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***Retrospective Study***

**Associations among pain catastrophizing, muscle strength, and physical performance after total knee and hip arthroplasty**

Hayashi K *et al.* Pain catastrophizing after TKA and THA

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**Abstract**

***AIM***

To investigate whether reductions in pain catastrophizing associated with physical performance in the early period after total knee arthroplasty (TKA) or total hip arthroplasty (THA).

***METHOS***

The study group of 46 participants underwent TKA or THA. The participants were evaluated within 7 d before the operation and at 14 d afterwards. Physical performance was measured by the Timed Up and Go (TUG) test, and 10-m gait time was measured at comfortable and maximum speeds. They rated their knee or hip pain using a visual analog scale (VAS) for daily life activities. Psychological characteristics were measured by the Pain Catastrophizing Scale (PCS). Physical characteristics were measured by isometric muscle strength of knee extensors and hip abductors on the operated side. The variables of percent changes between pre- and post-operation were calculated by dividing post-operation score by pre-operation score.

***RESULTS***

Postoperative VAS and PCS were better than preoperative for both TKA and THA. Postoperative physical performance and muscle strength were poorer than preoperative for both TKA and THA. The percent change in physical performance showed no correlation with preoperative variables. In TKA patients, the percent change of PCS showed correlation with percent change of TUG (*P* = 0.016), 10-m gait time at comfortable speeds (*P* = 0.003), and 10-m gait time at maximum speeds (*P* = 0.042). The percent change of muscle strength showed partial correlation with physical performances. The percent change of VAS showed no correlation with physical performances. On the other hand, in THA patients, the percent change of hip abductor strength showed correlation with percent change of TUG (*P* = 0.047), 10-m gait time at comfortable speeds (*P* = 0.001), and 10-m gait time at maximum speeds (*P* = 0.021). The percent change of knee extensor strength showed partial correlation with physical performances. The percent change of VAS and PCS showed no correlation with physical performances.

***CONCLUSION***

Changes in pain catastrophizing significantly associated with changes in physical performance in the early period after TKA. It contributes to future postoperative rehabilitation of arthroplasty.

**Key words:** Gait; Hip Arthroplasty; Knee Arthroplasty; Osteoarthritis; Pain; Pain management; Postoperative care

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**Core tip:** This clinical trial investigated whether reductions in pain catastrophizing are associated with physical performance in the early period after total knee arthroplasty (TKA) or total hip arthroplasty (THA). We found that changes in pain catastrophizing were significantly associated with physical performance in the early period after TKA. These findings may contribute to future postoperative rehabilitation of the arthroplasties in lower limbs. Treatment based on cognitive–behavioral therapy might be useful in the early period, particularly after TKA.

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**INTRODUCTION**

Osteoarthritis leads to considerable morbidity in terms of pain, functional disability, lowered quality of life, and psychological problems[1]. Total knee arthroplasty (TKA) and total hip arthroplasty (THA) improve pain and physical performance in participants with end-stage arthritis[1]. The number of TKA and THA procedures performed is increasing worldwide[1]. Early postoperative recovery is important in particularly rehabilitation; however, uncertainty exists about effective rehabilitation methods for physical performance.

Pain treatment has targeted not only pain intensity, but also pain catastrophizing, which has been conceptualized as a negative cognitive–affective response to pain[2]. The patients with high pain catastrophizing suggest that cognitive-behavioral intervention should incorporate in treatment[2]. Recently systematic review concludes better outcome associates with grater reduction in pain catastrophizing during treatment in low back pain[3]. The review shows a mediating effect is found in all studies assessing the impact of a decrease in catastrophizing during treatment[3]. In addition, some studies have reported pain catastrophizing associated with physical performance than pain intensity, in low back pain[4,5]. On the other hand, the impact of reduction in pain catastrophizing on outcome has not investigated in patients with TKA or THA, although pain catastrophizing has investigated only at baseline[6–11]. In changes of pain related variables, the changes in postoperative pain intensity associate with changes in physical performance within 16 days after either TKA or THA[12]. It has not investigated whether pain intensity or pain catastrophizing have mediating effect of physical performance.

The purpose of the present study is to determine whether reductions in pain catastrophizing are associated with physical performance in the early period after TKA or THA.

