Land-Based Exercise and Its Effect on Quality of Life Outcomes in Patients with Knee Osteoarthritis: A Systematic Review

Cody R. Buckner  
*University of Nevada, Las Vegas*

Lindsay C. Martin  
*University of Nevada, Las Vegas*

Michael L. Soukup  
*University of Nevada, Las Vegas*

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LAND-BASED EXERCISE AND ITS EFFECT ON QUALITY OF LIFE OUTCOMES IN PATIENTS WITH KNEE OSTEOARTHRITIS: A SYSTEMATIC REVIEW

By

Cody R. Buckner
Lindsay C. Martin
Michael L. Soukup

A doctoral project submitted in partial fulfillment of the requirements for the

Doctor of Physical Therapy

Department of Physical Therapy
School of Allied Health Sciences
The Graduate College

University of Nevada, Las Vegas

May 2013
THE GRADUATE COLLEGE

We recommend the doctoral project prepared under our supervision by

Cody R. Buckner
Lindsay C. Martin
Michael L. Soukup

Entitled

Land-Based Exercise and Its Effect on Quality of Life Outcomes in Patients with Knee Osteoarthritis: A Systematic Review

be accepted in partial fulfillment of the requirements for the degree of

Doctor of Physical Therapy
Department of Physical Therapy

Robbin Hickman, D.Sc., Research Project Coordinator

Merrill Landers , Ph.D., Research Project Advisor

Merrill Landers, Ph.D., Chair, Department of Physical Therapy

Thomas Piechota, Ph.D., Interim Vice President for Research &
Dean of the Graduate College

May 2013
Abstract

Background: The purpose of this systematic review was to examine effectiveness of land-based exercise interventions for improving quality of life (QOL) of individuals with symptomatic knee osteoarthritis.

Methods: A systematic search included PubMed, CINAHL, Scopus, Academic Search Premier, and the Cochrane Database of Systematic Reviews. Inclusion criteria included land-based exercise interventions aimed to improve lower extremity strength and QOL, published since 2000. Exclusion criteria included OA of joints other than the knee, and aquatic-based and surgical interventions. Studies were evaluated using a modified version of the American Academy of Cerebral Palsy and Developmental Medicine (AACPDM) methodology score.

Results: Level of evidence for 11 studies ranged from I strong (I-S) to IV. There were 1200 total participants 57.5 to 69.8 years of age with a mean of 64.5. Three common treatment groups were used; exercise, yoga, and education. Twenty outcome measures were used with the Western Ontario and McMaster Universities Arthritis Index (WOMAC), Short Form 36 (SF-36) and strength being most common.

Discussion: Inconsistencies in reporting outcome measures and their subgroups, data, and statistical analyses prevented further data analysis to compare individual intervention effectiveness. However, many articles reported significant improvements in varying QOL subgroups and strength measurements.

Conclusions: This review suggests treatment approaches involving physical activity will be beneficial across all levels of the International Classification of Functioning Disability and Health (ICF), including QOL.
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INTRODUCTION

Osteoarthritis (OA) is the most common type of joint disease.\(^1\) It is characterized by the breakdown of articular cartilage and subchondral bone within any joint.\(^1\) This dynamic pathological process involves all of the tissues within the synovial joint and leads to pain, stiffness, dysfunction, and disability.\(^2,3\) Radiographic images of OA reveal joint space narrowing, sclerotic bone changes, development of osteophytes, and subchondral cyst formation.\(^1\) OA is very prevalent within the geriatric community, and has been recognized as the third leading cause of life years lost to disability.\(^4\) Although OA can affect any joint, the most commonly affected large joint is the knee.\(^5\) Knee OA is the most prevalent chronic disease, and is one of the leading causes of disability in older adults.\(^3\)

Current estimates predict 40 to 80% of individuals with degenerative radiographic changes in their joints will have symptomatic knee OA.\(^1\) Research currently shows 40% of people aged 65 years or older are experiencing symptoms of knee OA.\(^3,4\) Rates and prevalence of OA are on the rise with the National Institutes of Health reporting the clinical prevalence of OA has grown from 21 million in 1995 to over 27 million in 2005.\(^3\) In 2005, an estimated 9,267,000 people were managing symptomatic knee OA (pain, stiffness, dysfunctions, and disability).\(^3\) This increase in incidence is being linked to the growing obesity epidemic and the rise in life expectancy.\(^6\) There is evidence to support the link between obesity and the increase in knee OA, however the major
independent risk factor for knee OA is age.\textsuperscript{5,7} Incidence rates are expected to rise further as the baby boomer population continues to age.\textsuperscript{8}

