The learning process of gait retraining using real-time feedback in patients with medial knee osteoarthritis

The objective of this study was to investigate the learning process of knee osteoarthritis (KOA) patients learning to change their foot progression angle (FPA) over a six-week toe-in gait training program.

Sixteen patients with medial KOA completed a six-week toe-in gait training program with real-time biofeedback. Patients walked on an instrumented treadmill while receiving real-time feedback on their foot progression angle (FPA) with reference to a target angle. The FPA difference (difference between target and actual FPA) was analyzed during i) natural walking, ii) walking with feedback, iii) walking without feedback and iv) walking with a dual-task at the start and end of the training program. Self-reported difficulty and abnormality and time spent walking and training were also analyzed.

The FPA difference during natural walking was significantly decreased from median 6.9 to median 3.6° i.e. by 3.3° in week six (p<0.001); adding feedback reduced FPA difference to almost zero. However the dual-task condition increased the FPA difference at week one compared to the feedback condition (median difference: 1.8°, p=0.022), but after training this effect was minimized (median difference: 0.6°, p=0.167). Self-reported abnormality and difficulty decreased from median 5 to 3 and from median 6 to 3 on the NRS respectively (p<0.05).

Patients with medial KOA could reduce the FPA difference during natural walking after the gait retraining program, with some evidence of a reduction in the cognitive demand needed to achieve this. Automation of adaptions might need support from more permanent feedback using wearable technologies.

Introduction

People with medial knee osteoarthritis (KOA) often have an increased knee adduction moment (KAM), which is associated with faster progression of the disease 1. Modifying the foot progression angle (FPA) during gait can reduce the KAM 2-9. Real-time biofeedback can be used to train gait modifications 3-5, 8-10. There is evidence that patients can learn to walk with gait modifications in the short-term (i.e. within session) and that the gait modifications have beneficial short-term biomechanical effects 2-5, 8, 9. There is, however, limited evidence to show whether the modifications can truly be learnt. Similarly, the cognitive demand of walking with a modified gait pattern is unknown, although increases in cognitive demand are expected during the motor learning process 11. Cognitive loading may be measured using functional near-infrared spectroscopy 12 or electroencephalography 13. However, both techniques present problems relating to drift when measuring over a long period of time. Use of a concurrent dual-task offers a practical, alternative method of estimating the effect of cognitive demand during walking. Use of a dual-task paradigm has demonstrated the relationship between the cognitive and motor systems 14. Deterioration of gait performance during walking with a dual-task condition suggests that gait is not completely automatic 15, despite locomotion control by the central pattern generator 16. The dual-task paradigm represents the many important distractions during walking that are encountered daily, e.g. talking while walking.

In the absence of injury or illness, little conscious effort during normal walking is needed and the gait pattern is easily adapted to changes in the environment and/or terrain. Learning to modify the gait pattern is likely to interrupt the automaticity of normal locomotion and hence require increased cognitive demand. According to the Fitts and Posner three stage model of motor learning 11, we would expect that walking with a modified gait pattern would initially cause a steep increase in cognitive demand and that it would be performed with significant errors (1st stage of learning; cognitive phase). With increased practice time, we would expect increasing automaticity and reduced cognitive demand (2nd stage; associative phase) and with sufficient practice time we would expect the task to be performed with little or no cognitive demand (3rd stage; autonomous phase).

We can also consider changes in the motor-learning in terms of fast and slow learning. Fast learning is learning over a short period of time, typically learning within-session. That fast learning occurs during gait retraining has been demonstrated 4, 8, 10. Slow learning occurs with repetitive practice over several training sessions with sufficient consolidation time, and leads to gradual, progressive improvements in performance 17. Slow learning leads to changes in the representation of the learnt activity in the motor-cortex and long-term retention of the learnt skill 18.
The aim of this study was to evaluate the motor learning process during a six-week gait retraining program focused on toe-in gait in patients with medial KOA by assessing the difference in FPA between the target FPA modification and the actual FPA as the primary outcome. Specifically, we aimed to assess changes in the FPA difference as a result of a six-week gait training program during a) normal walking condition and b) a dual task condition, designed to challenge the patients. We hypothesized firstly, that the FPA difference would reduce after the training, indicating slow learning and an increase in automaticity, and secondly that introduction of a dual-task would increase the FPA differences.

