 1 an
extensive literature search of the following databases
was conducted up to January 2011: MEDLINE,
EMBASE, CINAHL, Sports Discus, PEDro and the
Cochrane Library. The search terms relating to osteo-
arthritis and neuromuscular electrical stimulation
used in the MEDLINE search were modified for the
other databases (Appendix 1). Citation lists from all
included studies were also searched.

Inclusion criteria included randomized controlled
trials and controlled clinical trials, published in
English, or translated into English between 1986 and
2011, and conducted on human adults with a diagno-
sis of unilateral or bilateral knee joint osteoarthritis.
Studies that used neuromuscular electrical stimula-
tion in combination with any other therapeutic inter-
vention or exercise programme, as well as those
comparing neuromuscular electrical stimulation to
exercise interventions/non-exercise interventions or
combinations of exercise with different conservative
treatments were included. Exclusion criteria included
participants who had undergone total knee replace-
ment or uni-compartmental replacement or had any
history of inflammatory disease such as rheumatoid
arthritis. Studies that investigated the use of transcu-
taneous electrical nerve stimulation or pulsed elec-
tromagnetic stimulation were also excluded, along
with studies that used implantable electrodes.

In phase 2, two reviewers (OMG and GFC) assessed studies generated from the search strategy
for inclusion using the title and/or the abstract if
there was ambiguity in the study title. Full copies of
potentially relevant studies were then obtained for
detailed examination. The two reviewers then
reviewed the full text of the potential studies to deter-
mine their suitability. Where disagreement existed
between the reviewers on the inclusion of a study, a
third independent reviewer (BMF) was assigned to
review the manuscript. A detailed proforma was
developed to capture and categorize the results of the
included studies into three main themes: the effects
of neuromuscular electrical stimulation on pain, on
function and on quadriceps femoris muscle strength.

In phase 3, the quality of the studies was assessed
using the Thomas Test8 which has been identified in
the literature8 as the most appropriate tool for qual-
ity assessment for studies involving both random-
ized and non-randomized controlled trials. Two
reviewers (OMG and GFC) independently graded
the quality of the included studies according to the following components: selection bias, study design, confounders, blinding, data collection methods, withdrawals and drop-outs. These component ratings then gave a global rating of strong, moderate or weak. The strength of the evidence was then graded according to the grading system used in the Agency for Health Care Policy and Research (AHCPR) guidelines. Minor amendments were made to the grading system to include level B category for trials of moderate quality. Where appropriate, study results were pooled and meta-analyses were undertaken. Considering the clinical heterogeneity of the included studies the meta-analyses were limited to studies where outcome measures included the Western Ontario and McMaster Osteoarthritis Index (WOMAC) pain and function scores, and walking tests. The analysis was undertaken using Review Manager Software package RevMan 5 (version 5.0.25, updated 2010 Cochrane Collaboration). For the continuous data where different scales were employed by different studies for the assessment of the same outcome (e.g. walking test) the standardized mean difference (SMD) with 95% confidence intervals (CI) were calculated using a random effect model. Where the same scale was employed (e.g. for pain and function (WOMAC)), the mean differences with 95% CI were used. Authors were contacted in cases of incomplete data.

Results

Nine randomized controlled trials and one controlled clinical trial were included in the review. Figure 1 summarizes the results of all database searches. There was full agreement between the reviewers on the inclusion of all of the studies. A summary of the study characteristics is shown in Table 1.

Participants studied

In total, 409 patients (female \( n = 312 \), male \( n = 83 \), not reported \( n = 14 \)) with knee osteoarthritis were included in the ten studies (\( n = 395 \) for randomized controlled trials and \( n = 14 \) for controlled clinical trials), where patient numbers in each intervention study ranged from 7 to 57. All participants had either radiographic evidence (>grade 1 on the Kellgren and Lawrence Scale) of knee osteoarthritis, or where radiographic evidence was not reported, clinical evidence of knee osteoarthritis. Participants were recruited from a range of clinical settings: an osteoarthritis database, an outpatient department in the study centre, from a total knee arthroplasty waiting list or by self-selection (advertisements). Four studies did not detail the method of participant recruitment. All but one study identified the proportion of male and female participants, with a greater proportion of females participating in every study. The participants' age ranged from 52 to 71 years. Mean body mass index ranged from 29.3–32.9 kg/m\(^2\). Three studies did not detail the body mass index of the participants studied.

