Title: Effect of vibration intensity, exercise and motor impairment on leg muscle activity induced by whole-body vibration in people with stroke

Running head: Whole-Body Vibration in Stroke

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Abstract

Background. Whole-body vibration (WBV) has increasingly been used as an adjunct treatment in neurological rehabilitation. However, how muscle activation level **changes** during exposure to different WBV protocols in individuals after stroke remains understudied.

Objective. To examine the influence of WBV intensity on the magnitude of biceps femoris (BF) and tibialis anterior (TA) muscle activity and its interaction with **exercise** and severity of motor impairment and spasticity among individuals with chronic stroke.

Methods. Each of the 36 individuals with chronic stroke (**mean age±standard deviation=57.3 ±10.7 years**) performed eight different static exercises under three WBV conditions: (1) no WBV, (2) low-intensity WBV [20Hz, **0.60mm**, peak acceleration: 0.96 units of gravity of Earth (**g**)], and (3) high-intensity WBV (30Hz, **0.44mm**, 1.61**g**). The levels of bilateral TA and BF muscle activity were recorded using surface electromyography (EMG).

Results. The main effect of intensity was significant. Exposure to the low-intensity and high-intensity protocols led to a significantly greater increase in normalized BF and TA EMG magnitude in both legs compared with no WBV. The intensity × exercise interaction was also significant, suggesting that the WBV-induced increase in EMG activity was exercise-dependent. The EMG responses to WBV were similar between the paretic and non-paretic legs, and were not associated with level of lower extremity motor impairment and spasticity.

Limitations. Leg muscle activity was measured during static exercises only.

Conclusions. Adding WBV during exercise significantly increased EMG activity in TA and BF. The EMG responses to WBV in the paretic and non-paretic legs were similar, and were not related to degree of motor impairment and spasticity. The findings are useful for guiding the design of WBV training protocols for people with stroke.

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Stroke is a major public health issue that poses challenges to healthcare systems worldwide.[1] Muscle weakness is one of the most common physical post-stroke impairments,[2] and is related to poor balance, functional limitations, and a **lower level of participation in community activities**.[3-5] Therefore, researchers have been investigating effective rehabilitation strategies to tackle post-stroke muscle weakness.

Whole-body vibration (WBV) training has attracted much attention in both clinical practice and research recently.[6,7] Recent meta-analyses have revealed that WBV has significant therapeutic effects on balance, muscle strength, and mobility in older adults, although the optimal WBV protocol is unknown.[8,9] **There are two major types of WBV, namely synchronous vibrations and side-alternating vibrations.[10] In the former, the vibration platform generates vibrations in a predominantly vertical direction, and so the amplitude of the vibrations received would be largely the same regardless of the position of the feet on the vibration platform.[10] In contrast, in side-alternating vibrations, the platform rotates about an anteroposterior horizontal axis. Therefore, a greater distance from the axis of rotation would result in vibrations of larger amplitude. Side-alternating WBV also differed from synchronous WBV in that the force is applied alternately between the two sides, and that a mediolateral component of the force is also produced.[10] The use of synchronous[11-18] or side-alternating[12,19,20] WBV during exercise has also been shown to increase the level of muscle activation in young adults, as measured by surface electromyography (EMG).**

More recently, research has focused on the effects of WBV in people with neurological disorders.[21-25] A recent systematic review of RCTs found insufficient evidence to refute or support the use of WBV in individuals with stroke to improve neuromuscular function, mainly due to the limited number of studies and methodological weaknesses of the studies reviewed.[26]

The systematic review also emphasized that more fundamental research questions need to be addressed before a large-scale RCT is conducted.[26] One of the important questions pertains to the relationship between WBV intensity and the activation levels of different muscle groups, and how these factors interact with the different exercises performed and the severity of stroke.

Only one study has examined leg muscle activity during WBV in people after stroke.[27] Their results showed that leg muscle activity in both the vastus lateralis (VL) and gastrocnemius (GS) muscles could be significantly increased by 10%-20% [expressed as a percentage of maximal voluntary contraction (MVC)] during WBV exposure in people with chronic stroke, depending on the exercise performed.[27] **In addition, the EMG responses in the VL and GS muscles on the paretic and non-paretic sides during WBV were similar, and were not associated with spasticity.[27]** However, the EMG responses of the knee flexors and ankle dorsiflexors were not investigated, even though these muscles are equally, if not more highly, affected by stroke.[4] The weakness in these muscles contributes to abnormal gait patterns, including the failure to attain a heel strike at initial contact, and ineffective ankle dorsiflexion during the swing phase, causing the ‘drop foot’ phenomenon.[28] Other studies also found that knee flexor and ankle dorsiflexor strength was strongly related to walking speed, endurance and balance in people with stroke.[29,30] However, the way in which the EMG activity of the biceps femoris (BF) and tibialis anterior (TA) muscles **changes** during exposure to different WBV exercise protocols in individuals after a stroke remains unclear. Whether the EMG responses are related to severity of motor impairment has also never been investigated.

The objectives of this study were to examine the influence of WBV intensity on the muscle activity of the bilateral BF and TA and its interaction with **exercise** and the severity of leg motor impairment and **spasticity among** people with chronic stroke. It was hypothesized that: 1) the **magnitude** of the EMG activity of the bilateral BF and TA muscles would increase significantly with increasing WBV intensity; 2) the **magnitude** of the WBV-induced increase in leg muscle EMG activity would be exercise-dependent (i.e., WBV intensity × exercise interaction effect); 3) the WBV would exert similar effects on the EMG **magnitude** on the paretic side than on the non-paretic side (i.e., **no WBV intensity × side interaction effect**); and 4) the WBV-induced EMG activity in the BF and TA muscles on the paretic side would not be significantly associated with severity of leg motor impairment **and spasticity**. The findings would be crucial for guiding the design of WBV training protocols for people with stroke.

METHODS

Study Design

A three-way repeated measures design was adopted to investigate the bilateral TA and BF muscle activity during exposure to three different WBV protocols and eight exercise conditions.

Participants

Participants were recruited from local stroke self-help groups during the period between September 2012 and May 2013. The inclusion criteria were: the diagnosis of a hemispheric stroke ≥6 months, being a community dweller, the ability to perform the experimental exercises in the present study, and **having some degree of paresis in the affected leg (Chedoke-McMaster Stroke Assessment (CMSA) lower limb motor score of ≤13)**.[31] The exclusion criteria were: severe cardiovascular conditions (e.g., cardiac pacemaker), neoplasms, other neurologic disorders, cerebellar stroke or brainstem stroke, significant musculoskeletal conditions (e.g., amputations), or vestibular disorders.

Ethics Statement

All individuals gave written informed consent before enrollment. The study was approved by the Human Subjects Ethics Subcommittee of the Hong Kong Polytechnic University (approval number: HSEARS20130209001-01), and all experiments were conducted in accordance with the Declaration of Helsinki.

