Gluteus Maximus inhibition in proximal hamstring tendinopathy

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OBJECTIVE: The purpose of this study was to demonstrate the inhibition of the ipsilateral Gluteus Maximus in the presence of proximal hamstring tendinopathy and to collect information about its cause.

DESIGN: We studied three subjects with clinical evidence of proximal hamstring tendinopathy previously submitted to conservative treatment with poor results and exhibiting severe hypotrophy and diminished strength in the ipsilateral Gluteus Maximus in comparison with contralateral Gluteus Maximus.

INTERVENTIONS: Patients were submitted to evaluation of the Gluteus Maximus inhibition through handheld dynamometer strength measurements before and during neuromuscular electrical stimulation.

RESULTS: The three subjects exhibited increased strength in the affected Gluteus Maximus (mean 43%; range 27%-62%) when neuromuscular electrical stimulation was added in the evaluations.

CONCLUSION: This study demonstrates that individuals with proximal hamstring tendinopathy present ipsilateral Gluteus Maximus inhibition with hypotrophy and diminished strength. Neuromuscular electrical stimulation partially restores muscular strength. Further studies are required to evaluate the effects of this type of treatment.

KEYWORDS: Hip; Tendinopathy; Muscle Strength Dynamometer; Biomechanics.

INTRODUCTION

In general, tendinopathies are associated with muscular system overload.1 Although proximal hamstring tendinopathy was described for the first time in the nineteen eighties,2 and was found to affect athletic as well as the nonathletic populations, its cause still needs to be further clarified.3

The signs and symptoms have an insidious onset, worsen over time, and may be caused by an overload of physical activity. Pain in the proximal and posterior region of the thigh in the sitting position is a common complaint.2,4

There are studies pointing to a synergism between the Gluteus Maximus and the hamstring muscles during several activities. This implies that Gluteus Maximus weakness promotes hamstring myotendinous overload.5-8

Besides these biomechanical features, other studies have shown voluntary muscle recruitment deficits (muscular inhibition) in some musculoskeletal joint injuries. However, it is not common to associate this phenomenon with hip injuries and tendinopathies.9-11

Thus, the main objective of this case series was to present Gluteus Maximus strength and muscular inhibition in three individuals with proximal hamstring tendinopathy, in an attempt to improve knowledge about this condition.

METHODS

Authorization to use data, clinical information, and images of the subjects involved in this study was obtained...
through an informed consent form signed by all patients; the institutional ethics committee approved the study under case number 138.939.

The general demographic characteristics and complaints of the three patients reported in this case series are shown in Table 1.

These three patients were positive for hamstring tendinopathy and had presented poor results with previous conservative treatment. They were submitted to medical screening that was negative for any systemic or non-musculoskeletal disease (history of cancer, unexplained changes in weight, recent fever, or trauma). Past medical history was negative for previous surgeries, hypertension, and diabetes mellitus.

A differential diagnosis screening was performed for active, passive, and accessory motion of the lumbar spine, hip, sacroiliac joint, knee and ankle; no joint dysfunction was detected, and none of the subjects complained of pain in association with these movements.

The posterior region of the individuals’ thighs was evaluated. First an inspection was made in the complaint side (left thigh) using the asymptomatic side (right thigh) as the parameter of normality. During this examination, an important hypotrophy of the Gluteus Maximus was noted on the left (painful) side when compared with the contralateral asymptomatic side for the three patients.

A palpation exam was performed on the painful thigh. Tenderness was found in the middle portion of the long head of the Biceps Femoris and in the semitendinosus muscles (cases 02 and 03); significant hypotrophy in the left Gluteus Maximus was present in all cases. The left ischial tuberosity was not painful in this examination for any of the patients.

None of the subjects exhibited flexibility deficits; according to information collected they performed regularly a series of hamstring stretches in sports activities.

Gluteus Maximus muscular strength measurement was performed using a handheld Lafayette dynamometer (Lafayette Instrument Company, Lafayette, Indiana, USA). All Gluteus Maximus data were collected by a single physical therapist blinded to which was the painful thigh; this examiner showed excellent reliability according to intraclass correlation coefficients (ICC) = 0.96.12-14

Hip extension strength (Gluteus Maximus) was assessed with the individual in prone position on the massage table, with the knee flexed at 90° and hip in slight lateral rotation. Resistance was provided at the distal thigh 5 cm above the popliteal fossa. The handheld dynamometer was stabilized with a strap during these tests so as not to compromise the strength data collection.

During strength testing, two submaximal trials were used to familiarize the subjects with the test. A ten-second rest interval was allowed between the familiarization trials. After 10 more seconds, two maximal isometric contractions were standardized at 5 seconds, with a resting interval of 30 seconds between them. For data analysis, the average values of the 2 maximum effort trials were used.

Evaluation followed this order: the right Gluteus Maximus (asymptomatic) without and with neuromuscular electrical stimulation of medium frequency (NMES), followed by the left Gluteus Maximus (painful) without and with electrical stimulation.

After the evaluation of the right Gluteus Maximus (asymptomatic) without neuromuscular electrical stimulation, a standard one-minute rest period was allowed before evaluating the same muscle with stimulation, and a second one-minute rest period was allowed before the same evaluation on the opposite lower limb (painful). The one-minute rest period was provided before the evaluation of the left Gluteus Maximus with electrical stimulation. When the evaluator observed any compensatory movement during an evaluation, values were disregarded, and the test was repeated after 20 seconds of rest. Strength measurement may be repeated up to three times to avoid excessive overload and pain.