Treatment approaches

The neuromuscular electrical stimulation treatment protocols employed in each study are summarised in Table 1. All but one study reported the parameters used. The neuromuscular electrical stimulation pulse frequency used ranged from 25 to 50 Hz, with 50 Hz the most common frequency employed. Choice of machine, treatment times and electrode placement varied between the studies.

Outcome measures

Both self-report and objective outcome measures were included (Table 1). Self-report measures included disease-specific questionnaires (WOMAC and Lequense Index) and measures of pain (visual analogue scale, WOMAC pain subscale, McGill pain questionnaire, the pain subscale of the Arthritis Impact Measurement Scale 2, the Pain Rating Index Total, pain diary and the Present Pain Intensity scale). Quality of life measures (Short Form Health Survey 36, the Nottingham Health Profile) and a self reported measure of function (the Functional Performance Inventory) were also included.

Objective outcome measures included strength measurements (one-repetition maximum (1RM)
### Table 1. Study characteristics

<table>
<thead>
<tr>
<th>Author</th>
<th>Study design</th>
<th>Participants</th>
<th>Study characteristics</th>
<th>Intervention</th>
<th>Outcome</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burch15</td>
<td>RCT</td>
<td>N=109, K-L scale grade &gt;1 OA. Group 1: IF plus NMES (n=54, 36 female, 18 male, age: 62.6±10.5, BMI: 29.3±5.4) Group 2: TENS (n=55, 43 female, 12 male, age: 60.8±11.4, BMI: 31.7±5.8)</td>
<td>(i) WOMAC: pain, stiffness and function subscales (ii) Pain VAS (iii) Quality of life VAS</td>
<td>For both groups 35 min therapy was applied daily for 8 weeks. Group 1: 15 min of IF followed by 20 min of NMES. IF 5000 Hz and premodulated beat frequency sweeping between 1 and 150 Hz. NMES parameters: biphasic square wave, frequency 50 Hz, duty cycle 200 ms every 1500 ms, pulse width 3.39–102.2 µs, intensity 60 mA Group 2: 35 min of TENS, biphasic square wave with a 0.2 Hz frequency, amplitude of 60 mA, pulse width adjusted to give peak output of 73 nC</td>
<td>(i) Significantly greater reductions in WOMAC pain (P=0.002), stiffness (P=0.004) and function (P=0.003) subscales in IF+NMES group (ii) IF+NMES group had a greater, but non-significant decrease in overall pain (P=0.29) (iii) The mean change from baseline to follow-up in the quality of life VAS ratings were similar between the two groups (P=0.99)</td>
<td>An NMES combined with IF intervention demonstrated significantly greater improvements in self-reported measures of pain, stiffness and function following an 8 week intervention compared to a TENS intervention</td>
</tr>
<tr>
<td>Durmus12</td>
<td>RCT</td>
<td>N=50, female, K-L scale grade 1, 2, 3 OA. Group 1: NMES (n=25, age: 54.7±20, BMI: 32.6±0.7) Group 2: BF assisted isometric exercise (n=25, age: 54.6±1.7, BMI: 32.7±0.9)</td>
<td>(i) Pain:VAS in activity, at night and at rest (ii) WOMAC pain score (iii) WOMAC function, 50-m timed walk, timed stairs climb (iv) Strength: 1RM and 10RM</td>
<td>For both groups 20 min therapy was applied 5 days/week for 4 weeks Group 1: Asymmetric biphasic wave, frequency 50 Hz, pulse width 200 µs, duty cycle 10 s on–10 s off, intensity 70–120 mA Group 2: Isometric contractions held for 10 s, 50 s relaxation. Patient asked to increase the visual and auditory signals that she perceived at every contraction</td>
<td>(i) Both groups showed significant improvements in VAS and WOMAC pain, physical function and stiffness scores, 50 m walking time and 10 step stair climb, 1RM and 10RM No SD between the groups in any measure after therapy (P&gt;0.05)</td>
<td>A 4 week NMES intervention is as effective as an exercise intervention in improving pain, function and strength in knee osteoarthritis</td>
</tr>
<tr>
<td>Gaines6</td>
<td>RCT</td>
<td>N=38, K-L scale grade 1–4 OA. Group 1: NMES plus education (n=20, 17 female, 3 male, age: 70.7±5.4) Group 2: education only (n=18, 13 female, 5 male, age: 70.9±7.2)</td>
<td>(i) NMES pain diary (ii) Pain using PPI Scale, PRIT and McGill Pain Questionnaire (iii) AIMS2</td>