WBV Protocols

All experimental procedures were conducted in a laboratory located in the Hong Kong Polytechnic University, Hong Kong. A vibration platform that delivered **synchronous** vibrations (Jet-Vibe System, Danil SMC Co. Ltd., Seoul, Korea) with a frequency range of 20-55 Hz and corresponding preset amplitudes was used. The peak acceleration (a_{peak}) was calculated by the formula: $a_{peak}=(2\pi f)^2 A$, where A and f represented the amplitude and frequency of vibrations, respectively.[32] The a_{peak} was usually represented in terms of **gravity of Earth (1g=9.81m/s^2**) to facilitate comparisons across studies. We used synchronous WBV, as there is some evidence that it induced higher level of muscle activity than side-alternating WBV.[12] **The Jet-Vibe vibration parameters were verified by a tri-axial accelerometer (Model 7523A5; Dytran Instruments Inc., Chatsworth, CA).**

Each participant underwent three different WBV conditions in a single experimental session: (1) no WBV, (2) low-intensity WBV [frequency: 20Hz, amplitude: 0.60mm, peak acceleration: 0.96g, **i.e. subgravity**], and (3) high-intensity WBV [30Hz, 0.44mm, 1.61 **g**, **i.e. supragravity**]. **The sequence of WBV protocols used was decided randomly by drawing lots**. A frequency higher than 30Hz was not used, because it was shown in our pilot work to be associated with increased discomfort in this population. Frequencies lower than 20 Hz were not used due to potential resonance effects.[32]

Exercise Protocols

The complete set of eight static exercises (Figure 1) was repeated three times. The order of the exercises performed for each WBV condition was randomized. Practice trials were given to familiarize the participants with the exercises before the collection of actual EMG data. During each WBV condition, we used a goniometer (Baseline® HiRes™ plastic 360° ISOM Goniometer, Fabrication Enterprises, White Plains, NY, USA) to check that the desired knee angle was achieved for a specific exercise. **The duration of the rest period between the different exercises was set at 1-min.** For standardization, all participants held gently onto the handrail of the WBV device for maintaining body balance only.

Measurements

At the beginning of the first session, the demographic information and clinical history of all participants was obtained through interviews. Motor impairment level of the leg and foot was evaluated using the CMSA.[31] **The rating for each body part (i.e. the leg and foot) was based on a 7-point ordinal scale (i.e., 1=flaccidity, 3=obligatory synergistic movements, 7=normal movement patterns). The CMSA** lower extremity total score was computed by summing the leg and foot scores **(minimum score: 2; maximum score: 14),** with a higher score denoting less severe motor impairment. The spasticity of the paretic knee and ankle joints was examined using the Modified Ashworth Scale (MAS), which is a **six-point ordinal scale (i.e., 0=no spasticity, 4=affected part rigid)**.[33]

The activity of the bilateral BF and TA muscles was measured using surface EMG. After palpation of the muscle belly and appropriate skin preparation, the bipolar bar electrodes (Bagnoli EMG system, Delsys, Inc., Boston, MA, USA) were attached longitudinally over the middle of the belly of the bilateral BF and TA muscles.[34] In addition, the ground electrode was attached at the fibula head on the paretic side. The insulated EMG cables were secured to prevent their excessive motion.

Before measuring the EMG response during WBV exercise, participants were asked to undergo a test for maximal voluntary contraction (MVC). **The participants were seated on a chair with backrest placed against a wall, with the hip and knee joint placed at 90 degrees of flexion. The participants were asked to grasp the edge of the chair on each side for further stabilization. To measure the MVC of knee flexion (i.e., BF), the tested lower leg was strapped using a non-elastic belt that was attached to a fixed structure. The tested thigh was stabilized by the researcher's hand, and the participants were instructed to perform a maximal isometric knee flexion by pulling against the belt and sustain it for 10 seconds. To test the MVC of ankle dorsiflexion (i.e., TA), the foot was placed in a neutral dorsiflexion/plantarflexion position. One hand of the researcher stabilized the tested lower leg. The other hand was placed on the dorsal aspect of the tested foot to provide resistance, as the participants were asked to perform a maximal isometric ankle dorsiflexion by pushing against the researcher's hand, and maintain for 10 seconds. Three trials were performed for each muscle group, with a 1-minute rest interval between trials. Verbal encouragement was given by the researcher during the contractions to elicit maximal effort from the participants.**

The EMG root mean square (EMG_{rms}) value was calculated at intervals of 500ms.[35] For each participant, the average of the peak EMG_{rms} values obtained in the three MVC trials was used to normalize the EMG_{rms} obtained during the WBV exercise trials. Therefore, the EMG magnitude measured in the three **WBV conditions was expressed as a percentage of the peak EMG magnitude in the MVC trials (%MVC). We used the average of the 3 MVC trials, rather than the highest value achieved out of the 3 trials, to normalize the EMG data because the former may better reflect the typical performance of the participants. In addition, the reliability of the EMG measurements was excellent, based on the data from our three MVC trials ($ICC_{2,1}$=0.96-1.00). Therefore, using the average or the highest MVC values for normalizing the data should not create a substantial difference in the results.**

The participants were required to maintain each of the eight **exercises** (i.e., static exercises) (Figure 1) for 10 seconds and repeat them three times, with a 5-second pause between each trial. During that period, the bilateral TA and BF EMG activity was recorded. A 5-minute rest period was allowed after the completion of all eight static exercises for a given WBV condition.

The EMG signals were pre-amplified (×1000) and sampled at 1.0kHz (Bagnoli-8, DelSys, Inc., Boston, MA, USA) using LabView version 7.0 (National Instruments Corp., Austin, TX, USA) and saved directly onto a hard disk for offline analysis. The EMG data were further processed using a 20-500-Hz band-pass Butterworth filter. Using the Infinite Impulse Response rejector (MyoResearch XP, Master Package version 1.06, Noraxon USA, Inc., Scottsdale, AZ, USA), the associated harmonics (20Hz, 30Hz, and 60Hz) were removed from the EMG signals.[27] Bias was calculated and eliminated from the signals, followed by **full-wave rectification** of the data. The EMG_{rms} was then calculated in 100-ms windows around every data point.[20] The middle

6 seconds of each trial were selected to calculate the EMGrms.[27] For each specific WBV and exercise combination, the average of the normalized EMG_{rms} values obtained in the three trials (expressed as %MVC) was used for analysis.