**Method**

Sixteen patients with medial KOA (61.2±5.8years, 12 female), completed a six week gait retraining program (one session per week) in the Virtual Reality lab at the VUmc. Patients were recruited from a previous study in this lab 9, with inclusion criteria being medial KOA, aged between 50-75, and at minimum a 10% reduction in the first peak KAM between normal walking and modified walking conditions in our previous study. Further inclusion and exclusion criteria are given in 9. Ethical approval for this study was granted by the Medical Ethics Committee of the VU Medical Centrum, Amsterdam, Netherlands in September 2015. Patients provided written consent to participate in the study. Demographics of the included patients are presented in Table 5.1. Reflective markers positioned over the patient’s lower limbs and trunk were used to calculate the FPA and KAM in real-time 19 during walking on an instrumented treadmill. Marker position data were recorded at 100Hz, using a 10 camera Vicon motion-capture system. Ground reaction force data were recorded at 1000Hz using two ForceLink force plates embedded in the treadmill 9. Patients walked at self-selected comfortable walking speed.

Feedback on the participant’s FPA was presented on a 180° screen in front of the treadmill, in the form of two arrows. Targets for FPA were determined based on a previous study 9, with a mean (SD) target angle across the group of 3.0 (2.5) degrees in-toeing. The targets were set specifically for each patient with a mean (SD) target change of 7.3° (4.5) towards in-toeing. Targets were presented as stationary arrows, which changed colour according to the FPA difference, Figure. 5.1.

Training time increased from week 1 to week 5, while feedback time reduced after the third week, according to a faded feedback protocol 3, 4, 20, as shown in Table 5.2. This is considered to reduce reliance on feedback and improve retention of the learnt skill 21, 22. Due to additional measurements and time constraints, the total walking time in week six was reduced (unrelated to the faded feedback protocol).

### Table 5.1: Characteristics of patients completing the training program

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Mean (standard deviation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>61.1 (5.7)</td>
</tr>
<tr>
<td>Gender</td>
<td>12F 4M</td>
</tr>
<tr>
<td>Height</td>
<td>1.72 (0.08)</td>
</tr>
<tr>
<td>Weight</td>
<td>76.0 (12.2)</td>
</tr>
<tr>
<td>BMI</td>
<td>25.5 (2.9)</td>
</tr>
<tr>
<td>KL score</td>
<td>I: 10, II: 1, III: 4, IV: 1</td>
</tr>
</tbody>
</table>

**Figure 5.1:** Real-time feedback as seen by the patient while walking on the treadmill. The blue arrows represent the current position of the feet, with the larger arrows in the background representing the target angle. The difference between the actual and target angle is given by the colour of the large arrows (green is on target, orange is ≥2 degrees and ≤5 degrees either side of the target, red is > 5 degrees either side of the target). The patient aims to align their actual foot progression arrow with the target arrow of the left and right foot separately resulting in green arrows when the actual and target angles are the same.

### Table 5.2: Faded feedback protocol used during the training program

<table>
<thead>
<tr>
<th>Week</th>
<th>Training time (min)</th>
<th>Feedback time (% of total time)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 1</td>
<td>9 (3 x 3mins)</td>
<td>100</td>
</tr>
<tr>
<td>Week 2</td>
<td>12 (3 x 4mins)</td>
<td>100</td>
</tr>
<tr>
<td>Week 3</td>
<td>15 (3 x 5mins)</td>
<td>100</td>
</tr>
<tr>
<td>Week 4</td>
<td>18 (3 x 6mins)</td>
<td>75</td>
</tr>
<tr>
<td>Week 5</td>
<td>21 (3 x 7mins)</td>
<td>50</td>
</tr>
<tr>
<td>Week 6</td>
<td>12 (3 x 4mins)</td>
<td>25</td>
</tr>
</tbody>
</table>
During week one and week six we assessed the FPA difference during four conditions which were always performed in the same order: i) natural walking (no feedback), ii) walking with feedback on the FPA, iii) walking without feedback and iv) walking with a dual-task but without feedback on the FPA.

For the dual task, patients performed the Visual Stroop test whilst walking on the treadmill. Words were displayed on the screen in front of the patient at 2 second intervals. For example if the word “green” appeared on the screen in a red font the response should be “Red”. Patients were asked to maintain their modified FPA during the Stroop test, but were not told to prioritize either task.