**MATERIALS AND METHODS**

***Participants***

A total of 46 participants were enrolled. Twenty-three underwent initial TKA, and 23 underwent initial THA between September 2014 and April 2015 at Nagoya University Hospital (Table 1). Exclusion criteria were that the participant (1) was diagnosed with cognitive impairment; and (2) had pain in other body parts that was more severe than in the operative site. All participants underwent a baseline preoperative visit prior to their operation and received standardized in-participant treatment including usual rehabilitation, following either a primary total hip or total knee care pathway.

This cross sectional study was approved by the Ethics Committee of Nagoya University Hospital (No. 328). All the participants provided written informed consent.

***Measures***

Demographic data including age, sex, height, body weight, and body mass index (BMI) were measured. The participants were evaluated within 7 days before the operation and at 14 d afterwards. Physical performance was measured by the Timed Up and Go (TUG) test, and 10-m gait time was measured at comfortable and maximum speeds[13,14]. Participants were allowed to use a walking aid, based on walking ability. They rated their knee or hip pain using a visual analog scale (VAS) for daily life activities. Psychological characteristics were measured by the Pain Catastrophizing Scale (PCS)[15,16]. Physical characteristics were measured by isometric muscle strength of knee extensors and hip abductors on the operated side[17–22].

**Physical performance:** The 10-m gait test was used to measure the time it took the participant to walk 10 m at comfortable and maximum speeds. Timing at each of the two speeds was measured twice. Participants were timed using a stopwatch as they moved along a 10-m walkway. Participants stood directly behind the start line and were clocked from the moment the first foot crossed the start line until the lead foot crossed the finish line. Participants were instructed to continue at least 2 m past the finish line to eliminate the deceleration effects from stopping the gait. Gait speeds were then expressed as meters per second[13]. For the comfortable-gait speed trial, participants were instructed to walk at their normal comfortable speeds. For the maximum-speed trials, they were asked to walk as fast as they could safely do so without running. Each participant performed two valid trials, and the higher-speed trial was used for analysis.

The TUG test is a measure frequently used to assess function in older individuals[14]. Subjects were given verbal instructions to stand up from a chair, walk 3 m as quickly and as safely as possible, cross a line marked on the floor, turn around, walk back, and sit down. Each participant performed two valid trials, and the higher-speed trial was used for analysis.

**Psychological measures:**For the 13-item PCS, participants rate how frequently they have experienced various cognitions or emotions[15,16]. The PCS comprises three subscales: rumination (*e.g.,* “I keep thinking about how much it hurts”), magnification (*e.g.,* “I wonder whether something serious may happen”), and helplessness (*e.g.,* “There is nothing I can do to reduce the intensity of the pain”)[15,16]. The total score range is 0–52[15,16]. Several findings support this scale’s validity as a measure of PCS[15,16].

**Isometric muscle strength***:* The isometric muscle strength of the hip abductors and knee extensors was measured using a hand-held gauge meter (μ-Tas F-100; Anima, Tokyo, Japan). The strength of the hip abductors was measured in the supine position with both lower limbs in neutral position. The transducer was placed at the lateral femoral condyles[17]. The strength-testing position of the knee extensors was confirmed using a goniometer at a hip angle of 90° and knee flexed to 60°. If necessary, the feet were supported by a small bench[18–22]. A strap was attached between the examination couch and a point on the participant’s ankle, 5 cm above the lateral malleolus. The transducer was then placed at the front of the ankle under the strap to measure the extension strength. The participants were asked to push maximally against the force transducer for 5 s. Participants performed two contractions separated by a 60-s interval. The highest value was used for analysis. Muscle strength was expressed as the maximum voluntary torque with use of the external lever-arm length. The lever-arm length was the distance from the trochanter major to the center of the dynamometer for hip abductors and from the lateral femoral epicondyle to the center of the dynamometer for knee extensors.

***Statistical analysis***

All data are expressed as mean ± SD. The variables of percent changes between pre- and post-operation were quantified. It was calculated dividing post-operation score by pre-operation score[18]. Their resultant data were analyzed by paired *t*-test. The correlation of physical performance with psychological and physical variables was analyzed by the Pearson r rank test. The data were analyzed with SPSS software (version 20.0 for Microsoft Windows; SPSS, Chicago, IL, United States). A value of *P* < 0.05 was considered statistically significant.