Statistical analysis

Statistical analysis was conducted using the IBM SPSS software (version 20.0, IBM, Armonk, NY, USA) to test the four research hypotheses, using a desired power level of 0.9. The sample size estimation was based on a previous study that examined leg extensor EMG magnitude during WBV in people after stroke,[27] using the G*Power 3.1 software (Universitat Dusseldorf, Germany). It was found that WBV significantly increased EMGrms in VL and GS, yielding large effect sizes for the main effect of intensity (f=0.66-0.93) and moderate to large intensity × exercise interaction effect (f=0.23-0.44).[27] **Therefore, for addressing the main effect of WBV intensity (hypothesis 1), intensity × exercise interaction effect (hypothesis 2), and side × intensity interaction effect (hypothesis 3), a large effect size (f=0.4) was assumed. For hypothesis 1, based on ANOVA analysis (WBV intensity at 3-levels; exercise at 8-levels), and an alpha level of 0.017 (adjusted for comparisons of 3 WBV intensities), 24 participants would be required to detect a significant difference in normalized EMG response (%MVC) between the different WBV intensities. For hypothesis 2, based on the ANOVA analysis (WBV intensity at 3-levels; exercise at 8-levels) and alpha level of 0.05, a minimum of 32 participants would be required to detect a significant intensity × exercise interaction effect. For hypothesis 3, a minimum of 16 participants would be required to detect a significant intensity × side interaction effect (WBV intensity at 3-levels; limb involvement at 2-levels) at an alpha level of 0.05. For the correlation analysis between normalized EMG responses**

and CMSA and MAS scores (hypothesis 4), we assumed a moderate correlation (r=0.5). A total of 34 participants would be required for this analysis.

First, two separate 3-way ANOVA with repeated measures (limb involvement at 2-levels; WBV intensity at 3-levels; exercise at 8-levels) was used to analyze the normalized EMGrms values for the TA and BF muscles respectively. The 3-way ANOVA would simultaneously yield the results regarding the intensity × exercise × side interaction, main effect of WBV intensity (hypothesis 1), intensity × exercise interaction (hypothesis 2), and intensity × side interaction (hypothesis 3). If a significant intensity × exercise × side interaction was found in the 3-way ANOVA, separate 2-way ANOVA analyses with repeated measures would be done for the TA and BF muscles of the paretic and non-paretic sides. The Greenhouse-Geisser epsilon adjustment was applied when the sphericity assumption was not fulfilled. When significant results were obtained, contrast analysis using the Bonferroni adjustment was performed.

To further address how the increase in WBV intensity affected the normalized EMG responses (hypothesis 1), a trend analysis was performed. For each individual exercise, the mean normalized EMGrms values for the three WBV intensities were used for trend analysis using Microsoft Excel (version 2007, Microsoft Corp., Redmond, WA, USA).

Next, to address hypothesis 4, the degree of association of the difference in normalized EMGrms **(i.e., normalized EMGrms during WBV minus normalized EMGrms without WBV) i**n the paretic TA with CMSA foot motor score and ankle MAS score was assessed by **Spearman's correlation coefficients.** A similar correlational analysis was carried out for the paretic BF muscle, using the CMSA leg motor score and knee MAS score.

We did not formally test for order effects related either to exercise or to WBV protocol, but relied on randomization to minimize order effects.

RESULTS

Characteristics of participants

The study flow chart is shown in Figure 2. Thirty-six individuals (26 men, 10 women; (**mean (SD) age=57.3 (10.7) years)** with chronic stroke completed all the measurements (Table 1). Overall, the impairment level of the affected lower limb was moderate, as revealed by the CMSA lower extremity composite motor score **(median: 7; first quartile: 4; third quartile: 12)** All were ambulatory and 24 of them (67%) required walking aid for outdoor mobility.

Three-way ANOVA

Our 3-way ANOVA analyses revealed a significant intensity × exercise × side interaction effect for the TA ($F_{6.42, 224.75}$=2.82, P=0.01) and BF ($F_{7.87, 275.33}$=2.34, P=0.019) muscles, indicating that the EMG responses to WBV was influenced by the interaction of all three factors. The subsequent paragraphs would address the main effect of intensity (hypothesis 1), intensity × exercise interaction (hypothesis 2), intensity × side interaction (hypothesis 3), and the associations of EMG responses with motor impairment and spasticity (hypothesis 4).

Main effect of intensity

Our 3-way ANOVA models revealed a significant main effect of intensity on normalized EMG responses in the TA ($F_{1.11, 38.82}$=80.58, P<0.001) and BF ($F_{1.06, 37.23}$=140.08,

***P*<0.001), indicating that increasing WBV intensity resulted in an overall increase in EMG magnitude in these muscles tested. Further analyses using two-way ANOVA showed that the main effect of intensity remained significant if the TA and BF muscles in the paretic leg and non-paretic leg were analyzed separately (Table 2).** Post-hoc contrast analysis with Bonferroni adjustment revealed that the normalized EMG_{rms} values for the three WBV conditions all differed significantly from each other in BF muscles on both the paretic and non-paretic sides (*P*<0.05). In the paretic and non-paretic TA muscles, addition of low-intensity and high-intensity WBV during exercise led to significantly higher normalized EMGrms compared with the same exercises without WBV (*P*<0.05), **but the difference between the low-intensity and high-intensity protocols did not quite reach statistical significance (*P*=0.06).** The average increase in EMG activity was **10.8-12.1%, 19.9%-22.7%, 10.0-10.7%, and 20.6-23.1%** in the paretic TA, paretic BF, non-paretic TA, and non-paretic BF, respectively, depending on the WBV intensity.

Based on the trend analysis (Figure 3), it is clear that adding WBV to exercise considerably increased the EMG activity in the 4 muscle groups tested, but the relationship between WBV intensity and normalized EMG response was not a linear one. The data for each muscle group were fitted with a logarithmic curve.

Intensity by exercise interaction

The **normalized** EMG responses during the WBV trials are displayed in **Figure 4.** The 3-way ANOVA models revealed a significant WBV intensity × exercise interaction effect in the TA **($F_{6.72, 235.30}$=15.49, *P*<0.001) and BF muscles ($F_{5.41, 189.53}$=2.78, *P*=0.02), indicating that the differences in normalized EMGrms among the different WBV conditions were exercise-**

dependent. Further analyses using 2-way ANOVA showed that the WBV intensity × exercise interaction effect remained significant if the TA and BF muscles in the paretic and non-paretic legs were analyzed separately (Table 2).

Intensity by side interaction

The 3-way ANOVA model revealed no significant intensity × side interaction effect for the TA ($F_{1.26, 43.93}$=0.61, *P*=0.48) and BF muscles ($F_{1.08, 37.71}$=0.10, *P*=0.91), suggesting that the normalized EMG responses to WBV did not significantly differ between the two sides.

Association with leg motor impairment and spasticity

Of the 24 WBV exercise conditions for the four muscles tested, no relationship was found between WBV-induced changes in EMG activity in the paretic TA and BF muscles and the CMSA motor score or MAS score (*P*>0.05).