<td>12 week intervention Group 1: Biphasic rectangular wave, frequency 50 Hz, pulse width not reported, ramp up 3 s 10 s on–50 s off, intensity for first 4 weeks at 10–20% MVC, weeks 5–8 20–30% MVC, weeks 9–12 30–40% MVC, 15 min duration. Electrodes (4 in × 5 in) positioned over the vastus medialis oblique and proximal vastus lateralis Group 2: Arthritis self-help course, AIMS2 12h community-based education</td>
<td>(i) Significant decrease in knee pain after an NMES session (P&lt;0.001) (ii) No SD between groups in pain on the PPI and the PRIT following the intervention (iii) Non-significant 7% increase in pain for the NMES group and a significant 66% increase in pain for the education-only group on the AIMS2</td>
<td>NMES results in an immediate decrease in knee pain 15 min after treatment However, no long-term improvement in knee pain was observed in either group after a 12 week intervention period</td>
</tr>
<tr>
<td>Author</td>
<td>Study design</td>
<td>Participants</td>
<td>Outcome measures</td>
<td>Intervention</td>
<td>Outcome</td>
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<tr>
<td>Gibson</td>
<td>CCT</td>
<td>14 participants, two groups:</td>
<td>QF MVC, force, relaxation rate and fatiguability Markers of muscle protein synthesis QF histology</td>
<td>Group 1: Stimulation on the side of knee OA. Square wave, frequency 30 Hz, pulse width 300 ± 45 µs, duty cycle 2 s on–9 s off. Electrodes (9 cm × 5 cm) placed over proximal and distal QF. 1 h stimulation per day for 28 days Group 2: No treatment</td>
<td>NMES group: No SD in muscle protein concentration or fibre diameter between stimulated (osteoarthritic) and non-stimulated (healthy) side. Muscle protein synthesis was maintained on the affected side. No significant increase in MVC  Control group: Higher rate of protein synthesis on the side of knee OA</td>
<td>A 4 week NMES intervention results in an increase in quadriceps protein concentration, however there was no evidence of increased QF MVC following the intervention</td>
</tr>
</tbody>
</table>
| Kocaman      | RCT          | N = 38 K-L scale grade >1 OA, NMES group: (n = 19, 15 female, 4 male, age: 61.6 ± 10.1, BMI: 29.4 ± 3.9) Exercise group: (n = 19, 14 female, 5 male, age: 60.4 ± 7.6, BMI: 31.2 ± 6.1) | (i) Pain: VAS (ii) Knee range of motion (iii) Thigh and knee circumference (iv) Timed stairs climb (v) CSA of RF (vi) Lequesne and WOMAC | NMES: 23 min 5 times/week for 4 weeks. Stimulation parameters not reported Exercise: Maximal quadriceps contractions: 3 sets of 10 repetitions. 5 times/week for 4 weeks | Significant improvements in pain, thigh circumference, activity time, CSA of RF and Lequesne and WOMAC indices in both groups (P < 0.05) No SD between the groups Significant improvement in active knee range of motion in both groups, the improvement in the exercise group was more prominent (P < 0.05) | A 4 week NMES intervention is as effective as a 4 week exercise intervention in improving knee osteoarthritis symptoms and improving quality of life, however the exercise intervention results in significantly greater improvements in active knee range of motion than the NMES intervention | (Continued)
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<tr>
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<th>Participants</th>
<th>Intervention</th>
<th>Outcome</th>
<th>Conclusion</th>
</tr>
</thead>
</table>
| Oldham         | RCT          | N = 30 participants (n = 17 female, n = 13 male) allocated to one of 4 groups | (i) Uniform frequency stimulation: 8.4 Hz  
(ii) Patterned neuromuscular stimulation (PNMS): Stimulation replicating the discharge of a fatigued QF MU  
(iii) Random pattern: stimulation pattern generated by randomly shuffling the interpulse intervals in the fatigued QFMU discharge train  
(iv) or sham treatment.  
Stimulation protocol: Biphasic asymmetrical wave, pulse width 300 μs, duty cycle 30 s on–15 s off. Stimulation of QF for 3 h per day/6 weeks | No SD between all 4 groups in MVIT and endurance, Group (i) showed significant improvements in MVIT over group (ii) (P = 0.05) and (iv) (P = 0.02)  
Significant improvements (P < 0.05) in endurance at 3 weeks in group (ii) and (iv)  