Between sessions we asked participants to practice using the gait modification and to complete a weekly log book, to estimate a) time spent walking daily, b) time spent consciously using the modification daily (from 1 (not at all) to 4 (all of the time)), c) difficulty of walking with the modification (from 1 (no difficulty) to 10 (extreme difficulty)) and d) the abnormality of the modification (from 1 (completely normal) to 10 (completely abnormal)).

Data analysis
We post-processed the gait data using BodyMech (www.bodymech.nl), an in-house Matlab based biomechanics software used to calculate joint and segment angles. We analyzed the FPA difference of both feet during four conditions, specifically i) natural walking condition, ii) feedback condition, iii) retention condition (no feedback) and iv) dual-task condition (visual Stroop test). From each complete gait cycle, we calculated the mean FPA across the stance phase and compared it to the target FPA to compute the difference in the FPA, as shown in equation 1.

\[ \text{FPA difference} = \text{Target FPA} - \text{Actual FPA} \] (1)

Furthermore we investigated the percentage of on-target steps achieved by each patient during each trial. We defined on-target steps as those where the FPA was ≤ target angle + 2 degrees (i.e. all steps that were on-target or less than 2 degrees more externally rotated than the target).

Finally we investigated changes in the self-reported walking and training time and the self-reported difficulty and abnormality of the gait modification.

Statistical analysis
Prior to statistical analysis, all outcome measures were assessed for normality with Shapiro–Wilk and Kolmogorov-Smirnov tests. Firstly, we used Friedman’s test (non-parametric repeated measure analysis of variance) to compare the FPA differences and percentage of on-target steps between the different conditions (n=4) at the start and end of the gait training program. Post-hoc testing using the Wilcoxon signed rank test with correction for multiple tests was used to determine significant differences between the four conditions.

Secondly, we used the Wilcoxon signed rank test to assess differences in FPA difference and percentage of on-target steps between week one and week six within a specific condition.

Finally we used Friedman’s test to assess changes in self-reported walking time, training time, abnormality and difficulty of walking with the modification across the training program. All analyses were performed using SPSS software, version 22.0 (SPSS, Chicago, IL, USA) and statistical significance was set to α=0.05.

Results
Accuracy of Performance
Between week one and week six, the FPA difference reduced during all four conditions (p<0.001; Table 5.3 and Fig. 5.2).

In week one, significant differences were noted between the FPA difference during natural walking and the other three conditions (p<0.001) with lower FPA differences compared to the natural walking in all other conditions. Furthermore, the FPA difference during the dual-task condition was increased compared to the feedback (single task) condition (p=0.022). In week six, the FPA difference during natural walking was again significantly higher than in the other conditions (p<0.01), but no significant differences existed between the dual-task condition and the feedback condition (p=0.167) or the dual-task condition and the retention condition (p=1.000).

Consistency of performance
On a group level, consistency of performance improved between week one and week six with an increased percentage of on-target steps in all conditions in week 6 (Table 5.3). Consistency improved with feedback compared to the natural walking condition (p<0.001) and remained higher during the retention and dual-task conditions. Significant differences were evidence between the feedback and dual-task conditions in both week one and week six (p=0.012 and p=0.040 respectively). High between-subject variability was observed in the trials, evidenced by high IQRs (Table 5.3).
### Table 5.3: Error in foot progression angle and percentage of on-target steps (median, IQR) across four conditions and two time points.