DISCUSSION

Our results showed that paretic and non-paretic TA and BF muscle activity was increased significantly by adding WBV during exercise, and that the high-intensity WBV protocol (supragravity, 1.61 **g**) resulted in significantly higher EMG response than the lower-intensity WBV protocol (subgravity, 0.96 **g**) in the BF among individuals with chronic stroke. The degree of WBV-induced increase in muscle activity was consistent, regardless of the severity of motor impairment **and spasticity.**

Influence of WBV intensity

The first hypothesis was supported because the results revealed that the higher WBV intensity led to a significantly greater increase of muscle activity in TA and BF in both legs. Our results generally concur with previous WBV research in healthy adults. Typically, a higher WBV intensity is associated with greater EMG responses.[11-20] The increase in muscle activity with WBV varied across the various studies, and could be due to difference in characteristics of the participants (e.g., people with disability Vs people without disability), types of vibration, frequency, amplitudes, additional load, data processing methods, and exercise performed.

Liao et al.[27] examined the activity in the VL and GS muscles during WBV in people with stroke. Using the same WBV intensities, the EMG activity of both the paretic VL and GS muscles was significantly increased by the application of **WBV, by an average of 10.0%-10.1% and 14.9-17.5% respectively**, depending on the WBV intensity used.[27] However, they did not identify any significant difference in VL and GS EMG activity level induced by the low-intensity and high-intensity WBV protocols. In contrast, the effect of WBV intensity was more apparent in our study. First, the high-intensity protocol induced significantly higher EMG magnitude than the low-intensity protocol in the paretic BF muscle **during weight-shifted-forward, weight-shifted-backward, and single-standing exercises; and in the non-paretic BF muscle during deep-squat, weight-shifted-backward, and single-standing exercises**. **Second, the increase in BF EMG activity reported here (by 19.9%-23.1%MVC) was somewhat greater than that in leg extensors (Table 2).** The greater increase in EMG magnitude reported in this study was partially attributable to the very low EMG activity in the BF muscle without WBV (<5%MVC for most exercises) (Figure 4), whereas the EMG activity was higher in the VL and GS under control conditions (>10%MVC for the majority of exercises).[27]

The effects of WBV on muscle activation may not be entirely restricted to the peripheral mechanisms (e.g., reflex activation of muscles),[36,37] but may also involve corticospinal and intracortical processes.[38,39] Using transcranial magnetic stimulation, Mileva et al.[39] showed that, in a sample of healthy men, the application of WBV (30Hz, 1.5mm) during static squat exercises increased the motor-evoked potential of the TA muscle, indicating an increase in excitability of the corticospinal pathway. There was also evidence of a WBV-induced alteration of the intracortical processes (increased short-interval intracortical inhibition and decreased facilitation).[39]

Interaction effect between WBV intensity and exercise

The second hypothesis was also confirmed because a significant overall intensity × exercise interaction effect was found in all four muscles tested, indicating that the degree of WBV-induced increase in EMG magnitude was exercise-dependent (Figure 4).

Some other studies investigated intensity × exercise interaction effects,[18,40] but the results were conflicting. For example, Di Giminiani et al.[40] showed that the EMG response recorded during different positions was not affected by different vibration frequencies. In contrast, Roelants et al.[18] found a significantly greater increase in VL EMG activity in the one-leg-squat position (i.e., weight bearing on one leg) than in the high-squat and low-squat positions (i.e., weight bearing on both legs) when WBV was applied. **In the present study, the intensity by exercise interaction effect was more apparent in the TA muscles (Figure 4).** The WBV-induced TA EMG activity was less during weight-shifted-backward and deep squat exercises compared with the other exercises after WBV was applied (Figure 4A and 4B). This may have occurred because the bilateral TA muscles had the greatest pre-activation without WBV during these two exercises, and thus the further increase in EMG achieved by the application of WBV may be slighter. In addition, the vibration energy transmitted to the participants could have been affected by contact of the surface area with the vibration platform.[15] In the weight-shifted-backward exercise, the contact of the surface area with the vibration platform was the smallest among all **exercises. Hence, the effect of WBV may be reduced. Hazell et al.[14] also studied the EMG responses of the TA muscle during WBV in young healthy participants. Their results showed that the EMG magnitude of the TA was significantly lower during loaded dynamic squats compared with the same exercise under the unloaded condition. During loaded dynamic squat, the TA EMG magnitude was significantly increased with the application of WBV at 45Hz, but not 25 Hz or 35 Hz, when compared with the no-WBV condition.[14] Overall, it seems that the activation of the TA muscle is highly dependent upon specific exercise conditions and the intensity of WBV stimulation.**

Comparison of EMG responses between paretic and non-paretic legs

Our results revealed no significant intensity × side interaction, and thus supported our hypothesis that the WBV would induce similar EMG responses in the paretic and non-paretic sides. Hence, there was no evidence of preferential activation of either leg by WBV when performing the exercises described in our study. Similar results were found in a previous study that investigated the EMG responses in VL and GS muscles in people with chronic stroke.[27]

Relationship with motor impairment and spasticity

Our final hypothesis was supported, because no significant relationship was found between the WBV-induced increase in EMG magnitude and the CMSA and MAS scores. The results suggested that WBV had a similar influence on leg muscle activation, regardless of the severity of motor impairment and spasticity. The lack of association of EMG responses during WBV and spasticity has also been shown by Liao et al.[27] in their study of VL and GS muscle responses to WBV**.** It **is thus highly improbable that the increase in EMG activity during WBV exposure was due to muscle activity triggered by spasticity.**

Clinical Implications

Many of the exercises chosen here have been used in previous WBV studies and stroke exercise trials.[9,41] Significant improvements in leg muscle strength have been reported after regular training using these exercises without WBV.[9,41] Our findings showed that the muscle activity of TA and BF in both paretic and non-paretic legs can be increased considerably by the application of WBV, particularly the high-intensity protocol, during exercise. **Lee et al.[42] have investigated the level of EMG activity of the TA muscle during squatting exercise, an exercise commonly used in stroke rehabilitation programs for muscle strengthening purpose. It was found that the paretic TA EMG magnitude recorded during the maintenance phase of the dynamic squat exercise was on average 3.4 times that during static standing in people with stroke. In our study, we also found that the paretic TA EMG magnitude was greater during semi-squat (2.7%±2.9%MVC) than static standing (0.9%±0.8%MVC). When high-intensity WBV was added, the paretic TA EMG magnitude was further increased by an average of 12.5% MVC (SD=9.5%MVC). Only one study have examined the BF EMG activity after WBV training in people with stroke.[21] Tihanyi et al.[21] showed that after one WBV session (20Hz, peak-to-peak amplitude: 5mm), the EMGrms of VL during maximal isometric contraction was significantly increased by 44.9%, but that of**

BF was not significantly changed.