No SD between the groups in function and quality of life | No stimulation pattern emerged as being significantly better than the other in improving strength, function or quality of life |
| Palmieri-Smith | RCT          | N = 30. Female. K-L scale grade > 2 OA. Intervention group  
(n = 16, age: 58 ± 2.7, BMI: 32.7 ± 4.1).  
Control group  
(n = 14, age: 56.8 ± 2.9, BMI: 32.1 ± 5.1) | Intervention: NMES 3/week for 4 weeks. Waveform not reported, frequency 50 Hz, pulse width not reported, duty cycle ramp up 2 s, 10 s on–50 s off, intensity adjusted to at least 35% of MVC. 10 QF contractions  
Control group: no treatment; standard of care | (i) No SD in QF strength or activation for intervention group versus the control group  
(ii) No SD between groups in terms of WOMAC scores  
(iii) No SD between groups for 40-foot walk | A 4 week NMES intervention did not induce significant gains in QF muscle strength or activation as compared to a standard care control group. No significant improvements were observed either in the measures of pain, stiffness or function |
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<th>Outcome measures</th>
<th>Intervention</th>
<th>Outcome</th>
<th>Conclusion</th>
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<tr>
<td>Rosemffet</td>
<td>RCT</td>
<td>N = 26 participants (n = 20 female, n = 6 male), K-L scale grade &gt;2 OA, allocated to one of 3 groups. Group A (n = 8, BMI: 32.86) Group B (n = 10, BMI: 29.31) Group C (n = 8, BMI: 31.13)</td>
<td>(i) Pain: VAS (ii) WOMAC pain, stiffness and function (iii) QF torque (iv) 6-metre walk test (m)</td>
<td>8 week intervention Group A: NMES, 3 times/week for 30 min monophasic wave, 0.2 mV amplitude, frequency 25 Hz, pulse width not reported, duty cycle 5 s on–5 s off, voltage 60–80 V (n = 8) Group B: exercise programme, 1 h 15 min twice a week (n = 10) Group C: Combined NMES and exercise (n = 8)</td>
<td>(i) VAS pain improved significantly in all 3 groups (P &lt; 0.05) (ii) WOMAC indices improved significantly in all 3 groups (P &lt; 0.05) (iii) QF torque improved significantly in groups B and C (P &lt; 0.05) (iv) Walk test improved significantly in group B only (P &lt; 0.05)</td>
<td>A combined NMES and exercise intervention is more effective than either treatment modality alone in increasing QF muscle strength in knee OA Significant improvements in pain levels were observed following all 3 interventions Significant improvements in walking function were only observed following the exercise-only intervention</td>
</tr>
<tr>
<td>Talbot</td>
<td>RCT</td>
<td>N = 34 K-L scale grade &gt;1 OA Group 1: NMES + education (n = 18, female n = 15, male n = 3, age: 70.3 ± 5.6, BMI: 29.5 ± 4.1) Group 2: Education only (n = 16, female n = 12, male n = 4, age: 70.8 ± 4.9, BMI: 31.6 ± 5.9)</td>
<td>(i) AIMS2 and Functional Performance Inventory (ii) Maximal Isometric QF force (iii) Physical activity monitoring: accelerometer (iv) Timed 100-foot walk, stair climb, chair rise (s) (v) McGill pain Questionnaire</td>
<td>12 week intervention Group 1: symmetrical biphasic rectangular wave, frequency 50 Hz, pulse width 300 µs, duty cycle 3 s ramp-up 1.5 ramp-down 10 s on–10 s off, intensity adjusted to 10–40% of MVC. 2 (4 × 5 in) electrodes stimulated the QF muscle. 15 min 3/week for 12 weeks Group 2: Participants attended arthritis self-help course</td>
<td>Significant increase in QF strength in NMES group (P &lt; 0.05) SD in chair rise time and timed walk in NMES group (P &lt; 0.05) No SD in the severity of pain reported following intervention in both groups</td>
<td>A 12 week NMES intervention appears to increase QF strength and improve function in adults with knee OA. However no SD was observed in measures of pain between the control and NMES group following the intervention period</td>
</tr>
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</table>
and ten-repetition maximum (10RM), maximum voluntary contraction and force of the quadriceps femoris) and functional assessments/physical activity measurements (timed walk, timed stair climb, timed sit-to-stand, balance, accelerometry). Other objective measurements included knee range of motion, knee and thigh circumference, quadriceps femoris cross-sectional area and protein synthesis and histological markers.

