




OPEN ACCESS

## Early-stage innovation report

# Treatment of medial tibial stress syndrome using an investigational lower leg brace. A pilot for a randomised controlled trial.

William McNamara ,<sup>1,2</sup> Thomas Longworth,<sup>2</sup> Joo Y Sunwoo,<sup>2</sup> Syed MT Rizvi,<sup>2</sup> Christoph J Knee,<sup>2</sup> Brandi F Cole<sup>1,3</sup>

► Additional supplemental material is published online only. To view, please visit the journal online (<http://dx.doi.org/10.1136/bmjinnov-2022-001054>).

<sup>1</sup>Sydney Sports Medicine Centre, Sydney Olympic Park, New South Wales, Australia

<sup>2</sup>Eastern Suburbs Sports Medicine Centre, Sydney, New South Wales, Australia

<sup>3</sup>Shire Sports Medicine, Caringbah, New South Wales, Australia

**Correspondence to**

Dr William McNamara, Bankstown-Lidcombe Hospital, Bankstown, NSW 2200, Australia; [will\\_macka\\_1@hotmail.com](mailto:will_macka_1@hotmail.com)

Received 18 October 2022

Accepted 6 March 2023



© Author(s) (or their employer(s)) 2023. Re-use permitted under CC BY-NC. No commercial re-use. See rights and permissions. Published by BMJ.

**To cite:** McNamara W, Longworth T, Sunwoo JY, et al. *BMJ Innov* Epub ahead of print: [please include Day Month Year]. doi:10.1136/bmjinnov-2022-001054

**ABSTRACT**

**Objective** Medial tibial stress syndrome (MTSS) is common and often difficult to treat. The purpose of this study was to examine the effect of a lower leg brace on MTSS symptoms compared to a placebo.

**Methods** A pilot of a prospective double-blinded randomised placebo-controlled trial conducted in two private sports medicine practices. Included were those with symptomatic MTSS lasting 6 weeks or more. Excluded were those with other lower limb pathologies. Fourteen participants formed the study cohort who wore the brace or placebo. The brace applied counterforce pressure to the musculotendinous junctions of the soleus, compressed periosteum at the distal third of the posteromedial tibia and applied inferomedial torsion to the soleus muscle. Additional treatment modalities were recorded. Participants completed a standardised MTSS Severity Score at 0–6, 8, 12 and 24 weeks and recorded return to full activity.

**Results** The brace group demonstrated a significantly reduced MTSS severity score from 5 to 24 weeks ( $p < 0.03$ ) and had returned to full activity within 5 weeks. MTSS score in the placebo group remained unchanged ( $p > 0.05$ ), all participants experienced MTSS recurrence and none returned to full activity over 24 weeks.

**Conclusion** The lower leg brace demonstrated a reduction in MTSS symptoms from 5 weeks that was sustained over 6 months with a lower rate of MTSS recurrence compared with the placebo. If similar results are seen in a larger cohort, it has potential to benefit patients with MTSS as an adjunct to current treatment modalities. Further investigation regarding efficacy is needed.

**WHAT ARE THE NEW FINDINGS**

⇒ The use of an investigational lower limb orthosis significantly reduced Medial Tibial Stress Syndrome (MTSS) pain, assisted with an earlier return to sport and was associated with reduced recurrence of disease compared with a placebo in those with established disease.

**HOW MIGHT IT IMPACT ON HEALTHCARE IN THE FUTURE**

⇒ The use of the investigational lower leg brace as an adjunct in a multimodal management programme for MTSS may assist clinicians to achieve earlier symptom relief, return to full activity and prevention of MTSS recurrence.

**Trial registration**

**number** ACTRN12620000906954.

**INTRODUCTION**

Medial Tibial Stress Syndrome (MTSS) is a lower leg injury resulting from stress reactions of the tibia and surrounding musculature in response to repetitive muscle contractions and tibial strain.<sup>1</sup> It affects 4%–20% of the population<sup>1</sup> and has increased prevalence (35%) in athletes and military personnel.<sup>2–4</sup>

The most common complaint is diffuse pain of the lower leg associated with exertion.<sup>5,6</sup> Examination often reveals tenderness of the distal one-third of the posteromedial border of the tibia while the anterior tibia remains non-tender.<sup>7</sup> Patients with mild MTSS experience the worst pain when exercising that can reduce with rest and in more

severe cases pain symptoms may persist for a number of hours or days later despite adequate rest.<sup>7</sup>

The pathophysiology is believed to be a combination of tendinopathy, periostitis, periosteal remodelling and tibial stress reaction.<sup>4 5 8</sup> Dysfunction of the tibialis posterior, tibialis anterior and soleus muscles are commonly implicated<sup>4 5 8</sup> and these appear to be associated with alterations in tibial loading and bending.<sup>5</sup> Studies have attributed the pain to the disruption of Sharpey's fibres between the medial soleus fascia and its bony insertion.<sup>8</sup> This is consistent with radiography of chronic MTSS showing periosteal and bone marrow oedema and periosteal exostoses.<sup>4 7</sup>

As a result of calf tightening MTSS may also be associated with myofascial pain disorder characterised by the presence of hyperalgesic, firm nodules.<sup>9</sup> One treatment for this disorder is mechanotherapy<sup>10</sup> and allows for earlier commencement of rehabilitation. Similarly, Schulze *et al*<sup>11</sup> applied the fascial distortion model in a case control study showing excellent short term reduction in pain and improved performance with intensive physiotherapy.

Other studies have suggested MTSS develops from repetitive impact forces that eccentrically fatigue the soleus leading to tibial bending and impaired remodeling.<sup>5 12</sup>

Treatment of MTSS is predominantly conservative with few recent advances and limited well-conducted randomised controlled trials (RCTs).<sup>7 13 14</sup> Rest has been shown to be the most effective treatment.<sup>4 5 12 15</sup> For many athletes, however, prolonged rest is not ideal.

Other treatments include non-steroidal anti-inflammatories, icing<sup>7</sup> and stretching and strengthening of the calf muscles.<sup>2-5 12 15-17</sup> Footwear and orthotics have been shown to reduce the incidence of MTSS<sup>3-5 7 12-15 17 18</sup> and prevent repeat episodes.<sup>5 14</sup>

Some studies have introduced a lower leg brace in military populations,<sup>19-21</sup> however, due to methodological and brace design limitations significant results were not demonstrated. Despite the lack of evidence for leg bracing, this simple, self-directed modality should not be overlooked. The literature demonstrates a multifaceted syndrome and it is hypothesised a brace that addresses bone loading and myofascial aspects may be beneficial.

### Study rationale

The purpose of this study was to determine whether current MTSS treatment methods and an adjuvant novel brace are more effective in treating MTSS pain symptoms than current methods.

We hypothesised there would be reduced shin pain, lower recurrence rate and earlier return to full activities when using the brace. A placebo group was used to assess if the brace provided any additional treatment effect.

## METHODS

### Study design

Following ethics approval (HREC ref no: 2016-07-610), a pilot of a prospective double-blinded RCT was

conducted to determine the effect of a lower leg brace on MTSS. Participants were prospectively allocated by a single investigator not involved in data collection or analysis to brace or placebo groups using a computer-generated randomisation code in a 1:1 ratio (Random Allocation Software, Microsoft Basic V.6). Brace fitting, treatment protocol and specific instructions for brace use in each group were performed by an unblinded investigator who was not involved in data collection or analysis. Data were collected and analysed by blinded investigators. Participants were unknown to each other.

### Inclusion and exclusion criteria

Patients were reviewed by a blinded clinician and included if they had either bilateral or unilateral symptomatic MTSS for at least 6 weeks with palpable tenderness of the posteromedial tibial border and a history of diffuse, dull shin pain associated with physical exercise.