Some studies have investigated the level of TA or BF EMG activation in leg muscles in people with stroke after different forms of exercise training.[43,44] For example, Andersen et al.[43] showed that after 12 weeks of intervention comprising high-intensity resistance training and body weight supported treadmill training, the EMG magnitude of the paretic hamstrings muscle during concentric and eccentric knee flexion was increased by approximately 20-30% (expressed as a percentage of EMG magnitude of the corresponding muscle on the unaffected side) in a sample of people with chronic stroke. Lee et al.[44] found that in individuals with chronic stroke, six weeks of closed kinetic chain exercises led to a significant increase in the EMG magnitude of the paretic TA and BF muscles by 7-8%, whereas open kinetic chain exercises resulted in a significant increase in the EMG magnitude of the paretic BF muscle only, by about 5-6%. In this study, the amount of WBV-induced increase in EMG magnitude was approximately 10.8%-12.1% and 19.9%-22.7% in the paretic TA and BF muscles respectively (Table 2), when compared with the no-WBV condition. When comparing these values with those obtained from other forms of exercise training mentioned in the above studies, it seems that the WBV protocols used here may have potential in improving muscle activation in the paretic leg, but our current study design does not allow us to determine the effects on EMG activation after sustained WBV training. Nevertheless, our results suggested that, in addition to WBV intensity, both the choice of exercise and the target muscle group should be considered when prescribing WBV because these factors also affect the muscle response to WBV.

The increase in EMG activity was similar regardless of the level of motor impairment and spasticity, suggesting that individuals with more severe impairments or spasticity may potentially benefit equally from WBV as those with less severe impairments or spasticity. This is important, because people with severe stroke with limited active movements may find it difficult to engage in other forms of exercise for muscle strengthening purposes. In contrast, WBV training involves holding simple body exercises only and may suit those who have more severe motor or even cognitive impairments.

Methodological considerations

Surface EMG signals can be easily disturbed by vibration artefacts. Needle electrodes would probably have been a better choice but we did not use it because of its invasive nature. As in previous studies that used surface EMG to measure muscle responses to WBV[11-20], proper processing and filtering of the EMG signals were done to minimize the effects of artifacts that may be induced by WBV. The magnitude of increase in EMG activity reported in this study was quite comparable to previous research in other populations.[11-20] The origin of the EMG signals during WBV has been previously studied by Ritzmann et al.[37] In their experiments, dummy electrodes were placed close to the EMG electrodes to monitor motion artifacts. Their results showed that the dummy electrodes registered almost no activity during WBV. In rare occasions when the dummy electrodes showed peaks of activity, they did not systematically concur with the preset vibration frequency, and had large standard deviations. Their results thus showed that the contribution of motion artifacts to the overall EMG activity is insignificant. Taken together, we feel our data reasonably reflect the muscle activation level during WBV.

Limitations and Future Research Directions

First, many of the participants were middle-aged adults (<65 years). More men than women were tested. The generalizability of the findings may be compromised as a result. Second, the study only measured leg muscle activity during static exercises. The muscle response to WBV during dynamic exercises should also be addressed in the future to provide a more comprehensive picture of WBV-induced muscle response. **In addition, we only compared the EMG responses among 3 WBV intensities, incorporating more WBV intensities would enable us to more accurately estimate the trend of EMG responses with increasing WBV intensity, and also the EMG responses for intensities beyond 1.61g.** Finally, while this study found that low- and high-intensity WBV protocols could increase leg muscle activity during different exercises, whether long term training using these protocols can bring about actual improvement in muscle strength remains unknown. Randomized controlled trials that incorporate the measurement of muscle force production and functional capacity as outcomes are needed.

Conclusions

We found a positive relationship between the EMG magnitude of the TA and BF in both legs using a WBV intensity of up to 1.**61g**. The increase in EMG activity evoked by WBV was influenced by the specific exercise performed, but not degree of motor impairment and spasticity. Therefore, the WBV intensity and the **exercise** chosen are important guiding factors in designing WBV exercise protocols for the stroke population. The EMG magnitude was the greatest during exposure to the high-intensity protocol. Our results have thus provided a basis for future randomized controlled studies to test the efficacy of this protocol in modifying neuromuscular function after stroke.

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Ethical standard The experiments comply with the current laws of the country in which they were performed.

Conflict of interest The authors declare that they have no conflict of interest.

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Table 1. Characteristics of the Participants (n=36)

Variable	Value[a]
Basic demographics	
Age (year)	57.6 ±10.2
Gender, male/female, (n)	26/10
Body Mass Index, (kg/m^2)	24.9±2.8
Required walking aid for outdoor mobility, none/cane/quadrapod, n	12/20/4
Abbreviated Mental Test Score (out of 10)	9.1±0.8
Stroke characteristics	
Time since stroke onset (year)	5.0±3.2
Type of stroke, ischemic/hemorrhagic/unknown (n)	22/12/2
Side of hemiparesis, left/right, (n)	16/20
CMSA Lower Extremity Composite Score (out of 14), median **(first and third quartiles)**	7 (4-12)
CMSA leg score (out of 7), median **(first and third quartiles)**	4 (3-6)
CMSA foot score (out of 7), median **(first and third quartiles)**	3 (1-6)
Paretic knee MAS score (0–4)[b], median **(first and third quartiles)**	0 (0-1)
Paretic ankle MAS score (0–4), median **(first and third quartiles)**	1.5 (1-2)
Co-morbid conditions	
Hypertension (n)	23
High cholesterol (n)	19
Diabetes mellitus (n)	6
Knee osteoarthritis (n)	1
Medications	
Antihypertensive agents	21
Hypolipidemic agents (n)	19
Antidiabetic agents (n)	6
MVC EMGrms (μV)	
Paretic leg TA	479.3±222.8
Non-paretic leg TA	700.5±302.5
Paretic leg BF	251.2±102.9
Non-paretic leg BF	377.4±183.8

[a]Mean±SD presented for continuous variables.
[b]Modified Ashworth Scale is a 6-point ordinal scale. The category 1+ was converted to 1.5 for statistical analysis.
BF=biceps femoris, CMSA = Chedoke–McMaster Stroke Assessment, EMG=electromyography, MAS = Modified Ashworth Scale, MVC= maximum voluntary contraction, n=number count, rms=root mean square, TA=tibialis anterior.