**Study quality**

The Thomas Test rated the quality of two studies as strong,5,15 four studies as moderate1,11–13 and four studies as weak.6,10,14,17 The component ratings and global ratings are summarized in Table 2.

**Impact of neuromuscular electrical stimulation on pain**

Eight studies investigated the impact of neuromuscular electrical stimulation on pain.1,5,6,12–15,17 A range of self-report outcome measures were used: visual analogue scale,1,12–15 WOMAC pain subscale,1,12–15,17 the Pain Rating Index Total,6 a pain diary,6 the pain subscale of the Arthritis Impact Measurement Scale 2,6 the Present Pain Intensity scale6 and the McGill Pain Questionnaire.5,6

Inconsistent evidence (level D) from eight papers found that neuromuscular electrical stimulation alone, or in combination with other therapeutic interventions, had a significant impact on self-reported pain in osteoarthritis.

Four studies of moderate or strong methodological quality,1,12,13,15 reported that neuromuscular electrical stimulation alone or combined with other therapeutic interventions, such as infrared, interferential ultrasound and continuous passive movement,1 interferential therapy15 and exercise,13 can significantly improve pain in knee osteoarthritis. One study of weak methodological quality reported that neuromuscular electrical stimulation alone was as effective as conventional exercise in improving knee pain in osteoarthritis.14 However, three studies (one strong and two weak methodological quality studies) reported no significant difference in the
severity of pain following a neuromuscular electrical stimulation intervention.5,16,17

Impact of neuromuscular electrical stimulation on function

Eight studies investigated the impact of neuromuscular electrical stimulation on patient function.1,5,11–15,17 A range of self-report and objective outcome measures were used: WOMAC function subscale,1,12–15,17 timed walk,5,12,13,17 timed stairs climb,5,11,12,14 timed sit-to-stand,5,11 balance measure1 and the Functional Performance Inventory.5

Inconsistent evidence (level D) was found in the eight papers that neuromuscular electrical stimulation significantly improved patient function.

Four investigations demonstrated that neuromuscular electrical stimulation alone, or when combined with other therapeutic interventions (infrared, interferential therapy, ultrasound and continuous passive movement1) or exercise13 is as effective as conventional exercise in improving measures of function in knee osteoarthritis.1,12–14 Similarly, two investigations found that neuromuscular electrical stimulation is capable of significantly improving levels of function greater than a control
intervention.\textsuperscript{5,15} However, two studies reported no significant difference between intervention and control group; in a timed walk and timed sit-to-stand following interventions with different stimulation patterns,\textsuperscript{11} or in terms of self-reported function following a four-week neuromuscular electrical stimulation intervention.\textsuperscript{17}

**Impact of neuromuscular electrical stimulation on strength**

Eight studies investigated the impact of neuromuscular electrical stimulation on quadriceps femoris muscle strength.\textsuperscript{1,5,10–14,17} Objective measures of strength included one and ten repetition maximum,\textsuperscript{12} manual muscle testing\textsuperscript{14} and quadriceps femoris torque measurements.\textsuperscript{1,5,10,11,13,17} There is inconsistent evidence (level D) from the eight papers that neuromuscular electrical stimulation alone, or in combination with other therapeutic interventions, had a significant positive impact on measures of quadriceps femoris muscle strength in knee osteoarthritis.