**RESULTS**

Pre- and post-operative data are shown in Table 2. The mean ± SD of VAS in THA and TKA were at preoperative of 37.87 ± 24.20, and 41.91 ± 27.09, and postoperative at 14-day of 17.61 ± 20.29, and 25.22 ± 20.41. The mean ± SD of PCS in THA and TKA were at preoperative of 28.70 ± 9.28, and 28.26 ± 11.90, and postoperative at 14-day of 18.70 ± 11.19, and 20.26 ± 10.72. Postoperative VAS and PCS were better than preoperative for both TKA and THA. Postoperative physical performance and muscle strength were poorer than preoperative for both TKA and THA.

The correlations between physical performance and other variables are shown in Table 3. The percent change in physical performance showed no correlation with preoperative variables. In TKA patients, the percent change of PCS showed correlation with percent change of TUG (*P* = 0.016), 10-m gait time at comfortable speeds (*P* = 0.003), and 10-m gait time at maximum speeds (*P* = 0.042). The percent change of muscle strength showed partial correlation with percent change of physical performances. The percent change of VAS showed no correlation with percent change of physical performances. On the other hand, in THA patients, the percent change of hip abductor strength showed correlation with percent change of TUG (*P* = 0.047), 10-m gait time at comfortable speeds (*P* = 0.001), and 10-m gait time at maximum speeds (*P* = 0.021). The percent change of knee extensor strength showed partial correlation with percent change of physical performances. The percent change of VAS and PCS showed no correlation with percent change of physical performances.

**DISCUSSION**

The present study showed that changes in pain catastrophizing significantly associated with changes in physical performance in the early period after TKA, but not after THA. Changes in muscle strength significantly associated with changes in physical performance in the early period after TKA and THA. Quantification of early postoperative changes and their potential relationships to physical performance can reveal responsible mechanisms and contribute to future postoperative rehabilitation.

The importance of assessing pain catastrophizing has been highlighted in preoperative TKA or THA patients[6–11]. Pain catastrophizing associated with physical performance, more so than was pain intensity in low back pain[4,5]. In addition, better physical performance associated reduction in pain catastrophizing during treatment than scores at baseline in low back pain[3]. Some reports in low back pain showed pain catastrophizing at baseline was no predictive for disability at follow-up[3]. This study, first, showed reductions in pain catastrophizing associated with physical performance in the early period after TKA. It is important in early postoperative treatment outcome, at least after TKA. For example, treatment that incorporates a cognitive-behavioral intervention can lead to reduction in pain catastrophizing concurrent with reduction in pain-related activity interference and disability among persons with persistent pain[2]. The intervention targeted a decrease in maladaptive behaviors, an increase in adaptive behaviors, identification, and correction of maladaptive thoughts and beliefs, and an increase in self-efficacy for pain management[23]. It was introduced to reduce pain and psychological distress and to improve physical and role function[23]. Medical staff should expand their evaluations beyond traditional demographics and medical status variables to include pain-related psychological constructs when addressing perioperative participants.

The present study showed that, in the early period after THA, changes in physical performances were not significantly associated with changes in pain catastrophizing. The VAS and PCS at postoperative at 14-day in THA was less than in TKA, consistent with previous study[24]. In general, pain-related disability might be resolved at an earlier stage than 14 d after THA. However, a recent systematic review concluded that there is no evidence for psychological factors as an influence on outcome after THA[8]. Further investigation is needed to assess longitudinal changes after THA.

Preoperative and postoperative muscle weakness is a major contributor to poor physical performance after TKA and THA[25–27]. The present study showed changes in physical performance were associated with changes in muscle strength.

There are several limitations in this study. We included only a small number of participants from a single medical center, so our observations must be interpreted with caution. The present study investigated only the early postoperative period; these findings should be considered preliminary for TKA and THA, although other studies have considered physical function in the early period after TKA and THA[12,18,24]. Scores on the preoperative PCS in the present study were higher than those reported in previous TKA studies[9–11]. This finding might be confined to the patients with high pain catastrophizing. A larger and long-term study to investigate further the association among changes in pain catastrophizing, muscle strength, and physical performance is required.