Table 2. Effect of whole-body vibration (WBV) intensity on normalized EMGrms values

	WBV Intensity × exercise interaction effect		Main Effect of WBV intensity		Post-hoc contrast analysis					
					No WBV Vs Low-intensity WBV		No WBV Vs High-intensity WBV		Low-intensity WBV Vs High-intensity WBV	
Muscle	**F_{df}[c]**	***P*-value**	**F_{df}[c]**	***P*-value**	**Mean difference[a] (95% CI)**	***P*-value[b]**	**Mean difference (95% CI)**	***P*-value[b]**	**Mean difference (95% CI)**	***P*-value[b]**
Paretic TA	$6.13_{6.36,222.75}$	<0.001*	$55.13_{1.20,42.03}$	<0.001*	10.8 (7.0, 14.6)	<0.001*	12.1 (8.3, 15.9)	<0.001*	1.3 (-0.1, 2.7)	0.06
Non-paretic TA	$15.64_{6.08,212.87}$	<0.001*	$63.34_{1.07,37.45}$	<0.001*	10.0 (6.9, 13.1)	<0.001*	10.7 (7.4, 14.1)	<0.001*	0.8 (0.0, 1.5)	0.06
Paretic BF	$3.00_{5.63,196.89}$	0.01*	$119.88_{1.08,37.85}$	<0.001*	19.9 (15.5, 24.3)	<0.001*	22.7 (17.5, 27.9)	<0.001*	2.8 (1.4, 4.2)	<0.001*
Non-paretic BF	$2.20_{6.56,229.47}$	0.04*	$96.84_{1.05,36.89}$	<0.001*	20.6 (15.4, 25.9)	<0.001*	23.1 (17.2, 28.9)	<0.001*	2.4 (1.2, 3.6)	<0.001*

[a]EMG magnitude expressed as percent maximal voluntary contraction (%MVC)
[b]The p-values for the contrast analysis are Bonferroni corrected values.
[c]Greenhouse-Geisser epsilon adjustment was used to generate the F-score, degrees of freedom and P-values due to violation of the sphericity assumption.
*Statistically significant ($P<0.05$)
BF=biceps femoris, df=degrees of freedom, TA=tibialis anterior, WBV=whole-body vibration

FIGURE LEGENDS

Figure. 1 Exercise Protocol

A. Upright standing position (ST): Standing with their feet placed apart at shoulder width and knees slightly flexed at about 10º and holding for 10 seconds.
B. Semi-squat position (SSq): Standing with feet placed apart at shoulder width and knee flexed at30º and holding for 10 seconds.
C. Deep squat position (DSq): Standing with feet placed apart at shoulder width and knees flexed to 90º and holding for 10 seconds.
D. Weight-shifted-forward position (FWS): Starting position same as in upright standing exercise (A), then leaning body weight forward (right) as much as possible and raising heels up and holding for 10 seconds.
E. Weight-shifted-backward position (BWS): Starting position same as in upright standing exercise (A), then leaning body weight backward as much as possible and raising forefoot and holding for 10 seconds.
F. Weight-shifted-to-the-side position (WSTS): Starting position same as in upright standing exercise (A), then shifting body weight onto one leg as far as possible and holding for 10s. Repeating on the other side.
G. Forward lunge position (FL): Standing in a forward lunge position with the paretic leg placed in front of the non-paretic leg with paretic knee flexed at 10º, then leaning forward and shifting body weight onto the paretic leg as much as possible with knee flexed at 30 º, and holding for 10 seconds. Switching the positions of the two legs, with the non-paretic leg placed in front of the paretic leg.

H. Single-leg-standing position (SLS): Standing on the paretic leg with knee flexed at 10º, and holding for 10 seconds. Repeating on the non-paretic side.

Figure 2. Study flow chart.

A total of 36 people with stroke completed all measurements.

Figure 3. Trend analysis: illustration of the effect of WBV intensity

The relationship between normalized EMGrms and WBV intensity is shown for (A) paretic TA, (B) non-paretic TA, (C) paretic BF and (D) non-paretic BF muscles. Each data point represents the mean value of the normalized EMGrms for a given exercise at a particular WBV intensity. The error bar represents 1 standard error of the mean. For each exercise, the 3 data points were best fitted with a logarithmic curve. The thick purple line represents the trend after pooling the data of all 8 exercises. As it is impossible to fit the data with a logarithmic curve if one of the WBV intensities is 0g, a factor of 0.001g was added to yield WBV intensities of 0.001g, 0.961g and 1.611g respectively. Eight different static exercises were examined in each WBV condition: upright standing (ST), semi squat (SSq), deep squat (DSq), weight-shifted-forward (FWS), weight-shifted-backward (BWS), weight-shifted-to-the-side (WSTS), forward lunge (FL), and single-leg-standing (SLS).

Figure 4. Normalized EMG magnitude under different WBV exercise conditions

The **normalized** EMGrms of (A) paretic TA, (B) non-paretic TA, (C) paretic BF, and (D) non-paretic BF in each test condition is expressed as %MVC. **The white triangles (∆), gray squares (■), and black diamonds (♦) represent** the mean **normalized** EMGrms values recorded in the high-intensity WBV, low-intensity WBV and no-WBV conditions respectively. The error bars represent 1 standard error of the mean. Eight different static exercises were examined in each WBV condition: upright standing (ST), semi squat (SSq), deep squat (DSq), weight-shifted-forward (FWS), weight-shifted-backward (BWS), weight-shifted-to-the-side (WSTS), forward lunge (FL), and single-leg-standing (SLS). * denotes significant difference between the control condition (no WBV) and low-intensity WBV condition. † indicates significant difference between the control condition and high–intensity WBV protocol. # denotes significant difference between the low-intensity WBV and high-intensity protocols. Application of WBV resulted in an overall significant increase in **normalized** EMGrms of the TA and BF on both sides.