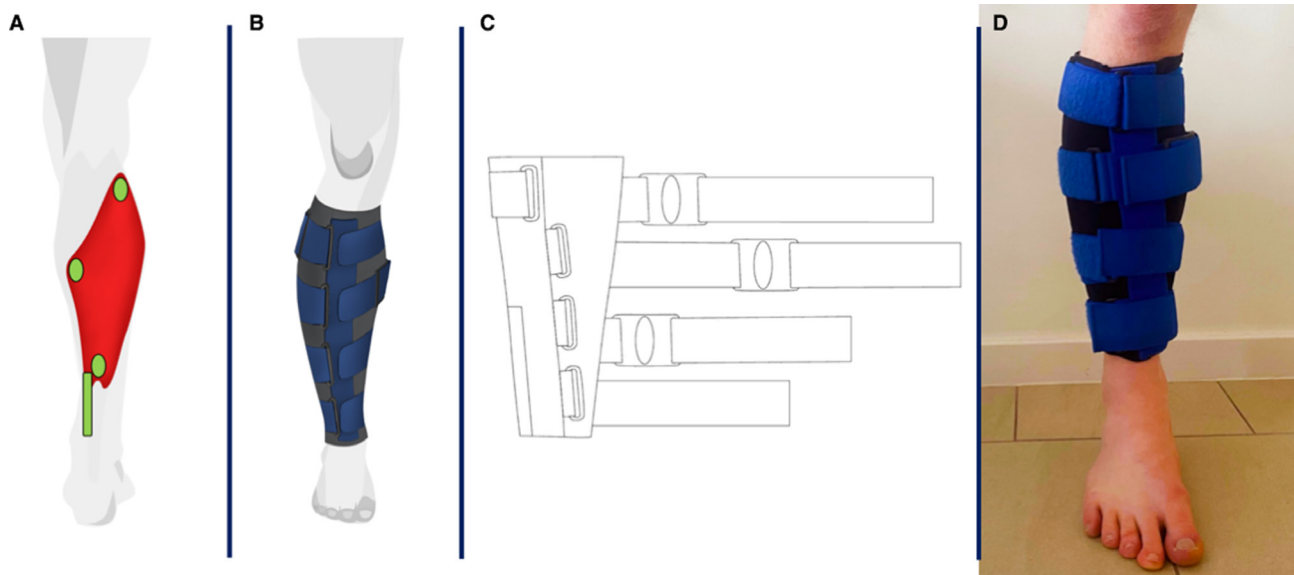
Exclusion criteria included a previous MRI diagnosis or clinical suspicion of lower limb stress fracture in the past 6 months,<sup>22</sup> plantar fasciitis, compartment syndrome, chronic exertional compartment syndrome, popliteal artery entrapment, complex regional pain syndrome, radicular leg pain, neurological disease affecting the lower leg, coagulopathy, pregnancy, age less than 18 years, individuals with disorders affecting the skin, a body mass index greater than 35, any previous lower limb fracture or surgery, or any condition that increases the risk of lower limb infection.

### The investigational brace

The design and function of the brace (Solushin, Australia) was different to any previously studied braces and are described in detail in figure 1. The functional components were designed to produce similar effects seen in lateral epicondylitis counterforce braces.<sup>23</sup> It was hypothesised this brace would unload the soleus and the tibia by dispersing muscular contraction forces across the soleus muscle thereby dampening the forces transmitted through the musculotendinous junctions<sup>6 24 25</sup> with the compressive ellipsoids further enhancing this effect.<sup>26</sup> In addition, soleus inferomedial torsion was used to reduce myofascial traction of the periosteum. Overall these components would optimise soleus function and reduce tibial loading forces. Another study suggested counterforce bracing also improved proprioception and thereby improved associated joint biomechanics and reduced overuse of the muscle.<sup>18</sup> Finally, the rod was designed to compress the distal posteromedial border of the tibia with the aim to reverse the tenting and elevation of Sharpey's fibres seen in MTSS.<sup>2</sup>

### The placebo

The placebo appeared visually identical, however, it lacked the functional ellipsoids and rod components of



**Figure 1** Diagrammatic representation of (A) The anatomical locations of the three compressive rubber ellipsoids (green) that were applied to the musculotendinous junctions of the soleus muscle (posterior to fibular head, mid-diaphysis of posteromedial tibia, Achilles tendon) and the compressive 10 cm semirigid rod at the posteromedial distal one-third of the tibia. These were secured with circumferential elastic strapping. (B) The investigational brace when applied to the leg. (C) The investigational brace layout comprising of a pocket for the compressive rod, four circumferential straps with loops allowing for adjustment of rubber ellipsoids and compression all components and a sleeve by which the functional components were secured. (D) Photographs taken of the investigational lower leg brace in use from the anterior view.

the brace. Therefore, it consisted of a spandex sleeve with four circumferential elastic straps that were tightened to apply firm pressure. This was an ideal placebo as previous research has demonstrated no clinical benefit of compressive garments for MTSS.<sup>27</sup>

#### Brace fitting and use

All eligible participants were fitted bilaterally with placebo or investigational braces by a single investigator, tested for comfort and instructed on self-application. Participants were instructed to wear their braces for up to 2 hours before and after exercise. Brace use during exercise was not permitted. On rest days participants were instructed to wear their braces for up to 2 hours in two separate sessions. This regimen was established after early prototype testing indicated use between 30 min and 2 hours once or twice daily achieved the desired effect. Participants followed these instructions for 6 months, continuing this regimen even if their pain resolved. The mean use-to-exercise ratio (days used/exercise sessions per week) was calculated to quantify adherence to brace or placebo use.

#### MTSS severity assessment

Participants completed a standardised MTSS severity questionnaire<sup>28</sup> prior to the study and from weeks 1–6, 8, 12 and 24 weeks, which appraised activity levels and pain, and formed a score out of 10. A score less than 2 was considered a clinically significant improvement whereby an individual was able to complete all activities with minimal pain. Return to full time activity was defined as an MTSS score less than 2. Recurrence of

MTSS was defined as any reduction in activity due to MTSS. In addition to the MTSS score, participants completed questions detailing exercise volume, duration, rest days, brace use and any concurrent treatments they were receiving. Participants were allowed to receive concurrent treatments as suggested by their treating clinician including physiotherapy, stretching and strengthening exercises, acupuncture, icing, massage, and orthotic use.

#### Return to full activity programme

Despite evidence that loading is a risk factor for MTSS and evidence that gait retraining can be effective,<sup>29</sup> currently, there are no published loading programme protocols available. However, as this was a potential effect modifier we developed a programme to control loading that was given to participants at commencement of the study that detailed an 11-stage return to activity programme.<sup>30</sup> Participants began at the stage that did not elicit pain and were progressed every 3 days if pain-free. If they experienced pain during or after activity they were given 24 hours relative rest then they continued from the preceding stage. For participants whose loading capabilities were beyond the scope of the programme, the researchers developed a tailored equivalent whereby the first stage reflected a level of exercise that was painless for the participant. Time to return to full activity was defined as time taken to reach an MTSS score less than 2.

#### Statistical analysis

Comparisons were made within groups using Wilcoxon signed-rank tests for categorical data and between

**Table 1** Cohort demographics of placebo and brace groups

Demographic	Placebo group (n=7)	Brace group (n=7)
Age (mean±SEM)	28±2.3 years (range 20–37 years)	26±1.8 years (range 22–32 years)
Male/female	4 male, 3 female	2 male, 5 female
Height (mean±SEM)	172 cm±3.7 cm; range 160–185 cm	172 cm±3.6 cm; range 160–190 cm
Weight (mean±SEM)	67 kg±3 kg	65 kg±3.2 kg
BMI (mean±SEM)	22.42±0.44	21.95±0.66
Duration of symptoms (mean±SEM)	23±9 months (range 2–52 months)	29±14 months (range 2.5–104 months)
Affected leg(s)	Left (1), right (0), both (6)	Left (1), right (1), both (5)
Previous history of MTSS	Yes (71%), no (29%)	Yes (43%), no (57%)
Highest level of sport achieved	Hobby (1), club (3), state (2), national (1)	Hobby (0), club (2), state (3), national (2)
Current level of sport	Hobby (3), club (3), state (1), national (0)	Hobby (2), club (2), state (2), national (1)
Previous surgeries	Nil	Nil
Concurrent treatment	Nil (1), physiotherapy (2), orthotics (3), acupuncture (1)	Nil (1), physiotherapy (2), orthotics (3), stretching (1)

BMI, body mass index; MTSS, Medial Tibial Stress Syndrome.

groups using Mann-Whitney rank-sum tests for categorical data and Student's t-test for continuous data. Statistical significance was set at  $p < 0.05$ .

#### Patient and public involvement statement

Participants were not involved in the design, conduct, reporting or dissemination of the research findings. Participants were provided with informed consent regarding intervention burden and time commitment of the intervention.

## RESULTS

### Study group

Between June 2017 and December 2018, 20 individuals presented with shin pain. Three were excluded for stress fracture, one for plantar fasciitis and two were unwilling to commit to the study period. The remaining 14 participants formed the study cohort. There were no withdrawals from the study, however, one participant in the brace group had incomplete data at 3 and 6 months.

### Cohort demographics

The study cohort was randomised to placebo and brace groups. [Table 1](#) summarises the relevant demographic data of each group. There were no statistically significant differences between groups ( $p > 0.05$ ).

### Protocol modifications

There were several minor changes from the study protocol.<sup>30</sup> The sample size was 14 instead of 46 as suggested by the power analysis. Due to resource constraints, an interim analysis for a pilot study was

performed at a sample size of 14 and was found to reach statistical and clinical significance. Knee to wall testing was excluded from the study as it required in-person clinical assessment that most participants were unable to attend.

### Brace usage

Over 6 months the mean weekly usage for the placebo was 116 (left) and 119 (right) min daily for  $5.18 \pm 0.3$  days (range 4.8–5.8 days). The mean weekly usage for the brace was 100 (left) and 104 (right) min each day for  $3.66 \pm 0.4$  days (range 3.1–4.2 days) per week. Comparison between groups at each time point did not identify any statistically significant differences in usage time ( $p > 0.05$ ). Total usage for the placebo demonstrated significantly greater usage time compared with the brace (placebo  $609 \pm 91$  (left) and  $618 \pm 84$  (right) min/week; brace  $364 \pm 73$  (left) and  $378 \pm 66$  (right) min/week) ( $p < 0.05$ ). Total usage remained consistent within groups throughout the study period ( $p > 0.05$ ). The mean use-to-exercise ratio for the placebo ( $1.7 \pm 0.3$  days/session) was greater than the brace ( $1.1 \pm 0.2$  days/session) at a statistically significant level ( $t_{16} = 5.7$ ,  $p < 0.001$ , 95% CI 0.4 to 0.9).