<table>
<thead>
<tr>
<th></th>
<th>Natural walking (NW)</th>
<th>Feedback (FB)</th>
<th>Retention (R)</th>
<th>Dual Task (DT)</th>
<th>p value (across time)</th>
<th>p value (across conditions)</th>
<th>p value (post-hoc pairwise testing between week one and week six)</th>
<th>p value (post-hoc pairwise testing between conditions in week six)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Week 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difference in foot progression angle (°)</td>
<td>6.9 (4.7)</td>
<td>3.6 (2.7)*</td>
<td>0.7 (2.5)*</td>
<td>0.1 (2.1)*</td>
<td>&lt;0.001</td>
<td>NW, p&lt;0.001</td>
<td>NW &gt; FB, p&lt;0.001</td>
<td>NW &gt; FB, p&lt;0.001</td>
</tr>
<tr>
<td>% of on-target steps</td>
<td>0.0 (7.9)</td>
<td>14.7 (41.6)</td>
<td>68.5 (44.7)</td>
<td>90.8 (32.0)*</td>
<td>&lt;0.001</td>
<td>NW, p&lt;0.001</td>
<td>NW &gt; FB, p&lt;0.001</td>
<td>NW &gt; FB, p&lt;0.001</td>
</tr>
<tr>
<td><strong>Week 6</strong></td>
<td>3.6 (2.7)*</td>
<td>0.7 (2.5)*</td>
<td>0.1 (2.1)*</td>
<td>0.7 (3.5)*</td>
<td>&lt;0.001</td>
<td>NW &gt; R, p&lt;0.001</td>
<td>DT &gt; FB, p=0.022</td>
<td>DT &gt; FB, p=0.022</td>
</tr>
<tr>
<td></td>
<td>62.2 (26.6)</td>
<td>80.9 (41.6)*</td>
<td>66.6 (88.7)</td>
<td>77.8 (33.7)</td>
<td>&lt;0.001</td>
<td>NW &gt; DT, p&lt;0.001</td>
<td>DT = FB, p=1.000</td>
<td>DT = FB, p=1.000</td>
</tr>
</tbody>
</table>

With Bonferroni correction for multiple testing N.B. Positive FPA error represents a FPA that was more externally rotated than the target.

* significant difference between week one and week six at α=0.05

Significant differences between conditions (post-hoc testing) at α=0.05 shown in bold.

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**Figure 5.2:** Foot progression angle (FPA) difference in week 1 (start of training) and week 6 (end of training) between the natural walking condition and the feedback condition.

**Figure 5.3:** Self-reported time spent walking daily (a), time spent training time (time spent walking with the modification) (b), self-reported difficulty on a scale of 1-10 where 1 represents no difficulty and 10 represents extreme difficulty (c) and self-reported abnormality on a scale of 1 to 10 where 1 represents completely normal and 10 completely abnormal (d) of walking with the gait modification. The time spent walking with the modification was assessed on a four point scale, where 1 represents completely normal and 10 completely abnormal (d) of walking with the gait modification.
Self-reported daily walking time did not change significantly during the training program, p=0.261 (Fig. 5.3a). Of the total time spent walking, the self-reported training time, defined as the time spent walking with the modification, increased between week one and week five (from 3 to 4 on the NRS, p=0.023) and week one and week 6 (from 3 to 4 on the NRS, p=0.005) (Fig. 5.3b).

Difficulty of walking with the modification decreased during the training program (p<0.001), with statistically significant changes noted between week one (median 5) and six (median 3, p=0.002) and week two (median 5) and six (median 3, p=0.014), as shown in Fig. 5.3c. The abnormality of walking decreased significantly during the training program with statistically significant reductions between week one (median 6) and six (median 3, p<0.001), week two (median 6) and six (median 3, p=0.002) and week one (median 6) and five (median 3.5, p=0.006), Fig. 5.3d.

Discussion

In this study we explored the learning process during toe-in gait retraining of patients with medial knee OA over a six-week gait training program. We analyzed firstly, accuracy of performance, expressed by the FPA difference and secondly, consistency of performance, expressed by the percentage of on-target steps, under four conditions (natural walking, feedback, retention and dual-task conditions). Both accuracy and consistency of performance improved over the training period with large reductions in the FPA difference and an increased percentage of on-target steps observed in all conditions. This suggests that medial KOA patients not only are able adapt their gait pattern within-session, but also to learn and adopt the gait modifications over several sessions. Despite these improvements, during natural walking in week six, the FPA difference and the percentage of steps on-target indicated that, for some patients, it was still difficult to achieve the target gait modification while for others it was more autonomous, as evidenced by a median FPA difference of 3.6° (IQR 3.7°) and median 14.7% on-target steps with a high IQR, 45.4%.