Presently there is no known cure for knee OA. The progressive nature of the disease and the pain and disability associated with knee OA greatly impacts an individual’s ability to complete activities of daily living, thus decreasing function, mobility, and quality of life (QOL).\textsuperscript{9} A large community-based survey discovered that knee OA accounts for the highest level of disability in walking, stair climbing, and general disability.\textsuperscript{1,8} Exercise, specifically exercise focused on increasing the strength of the quadriceps femoris muscle (QFM), has been shown to decrease this pain and dysfunction. Although people diagnosed with knee OA may initially avoid exercise due to pain, discomfort, or the belief that exercise will worsen their symptoms, there is substantial evidence to support the benefits of exercise in improving the symptoms of OA.\textsuperscript{1,2,4,8,10} In fact, the American College of Rheumatology has recommended a strength training exercise program as a form of treatment for knee OA on their website and in their literature.\textsuperscript{10}

<<Insert Figure 1>>

Traditionally, most researchers have focused on improving impairments of body structure and function when designing studies of individuals with knee OA, and those improvements in impairments are assumed to have an impact on an individual’s participation level and overall well-being. For example, it is often assumed that a change in the body structure and function category of the World Health Organization’s
International Classification of Functioning, Disability and Health (ICF) model, e.g. strengthening of weakened muscles, will have an impact on the participation level of the ICF, e.g. QOL (Figure 1). However, the focus was instead on determining whether functional interventions (activity level of ICF) have an impact on an individual’s QOL (participation level of ICF). In other words, this review will examine land-based exercise intervention and their effects on QOL in individuals with knee OA. The review looks more closely at the impact of functional activities on participation. For example, will a change in activity (e.g. improved ability to climb stairs) have an impact on participation (QOL)? And if so, what impact does it have? This review will highlight the effect of the activity (exercise) level of the ICF on the participation (QOL) level for individuals with knee OA.

Exercise has demonstrated many effects on QOL including improved psychological well-being, increased strength of muscles required for daily activities, and improving or maintaining cartilage integrity, all of which can greatly improve QOL. There is much debate, however, about which type of exercise will improve QOL the most for patients who are living with knee OA. Therefore, the purpose of this systematic review was to evaluate existing literature to determine which land-based intervention in the literature provides the greatest improvement in QOL for patients with knee OA. It has been shown that strengthening the QFM in people with knee OA decreases pain, and it is important to understand whether the interventions that decrease pain and improve strength also bring about significant improvements in QOL.
METHODS

Population

The target population of this review included adults who had been diagnosed with, or had reported symptoms of knee OA, including joint pain, stiffness, dysfunction and disability. Individuals were included if they had been involved in a conservative land-based exercise intervention for the treatment and management of symptoms of knee OA. Individuals were excluded if they had sought surgical intervention for symptoms, if they were involved with any aquatic therapy intervention, or if they had reported OA of other joints, including, but not limited to, hip or ankle OA.

Intervention

There are many methods of decreasing the pain and disability of knee OA, including surgical intervention, total knee arthroplasty, exercise, physical therapy, yoga, aquatic therapy and many more. Interventions of interest for this review, however, included any land-based physical therapy exercise intervention designed to strengthen the QFM group. Land-based physical therapy exercise interventions were of particular interest as they allow participants to continue managing knee OA symptoms individually in their homes after the completion of the studies. Therefore, studies involving aquatic interventions were excluded from this review. Studies must have also included some obvious measure of strength gain during the intervention, as well as a reported QOL measure. Interventions not including a control group were accepted secondary to the lack of studies meeting QOL search criteria.
Search Strategy

The American Academy of Cerebral Palsy and Developmental Medicine (AACPDM) methodology was used to establish a valid and reliable manner of searching the literature. By following the steps provided by the methodology, the study population and interventions of interest were defined as described above.

Systematic searches and article assessment were performed independently by three individuals then collectively assessed. Databases were limited to those containing primary sources relevant to the field of physical therapy. Of greatest interest were those databases including exercise interventions relating to the purpose of the study, namely which interventions are best suited to increase QFM strength and QOL (Figure 2).