### MTSS severity score

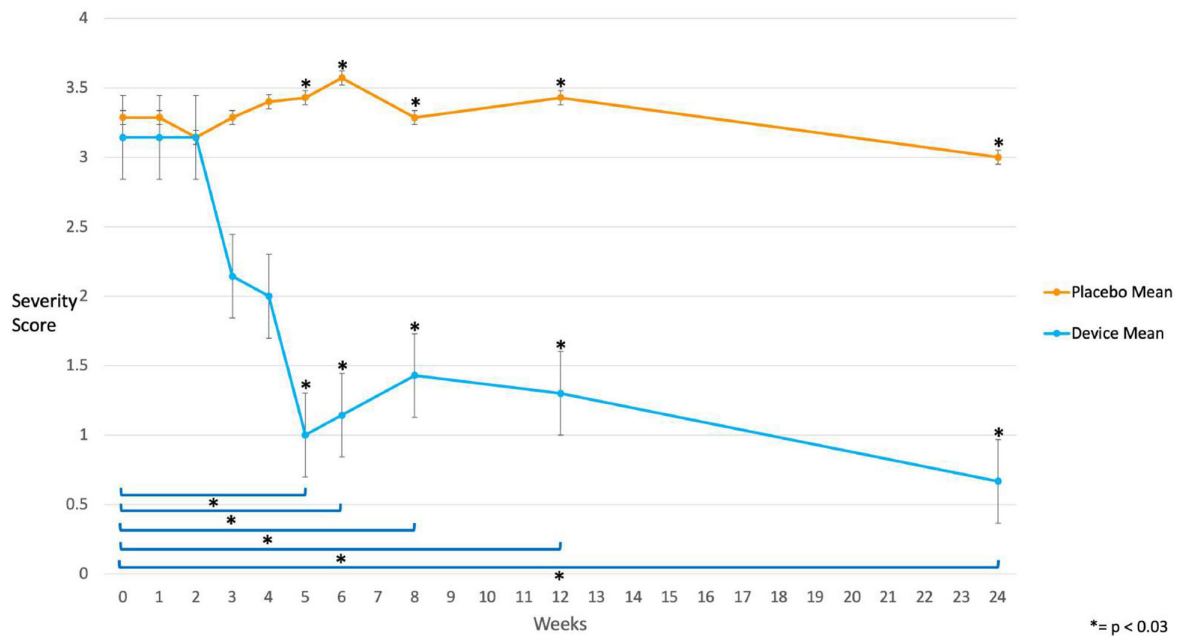
Comparisons were made between groups and within groups comparing progression over time ([figure 2](#)). There was no difference in MTSS severity score between groups from weeks 0 to 4 ( $p > 0.05$ ). However, from weeks 5 to 24, the brace group demonstrated a lower score compared with the placebo that was clinically and statistically significant ( $p < 0.03$ ).

Comparison within the placebo group demonstrated a consistently poor severity score throughout the study period ( $p > 0.05$ ). Comparison within the brace group yielded a statistically and clinically significant reduction in MTSS severity from 0 to 5, 6, 8, 12 and 24 weeks ( $p < 0.03$ ). At 5 weeks, the brace group had returned to full activity with a mean score less than 2. Two participants in the brace group experienced recurrence of symptoms. One participant was forced to reduce their activity volume from weeks 6–8 and the other was forced to do alternative activities from weeks 4, 5 and 8.

All participants with the placebo experienced recurrence of symptoms. Three participants were forced to reduce their activity volume only (weeks 6–8; 3 and 12; 1–5, 12–24), and four participants were forced to engage in alternative activities (weeks 3–5, 8 and 12; 2 and 6; 5, 6 and 8; 2, 3, 5 and 6). In addition, three participants were unable to return to full activities.

### Exercise session frequency

The mean weekly sessions for the placebo group were  $3.7 \pm 0.2$  (range 2.9–4.3) and  $4.2 \pm 0.2$  (range 3.7–5.3) for the brace group. There was no statistically significant difference in session frequency in the first 5 weeks



**Figure 2** Comparison of MTSS severity score between brace and placebo groups from study commencement to 6 months postintervention showing a statistically significant difference between groups from 5 weeks that was sustained until 6 months. The placebo group demonstrated a consistently poor severity score ( $p>0.05$ ). The brace group yielded a statistically significant reduction in MTSS severity from 0 to 5 weeks, 0 to 6 weeks, 0 to 8 weeks, 0 to 12 weeks and 0 to 24 weeks ( $p<0.03$ ). MTSS, Medial Tibial Stress Syndrome.

( $p>0.05$ ). At 6 weeks, session frequency was similar between groups (brace  $4.7\pm 0.6$  sessions (range 2–7); placebo  $4.1\pm 0.9$  (range 2–9);  $p>0.05$ ). At 3 months, the brace group completed a significantly greater number of sessions compared with the placebo (brace  $4.8\pm 0.7$  (range 2–7); placebo  $2.9\pm 0.5$  (range 1–4);  $p<0.05$ ). This difference continued at 6 months at a statistically significant level (brace  $5.3\pm 0.9$  (range 1–7); placebo  $3\pm 0.3$  (range 2–4);  $p<0.05$ ).

## DISCUSSION

This pilot study demonstrated feasibility of the methodology and showed participants who wore the brace had reduced pain and improved function from 5 weeks. This effect was sustained until 6 months postintervention with a lower rate of recurrence compared with the placebo.

To our knowledge, this is the first study to demonstrate an improvement in MTSS symptoms when using a lower limb brace. Participants with symptomatic MTSS who wore the brace achieved a reduction in pain and improvement in function from 5 weeks to 6 months with a low rate of MTSS recurrence. This was compared with a placebo group whose symptoms and function remained similar throughout the study. As a pilot, these findings may reflect a statistically and clinically significant difference that may be seen in a larger study or may be due to chance.

Several studies have investigated the use of a lower limb brace in the treatment of MTSS.<sup>19–21</sup> One study showed no benefit of a rigid rod spanning the length

of the posteromedial tibia.<sup>31</sup> Another study investigated a pneumatic brace commonly used for tibial stress fractures, however, this did not demonstrate efficacy.<sup>21</sup> Finally, some studies have examined the use of calf compression sleeves and, despite their popularity, there was no benefit.<sup>27</sup> In comparison, our study used a compression sleeve as a placebo compared with the brace with a low withdrawal rate and good compliance. This may be attributed to having a small group of highly motivated participants and regular follow-up.

Initially, we observed exercise session frequency was similar between groups, however, at 3 and 6 months the brace group completed ~2 more sessions per week compared with the placebo group suggesting the brace assisted participants to better manage load and maintain consistency with their exercise. Furthermore, this usage data may help clinicians to establish a realistic treatment regimen for their patients and aid planning of future studies.

The strengths of this pilot study are the randomised, double-blinded design with prospectively collected data, compliance with brace use and the use of a verified placebo.<sup>27</sup> The use of the MTSS severity score was a reliable method of assessing MTSS severity and tracking progress.<sup>28</sup> A future RCT using this study design with a larger sample size is feasible and would help determine if the findings of this study are statistically and clinically significant.

A major limitation of this study was sample size. In comparison to other studies investigating a lower limb orthosis for the treatment of MTSS, this study has a similar sample size and reflects the challenges of participant recruitment in sports medicine research.<sup>19 20 27</sup> We acknowledge that we did not reach the sample size required to reach appropriate power for the study, however, as a pilot it demonstrated feasibility of the study design and promising early findings. We also noted that participants wore the placebo ~15 min longer each day compared with those with the brace. In a larger cohort, this difference would reach statistical significance. Participants may have been more comfortable in a softer compressive sleeve, or they may have extended their use while striving for a clinical benefit. Given the sufficient duration of brace use and the previously established placebo,<sup>27</sup> increased placebo use is unlikely to have affected the outcome but is an important consideration for future studies. Finally, this study was conducted over a relatively short-to-medium term and may not have accounted for recurrence of symptoms in the long term.

In conclusion, this pilot RCT demonstrated the lower leg brace reduced MTSS pain symptoms and recurrence, and it facilitated earlier return to full activities and provided symptom relief up to 6 months. These results are promising and provides clear implications for a future RCT with a larger sample size that would have greater power, and closely scrutinise clinical significance. Future investigation into cost-effectiveness of the intervention is also necessary.

**Contributors** All authors included in this manuscript have contributed significantly to the study design, implementation, recruitment, data analysis and paper submission.

**Funding** The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

**Competing interests** The corresponding author is the inventor of the investigational lower leg brace, owns a patent for its design and has shares in the associated company (Solushin, Australia). Currently, the corresponding author does not receive any financial benefits as the brace is yet to generate revenue. All other authors do not have any interests to disclose.

**Patient consent for publication** Not applicable.

**Ethics approval** This study involves human participants and was approved by Bellberry LtdID: HREC ref no: 2016-07-610. Participants gave informed consent to participate in the study before taking part.