Previous studies investigating gait modifications in KOA have focused on reporting changes in KAM under standardized laboratory conditions 2, 3, 5, 6, 24, 25 and most trained the gait modifications within a single session (and single-task conditions) only. These studies provide evidence of fast-learning but not of slow-learning, required for longer-term retention of the learnt gait pattern. Studies over longer training periods (several weeks) have shown mixed results regarding retention of the learnt gait pattern. Barrios, et al. (2010)20 trained eight healthy subjects with varus malalignment to walk with reduced knee varus but reported no change post-training. This is in contrast to the changes in FPA in our results and suggests that slow learning did not occur in the participants in 21. Hunt and Takacs (2014)4 reported that during a ten-week toe-out gait intervention, patients walked with an average FPA difference of 2.6° during training sessions. Post-training the average change in self-selected FPA was 6.7°. Patients were encouraged to change their FPA by 10 degrees, but individual data shows that only 5/15 patients achieved this target 4. These results together suggest that, while within-session fast learning means that short-term modifications in the gait pattern appear to be easily achievable 2, 6, 10, it is more difficult to maintain the modifications over a longer period. This suggests limited slow-learning.

The patient’s own perception of difficulty and abnormality of using the modifications may influence the ability to learn the modifications. Our results show decreases in self-perceived abnormality and difficulty over the training program, similar to 4 and 20. Reduced difficulty may facilitate the motor learning process and allow the gait modification to be performed more automatically. According to the Fitts and Posner model of motor learning 11 the cognitive demand of a given motor task decreases with time/practice as the skill becomes more automatic. This reduction in cognitive loading and difficulty could be important for transferring the learnt skill from the laboratory to the real-world environment.

In this study, between-session changes in the FPA were generally lower than the between-condition changes. This can be explained by considering that fast learning is generally associated with large improvements compared to smaller, incremental improvements during slow learning. For sustainable and long-term effects, slow learning, involving mechanisms of neuronal organization, is likely required 12.

Considering the three stages of learning proposed by Fitts and Posner (1967)11, we suggest that post-training, patients were in the 2nd stage, the associative stage where the task was performed with improved consistency and less cognitive demand, but was not completely automatic. Reaching the 3rd stage of learning (autonomous stage) of the gait pattern seems necessary in order for the gait modifications to be clinically useful. To achieve this, practice hours should increase, for which small and wearable sensors that can be used for training in the home environment may be needed. Recent developments in this field include devices to discretely measure the FPA 26 or to estimate the KAM 27-30. Furthermore, real-time feedback to the patient via a simple and discrete device may facilitate faster motor learning.

In this study, we used a dual-task paradigm to investigate the additional cognitive demand of walking with toe-in gait in people with medial KOA. Previous research in healthy controls showed that self-perceived cognitive demand increases significantly when using gait modification 13. As expected, we observed a deterioration in the accuracy of performance in the gait task (increased FPA difference) during the dual task,
particularly in week one. This effect is similar to the deterioration of gait performance with a dual-task observed in older adults during target stepping tasks. Dual-task walking is associated with increased activation in the pre-frontal and pre-motor cortex, with strong correlations between the increased cerebral activity and the gait deficits. Furthermore, dual-task performance is influenced by pain, with improvements in performance observed with a reduction in knee pain. In our study, however, the self-reported baseline pain levels were low (median 2, IQR: 3 on a 10-point scale), hence we expect that pain did not influence dual-task performance.

After six weeks gait training, the effect of the dual-task (in comparison with the single-task, feedback condition) was diminished, indicating reduced interference of the dual-task and reduced cognitive loading. This can be explained by considering that as the motor task becomes more autonomous with increased practice time, the cognitive demand reduces; hence the dual-task (Stroop test) can be performed without interruption to the motor task. This effect is also known from psychological experiments, where practicing the requested task minimized the interference effect during a dual-task condition.

We must address certain limitations in this study. Firstly, the motivation of a KOA patient for future studies to use discreet wearable sensors, as in , to enable FPA measurements is spent walking and training. Given this, speculation on the effect of home training time on the patient's performance observed with a reduction in knee pain. In our study, however, the self-reported baseline pain levels were low (median 2, IQR: 3 on a 10-point scale), hence we expect that pain did not influence dual-task performance.

In conclusion, KOA patients reduced the FPA difference and increased the on-target demand and evidence of slow learning. Despite this, the modified gait pattern was not fully autonomous after the training program. Future studies should consider home training with wearable technology to encourage full autonomy of the modified gait pattern.

References