Once these databases were identified, a series of systematic search terms were applied to find relevant articles. The Boolean search terms “knee osteoarthritis AND quadriceps strength AND quality of life” were used universally throughout the databases. Next, a system of terms (described in Figure 3) was applied to narrow the results to less than 100 articles per database.

Articles were compiled after an exhaustive search by each individual and included all articles from each individual. Duplicated articles were excluded, and remaining articles were independently reviewed. The results of the initial search procedure left uncertainty with regard to the actual relevance of some articles.
Therefore, it was necessary to use manual exclusion criteria to eliminate irrelevant articles (Figure 4).

<<Insert Figure 4>>

After an article met the inclusion criteria, it was further evaluated for its relevance to physical therapy treatment, QFM strengthening, and QOL outcome measures. Finally, if an article included and reported on these topics it met the inclusion criteria and was retained for further review. Assessors collectively compared and discussed their assessment of each article until a consensus was reached.

Overall, five databases were found to have met the requirements for inclusion in the review: PubMed, CINAHL, Scopus, Academic Search Premier, and the Cochrane Database of Systematic Reviews. In total, 115 articles met the inclusion criteria. After exclusion criteria were evaluated and duplicate articles were removed, there were eleven articles remaining for further analysis.
RESULTS

Table 1 is an illustration of the extracted evidence from each individual source, describing level of evidence, target population, intervention, and outcome measurements used in each study.

<<Insert Table 1>>

Level of evidence

Articles reviewed were assessed for quality of evidence via methods presented in the AACPDM\textsuperscript{12} guidelines for developing a systematic review. The evidence presented in the articles ranged from a strong Level I study (I-S) to a Level IV study. Six of the studies were rated as a Level I study with four of those being rated as strong \textsuperscript{13-16}, one as medium \textsuperscript{17}, and one as weak.\textsuperscript{2} Four studies were rated Level II medium,\textsuperscript{10,18-20} and one was determined to be a Level IV study.\textsuperscript{21}

Target population

The target population age of the studies ranged from 57.5 to 69.8 years. The combined mean age was 64.5 (SD +/- 4.79) years of age. Combined, there were 1200 subjects analyzed and assessed between the studies with 332 subjects being male and 868 subjects female. Inclusion and exclusion criteria differed between studies. Five studies required either radiographic evidence or clinical symptoms, but also accepted both for inclusion in the study.\textsuperscript{13,14,16,18,19} Two studies included participants based upon radiographic evidence of knee OA alone,\textsuperscript{2,15} one article required only clinical evidence of OA,\textsuperscript{20} and one article required both radiographic and clinical diagnosis for inclusion.\textsuperscript{10}
Two articles were not specific about requirements for inclusion with Mikesky et al\textsuperscript{17} using participants from a previous knee OA study and Bukowski et al\textsuperscript{21} not reporting requirements for inclusion.

**Intervention and Comparison Groups**

Of the studies evaluated, there were three distinct types of interventions tested across the 11 studies reviewed. Eight articles utilized a form of lower extremity (LE) progressive resistive exercises,\textsuperscript{2,10,14,15,17-19,21} two articles investigated education specific to knee OA\textsuperscript{13,16}, and two articles investigated Iyengar yoga as their intervention\textsuperscript{20,21}.

Six of the studies utilized some form of comparison group in testing the interventions, with a wide variety of interventions used for controls. Comparison interventions included general arthritis education,\textsuperscript{13} exercise without biofeedback,\textsuperscript{19} ROM/flexibility,\textsuperscript{17} sham ultrasound,\textsuperscript{14} no intervention,\textsuperscript{2,15,21} and nutrition education.\textsuperscript{10} Bukowski et al\textsuperscript{21} utilized two treatment groups (yoga and progressive resistive exercise) compared to a control who received no intervention. Three articles utilized a repeated measures design in which subjects served as their own controls.\textsuperscript{16,18,20}

The length of intervention differed among groups with the shortest being three weeks,\textsuperscript{19} and the longest being 12 months.\textsuperscript{17} Four studies performed the intervention over six weeks,\textsuperscript{13,15,16,21} three over 8 weeks,\textsuperscript{2,18,20} and one each of 12 weeks\textsuperscript{14} and 16 weeks.\textsuperscript{10}