**Provenance and peer review** Not commissioned; externally peer reviewed.

**Supplemental material** This content has been supplied by the author(s). It has not been vetted by BMJ Publishing Group Limited (BMJ) and may not have been peer-reviewed. Any opinions or recommendations discussed are solely those of the author(s) and are not endorsed by BMJ. BMJ disclaims all liability and responsibility arising from any reliance placed on the content. Where the content includes any translated material, BMJ does not warrant the accuracy and reliability of the translations (including but not limited to local regulations, clinical guidelines, terminology, drug names and drug dosages), and is not responsible for any

error and/or omissions arising from translation and adaptation or otherwise.

**Open access** This is an open access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited, appropriate credit is given, any changes made indicated, and the use is non-commercial. See: <http://creativecommons.org/licenses/by-nc/4.0/>.

**ORCID iD**

William McNamara <http://orcid.org/0000-0002-7524-2325>

## REFERENCES

- Craig DI. Current developments concerning medial tibial stress syndrome. *Phys Sportsmed* 2009;37:39–44.
- Franklyn M, Oakes B. Aetiology and mechanisms of injury in medial tibial stress syndrome: current and future developments. *World J Orthop* 2015;6:577–89.
- Fredericson M, Bergman AG, Hoffman KL, *et al*. Tibial stress reaction in runners. Correlation of clinical symptoms and scintigraphy with a new magnetic resonance imaging grading system. *Am J Sports Med* 1995;23:472–81.
- Fredericson M. Common injuries in runners. diagnosis, rehabilitation and prevention. *Sports Med* 1996;21:49–72.
- Beck BR. Tibial stress injuries. An aetiological review for the purposes of guiding management. *Sports Med* 1998;26:265–79.
- Meyer NJ, Pennington W, Haines B, *et al*. The effect of the forearm support band on forces at the origin of the extensor carpi radialis brevis: a cadaveric study and review of literature. *J Hand Ther* 2002;15:179–84.
- Galbraith RM, Lavalley ME. Medial tibial stress syndrome: conservative treatment options. *Curr Rev Musculoskelet Med* 2009;2:127–33.
- Detmer DE. Chronic shin splints. Classification and management of medial tibial stress syndrome. *Sports Med* 1986;3:436–46.
- Wheeler AH. Myofascial pain disorders: theory to therapy. *Drugs* 2004;64:45–62.
- Khan KM, Scott A. Mechanotherapy: how physical therapists' prescription of exercise promotes tissue repair. *Br J Sports Med* 2009;43:247–52.
- Schulze C, Finze S, Bader R, *et al*. Treatment of medial tibial stress syndrome according to the fascial distortion model: a prospective case control study. *ScientificWorldJournal* 2014;2014:790626.
- Couture CJ, Karlson KA. Tibial stress injuries: decisive diagnosis and treatment of “shin splints.” *Phys Sportsmed* 2002;30:29–36.
- Rome K, Handoll HHG, Ashford R. Interventions for preventing and treating stress fractures and stress reactions of bone of the lower limbs in young adults. *Cochrane Database Syst Rev* 2005;2005:CD000450.
- Thacker SB, Gilchrist J, Stroup DF, *et al*. The prevention of shin splints in sports: a systematic review of literature. *Med Sci Sports Exerc* 2002;34:32–40.
- Wilder RP, Sethi S. Overuse injuries: tendinopathies, stress fractures, compartment syndrome, and shin splints. *Clin Sports Med* 2004;23:55–81.
- Dugan SA, Weber KM. Stress fractures and rehabilitation. *Phys Med Rehabil Clin N Am* 2007;18:401–16.
- Kortebein PM, Kaufman KR, Basford JR, *et al*. Medial tibial stress syndrome. *Med Sci Sports Exerc* 2000;32:S27–33.

- 18 Chan HL, Ng GYF. Effect of counterforce forearm bracing on wrist extensor muscles performance. *Am J Phys Med Rehabil* 2003;82:290–5.
- 19 Johnston E, Flynn T, Bean M, *et al.* A randomized controlled trial of a leg orthosis versus traditional treatment for soldiers with shin splints: a pilot study. *Mil Med* 2006;171:40–4.
- 20 Moen MH, Bongers T, Bakker EWP, *et al.* The additional value of a pneumatic leg brace in the treatment of recruits with medial tibial stress syndrome; a randomized study. *J R Army Med Corps* 2010;156:236–40.
- 21 Winters M, Eskes M, Weir A, *et al.* Treatment of medial tibial stress syndrome: a systematic review. *Sports Med* 2013;43:1315–33.
- 22 Hislop M, Kennedy D, Cramp B, *et al.* Functional popliteal artery entrapment syndrome: poorly understood and frequently missed? A review of clinical features, appropriate investigations, and treatment options. *J Sports Med (Hindawi Publ Corp)* 2014;2014:105953.
- 23 Nirschl RP, Ashman ES. Elbow tendinopathy: tennis elbow. *Clin Sports Med* 2003;22:813–36.
- 24 Meyer NJ, Walter F, Haines B, *et al.* Modeled evidence of force reduction at the extensor carpi radialis brevis origin with the forearm support band. *J Hand Surg Am* 2003;28:279–87.
- 25 Naderi A, Moen MH, Degens H. Is high soleus muscle activity during the stance phase of the running cycle a potential risk factor for the development of medial tibial stress syndrome? A prospective study. *J Sports Sci* 2020;38:2350–8.
- 26 Walther M, Kirschner S, Koenig A, *et al.* Biomechanical evaluation of braces used for the treatment of epicondylitis. *J Shoulder Elbow Surg* 2002;11:265–70.
- 27 Moen MH, Holtslag L, Bakker E, *et al.* The treatment of medial tibial stress syndrome in athletes; a randomized clinical trial. *Sports Med Arthrosc Rehabil Ther Technol* 2012;4:12.
- 28 Winters M, Moen MH, Zimmermann WO, *et al.* The medial tibial stress syndrome score: a new patient-reported outcome measure. *Br J Sports Med* 2016;50:1192–9.
- 29 Zimmermann WO, Linschoten CW, Beutler A. Gait retraining as part of the treatment programme for soldiers with exercise-related leg pain: preliminary clinical experiences and retention. *SA J Sports Med* 2017;29:1–6.
- 30 McNamara WJ, Longworth T, Sunwoo JY, *et al.* Treatment of medial tibial stress syndrome using an investigational lower leg device. A randomised controlled trial investigating pain severity and return to sport. *Australian New Zealand Clinical Trials Registry* 2019;22:ACTRN12620000906954.
- 31 Konor MM, Morton S, Eckerson JM, *et al.* Reliability of three measures of ankle dorsiflexion range of motion. *Int J Sports Phys Ther* 2012;7:279–87.

## Treatment of Medial Tibial Stress Syndrome using an Investigational Lower Leg Device. A Randomised Controlled Trial.

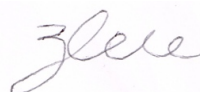
Version Number: 11

Date of Protocol: 13/2/2017

**Declaration of the Principal Investigator:** I have read and understood the protocol document and agree to conduct the study as outline in the protocol and also in accordance with Australia Research Guidelines.

NAME OF PRINCIPAL INVESTIGATOR: Brandi Cole

SIGNATURE OF PRINCIPAL INVESTIGATOR:



DATE:13/2/17



## SYNOPSIS

Treatment of Medial Tibial Stress Syndrome using an Investigational Lower Leg Device. A Randomised Controlled Trial.

Protocol version: 4

## LIST OF INVESTIGATORS

Principal Investigator: Dr Brandi Cole  
Orthopaedic Research Institute  
Level 2, Research and Education Centre  
St George Hospital  
4 – 10 South St  
Kogarah, NSW 2217  
Telephone no.: 9113 2827  
Fax no.:9113 3967  
Email: [brandisnap@yahoo.com.au](mailto:brandisnap@yahoo.com.au)

Co Investigator: Dr Patrick Lam  
Orthopaedic Research Institute  
Level 2, Research and Education Centre  
St George Hospital  
4 – 10 South St  
Kogarah, NSW 2217  
Telephone no.: 9113 4062  
Fax no.:9113 3967  
Email: [patlam.ori@gmail.com](mailto:patlam.ori@gmail.com)

Co Investigator: Dr Tom Longworth  
Sydney Sports Medicine Centre  
Level 2, NSWIS Building  
6 Figtree Dr  
Sydney Olympic Park  
Telephone no.: 9764 3131  
Fax no.:9764 3443  
Email:

Co Investigator: Mr William McNamara  
Orthopaedic Research Institute  
Level 2, Research and Education Centre  
St George Hospital  
4 – 10 South St  
Kogarah, NSW 2217  
Telephone no.: 9113 2827  
Fax no.:9113 3967  
Email: [will\\_macka\\_1@hotmail.com](mailto:will_macka_1@hotmail.com)

TREATMENT OF MEDIAL TIBIAL STRESS SYNDROME USING AN INVESTIGATIONAL LOWER LEG DEVICE. A RANDOMISED CONTROLLED TRIAL. VERSION 11 (13/2/17).