Significant improvements in quadriceps femoris strength measures were noted following a neuromuscular electrical stimulation intervention in three studies.\textsuperscript{5,12,14} One paper\textsuperscript{1} reported that combined continuous passive movement and neuromuscular electrical nerve stimulation is effective in increasing strength in this population. However, three studies demonstrated no significant improvements in strength following a neuromuscular electrical stimulation intervention.\textsuperscript{10,13,17} It has been suggested that there may be a significant placebo effect associated with neuromuscular electrical stimulation, as strength gains were observed in this study following sham stimulation.\textsuperscript{11}

**Meta-analyses results**

Pooled data from six studies examining pain and function outcome measures were included in the meta-analyses.\textsuperscript{1,5,12,13,15,17} One study was excluded as original data could not be obtained from the authors.\textsuperscript{14} A meta-analysis was undertaken to determine the impact of neuromuscular electrical stimulation on the WOMAC function scores. From a total of 233 patients, the point estimate for differences between the experimental and control groups at follow-up was $-5.31$ ($-10.32$ to $-0.40$) in favour of the experimental group (Table 3).

A pooled analysis was also undertaken for the WOMAC pain scores. From a total of 225 patients, the point estimate for differences between the experimental and control groups at follow-up was $-1.32$ ($-2.40$ to $-0.23$) in favour of the experimental group (Table 4).
### Table 3. Meta-analysis of neuromuscular electrical stimulation and WOMAC function scores

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>Experimental Mean</th>
<th>SD</th>
<th>Total</th>
<th>Control Mean</th>
<th>SD</th>
<th>Total</th>
<th>Weight</th>
<th>IV, Random, 95% CI</th>
<th>Mean Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burch (15)</td>
<td>19.94</td>
<td>5.8</td>
<td>52</td>
<td>26.96</td>
<td>6.3</td>
<td>53</td>
<td>38.1%</td>
<td>-7.02 [-9.34, -4.70]</td>
<td>-7.02 [-9.34, -4.70]</td>
</tr>
<tr>
<td>Durmus (12)</td>
<td>8.72</td>
<td>1.68</td>
<td>25</td>
<td>10.4</td>
<td>1.39</td>
<td>25</td>
<td>41.1%</td>
<td>-1.68 [-2.53, -0.83]</td>
<td>-1.68 [-2.53, -0.83]</td>
</tr>
<tr>
<td>Palmieri-Smith (17)</td>
<td>22.85</td>
<td>9.04</td>
<td>20</td>
<td>35.5</td>
<td>17.66</td>
<td>18</td>
<td>17.2%</td>
<td>-12.65 [-21.72, -3.58]</td>
<td>-12.65 [-21.72, -3.58]</td>
</tr>
<tr>
<td>Total (95% CI)</td>
<td>20.94</td>
<td>3.52</td>
<td>116</td>
<td>26.31</td>
<td>5.38</td>
<td>112</td>
<td>100.0%</td>
<td>-5.31 [-10.22, -0.40]</td>
<td>-5.31 [-10.22, -0.40]</td>
</tr>
</tbody>
</table>

Heterogeneity: Tau² = 0.157; Chi² = 23.42, df = 3 (P < 0.0001); I² = 87%
Test for overall effect: Z = 2.12 (P = 0.03)

### Table 4. Meta-analysis of neuromuscular electrical stimulation and Western Ontario McMaster (WOMAC) osteoarthritis index pain scores