Changes in levels of pain catastrophizing were associated with changes in physical performance in the early period after TKA; and changes in muscle strength were associated with changes in physical performance in this period after both TKA and THA. These findings may contribute to future postoperative rehabilitation of lower-limb arthroplasties. Treatment based on cognitive–behavioral therapy might be useful in the early period, at least after TKA.

**COMMENTS**

***Background***

Pain treatment has targeted not only pain intensity, but also pain catastrophizing, which has been conceptualized as a negative cognitive–affective response to pain. The changes in postoperative pain intensity associate with changes in physical performance after total knee arthroplasty (TKA) or total hip arthroplasty (THA). On the other hand, the impact of changes in pain catastrophizing on outcome has not investigated in patients with TKA or THA.

***Research frontiers***

The purpose of the present study is to determine whether reductions in pain catastrophizing are associated with physical performance in the early period after TKA or THA.

***Innovations and breakthroughs***

This study, first, showed reductions in pain catastrophizing associated with physical performance in the early period after TKA.

***Applications***

The findings may contribute to future postoperative rehabilitation of lower-limb arthroplasties. Treatment based on cognitive–behavioral therapy might be useful in the early period, at least after TKA.

***Peer-review***

It is an interesting manuscript on investigating and comparing physical performance, pain ratings, pain catastrophizing, and muscle strength. This study is definitely worth publishing.

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**Table 1 Participant characteristics**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **THA** | | |  | **TKA** | | |
| Sex (Male/Female) | 4/19 |  |  |  | 9/14 |  |  |
| Age | 61.17 ± 10.32 |  |  |  | 69.65 ± 8.52 |  |  |
| Height (cm) | 155.84 ± 8.34 |  |  |  | 153.01 ± 10.37 |  |  |
| Body Weight (kg) | 58.66 ± 13.75 |  |  |  | 60.78 ± 12.87 |  |  |
| Body Mass Index (kg/m2) | 24.05 ± 4.30 |  |  |  | 25.80 ± 4.25 |  |  |

Data for age, height, body weight, and body mass index are presented as mean ± SD. THA: Total hip arthroplasty; TKA: Total knee arthroplasty.

**Table 2** **Pre- and postoperative data according to site of replacement**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **THA** | | | | | | |  |  |  |  | **TKA** | | | | | | |  |  |  |
|  | **Preoperative** | | |  | **Postoperative**  **at 14-day** | | |  | ***P*-value** |  |  | **Preoperative** | | |  | **Postoperative**  **at 14-day** | | |  | ***P* -value** |  |
| TUG (s) | 11.51 ± 3.82 | | |  | 13.67 ± 5.65 | | |  | 0.004a |  |  | 12.22 ± 4.33 | | |  | 16.42 ± 9.09 | | |  | 0.004a |  |
| 10 m gait speeds at comfortable (m/s) | 0.97 ± 0.23 | | |  | 0.92 ± 0.20 | | |  | 0.187 |  |  | 0.99 ± 0.24 | | |  | 0.77 ± 0.23 | | |  | 0.000a |  |
| 10m gait speeds at maximum (m/s) | 1.28 ± 0.34 | | |  | 1.11 ± 0.32 | | |  | 0.005a |  |  | 1.19 ± 0.34 | | |  | 0.95 ± 0.32 | | |  | 0.000a |  |
| VAS | 37.87 ± 24.20 | | |  | 17.61 ± 20.29 | | |  | 0.001a |  |  | 41.91 ± 27.09 | | |  | 25.22 ± 20.41 | | |  | 0.004a |  |
| PCS | 28.70 ± 9.28 | | |  | 18.70 ± 11.19 | | |  | 0.000a |  |  | 28.26 ± 11.90 | | |  | 20.26 ± 10.72 | | |  | 0.003a |  |
| Muscle Strength (kgf\*m) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| - Hip abductor strength (operated side) | 2.62 ± 1.63 | | |  | 2.04 ± 1.36 | | |  | 0.026a |  |  | 3.49 ± 2.06 | | |  | 2.10 ± 1.63 | | |  | 0.001a |  |
| - Knee extensor strength (operated side) | 4.78 ± 3.19 | | |  | 3.99 ± 1.59 | | |  | 0.240 |  |  | 4.46 ± 2.82 | | |  | 2.55 ± 2.13 | | |  | 0.001a |  |