2

## Summary

Study title:	Treatment of Medial Tibial Stress Syndrome using an investigational Lower Leg Device. A Randomised Controlled Trial.
Protocol version	1
Objectives	<p>Primary objective: Return to full-time sport/activity levels and recurrence of MTSS after return to full-time sport.</p> <p>Secondary objectives: <a href="#">Level of shin pain during rest, with ADLs and during rehabilitation running each week prior to return to activity, time to progress through each stage of the rehabilitation protocol prior to return to full activity, bilateral active dorsiflexion range of motion at initial assessment, at return to full-time activities and at 6 weeks, 3 months and 6 months after return to full-time activities, compliance with device use and overall patient satisfaction with the device.</a></p>
Study design	Prospective, double-blinded, randomised controlled trial
Planned sample size	50
Selection criteria	Symptomatic medial tibial stress syndrome of at least 6 weeks duration diagnosed on the basis of history of diffuse, dull lower leg pain with activity, and palpable tenderness of the posteromedial tibial border.
Study procedure	Patients randomized to one of two groups to receive either the novel device or a placebo to be worn on the lower leg, first fitted at initial visit. They will then undergo a home rehabilitation program and be followed up at 6 weeks, 3 months, and 6 months in the clinic.
Statistical considerations	<p>Sample size 50</p> <p>Statistical analysis will be performed using SigmaPlot v11 (Systat Software, Inc. Chicago, IL,USA).</p>
Duration of the Study	8 month follow up

## Table of Contents

<b>1. BACKGROUND</b> .....	<b>5</b>
1.1. Disease Background*.....	5
1.2. Rationale for Performing the Study*.....	7
<b>2. STUDY OBJECTIVES*</b> .....	<b>7</b>
2.1. Primary Objective* .....	7
2.2. Secondary objectives.....	7
<b>3. STUDY Design*</b> .....	<b>8</b>
3.1. Design* .....	8
3.2. Study Groups .....	8
3.3. number of participants* .....	8
3.4. number of centres .....	8
3.5. duration .....	8
<b>4. Participant section</b> .....	<b>8</b>
4.1. Inclusion Criteria* .....	8
4.2. Exclusion Criteria* .....	8
<b>5. STUDY Outline*</b> .....	<b>9</b>
5.1. Study Flow Chart .....	9
5.2. Investigation plan* .....	9
5.3. Study Procedure Risks* .....	11
5.4. Recruitment and Screening* .....	11
5.5. Informed Consent Process* .....	12
5.6. Enrolment Procedure* .....	12
5.7. Randomisation Procedure.....	12
<b>6. SAFETY*</b> .....	<b>12</b>
6.1. Adverse Event Reporting* .....	12
<b>7. BLINDING AND UNBLINDING</b> .....	<b>12</b>
<b>8. STATISTICAL CONSIDERATIONS*</b> .....	<b>12</b>
<b>9. STORAGE AND ARCHIVING OF STUDY DOCUMENTS*</b> .....	<b>13</b>
<b>10. Ethical considerations</b> .....	<b>13</b>
<b>11. Financing and Insurance</b> .....	<b>14</b>
<b>12. Publication policy</b> .....	<b>14</b>
<b>13. REFERENCES*</b> .....	<b>14</b>
<b>14. Appendix 1: Modified bruce protocol</b> .....	<b>17</b>
<b>15. Appendix 2: Participant Questionnaire</b> .....	<b>18</b>

## 1. BACKGROUND

### 1.1. DISEASE BACKGROUND\*

Shin splints, also known as Medial Tibial Stress Syndrome (MTSS), is an overuse injury or repetitive-stress injury of the shin area. A range of stress reactions of the tibia and surrounding musculature occur when the body is unable to heal properly in response to repetitive muscle contractions and tibial strain<sup>14</sup>.

MTSS occurs in approximately 4-20% of the general population<sup>14</sup> and has significantly increased prevalence (35%) in athletes, particularly runners, and military personnel<sup>13</sup>.

The most common complaint is vague, diffuse pain of the lower extremity along the medial distal tibia and is associated with exertion<sup>1,5</sup>. Clinical examination of the distal one-third of the medial border of the tibia often reveals tenderness to palpation with the anterior tibia often being non-tender<sup>13</sup>. Patients with early phase MTSS experience the worst pain at the beginning of exercise and this gradually subsides during training or within minutes of cessation of exercise. As the disease progresses the pain presents with less activity and may occur at rest<sup>13</sup>.

There are multiple risk factors for developing MTSS, however, muscle imbalance and inflexibility, especially tightness of the triceps surae (gastrocnemius, soleus, and plantaris muscles) has been documented heavily in the literature as being commonly associated with MTSS<sup>1,6,7</sup>.

The pathophysiology is not well understood, however, it is believed to be a combination of tendinopathy, periostitis, periosteal remodelling, and stress reaction of the tibia<sup>1-3</sup>. Dysfunction of the tibialis posterior, tibialis anterior, and soleus muscles are also common implicated<sup>1,2,3</sup>. These various tibial stress injuries appear to be caused by alterations in tibial loading, as chronic, repetitive loads cause abnormal strain and bending of the tibia<sup>1</sup>. Studies have attributed the pain experienced in MTSS to the disruption of Sharpey fibers that are connected to the medial soleus fascia and run through the periosteum of the tibia to insert into the bone<sup>22</sup>. Interestingly, in patients with chronic MTSS radiography has shown periosteal involvement including periosteal exostoses<sup>13</sup>. Periosteal oedema and subsequent bone marrow oedema into the periosteum has also been shown as a significant feature of chronic MTSS<sup>3</sup>.

There is also discussion that MTSS, as a result of calf tightening, may be associated with a myofascial pain disorder which is 'composed of hypercontracted extrafusal muscle fibres' characterised by the presence of tender, firm nodules called trigger points<sup>21</sup>. These nodules are hyperirritable upon palpation. One recommended treatment for myofascial pain disorder is mechanotherapy<sup>20</sup> to provide acute

symptomatic treatment and allow for more rapid commencement of an appropriate rehabilitation program.

In concordance with both bone loading and myofascial pain theories, other studies have suggested that MTSS develops as a result of repetitive impact forces that eccentrically fatigue the soleus leading to tibial bending or bowing and overloading the capacity for bone remodelling<sup>1, 12</sup>.

Treatment is predominantly conservative (rest, ice, analgesia, stretching, massage), however, few advances have been made in the treatment of MTSS over the last few decades<sup>13</sup>. Current treatments are mostly based on expert opinion and clinical experience with few well-conducted randomised control trials (RCT)<sup>4</sup>. Rest has been shown to be the single most important treatment in acute MTSS<sup>1,3,7,12</sup>. For many athletes, however, prolonged rest is not ideal.

Other treatments include use of NSAIDs for analgesia along with ice for ~15-20mins in the acute phase<sup>13</sup>. Physiotherapy has been shown to be helpful (ultrasound, whirlpool baths, phonophoresis, soft tissue mobilisation, electrical stimulation, and unweighted ambulation have been shown to be effective in the acute setting)<sup>1,3,5-7,9,12</sup>. However, many athletes require more regular treatment that suggests a more athlete self-directed method of treatment could be helpful in the setting of MTSS.

Similarly, a regular program of stretching and strengthening exercises has been shown to be effective in prevention of, and in the rehabilitation period following, MTSS<sup>1,3,5-7,9,12</sup>.

Appropriate footwear and orthotics has been shown to reduce the incidence of MTSS<sup>1,3,4-8,12</sup> and can prevent repeat episodes<sup>1,4</sup>. Shock-absorbing insoles have shown potential in prevention and treatment of MTSS in a military population, however, with unclear results due to methodological flaws<sup>23</sup>. Finally, a systematic review has highlighted that correction of musculoskeletal dysfunctions can improve pain and overall function and may be helpful in preventing recurrence<sup>13</sup>.

Some studies have introduced a lower limb brace designed to treat MTSS, with particular focus on a military population<sup>16,19</sup>. However, statistical significant results were not demonstrated between experimental and control groups. This has been attributed to methodological limitations such as a small sample size ( $n < 25$ ), compliance issues, non-validated outcome measures, and a short time period for evaluation of efficacy<sup>17</sup>.

Despite previous studies showing little efficacy of a lower limb brace for the treatment of MTSS, this simple and patient self-directed option should not be disregarded for its potential role in mechanotherapy<sup>20</sup>. With a carefully constructed study

methodology, appropriate sample size, using newly developed evaluation tools not previously available for use in clinical settings<sup>18</sup>, over a longer period of time compared to previous brace studies we believe a more clinically relevant picture of the role of lower limb braces in the treatment of MTSS may be realised.

As agreed upon by a large body of evidence, the key to treatment of MTSS is prevention<sup>1</sup>, however, to date, there is limited evidence to support our current treatment and interventions for MTSS<sup>4</sup>.

The current literature regarding MTSS clearly demonstrates a multifaceted syndrome in its etiology and associations. To improve our current treatment, therefore, requires a multifaceted approach that addresses both bone loading and myofascial aspects of the condition.