**Outcome measures**
There were a total of 20 different outcome measures used within the studies reviewed. Commonly used QOL outcome measures included the Western Ontario and McMaster Universities Arthritis Index (WOMAC) in 8 articles,\textsuperscript{10,13-15,17,19-21} Short Form-36 (SF-36) in three articles,\textsuperscript{10,13,14} Knee Injury and Osteoarthritis Outcome Score (KOOS) in one article,\textsuperscript{18} and Arthritis Impact Measurement Scales (AIMS) in one article.\textsuperscript{2} Of the articles reporting similar outcome measures, there was no consistency in the reporting of subcategories; and comparisons were made at varying time intervals, sometimes within groups and sometimes between groups, regardless of study design.

Of the articles reporting LE strength, there were four different units of measurement utilized, and one article did not report any unit of measurement.\textsuperscript{20} Many different devices were used to assess strength, with the most popular being various types of dynamometers. Six articles reported strength in Kilograms (Kg),\textsuperscript{2,10,13,15,18,21} three articles reported strength in Newton meters (Nm),\textsuperscript{17-19} one in Newtons (N),\textsuperscript{16} and one in Newtons per Kg body weight (N/Kg).\textsuperscript{14}

**Summary of Findings**

There were many inconsistencies in reporting data related to strength and QOL outcome measures. Studies using similar outcome measures did not report the same subcategories of each outcome measure. Six articles did not report p-values for each outcome used and reported, with most of the unreported p-values regarding data with no statistical significance.\textsuperscript{13-15,17,20,21} Statistical significance of interventions was unable to be determined in 3 articles due to a lack of information, data, or p-values.\textsuperscript{2,14,21}
Kuptniratsaikul et al\textsuperscript{2} reported data with significant results within each group, but did not report information regarding a comparison between the experimental and control groups. Yilmaz et al\textsuperscript{19} reported a statistical significance with regard to pre and post measurements of each group, but reported there was no significant difference between the experimental and control groups. Three articles reported a significant improvement in some aspect of QOL, but no improvement of LE strength.\textsuperscript{17,18,20} One article reported only an improvement in strength,\textsuperscript{15} two had improvements in both strength and QOL,\textsuperscript{10,16} and two studies reported no statistically significant improvement in either QOL or LE strength.\textsuperscript{13,19} Two articles reported there were significant improvements between or within groups during the intervention, but these improvements were not maintained once subjects discontinued treatment.\textsuperscript{13,17} It is important to note no articles demonstrated worsening of symptoms across any ICF level.

These findings can be summarized in figures 5-11.

<<Insert Figures 5-11>>
DISCUSSION

This systematic review investigated the effects of land-based exercise intervention for improving QOL for people diagnosed with knee OA. Based upon the evidence gathered, physical activity and mobility had a positive impact on the QOL of patients experiencing symptoms of knee OA. Most studies reviewed demonstrated some improvement in regard to QOL or strength during the interventions. 10,13,15-18,20,21 This indicates that an approach involving exercise would be an appropriate intervention for people with knee pain related to OA. However, it is difficult to determine which exercise program is most effective in improving strength and QOL.

The difficulty in establishing a conclusive exercise intervention for treating symptomatic knee OA is due to the heterogeneity of the measurements used in the studies analyzed. Although several studies reported gains in strength and QOL, there is not enough consistency in data collection and reporting to draw a solid conclusion about which, if any, approach is most successful in improving QOL. 10,13,15-18,20,21 Because of this observed lack of uniformity in results and data, including differences in units and outcome measures used, meta-analysis of the data was not possible.

Based on the assessment of the data, it appears interventions focused on the activity level of the ICF (e.g. yoga, progressive resistive exercise) may have a positive impact on the participation level (e.g. QOL) for people with knee OA. This effectively demonstrates that task-specific interventions (activity, e.g. stair climbing) are important to improving well-being and can be used as intervention techniques, either alongside of
strengthening interventions (body structure and function level of the ICF) or independently, to positively impact the QOL (participation) of people experiencing symptoms of knee OA. This finding corroborates the findings of other studies stating that immobility decreases the health of cartilage and may contribute to increased symptoms of osteoarthritis, and therefore, be detrimental to a person’s QOL.\textsuperscript{22,23}

In order for future studies to be combined and analyzed, more effort will be necessary to determine consistent methods and units of measurement. This can be achieved by developing an APTA-managed database in which outcome measures for specific tests and measures are established and must be used in research. By doing this, it would allow for more uniformity in research and enable data to be compared for higher quality research, including meta-analyses.