Figure 1

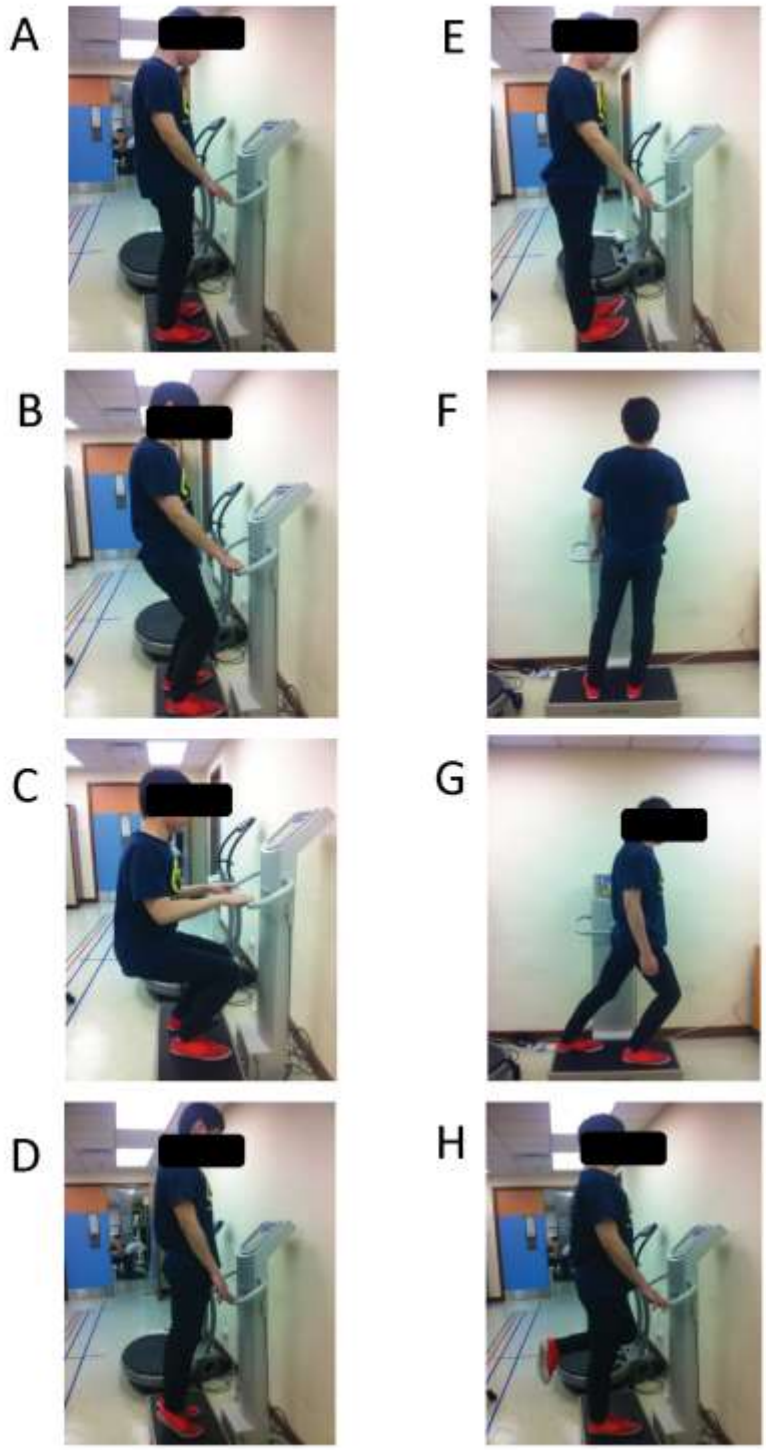
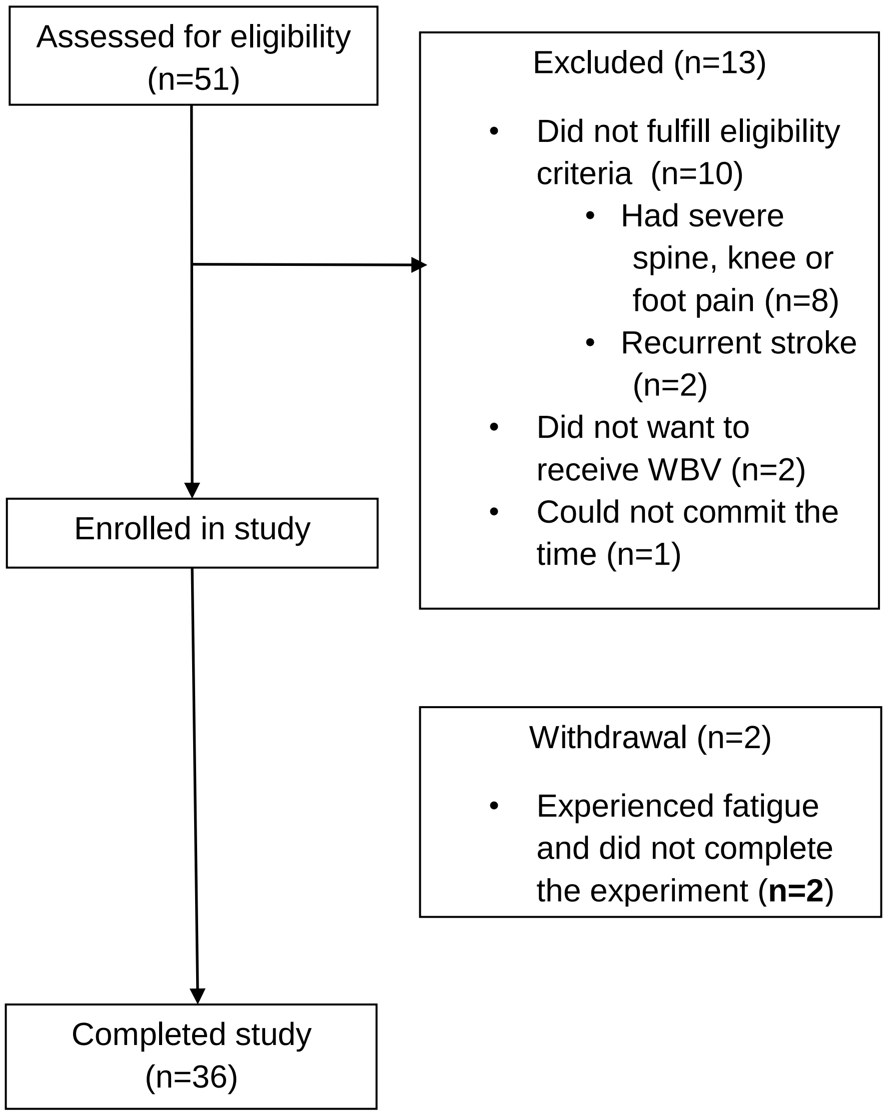
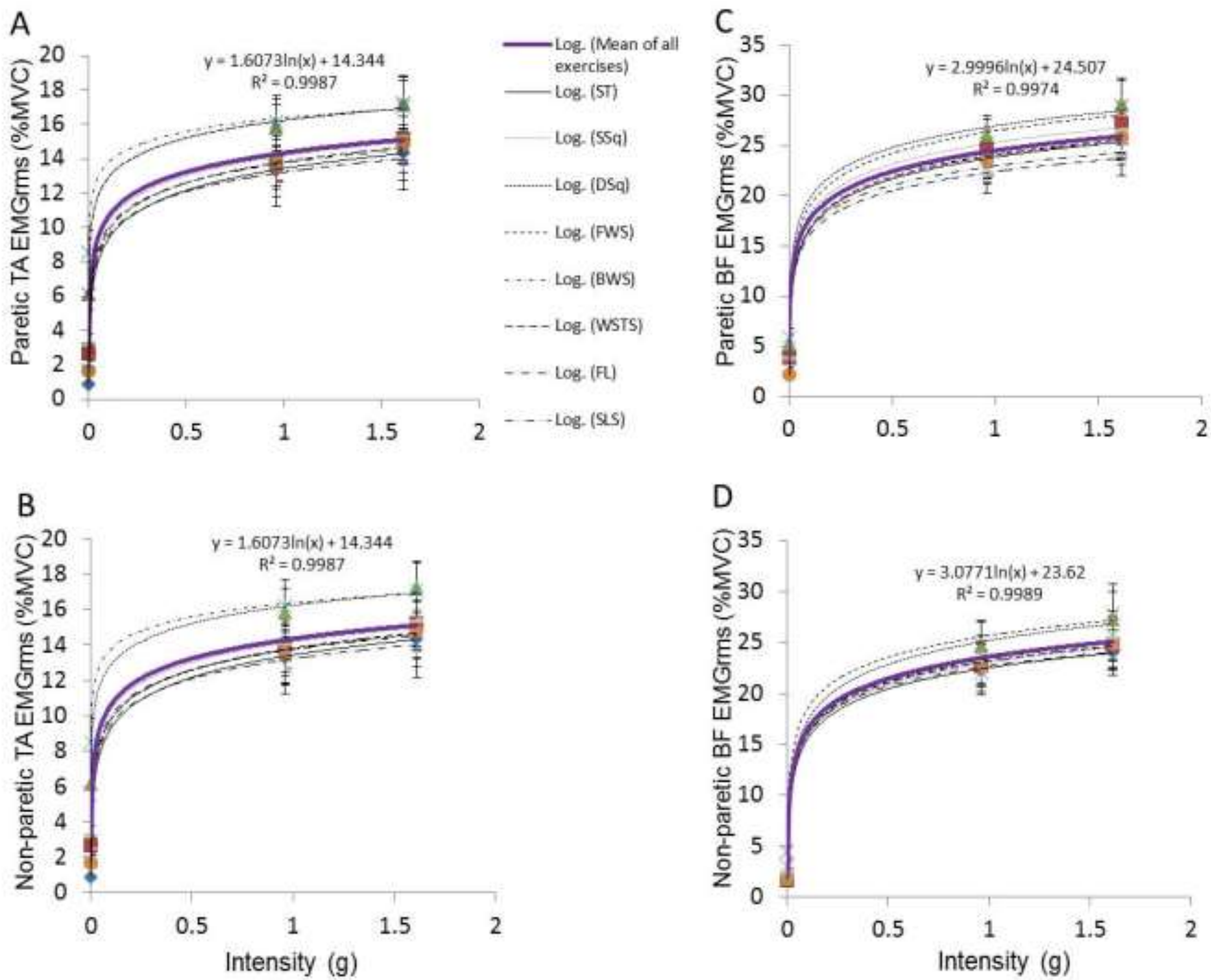