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>Experimental Mean</th>
<th>SD</th>
<th>Total</th>
<th>Control Mean</th>
<th>SD</th>
<th>Total</th>
<th>Weight</th>
<th>IV, Random, 95% CI</th>
<th>Mean Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burch (15)</td>
<td>5.62</td>
<td>0.99</td>
<td>52</td>
<td>7.4</td>
<td>0.47</td>
<td>53</td>
<td>43.7%</td>
<td>-1.78 [-2.08, -1.48]</td>
<td>-1.78 [-2.08, -1.48]</td>
</tr>
<tr>
<td>Durmus (12)</td>
<td>2.44</td>
<td>0.51</td>
<td>25</td>
<td>3.04</td>
<td>0.48</td>
<td>25</td>
<td>44.0%</td>
<td>-0.60 [-0.87, -0.33]</td>
<td>-0.60 [-0.87, -0.33]</td>
</tr>
<tr>
<td>Palmieri-Smith (17)</td>
<td>7.23</td>
<td>3.03</td>
<td>16</td>
<td>10.3</td>
<td>4.83</td>
<td>14</td>
<td>10.5%</td>
<td>-3.07 [-6.00, -0.14]</td>
<td>-3.07 [-6.00, -0.14]</td>
</tr>
<tr>
<td>Tok (1)</td>
<td>30.36</td>
<td>13.03</td>
<td>20</td>
<td>27.61</td>
<td>12.51</td>
<td>20</td>
<td>1.8%</td>
<td>2.75 [-5.17, 10.67]</td>
<td>2.75 [-5.17, 10.67]</td>
</tr>
<tr>
<td>Total (95% CI)</td>
<td>30.36</td>
<td>13.03</td>
<td>113</td>
<td>27.61</td>
<td>12.51</td>
<td>112</td>
<td>100.0%</td>
<td>-1.32 [-2.40, -0.23]</td>
<td>-1.32 [-2.40, -0.23]</td>
</tr>
</tbody>
</table>

Heterogeneity: Tau² = 0.68; Chi² = 35.24, df = 3 (P < 0.00001); I² = 91%
Test for overall effect: Z = 2.38 (P = 0.02)
A meta-analysis was also undertaken to determine the impact of neuromuscular electrical stimulation on a walking test. From a total of 134 patients, the point estimate for differences between the experimental and control groups at follow-up was 0.23 (–0.33 to 0.80), indicating no significant difference between the experimental and control groups (Table 5).

**Discussion**

Ten studies investigating the impact of neuromuscular stimulation in the treatment of knee osteoarthritis fulfilled the inclusion criteria for the review. The quality of the studies was strong (n = 2), moderate (n = 4) or weak (n = 4). Overall there is inconsistent evidence (level D) that neuromuscular electrical stimulation significantly reduced pain and increased strength and function in patients with knee osteoarthritis. However, the results of the pooled analyses from six studies found that neuromuscular electrical stimulation improved levels of self-reported pain and function, but not objective measures of function in this population. Nonetheless, these results should be interpreted with caution due to the heterogeneity of studies and the low number of studies included as demonstrated by the $I^2$ statistic.

The results of the present review should be considered with respect for the following limitations. Both randomized controlled trials and a controlled clinical trial were included in this review. While there is less agreement on critical appraisal tools for the evaluation of non-randomized studies, a valid and reliable tool previously used in systematic reviews (Thomas Test) rated the quality of the studies. In addition only studies published in English or translated into English were included, meaning that some studies may have been overlooked. The limited number of studies included in the meta-analyses due to study heterogeneity may also limit findings.

The development of treatment protocols for the management of symptoms (pain, reduced strength and function) in patients with knee osteoarthritis is important. It is estimated that 10% of people older than 55 years have symptoms of osteoarthritis, a quarter of whom are severely disabled.\(^{18}\) As a
disease, osteoarthritis is now also being identified in adults at younger ages,\textsuperscript{,19} thus if effective interventions are not developed, joint replacement surgery will be needed at earlier ages to maintain mobility and quality of life.

In the elderly population with knee osteoarthritis reduced quadriceps strength and increased postural sway have been reported, both of which may be related to falls.\textsuperscript{20,21} Falls in the older population has been recognized as a significant health issue in today’s society.\textsuperscript{22} It is estimated that one in every three people over the age of 65 and one in two people over the age of 80 years fall every year\textsuperscript{23} with fall-related injuries the leading cause of injury and disability among adults greater than 65 years.\textsuperscript{24} Given the expected rise in the age of the population in Europe,\textsuperscript{25} developing protocols to maximize strength and proprioception in the lower extremity is important.