As a final note, none of the studies involved in this systematic review addressed the topic of continuing an exercise program at home after the completion of the study. Self-management of pain and dysfunction is an important aspect to the rehabilitation process as it allows patients to control symptoms after medical assistance has ended, and thus, save money and time. Future research should examine the feasibility of an exercise program to be performed at home, in order to allow participants to maintain gains or further improve their strength, health and QOL.
Figure 1. ICF Model adapted for knee OA

Health Condition
Knee OA

Body Structure and Function
E.g. QFM weakness

Activity
E.g. Stair Climbing

Participation
E.g. QOL

Environmental Factors
E.g. Occupation

Personal Factors
E.g. Obesity
Figure 2. Algorithm for including/excluding databases for terms search
Figure 3. System of terms used to reduce results to less than 100 per database

Knee osteoarthritis
AND quadriceps strength
AND quality of life

How many articles returned?

<100
Proceed to manual exclusion criteria

>100
Add: NOT arthroplasty
Add: Limit publications to 2000 – present
Add: English publications only
Add: Human subjects only
Add: NOT prescription drugs
Add: Journal articles only
Figure 4. Inclusion/exclusion criteria for final review

Manual Exclusion Criteria

Does the article...

Discuss physical therapy treatment?

Yes

Discuss Quad Strength?

Yes

Address QOL outcomes?