These data were analyzed with paired t-tests. Data for TUG, 10-m gait speeds, VAS, PCS, and muscle strength are presented as mean ± SD. a*P* < 0.05. THA: Total hip arthroplasty; TKA: Total knee arthroplasty; TUG: Timed Up and Go; VAS: Visual analog scale; PCS: Pain Catastrophizing Scale.

**Table 3 Correlation between percent changes from pre- to post-operative physical performance and other variables**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  | **THA** |  |  |  |  | **TKA** |  |
|  |  | **ΔTUG (s)** | **Δ10m gait speeds at comfortable (m/s)** | **Δ10 m gait speeds at maximum (m/s)** |  |  | **ΔTUG (s)** | **Δ10m gait speeds at comfortable (m/s)** | **Δ10 m gait speeds at maximum (m/s)** |
| ***Preoperative*** |  |  |  |  | ***Preoperative*** |  |  |  |  |
| VAS |  | *r* = 0.184 | 0.083 | -0.025 | VAS |  | *r* = 0.237 | -0.177 | -0.287 |
|  | *P =* 0.402 | 0.707 | 0.908 |  | *P =* 0.276 | 0.419 | 0.184 |
| PCS |  | *r* = 0.270 | 0.021 | -0.119 | PCS |  | *r* = -0.184 | 0.122 | 0.169 |
|  | *P =* 0.213 | 0.923 | 0.588 |  | *P =* 0.400 | 0.579 | 0.442 |
| Hip abductor strength (operated side, kg\*f) |  | *r* = 0.063 | -0.165 | -0.161 | Hip abductor strength (operated side, kg·f) |  | *r* = -0.168 | 0.142 | 0.084 |
|  | *P =* 0.774 | 0.452 | 0.464 |  | *P =* 0.444 | 0.517 | 0.703 |
| Knee extensor strength (operated side, kg\*f) |  | *r* = 0.044 | -0.235 | -0.278 | Knee extensor strength (operated side, kg·f) |  | *r* = -0.077 | 0.070 | -0.102 |
|  | *P =* 0.842 | 0.281 | 0.199 |  | *P =* 0.726 | 0.751 | 0.643 |
| ***Percent changes*** |  |  |  |  | ***Percent changes*** |  |  |  |  |
| ΔVAS |  | *r* = 0.225 | -0.093 | -0.212 | ΔVAS |  | *r* = 0.085 | -0.265 | -0.129 |
|  | *P =* 0.302 | 0.672 | 0.332 |  | *P =* 0.699 | 0.221 | 0.558 |
| ΔPCS |  | *r* = 0.117 | -0.042 | -0.047 | ΔPCS |  | *r* = **0.495** | **-0.583** | **-0.427** |
|  | *P =* 0.594 | 0.849 | 0.831 |  | *P =* **0.016**a | **0.003**a | **0.042**a |
| ΔHip abductor strength (operated side, kg\*f) |  | *r* = -0.418 | 0.642 | 0.479 | ΔHip abductor strength (operated side, kg·f) |  | *r* = -0.333 | 0.373 | 0.546 |
|  | *P =* 0.047a | 0.001a | 0.021a |  | *P =* 0.121 | 0.079 | 0.007a |
| ΔKnee extensor strength (operated side, kg\*f) |  | *r* = -0.247 | 0.434 | 0.530 | ΔKnee extensor strength (operated side, kg·f) |  | *r* = -0.389 | 0.474 | 0.656 |
|  | *P =* 0.257 | 0.038a | 0.009a |  | *P =* 0.066 | 0.022a | 0.001a |

These data were analyzed by the Pearson r rank test, with the r value as the correlation coefficient; a*P* < 0.05. THA: Total hip arthroplasty; TKA: Total knee arthroplasty; TUG: Timed Up and Go; VAS: Visual Analog Scale; PCS: Pain Catastrophizing Scale.