A previous systematic review has provided strong evidence demonstrating that conventional exercise has significant benefits in terms of knee pain and physical function in knee osteoarthritis.\textsuperscript{26} Neuromuscular electrical stimulation has been suggested as a method for increasing strength of the quadriceps femoris and decreasing pain in knee osteoarthritis, but findings to date have been inconclusive. The findings of the current review concur with the findings reported by Monaghan et al.\textsuperscript{4} who found that there was inconclusive evidence regarding the effectiveness of surface neuromuscular electrical stimulation as a means of improving quadriceps femoris strength in knee osteoarthritis patients both before and after total knee replacement. This review was very small with only two studies included, both with a high risk of methodological bias. Hulme et al.\textsuperscript{27} also reported inconclusive findings in their review regarding the effects of pulsed electromagnetic stimulation in the treatment of osteoarthritis. Conversely, Marks and colleagues\textsuperscript{7} suggested that there was strong evidence to support the application of neuromuscular electrical stimulation to strengthen the quadriceps femoris muscle; however, confidence in these conclusions is weakened by the limitations presented earlier.

The challenge of developing protocols for this patient cohort is that in the published literature there is no consistency in the neuromuscular electrical stimulation parameters used. In the current review six studies employed neuromuscular electrical stimulation at a frequency of 50 Hz\textsuperscript{1,5,6,12,15,17} to produce smooth tetanic muscle contractions,\textsuperscript{10,28} a condition which is favourable for strengthening the quadriceps femoris muscle.\textsuperscript{29} However, a range of other frequencies were also included (25 Hz,\textsuperscript{13} 30 Hz\textsuperscript{10} and pulse patterns at a frequency of 8.4 Hz\textsuperscript{11}). In addition, parameters of pulse width versus duration and intensity showed great variability between studies: one paper\textsuperscript{5} applied stimulation at an intensity which produced quadricep femoris contractions at 10–40\% of maximum voluntary contraction, while a second\textsuperscript{17} reported using stimulation intensities which produced at least 35\% of maximum voluntary contraction. Further research is necessary to clearly establish the optimal neuromuscular electrical stimulation parameters for use in this population. In addition, standardizing interventions is warranted in the development of protocols for use in the clinical setting to maximize the impact of this intervention. In the current review the lack of consistency between studies makes this difficult: six studies\textsuperscript{10–14,17} investigated the application of neuromuscular electrical stimulation alone, while a further four studies combined neuromuscular electrical stimulation with other therapeutic interventions.\textsuperscript{1,5,6,15}

The conflicting data from the studies identified in the current review does not allow any definitive conclusion to be made with regard to the use of neuromuscular electrical stimulation to reduce pain and to increase quadriceps femoris strength and function in knee osteoarthritis. Nevertheless, the existing evidence is promising, with a greater number of moderate–strong quality randomized controlled trials suggesting the use of neuromuscular electrical stimulation in this population. In particular, neuromuscular electrical stimulation may prove to be a useful therapeutic alternative for individuals with knee osteoarthritis who are unable to carry out conventional exercise due to the presence of coexisting disease. Future studies in this field should be conducted to establish protocols using neuromuscular electrical stimulation to increase patient function, reduce pain and maximize quality of life.
Clinical messages

- There is inconsistent evidence regarding the impact of neuromuscular electrical stimulation on measures of pain, function and quadriceps femoris muscle strength in knee osteoarthritis.
- Future work is needed in this field to clearly establish the role of neuromuscular electrical stimulation in knee osteoarthritis and to determine the optimal neuromuscular electrical stimulation protocol to use in this population.

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References


**Appendix 1 – Online database search strategy for MEDLINE Database**

‘Electric Stimulation’ [MeSH] OR
‘Neuromuscular Electrical Stimulation’ OR
‘Functional Electrical Stimulation’ OR
‘Electrical Stimulation Therapy’ OR
‘Electric Stimulation Therapy’ OR
‘NMES’ OR
‘FES’ OR
‘EMS’
AND
‘Osteoarthritis’ [MeSH] OR
‘Arthritis’ OR
‘Knee Osteoarthritis’
Limits: Humans, English, Randomised controlled trials, Clinical trial