Real-time sonoelastography of the patellar and quadriceps tendons: pattern description in professional athletes and healthy volunteers.

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Abstract

Aims: The comparison of elastographic features of quadriceps and patellar tendons in a group of professional athletes and healthy volunteers and the description of elasticity characteristics of these tendons. Material and methods: Thirty-nine professional athletes (22 male, 17 female; mean age 18.5 years) and 35 healthy volunteers (21 male, 14 female; mean age 19 years) were included. They were divided into two groups by gender. Quadriceps tendon, patellar side of the patellar tendon, and tibial side of the patellar tendon elasticity patterns and strain ratios were investigated with real-time ultrasound elastography. The elasticity features of the dominant leg and non-dominant leg of athletes and volunteers legs were compared. In addition quadriceps and patellar tendons were compared separately for three distinct tendon locations. Results: There was no difference between the athletes and the healthy volunteers and also between the dominant leg and non-dominant leg of athletes. At tendon comparison, the quadriceps tendon was harder than the patellar tendon at both side and patellar side of patellar tendon was found to be stiffer than the tibial side of patellar tendon. Conclusions: Although biomechanical studies showed that tendon stiffness increased after long exercise, no significant difference was found between athletes' and healthy volunteers’ tendon elasticity. These three tendon locations exhibit different elasticity features and the knowledge of the elasticity feature will be useful in assessing tendon pathologies.

Keywords: Real-time sonoelastography, quadriceps tendon, patellar tendon, musculoskeletal ultrasound

Introduction

Sonoelastography is a new ultrasonographic diagnostic technique evaluating the tissue elasticity based on differences in stiffness with pathological changes versus normal adjacent tissue [1,2]. There are several types of sonoelastography available and real-time ultrasound elastography (RTE) is one of the most widely used methods. In RTE, after compression with the transducer, the tissue that depicts more deformation is softer, and vice versa, less deformation corresponds to stiff tissue.

Although it is known that pathological conditions change the elasticity of tissues, B-mod ultrasound cannot appreciate this modification and conventionally the elasticity is established just by manual palpation [2]. Instead of palpation, elastographic techniques are used for this purpose, offering qualitative and quantitative informations. RTE was used to study tissue elasticity alterations in different tissues such as thyroid, breast, lymph node, prostate, and musculoskeletal system [3-9].

Up to now, in musculoskeletal applications, RTE has been used especially for Achilles tendon imaging, the normal and abnormal Achilles tendon elasticity being studied [10-12]. RTE has been used for the assessment of patellar tendon elasticity in only one study, while no data are present in the literature concerning quadriceps elasticity.

The aim of our work was to describe patellar and quadriceps tendon RTE features in healthy volunteers and professional athletes.
Material and methods

Study population

The study was approved by the Ethical Committee at our institution and informed oral and written consent was obtained from all participants.

Quadriceps and patellar tendons of professional athletes and healthy volunteers were assessed in this study. Quadriceps and patellar tendon complaints or systemic inflammatory disorders that might have influenced our results, such as connective tissue, metabolic or endocrine diseases, or those taking steroids or estrogen medication were ruled out. During B-mod ultrasound, two patients were excluded from the study, one patient with intratendinous lipoma and one with calcification.

Thirty-nine professional athletes (22 male, 17 female; mean age 18.5 years, range 18-24 years) and 35 healthy volunteers (21 male, 14 female; mean age 19 years, range 18-23 years) were included in the study. A total of 148 leg and 444 tendon locations were assessed. The professional athletes’ mean sports time was 7 +/- 0.3 years.

Examination protocol

Before elastographic assessment, all 39 professional athlete and 35 healthy volunteer tendons were analyzed in grey scale ultrasound. Quadriceps and patellar tendons showed homogeneous and fibrillar echotexture in grey scale ultrasound for all subjects.