## 1.2. RATIONALE FOR PERFORMING THE STUDY\*

The proposed study is designed to determine whether current treatment methods with an adjuvant novel device for medial tibial stress syndrome are more effective than the current treatment methods without the novel device. Rest is currently the most effective treatment modality, however, many active individuals find this period of rest frustrating and detrimental to their goals, particularly amongst those competing in high level sport. The aim of the device is to reduce the amount of rest required to return to previous activity levels whilst also symptomatically treating the pain associated with medial tibial stress syndrome.

It is expected that we should be able to show a treatment effect of the device in terms of time taken to return to full activity load, recurrences after return to full activity load and overall shin pain. This will be compared to that of the placebo group to see if the device provides any additional treatment effect beyond that of the placebo group.

## 2. STUDY OBJECTIVES\*

### 2.1. PRIMARY OBJECTIVE\*

Time to return to full-time sporting activities, and recurrence of symptoms after return to full-time activities.

### 2.2. SECONDARY OBJECTIVES

Level of shin pain during rest, with ADLs and during rehabilitation running each week prior to return to activity, time to progress through each stage of the rehabilitation protocol prior to return to full activity, bilateral active dorsiflexion range of motion at initial assessment, at return to full-time activities and at 6 weeks, 3 months and 6 months after return to full-time activities, compliance with device use and overall patient satisfaction with the device.

### 3. STUDY DESIGN\*

#### 3.1. DESIGN\*

- Prospective, double-blinded, randomized controlled trial.

#### 3.2. STUDY GROUPS

- Normal Treatment with the Novel Device Group (Device group)
- Normal Treatment with placebo Device Group (Placebo group)

#### 3.3. NUMBER OF PARTICIPANTS\*

50

#### 3.4. NUMBER OF CENTRES

1

#### 3.5. DURATION

- Start date May 2016, expected end date May 2020
- Expected time period for the recruitment phase of the study is 24 months

### 4. PARTICIPANT SECTION

#### 4.1. INCLUSION CRITERIA\*

- Symptomatic medial tibial stress syndrome of at least 6 weeks duration, diagnosed on the basis of:
  - History of diffuse, dull shin pain that is associated with exercise,
  - Palpable tenderness of the posteromedial tibial border

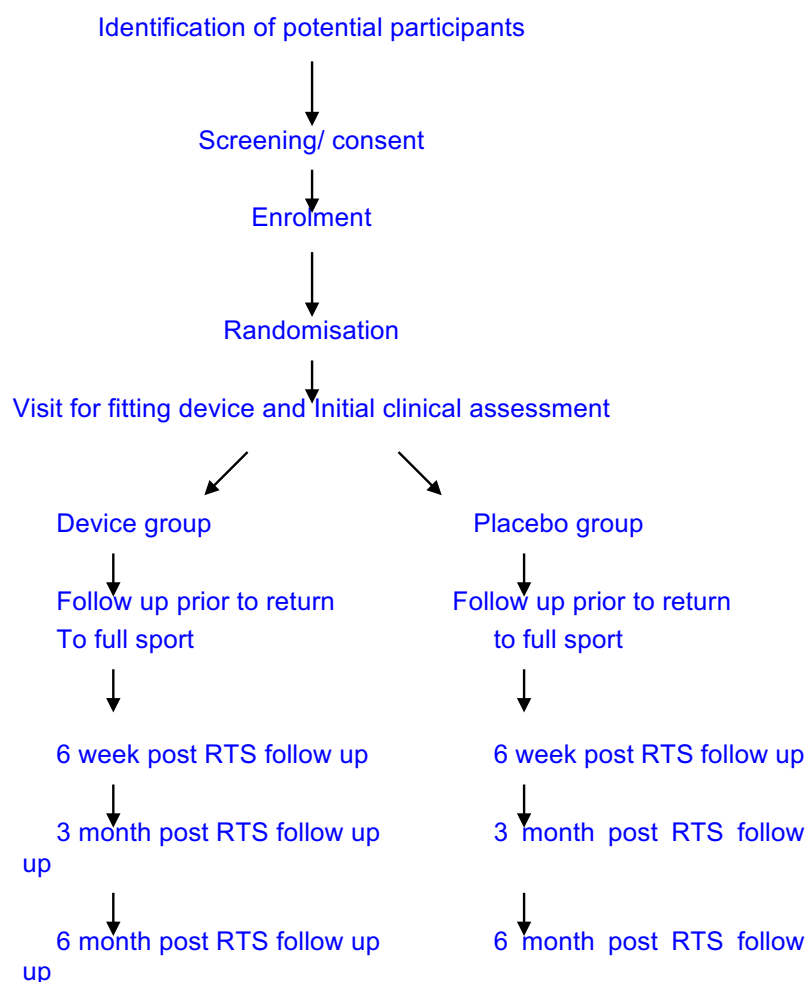
#### 4.2. EXCLUSION CRITERIA\*

- Diagnosis of stress fracture in the previous 6 months
- Clinical suspicion of a current stress fracture due to localised point tenderness on the anterior or medial border of the tibia unless ruled out by an MRI (MRI negative for bone stress reaction)
- Signs of plantar fasciitis including heel pain on first steps in the morning and tenderness to palpation over the posteromedial calcaneal tuberosity
- Previous diagnosis of compartment syndrome
- Suspicion of chronic exertional compartment syndrome on the basis of history of shin or calf pain brought on at a predictable point in activity, that worsens if exercise continues and is relieved by rest, unless excluded with compartment pressure testing
- Clinical signs of complex regional pain syndrome including pain out of proportion to the inciting event, allodynia, hyperalgesia, diffuse oedema, skin changes and difference in temperature between limbs
- Previous diagnosis of popliteal artery entrapment syndrome
- Clinical suspicion of popliteal artery entrapment syndrome based on disappearance of pedal pulses on repetitive plantarflexion
- Clinical suspicion of radicular leg pain including history of back pain associated with the leg pain and/or reproduction of leg pain on SLR testing with added dorsiflexion
- Neurological disease affecting the lower leg
- Coagulation disease
- Pregnancy

- Age less than 18
- Individuals with increased risk of fungal infection
- Individuals with disorders affecting the skin
- BMI > 35
- Any condition that increases risk of infection of the lower limb

## 5. STUDY OUTLINE\*

### 5.1. STUDY FLOW CHART



### 5.2. INVESTIGATION PLAN\*

List Interventions	Enrolment visit	Initial assessment	Assessment prior to	6 week follow up	3 month follow up	6 month follow up
--------------------	-----------------	--------------------	---------------------	------------------	-------------------	-------------------

TREATMENT OF MEDIAL TIBIAL STRESS SYNDROME USING AN INVESTIGATIONAL LOWER LEG DEVICE. A RANDOMISED CONTROLLED TRIAL. VERSION 11 (13/2/17).

9



		and fitting of device/placebo	return to sport			
Informed Consent	✓					
Inclusion / Exclusion criteria	✓					
Patient filled form - evaluation of shin pain and function (to be completed weekly)		✓	✓	✓	✓	✓
Physical examination		✓	✓	✓	✓	✓
Treadmill testing		✓	✓	✓	✓	✓
Adverse Event & Serious Adverse Event Assessment			✓	✓	✓	✓

At the enrolment visit, patients will be examined to determine a clinical diagnosis of MTSS according to the inclusion and exclusion criteria. Following confirmation of eligibility for enrolment in the study, patients will be asked to read a patient information sheet that outlines the purpose of the study and what is involved. They will then be given a consent form and asked to complete it if they wish to partake in the study.

Once informed consent is obtained, the patient's age, gender, occupation, duration of symptoms, leg(s) involved, highest level of sport achieved, and previous history of MTSS will be recorded.

Participants will be randomised to the novel device group or the placebo group. The novel device group will receive the Solushin (Solushin Pty Ltd, Australia), complete with compressive hemispheres and rod, fitted to the patient. The placebo group will receive a garment that appears to look the same as the Solushin, however, it will lack the functional elements of the device. If participants have bilateral MTSS they will be given the same device for both legs – that is, a participant randomized to the investigational device group with bilateral MTSS will receive one investigational device for each leg and vice versa.

All patients will be instructed on the correct application of the Solushin device or the placebo, respectively, with both groups being required to wear their device from commencement of the study up until 6 weeks after return to full-time activity. Patients will be instructed to wear their device for at least 2 hours prior to undergoing their return to full activity program and 2 hours after completing their activities. If patients do not participate in exercise in any day, they will be instructed to wear their device for at least 2hrs in the morning and 2hrs in the afternoon during those days.

Participants will be instructed by the clinician to follow a standardized return to full activity protocol with graded progression based on symptoms. They will be asked to refrain from any other running or load bearing activities other than activities of daily living and the rehabilitation exercises until return to full activity. They will be permitted to cycle, swim and participate in resistance programs should they choose to.

All participants will also have the option to undergo other treatment procedures such as ice, stretching, massage and soft tissue techniques recommended by their usual treating clinician.

Initial assessment of MTSS will require participants to perform an active range of dorsiflexion test followed by a treadmill running test whereby patients will be progressed through a modified Bruce protocol (Appendix 1) (see my note on appendix) and asked to stop at the point at which their leg pain is elicited. The end of the test will occur when they complete the protocol or when they reach their maximal heart rate ( $220 - \text{age}$ ) if no symptoms occur. Patients will be asked to complete a VAS Score to rate their pain prior to, immediately after and 5 minutes after treadmill testing. The same assessments will be made at follow-up appointments in the clinic prior to return to full activity and again at 6 weeks, 3 months and 6 months after return to full load activities.