Yes

Include

No

No

Exclude

No

Exclude
### Table 1. Data from selected studies

<table>
<thead>
<tr>
<th>Source</th>
<th>Level of Evidence</th>
<th>Target Population</th>
<th>Intervention (Freq, Duration, Intensity)</th>
<th>Outcome Measure</th>
<th>Significant Findings</th>
<th>Comparison Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coleman S. et al (2012)*</td>
<td>I-S</td>
<td>Mean age = 65 yrs</td>
<td>Knee OA specific self-management education program vs. general arthritis education 6 weeks, 1x/wk 2.5hrs/session</td>
<td>WOMAC</td>
<td>No (p=.057)</td>
<td>RCT</td>
</tr>
<tr>
<td></td>
<td></td>
<td>37 Male 109 Female</td>
<td></td>
<td>SF-36</td>
<td>No, Pain (p=.384)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Mecmesin Force Gauge Dynamometer</td>
<td>No, Function (p=.122)</td>
<td></td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>McQuade KJ (2011)</td>
<td>II-M</td>
<td>Mean age = 55.8 yrs</td>
<td>Progressive resisted exercises for knee flexors and extensors 3x/wk, 8 wks</td>
<td>KOOS</td>
<td>Yes, Pain (p=.008)</td>
<td>Repeated measures</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 Male 16 Female</td>
<td></td>
<td>Knee flex/ext</td>
<td>Yes, ADL (p=.02)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes, QOL (p=.01)</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No, (p=.65)</td>
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<tr>
<td>Yilmaz OO. et al (2010)***</td>
<td>II-M</td>
<td>Mean age = 57.5 yrs</td>
<td>Exercise with or without biofeedback Supervised group 3x/wk, 3wks, 2x @home on supervised days 3x @home on unsupervised days</td>
<td>WOMAC</td>
<td>No, Pain (p=.67)</td>
<td>RCT</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 Male 35 Female</td>
<td></td>
<td>Isokinetic dynamometry with cybex</td>
<td>No, Function (p=.94)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No (p=.26)</td>
<td></td>
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<td>Source</td>
<td>Level of Evidence</td>
<td>Target Population</td>
<td>Intervention (Freq, Duration, Intensity)</td>
<td>Outcome Measure</td>
<td>Significant Findings</td>
<td>Comparison Group</td>
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<tr>
<td>Bukowski EL, et al (2006)</td>
<td>IV</td>
<td>Mean age = 63.8 yrs 2 Male 13 Female</td>
<td>Iyengar Yoga vs. progressive resisted exercise vs. non-exercise</td>
<td>WOMAC</td>
<td>3-93%** 2-210%**</td>
<td>RCT</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2x/wk for 6wks</td>
<td>Quadriceps strength</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mikesky AE, et al (2006)*</td>
<td>I-M</td>
<td>Mean age = 69 yrs 93 Male 128 Female</td>
<td>Progressive LE exercise vs. ROM and flexibility with same schedule</td>
<td>WOMAC</td>
<td>No, Pain**</td>
<td>RCT</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2x/wk at facility 1x @home for 3months 1x at facility and 2x@home for 3months Every other week for 3 months with all others at home 1x/month for 3 months all others at home 6 month follow up to 30 month mark</td>
<td>SF-36 Kincom 3 dynomometer</td>
<td>Yes, Function (p=.014) No, Function (p=.254) No (p=.09)</td>
<td></td>
</tr>
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<td></td>
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<tr>
<td>Source</td>
<td>Level of Evidence</td>
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<tr>
<td>Bennell KL, et al (2005)</td>
<td>I-S</td>
<td>Mean age = 68.6 yrs 46 Male 94 Female</td>
<td>Knee tapping, soft tissue massage, t-spine manipulation, and graded exercise vs. sham ultrasound 12wks with 12wk follow-up 1x/wk, 4wks every other week for 8wks</td>
<td>WOMAC</td>
<td>Unable to determine**</td>
<td>RCT</td>
</tr>
<tr>
<td>Kolasinski SL, et al (2005)</td>
<td>II-M</td>
<td>Mean age = 58.6 yrs 0 Male 7 Female</td>
<td>Iyengar Yoga 1x/wk for 8wks 1-1.5hr session</td>
<td>WOMAC</td>
<td>Yes, Pain(p=.04) Yes, Function (p=.04) No**</td>
<td>Repeated measures</td>
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<tr>
<td>Foley A, et al (2003)</td>
<td>I-S</td>
<td>Mean age = 69.8 yrs 30 Male 37 Female</td>
<td>Progressive resistive exercise vs. telecommunication with control group 3x/wk for 6wks 30min/session</td>
<td>WOMAC</td>
<td>No** Yes, (p&lt;.001)</td>
<td>RCT</td>
</tr>
<tr>
<td>Kuptniratsaikul V, et al (2002)****</td>
<td>I-W</td>
<td>Mean age = 67.7 yrs 86 Male 306 Female</td>
<td>Resisted exercise for quad vs. control group 2x/wk for 8wks 1hr session</td>
<td>Functional incapacity Dynamometer</td>
<td>Undetermined</td>
<td>RCT</td>
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<tr>
<td>Source</td>
<td>Level of Evidence</td>
<td>Target Population</td>
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<td>----------------------------------------------------------------------------------------------------------</td>
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<td>-------------------------------------------------------------------------------------</td>
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<tr>
<td>Baker KR (2001)</td>
<td>II-M</td>
<td>Mean age = 68.5 yrs 10 Male 36 Female</td>
<td>4 month home-based progressive resistance strength training vs. nutrition education 2 sets of 12 reps for 3x/wk for 16wks</td>
<td>WOMAC</td>
<td>Yes, pain (p=.013) No, Function (p=.07) No, Pain (p=.06) Yes, Function (p=.01) Yes (p=.002)</td>
<td>RCT</td>
</tr>
<tr>
<td>Hopman-Rock M (2000)</td>
<td>I-S</td>
<td>Mean age = 65.3 yrs 18 Male 87 Female</td>
<td>1hr education 1hr progressive resisted exercise 1xwk/6wks 2hrs/session</td>
<td>QOL VAS</td>
<td>Yes (p=.039) Yes (p=.028)</td>
<td>Repeated measures</td>
</tr>
</tbody>
</table>

*Significance found during study but did not hold over time
**p-values were not listed for this measure
*** Significance found pre-vs. post treatment but not between groups
****Study reported within-group p-values but not between group values
Figure 5. Summary of significant findings in WOMAC function

<table>
<thead>
<tr>
<th>WOMAC, Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hopman-Rock M (2000) PRE</td>
</tr>
<tr>
<td>McQuade KJ (2011) PRE</td>
</tr>
<tr>
<td>Not Significant Improvement</td>
</tr>
<tr>
<td>Data Not Reported</td>
</tr>
<tr>
<td>Significant Improvement</td>
</tr>
</tbody>
</table>