Figure 2


Assessed for eligibility (n=51)
Excluded (n=13)
• Did not fulfill eligibility criteria (n=10)
• Had severe spine, knee or foot pain (n=8)
• Recurrent stroke (n=2)
• Did not want to receive WBV (n=2)
• Could not commit the time (n=1)
Enrolled in study
Withdrawal (n=2)
• Experienced fatigue and did not complete the experiment (n=2)
Completed study (n=36)

716 **Figure 3**



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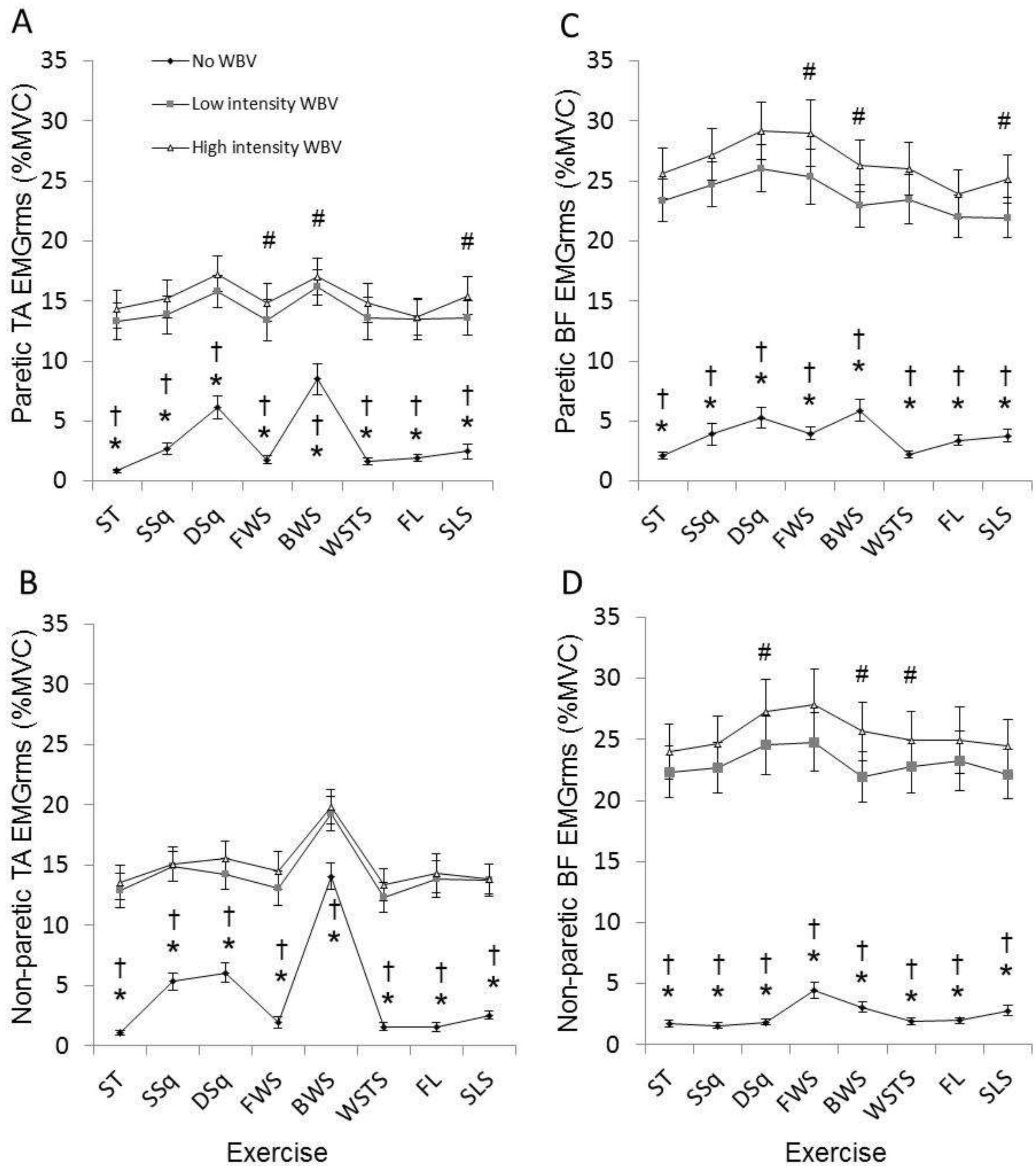
718 **Figure 4**



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