RTE was performed with a high frequency 6-15 MHz linear probe, and a General Electrics Logiq E9 machine was used. All tendons were examined with the patient in the supine position and knee in a 20-30° flexed position to deactivate the extensor mechanism and to avoid anisotropy due to the quadriceps tendon concave status. Bilateral quadriceps and patellar tendons were examined axially and longitudinally by a radiologist who was experienced in musculoskeletal ultrasound. RTE was performed in the longitudinal plane and the transducer was placed perpendicular to the tendon. The RTE applied transducer position was observed from the B-mod window adjacent to the elastographic color window. The compression quality factor applied to the tendon was displayed on a bar scale from 1 to 7 and only images on the bar scale from 5 to 7 showing optimal compression were evaluated. Elastography measurements were also made from these images.

Data analysis

Measurements were performed from a single location at the distal end of the quadriceps tendon, and from two locations on the patellar and Tibial side of the patellar tendon.

The elasticity pattern and strain ratio of tendons were investigated with RTE. According to the elasticity pattern, tendons were evaluated in 4 groups as blue (hardest tissue; type 1), blue-green (hard tissue; type 2), green (intermediate tissue; type 3), and yellow-red (soft tissue; type 4) (fig 1). With the strain ratio calculation, a semi-quantitative result was obtained comparing tendons with underlying fat pads: the one elliptical ROI was placed in the tendon and other in the suprapatellar fat pad (for the quadriceps tendon) and Hoffa’s fat pad (for the patellar tendon) (fig 2).
Professional athletes and healthy volunteers were divided into groups by gender, resulting in a total of four groups. For professional athletes, the commonly used extremity during sports activity was defined as the dominant side. To compare the professional athlete’s dominant side with healthy tendon volunteers, the left side was selected since there was no dominance in the normal population. After noting all the values of the three locations (quadriceps tendon, patellar side of the patellar tendon, tibial side of the patellar tendon), the professional athletes’ dominant side was compared with the non-dominant side and the professional athletes’ dominant side was compared with the healthy volunteers’ left extremity, individually for men and women, for elasticity pattern and strain ratio. All groups were combined and the three tendon location elasticity patterns and strain ratios were compared. Finally, the mean values were calculated individually for the three tendon locations for all cases.

### Statistical analysis

Data analyses were performed using SPSS (Statistical Package for Social Sciences version 18.0 Chicago, IL, USA).

Professional athletes and healthy volunteers were divided into groups as male and female, a total of four groups. Statistical analysis was performed between these groups and also all groups were combined and the three tendon locations were compared.

Wilcoxon test, Mann-Whitney U test and Friedman test were used for statistical analysis of groups. Mann-Whitney U test was used to compare the professional athletes’ dominant side with the healthy volunteers’ left side tendon and Wilcoxon test was used for the comparison of the professional athletes’ dominant side with the non-dominant side.

Table I. Mean strain ratios in tendons of professional athletes and healthy volunteers.

<table>
<thead>
<tr>
<th></th>
<th>Quadriceps tendon</th>
<th>Patellar tendon – patellar side</th>
<th>Patellar tendon – tibial side</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male athlete DL</td>
<td>1.73±0.32</td>
<td>0.51±0.21</td>
<td>0.41±0.13</td>
</tr>
<tr>
<td>Male athlete NDL</td>
<td>1.76±0.5</td>
<td>0.41±0.17</td>
<td>0.34±0.17</td>
</tr>
<tr>
<td>Female athlete DL</td>
<td>1.7±0.39</td>
<td>0.62±0.23</td>
<td>0.45±0.28</td>
</tr>
<tr>
<td>Female athlete NDL</td>
<td>1.58±0.36</td>
<td>0.59±0.25</td>
<td>0.38±0.21</td>
</tr>
<tr>
<td>Male volunteer LL</td>
<td>1.53±0.38</td>
<td>0.55±0.22</td>
<td>0.43±0.24</td>
</tr>
<tr>
<td>Female volunteer LL</td>
<td>1.47±0.33</td>
<td>0.60±0.17</td>
<td>0.42±0.18</td>
</tr>
</tbody>
</table>