The nominated Medical Monitor is Dr Donald Kuah who will follow up with any participants who are unhappy with their management or any other aspect of the trial. Participants will be able to contact Dr Kuah for review whether that is a medical review, a second diagnostic opinion or a conversational review about the conduct of the study. In addition the first 5 participants enrolled in the study will be closely monitored in the early stages of use of the device for adverse effects. This will be done via a clinical examination once a week for the first two weeks, then fortnightly for the next two fortnights for a clinical examination. Additionally, there will be a phone interview every two days for the first week prior to the in-person clinical examination allowing the investigators to identify and act on issues earlier than the one week visit. Patients will be asked to complete a questionnaire and send it to the clinician once a week until return to full-time activity, then every fortnight for the duration of the study (Appendix 2).

The nominated Data Safety Monitoring Committee consists of Dr Donald Kuah and Professor George Murrell who will monitor safety during the trial via reviewing the results of the first 5 participants enrolled in the study and any other participants who report adverse events throughout the trial.

#### 5.3. STUDY PROCEDURE RISKS\*

The risks in this study are related to the device material. There is a low risk that the material in both the device group and the placebo group can promote fungal or bacterial colonization of the skin that is in direct contact with device. This risk is lowered by the use of an antifungal and antibacterial material that is machine washable. Due to the compressive nature of the device, there is a low risk that it will produce a tourniquet effect that could compromise haemodynamics and lead to formation of thromboemboli. However, the device is not designed to reach pressures consistent with tourniquets.

#### 5.4. RECRUITMENT AND SCREENING\*

Participants will be recruited via face to face discussion, sending of letters and/or flyers to Sydney physiotherapists, doctors as well as using social media platforms such as Facebook and Instagram.

Any patients who fit the inclusion criteria (identified from their initial history and clinic examination) will be considered as potential participants. Eligible patients will then be informed about the study and invited to attend a clinic appointment where they will be further examined to ensure they fit the inclusion criteria, don't meet any exclusion criteria and are willing to participate in the trial. Patients who fit the criteria will be given the PICF and given time to consider whether they would like to be a part of the study and if they are not sure we suggest that they go home to think about it and call to make another appointment if they wish to partake.

#### 5.5 INFORMED CONSENT PROCESS\*

The study will be explained verbally to the suitable participants and if they agree to participate they will be provided with a written explanation of the study and will fill out and sign a written informed consent form which will be put in their medical file.

#### 5.6 ENROLMENT PROCEDURE\*

If the participant meets inclusion criteria, has no exclusion criteria and agrees to participate in the trial they will be enrolled into the study after informed consent has been completed. The participant will receive a study enrolment number and this will be documented in the participant's medical record and on all study documents.

#### 5.7 RANDOMISATION PROCEDURE

After enrollment participants will be randomized into one of two groups using a computer generated randomization code that will be held by an administrative staff member with no other involvement in the trial.

### 6. SAFETY\*

#### 6.1. ADVERSE EVENT REPORTING\*

Adverse events will be assessed at each follow up and recorded in the participant's medical notes. We will also keep a log of all adverse events. We are considering adverse events to be any untoward medical occurrence in a participant which does not necessarily have a causal relationship with the study treatment. An adverse event can therefore be any unfavorable or unintended sign, symptom or condition and/or an observation that may or may not be related to the study treatment.

If participants feel that their shin pain has worsened, they will be re-evaluated at the 6 week follow-up visit for possible other causes of lower leg pain.

Participants are able to call or return to clinic at any time between the initial visit and the prior to return to sport visit. They have the option of obtaining an external second opinion of their condition at any time and proceeding with any other recommended treatment. Any other treatment received will be recorded at each subsequent visit.

All adverse events will be recorded in a case report form. It will not be reported to the ethics review committee immediately unless it impacts on the research and action is planned.

All serious adverse events will be recorded and reported individually to HREC if the information materially impacts the continued ethical acceptability of the trial or indicates a need for change to the trial protocol, otherwise they will be included in the annual Serious Adverse Events Summary Report.

### 7. BLINDING AND UNBLINDING

Patients will be blinded to which group they have been assigned and all groups will be given an identically shaped device. The clinician fitting the device and instructing treatment protocol will not be blinded as it is important to fit the device correctly and provide instructions for correct application. This clinician will not be involved in collection or reporting of any data for the research project. The outcome assessors will be blinded to treatment group.

### 8. STATISTICAL CONSIDERATIONS\*

Fifty participants will be recruited into the study and equally randomized into two groups of 25. The sample size was chosen based on a similar previous study conducted by Johnston et al. (2006) that examined the use of a lower leg brace in the treatment of

MTSS<sup>20</sup>. Based on data from this RCT, a sample size calculation using an ANOVA model was performed:

Minimum detectable difference = 7 days return to full-time activity

Expected Standard deviation of residuals = 3.47 days (Based on previous RCT (SEM data) and sample size for one group is 23, maximum standard deviation is (SEM=STD/SQRT(23)), or (SEM\*SQRT(23)=STD) => (6\*SQRT(23)= 7 days)

Number of groups = 2

Desire Power = 0.8 (80%)

Alpha = 0.05 (p-value)

The minimum sample size for each group is 23, and 46 in total, ie 23 patients in each group will be enough to detect a difference between the groups in return to full load activities.

For parametric data such as active range of dorsiflexion, VAS pain scores and patient device use data un-paired student's t-test will be used to assess differences between groups at different time points, with significant level set at 0.05.

For non-parametric data such as patient satisfaction with the device we will use a repeated measures ANOVA.

Statistical analysis will be performed using SigmaPlot v11 (Systat Software, Inc. Chicago, IL,USA).

## 9.STORAGE AND ARCHIVING OF STUDY DOCUMENTS\*

Information will be stored in a computer file in the ORI, on USB backup and a paper copy stored in the medical records. Electronic data is stored in password protected files and physical data will be stored in a locked cabinet. Data will be stored for 15 years after the completion of the project and then destroyed.

## 10.ETHICAL CONSIDERATIONS

The study has been devised so as to adhere to the guidelines set out in chapter 4.3: People in Dependent or Unequal Relationships of the National Statement on Ethical Conduct in Human Research (2007). Consent will be negotiated in the form of a thorough patient information and consent form which outlines the purpose of the study and the requirements of each participant. Potential participants will be encouraged to discuss participation in the study with their regular clinician who is not involved.

The study is designed to minimize potential detrimental effects of the researcher-participant relationship by making sure the researchers are not involved with the treatment of the patient outside of the study parameters and within the study participants are asked that they report any difficulties, complaints or adverse events to the researchers so that participants can be assessed immediately followed by the appropriate course of action.

Potential participants who are already involved in a separate study will be advised to remain in that study as a participant and not engage in another.

Researchers will minimize any dependency of participants by following the strict study protocol and instructing participants to do the same. Realistic participant explanations will be ensured through provision of the patient information sheet and consent form. Persons who decline participation or withdraw from the study will not be denied any treatment or be disadvantaged in any way.

Throughout the study, participants will be treated with respect, consent will be sought by an investigator who has no pre-existing relationship with potential participants and all information will be kept confidential as per section 9 of this protocol.

This protocol has been reviewed by Bellberry Human Research Ethics.

## 11. FINANCING AND INSURANCE

The researchers will conduct the study voluntarily in their free time. The experimental devices and placebo will be provided by Solushin Pty Ltd for no fee. Participants will be allowed to keep their device after completion of the study if they so wish. All clinicians (principal researcher and first author) have medical indemnity insurance that encompasses clinical trials.

## 12. PUBLICATION POLICY

Participants will be provided with a patient information and consent form which outlines the purpose of the study and the methodology, informing them that their information will be kept confidential, they may receive a placebo device and they have the right to withdraw from the study at any time. The plan for the study is to improve the management of medial tibial stress syndrome. Therefore, on completion the study will be submitted to publication to an appropriate peer-reviewed journal.

## 13. REFERENCES\*

1. Beck, B. (1998). Tibial stress injuries: an aetiological review for the purposes of guiding management. *Sports Med*, 26(4), 265-79.
2. Detmer, D. (1986). Classification and management of medial tibial stress syndrome. *Sports Med*, 3(6), 436-46.
3. Fredericson, M., Bergman, G., Hoffman, K. & Dillingham, M. (1995). Tibial stress reaction in runners: correlation of clinical symptoms and scintigraphy with a new magnetic resonance imaging grading system. *Am J Sports Med*, 23, 427-81.
4. Thacker, S., Gilchrist, J., Stroup, D. & Kimsey, C. (2002). The prevention of shin splints in sports: a systematic review of literature. *Med Sci Sports Exerc*, 34(1), 32-40.
5. Kortebein, P., Kaufman, K., Basford, J. & Stuart, M. (2000). Medial tibial stress syndrome. *Med Sci Sports Exerc*, 32(3), S27-33.
6. Fredericson, M. (1996). Common injuries in runners. Diagnosis, rehabilitation and prevention. *Sports Med*, 21, 49-72.
7. Wilder, R. & Seth, S. (2004). Overuse injuries: tendinopathies, stress fractures, compartment syndrome, and shin splints. *Clin Sports Med*, 23, 55-81.
8. Strakowski, J. & Jamil, T. (2006). Management of common running injuries. *Phys Med Rehabil Clin N Am*, 17(3), 537-52.
9. Dugan, S. & Weber, K. (2007). Stress fracture and rehabilitation. *Phys Med Rehabil Clin N Am*, 18(3), 401-16.