The same verbal command was always used (“GO, GO, GO”) to encourage the patients during the strength tests.15

| Table 1 - General characteristics of included patients |
|-----------------|-----------------|-----------------|-----------------|-----------------|
| **Patient** | **Gender** | **Age** | **Height (cm)** | **Weight (kg)** | **Occupation (Description)** | **Sport (intensity)** | **Symptom onset** | **Present complaint** |
| 1 | male | 48 | 175 | 72 | Computer operator (8 hr/ day, seated) | Weightlifting (light 3x/ week) | 2007 | Pain, left thigh proximal and posterior region (left ischial tuberosity); VAS = 5.6 - sitting for 5 minutes. |
| 2 | male | 35 | 180 | 88 | Computer operator (9 hr/ day, sitting) | Swimming (light 2x/ week) | 2009 | Pain, left thigh proximal and posterior region (left ischial tuberosity); VAS = 9.0 - sitting for 20 minutes. |
| 3 | female | 51 | 159 | 65 | Computer operator (9 hr/ day, sitting) | none | 2005 | Pain, left thigh proximal and posterior region (left ischial tuberosity) VAS = 9.0 - sitting for 15 minutes. |
Gluteus maximus inhibition

The neuromuscular electrical stimulation equipment was set up with the following parameters: frequency: 70 Hertz; work cycle: 50%; 5 sec turn-on (contraction) followed by a 30 sec turn-off (rest). The electrodes were placed on the Gluteus Maximus muscle belly. The stimulus intensity was increased until the maximum asymptomatic perception was achieved in each patient.

After the strength data collection comparisons were performed for the left Gluteus Maximus without neuromuscular electrical stimulation versus the other three measured parameters: left Gluteus Maximus with stimulation and right Gluteus Maximus with and without stimulation.

**RESULTS**

Taken jointly, the strength measurements exhibited in Figure 1 show that the subjects presented:

![Figure 1 - Subjects' strength (N*m) in all conditions evaluated. Values for three individual and the average show that the non-stimulated left (painful) Gluteus Maximus developed 34% less torque in comparison to the other three measured parameters. NMES: neuromuscular electrical stimulation with the following parameters: frequency: 70 Hertz; work cycle: 50%; 5 sec turn-on (contraction) followed by a 30 sec turn-off (rest).](image)

i. No differences for torque developed by the right (healthy) Gluteus Maximus with or without neuromuscular electrical stimulation and for the left (painful) Gluteus Maximus with stimulation

ii. An average deficit of 34% for the torque developed by the non-stimulated left (painful) Gluteus Maximus versus the other three measurements.

**DISCUSSION**

This case series showed Gluteus Maximus inhibition on the affected side of three patients with proximal hamstring tendinopathy.

The three patients complained of pain in the proximal and posterior region of the thigh, especially in a sitting position at work. This is a common clinical sign and is usually associated with tendon morphological changes, which may actually be the cause of the primary complaint; however the presence of Gluteus Maximus hypotrophy and decreased muscle cushion may increase pain, because the hamstring tendon would be more exposed to pressure imposed by the sitting position.

Furthermore, proximal hamstring tendinopathy promotes diffuse pain in the proximal and posterior region of the thigh during sport activity. This could be correlated with hamstrings and Gluteus Maximus imbalances, which lead to progressive proximal hamstring tendon overload, injury, and pain.

Patients in this study also presented this complaint. Although they are non-athletes, Gluteus Maximus inhibition was noted in the painful side; this may have enhanced the hamstring tendon overload during their recreational sports activities.

Muscular inhibition is generally present in several clinical situations associated with pain, such as was the case with the subjects evaluated in this study. This muscular inhibition has been described as a limiting factor in the rehabilitation process. Therefore, an accurate assessment of the muscle’s ability to produce force becomes essential.

Handheld dynamometry has shown good results of intra- and inter-observer reliability, as well as in muscular strength test and rest, especially when the evaluations occur with and without neuromuscular electrical stimulation in the muscle to be investigated. The use of such stimulation increases the capacity of the central nervous system to voluntarily activate the muscle. This feature recruits all viable motor units during voluntary muscle contraction. Due to this characteristic, this evaluation protocol was applied in this study.

The difficulty of achieving good results with conservative treatment in proximal hamstring tendinopathy may be due to a non recognition of all the biomechanical and physiological features of the subjects enrolled in this study that presented Gluteus Maximus hypotrophy, and led us to investigate Gluteus Maximus inhibition.

Although we have noticed the presence of Gluteus Maximus inhibition in individuals with proximal hamstring tendinopathy, this study presented some limitations, namely the small number of patients, the lack of a functional assessment (specific questionnaires), and the lack of an electromyographical evaluation of Gluteus Maximus activation time. Future research should propose new and more efficient protocols concerning conservative treatment of proximal hamstring tendinopathy.
**CONCLUSÃO**

Os três indivíduos com tendinopatia proximal dos músculos isquiotibiais apresentaram inibição, hipotrofia e redução da força do glúteo máximo ipsilateral quando comparado com o contralateral. Os indivíduos foram submetidos a avaliações na inibição do glúteo máximo mediante mensurações de força com e sem eletroestimulação neuromuscular deste músculo.

**RESULTADOS:** Os três indivíduos exibiram aumento da força do glúteo máximo afetado (média: 43%; 27%-62%) quando a eletroestimulação neuromuscular foi adicionada nas avaliações.

**CONCLUSÃO:** Este estudo demonstrou que os indivíduos com tendinopatia proximal dos músculos isquiotibiais apresentaram inibição, hipotrofia e redução da força do glúteo máximo ipsilateral. A eletroestimulação neuromuscular restaurou parcialmente a força. Estudos futuros são necessários para avaliar o efeito desta intervenção nos programas de reabilitação.

**PALAVRAS-CHAVE:** Quadril, Tendinopatia, Dina-mômembre de Força Muscular, Biomecânica.

**REFERENCES**