DL – Dominant leg, NDL – Non-dominant leg, LL – Left leg

Table II. Elasticity pattern distribution in all cases

<table>
<thead>
<tr>
<th></th>
<th>Quadriceps tendon</th>
<th>Patellar tendon – patellar side</th>
<th>Patellar tendon – tibial side</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1</td>
<td>106 (% 71.6)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Type 2</td>
<td>41 (% 27.7)</td>
<td>40 (% 27)</td>
<td>5 (% 3.3)</td>
</tr>
<tr>
<td>Type 3</td>
<td>1 (% 0.67)</td>
<td>76 (% 51.4)</td>
<td>99 (% 60.1)</td>
</tr>
<tr>
<td>Type 4</td>
<td>-</td>
<td>32 (% 21.6)</td>
<td>54 (% 36.5)</td>
</tr>
</tbody>
</table>

After combining all groups, the Friedman test was used to determine the statistical relationship between the three tendon locations’ elasticity pattern and strain ratio values. p<0.05 was considered significant.

### Results

No statistical differences were found for both men and women for the three tendon locations when comparing the dominant leg of athletes and the left leg of the control group or the dominant leg and non-dominant leg of athletes in terms of elasticity pattern and strain ratios, for both men and women (p>0.05). Professional athlete and healthy volunteer mean strain ratios are shown in table I.

Because of the lack of a significant difference, elasticity features of the professional athlete and healthy volunteer tendons for all groups were combined and the three locations’ elasticity patterns and strain ratios were compared with each other. A significant difference was found between the quadriceps tendon and the patellar and tibial side of the patellar tendon of the same leg in terms of strain ratio (table II) and elasticity pattern (p<0.001). The quadriceps tendon was harder than the patellar tendon and the patellar side of the patellar tendon was harder than the tibial side (p<0.001). Additionally, when we assessed the relationship between the tibial side and patellar side of the patellar tendon, the patellar side was found to be stiffer both in terms of elasticity pattern and strain ratio (p<0.001).

When all cases were assessed together, the elasticity pattern of the quadriceps tendon was calculated as 71.6% type 1 and 27.7% type 2. The proximal patellar tendon was 27% type 2, 51.4% type 3, and 21.6% type 4.
the tibial side was 3.3% type 2, 60.1% type 3, and 36.5% type 4 (table II). When all cases were assessed together, strain ratios were 1.64 ± 0.39 in the quadriceps tendon, 0.55 ± 0.22 for the patellar side of the patellar tendon, and 0.40 ± 0.20 for the tibial side.

Discussions

The quadriceps and the patellar tendon are components of the knee extensor mechanism. In addition to contributing to knee function, knowledge about the biomechanical properties of the patellar tendon is important because it is commonly used as autograft material in the reconstruction of ligaments. Tendon strength and mechanical properties are affected by tendon dry mass, collagen content, and cross-linking [12-16]. Although the impact of exercise training on collagen content and cross-linking in human tendon tissue is unknown, animal data has shown increased collagen content with chronic training and biomechanical studies have revealed that tendon stiffness increases in tendons after long exercise [17,18]. This is the first study that has investigated the elasticity features of the patellar tendon in addition to the quadriceps tendon in athletes and healthy volunteers. With the definition of normal elasticity features of patellar and quadriceps tendons, we can constitute reference values and these values can give us additional information to grey scale US findings to use for the assessment of symptomatic and presymptomatic tendons.

In this study, professional athlete and healthy volunteer patellar tendon and quadriceps tendon elasticity pattern and strain ratios were put forward and differences between the two groups were explored as to whether exercise effects on tendon structure could be demonstrated with RTE. No differences were found between tendon elasticity features among professional athlete and healthy volunteer tendons or between the dominant and non-dominant knees of the healthy athletes as detected by Zhang et al [19]. When all tendons were assessed in the three distinct locations, the quadriceps tendon was harder than the patellar tendon and the patellar side of the patellar tendon was harder than the tibial side.