10. Brunet, M., Cook, S., Brinker, M. & Dickson, J. (1990). A survey of running injuries in 1505 competitive and recreation runners. *J Sports Med Phys Fitness*, 30(3), 307-15.
11. Yates, B. & White, S. (2004). The incidence and risk factors in the development of medial tibial stress syndrome among naval recruits. *Am J Sports Med*, 32(3), 772-80.
12. Couture, C. & Karlson, K. (2002). Tibial stress injuries: decisive diagnosis and treatment of 'shin splints'. *Phys Sportsmed*, 30(6), 29-36.
13. Galbraith, R.M. & Lavallee, M.E. (2009). Medial tibial stress syndrome: conservative treatment options. *Curr Rev Musculoskelet Med*, 2, 127-133.
14. Craig, D.I. (2009) Current developments concerning medial tibial stress syndrome. *Phys Sports Med*, 37(4), 39-44.
15. Fredericson, M., Bergman, A.G., Hoffman, K.L. & Dillingham, M.S. (1995). Tibial stress reaction in runners: correlation of clinical symptoms and scintigraphy with a new magnetic resonance imaging grading system. *Am J Sports Med*, 23, 472-481.
16. Moen MH, Bongers T, Bakker EW, Weir A, Zimmermann WO, van der Werve M & Backx, FJ. (2010). The additional value of a pneumatic leg brace in the treatment of recruits with medial tibial stress syndrome; a randomized study. *J R Army Med Corps*. 156(4), 236-40.
17. Winters M, Eskes M, Weir A, Moen MH, Backx FJ & Bakker EW. (2013). Treatment of medial tibial stress syndrome: a systematic review. *Sports Med*. 43(12), 1315-33.
18. Winters M, Moen MH, Zimmermann WO, Lindeboom R, Weir A, Backx FJ & Bakker EW. (2015). The medial tibial stress syndrome score: a new patient-reported outcome measure. *Br J Sports Med*. 2015 Oct 28 pii: bjsports-2015-095060. doi: 10.1136/bjsports-2015-095060. [Epub ahead of print].
19. Johnston E, Flynn T, Bean M, et al. A randomized controlled trial of a leg orthosis versus traditional treatment for soldiers with shin splints: a pilot study. *Mil Med*. 2006;171(1):40-4.
20. Khan, K.M. & Scott, A. (2009). Mechanotherapy: how physical therapists' prescription of exercise promotes tissue repair. *Br J Sports Med*. 43:4, 247-252.
21. Wheeler AH. (2004). Myofascial pain disorders: theory to therapy. *Drugs*. 64(1), 45-62.
22. Rome K, Handoll HH, Ashford R. (2005). Interventions for preventing and treating stress fractures and stress reactions of bone of the lower limbs in young adults. *Cochrane Database Syst Rev*. 18(2).

23. Bruce, RA, Lovejoy Jr, FW, Pearson, R, Yu, PNG, Brothers, GB & Velasquez, T. (1949). Normal respiratory and circulatory pathways of adaptation in exercise. *J Clin Invest.* 28 (6), 1423-1430.
24. Bruce, RA, Pearson, R, Lovejoy Jr, FW, Yu, PNG & Brothers, GB. (1949). Variability of respiratory and circulatory performance during standardized exercise. *J Clin Invest.* 28 (6), 1431-1438.
25. Brinkman MJL, Buist I, Bredeweg SW. (2013). The treatment effect of pulsed electromagnetic field in sports athletes with medial tibial stress syndrome; a pilot study (in press).
26. Gourgiotis, S., Aggelakas, J., Salemis, N., Elias, C., & Georgiou, C. (2008). Diagnosis and surgical approach of popliteal artery entrapment syndrome: a retrospective study. *Vascular Health and Risk Management*, 4(1), 83–88.
27. Goff, JD & Crawford, R. (2011). Diagnosis and treatment of plantar fasciitis. *Am Fam Physician.* 84(6), 676-82.
28. Kvist, MH & Heinonem, OJ. (1991). Calcaneal apophysitis (Sever's disease) — a common cause of heel pain in young athletes. *Scandinavian Journal of Medicine & Science in Sports.* 1(4), 235-238.
29. Leach, RE, Hammond, G & Stryker, WS. (1967). Anterior tibial compartment syndrome. *J Bone Joint Surg Am.* 49(3), 451-462.
30. Harden, NR, Bruehl, S, Stanton-Hicks, M, Wilson, PR. (2007). Proposed new diagnostic criteria for complex regional pain syndrome. *Medicine.* 8(4), 326-331.
31. NHMRC (2007) National statement on ethical conduct in human research. *Updated May 2015.*

**14. APPENDIX 1: MODIFIED BRUCE PROTOCOL**

Patients will spend 2 minutes on each stage before progressing.

Stage	Speed (km/hr)	Gradient
1	5.47	14
2	6.76	17
3	8.05	20
4	8.85	23
5	9.65	26
6	10.46	29
7	11.26	32
8	12.07	35
9	12.67	38
10	13.29	41



## 15. APPENDIX 2: PARTICIPANT QUESTIONNAIRE

### Medial Tibial Stress Syndrome Score

Name:

Date:

I have complaints in:

- Both shins
- Only the **left** shin
- Only the **right** shin

#### In case of complaints in both shins:

I have most complaints in:

- My left shin
- My right shin

#### Instructions:

- While completing this questionnaire, keep in mind the pain as you have experienced maximally over the past days, and check the answer that fits **best** this shin pain
- While completing this questionnaire, keep in mind your **shin with most** complaints.
- Please read **all** options before you select a checkbox.
- For **all** questions, choose **one** answer per question only.

#### Sporting activities

For military: Marching is considered to be a sporting activity.

- | 1) Presently:  | P |
|--|---|
| I perform all of my usual sporting activities <input type="checkbox"/>   | 0 |
| I am forced to do <u>less</u> of my usual sporting activities due to pain in my shin <input type="checkbox"/>        | 1 |
| I am forced to do <u>alternative</u> sporting activities <u>only</u> due to pain in my shin <input type="checkbox"/> | 2 |
| I <u>cannot</u> do any sporting activity due to pain in my shin <input type="checkbox"/>                             | 3 |
| <br>   |   |
| 2) While performing sporting activities:   |   |
| I have <u>no pain</u> in my shin <input type="checkbox"/>  | 0 |
| I have <u>some pain</u> in my shin <input type="checkbox"/>  | 1 |
| I have <u>a lot of pain</u> in my shin <input type="checkbox"/>  | 2 |
| I <u>cannot</u> do any sporting activity due to my shin pain <input type="checkbox"/>                                | 3 |

**Walking**

<b>3) While walking:</b>		<b>P</b>
I have no pain in my shin	<input type="checkbox"/>	0
I have <u>some</u> pain in my shin	<input type="checkbox"/>	1
I have <u>a lot of pain</u> in my shin	<input type="checkbox"/>	2
I <u>cannot</u> walk due to pain in my shin	<input type="checkbox"/>	2

**Pain at rest**

e.g. sitting or laying down

<b>4) At rest, my shin is:</b>		
<u>Not</u> painful	<input type="checkbox"/>	0
<u>Sensitive</u>	<input type="checkbox"/>	1
<u>Painful</u>	<input type="checkbox"/>	2
<u>Very</u> painful	<input type="checkbox"/>	2

**5) Number of exercise sessions per week**

**6) Average minutes per session**

**7) Activity type during each session (e.g. hopping, running, swimming)**

**8) Surface types (e.g. concrete, grass, water)**

**9) Average rate of perceived exertion in sessions**

/10

**10) How many pre-sessions/post- sessions/days in the past week did you wear the device?**

**11) On average, for how long do you wear the device each day? (please circle one)**

Not at all   30mins-1hr   1hr-2hrs   2hrs+

**12) Have you used any other treatments for your shin splints instructed by your clinician in the past week (stretching, icing, strengthening, massage**

etc)? If so, what were they and how often did you use them? (NB: please indicate if there is no change since your previous response)

**13) Overall, how happy are you with the device? (please circle one)**

useless

little use

neutral

useful

very useful

## 16. APPENDIX 3: RETURN TO FULL ACTIVITY PROGRAM



- **Patients can progress each stage every 3 days if no pain with or following activity. No more than 2 running days in a row (i.e. one rest day out of every three)**
- **If experiences pain during or after activity or at rest – must have relative rest for 24 hours and continue with flow chart from one step back.**
- **Lack of progression or regression on flow chart will need medical review by trial doctor(s).**
- **Present for return to full training/sport assessment when completed flow chart pain free. Absolute minimum time is 33 days.**