A tendon elasticity score was first developed for the Achilles tendon (on a 3-point scale) by De Zordo et al and afterwards different classifications were described by different researchers [10]. Ooi et al analyzed the patellar tendon as two groups – hard and soft – in their prospective study [20]. In the present study, we used four types of elasticity pattern, as detailed in Table 1. These patterns, modified from the elastography pattern described by De Zordo et al, constitute a new pattern to use for the quadriceps tendon and the patellar tendon [10]. Although biomechanical studies have shown that tendon stiffness increased in tendons such as tibialis posterior or Achilles after long exercise, in the present study no differentiation was found between tendon elasticity features between professional athletes' and healthy volunteer tendons [21]. In addition, the impact of physical activity on tendon elasticity biomechanical studies also point out that viscoelastic properties of the normal Achilles tendon varies with age and sex [22,23]. As our study, Drakonaki et al did not find any difference with age or sex [12]. On the other hand, Turan et al found that the Achilles tendon was remarkably stiffer in elderly subjects compared to young subjects in all parts of the tendon examination [24]. Despite biomechanical studies demonstrating different viscoelastic properties with physical activity, we could not quantify the difference with sonoelastography.

When all tendons were assessed at three distinct locations, the quadriceps tendon was harder than the patellar tendon and the patellar side of the patellar tendon was harder than the tibial side. In contrast to previously reported conclusions regarding tendon elasticity, the patellar tendon showed a more elastic pattern in our study. Our findings correlate with Porta et al results in which they found patellar tendon elasticity with RTE to be softer than other previously reported research on other tendons [25]. In addition, they found the patellar tendon patellar side to be green and violet and the tibial side to be mostly green, corresponding to our results showing the tibial side of the patellar tendon to be stiffer. Porta et al suggested that while a tendon connecting two bones appears highly elastic [25], in contrast to patellar tendon other tendons linking bones and muscles are stiffer. Maybe these tendons can be stiffer because of the elastic properties of the muscles they bind.

In addition to elasticity patterns, we performed a quantitative calculation (strain ratio) to evaluate tendon elasticity compared to the fat pad beneath the tendon. Tu disco et al use adjacent bone and Busilacchi et al used fat pad as the reference tissue to calculate strain ratio [26,27]. Fat pads were established as having a mosaic pattern with different colors, as described by Drakonaki et al [12]. They clarified this condition from stiffness differences in the boundaries between the fat lobules, fibrous septa, and vessels [12]. We found that the quadriceps tendon was harder than the patellar tendon and the patellar side of the patellar tendon was harder than the tibial side (p<0.001). Additionally, when we assessed the relationship between the tibial side of the patellar tendon and the patellar side of the patellar tendon, the patellar side was found to be stiffer (p<0.001).

There are some limitations in this study. First of all, the professional athletes were not performing the same sport,
with male professional athletes generally from football and females from volleyball. If we had a homogeneous athlete group comparison among athletes and healthy volunteers, this might have given us more accurate information.

Secondly, after athletes and healthy volunteers were divided into subgroups, the relatively small number of patients in each group may have led to limited statistical power.

The elastography technique, on account of the application of pressure to the probe, has general dependence on the individual operator, and therefore strain values may be affected by different degrees of manual compression. Another limitation was that interobserver and intraobserver variability were not assessed in our study. Although strain ratio calculation was a quantitative method, interobserver and intraobserver analysis assessment could enrich the elasticity pattern evaluation and show whether RTE results were dependent on the operator or not.

**Conclusion**

Sonoelastography is an appropriate technique for evaluation of quadriceps and patellar tendons. In our study, no significant difference was determined between athletes and healthy volunteers in terms of elasticity. When all tendons were assessed at three distinct locations, the results were dependent on the operator or not.

**Conflict of interest:** none

**References**