Not Significant Improvement

Data Not Reported

Significant Improvement
Figure 6. Summary of significant findings in WOMAC pain

<table>
<thead>
<tr>
<th>Not Significant Improvement</th>
<th>Data Not Reported</th>
<th>Significant Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>McQuade KJ (2011) PRE</td>
</tr>
</tbody>
</table>
**Figure 7.** Summary of significant findings in SF-36 function

<table>
<thead>
<tr>
<th>SF-36, Function</th>
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</thead>
<tbody>
<tr>
<td>Hopman-Rock M (2000) PRE</td>
</tr>
<tr>
<td>McQuade KJ (2011) PRE</td>
</tr>
<tr>
<td>Not Significant Improvement</td>
</tr>
<tr>
<td>Data Not Reported</td>
</tr>
<tr>
<td>Significant Improvement</td>
</tr>
</tbody>
</table>

Figure 8. Summary of significant findings in SF-36 pain

SF-36, Pain

<table>
<thead>
<tr>
<th>Not Significant Improvement</th>
<th>Data Not Reported</th>
<th>Significant Improvement</th>
</tr>
</thead>
</table>

Data Not Reported: McQuade KJ (2011) PRE

Figure 9. Summary of significant findings of other measures of function

Other Measures, Function

- McQuade KJ (2011) PRE

Not Significant Improvement | Data Not Reported | Significant Improvement
**Figure 10.** Summary of significant findings of other measures of pain

<table>
<thead>
<tr>
<th>Not Significant Improvement</th>
<th>Data Not Reported</th>
<th>Significant Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hopman-Rock M (2000) PRE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>McQuade KJ (2011) PRE</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Figure 11. Summary of significant findings of strength

Not Significant Improvement | Data Not Reported | Significant Improvement
--- | --- | ---
McQuade KJ (2011) PRE
Hopman-Rock M (2000) PRE
Appendix

Letter of Grant Award

May 24, 2012

Sue Schuerman
UNLV School of Allied Health Sciences

Dear Dr. Schuerman:

Congratulations! I am pleased to inform you that your proposal, entitled “Self-management and Quality of Life of Overweight/Obese Women with Knee Osteoarthritis,” has been approved for funding by the School of Nursing & School of Allied Health.

Your requested funds totaling $24,451 will be deposited in an account for your project. You will be able to access these funds once you have obtained IRB approval, submitted a copy of the IRB approval to Lisa Escher, and your team has attended postaward training. The training will be scheduled within 30 days of receipt of the IRB approval letter. Please schedule an appointment with your chair later in the semester to discuss the progress of your project. As stated in the School of Nursing Intramural grant policy, you are expected to submit a final report to me within 1 month of the project end date. Additionally, as stated in the A-26 policy (attached), you are expected to submit a proposal for extramural funding. Please note that if this project is not completed and funds not expended with 24 months, your account will be closed and these funds will be used to support other research studies.

Wishing you the best as you begin this project,

Carolyn Yucha
PhD, RN, FAAN
Dean and Professor
Schools of Nursing and Allied Health Sciences

Cc: Patricia Alpert
Lisa Escher
References


Cody Buckner  APTA Member# 533102  Lic# OR, Pending

Education
University of Nevada, Las Vegas  June 2010 – May 2013
- Doctor of Physical Therapy

- B.S. Exercise Science
- Minor in Spanish (member Sigma Delta Pi honor society)

Faculty Directed Research  Feb 2011 – June 2013
- Headed group of students in successful writing grant proposal for UNLV School of Nursing & School of Allied Health ($30,000)
- Prepared budget for implementation of study
- Organized and directed writing of a systematic review regarding land based exercise programs for people with knee osteoarthritis

Related Work Experience
George E. Wahlen Veterans Affairs Medical Center – Clinical Affiliation  Jan – Apr 2013
(Salt Lake City, UT)

Pro-Motion Physical Therapy – Clinical Affiliation  Oct – Dec 2012
(Yakima, WA)

Intermountain Heath Care
Utah Valley Regional Medical Center – Clinical Affiliation  July – Sept 2012
(Provo, UT)

Physiotherapy Assoc. Children’s Therapy Center – Clinical Affiliation  June – July 2011
(Henderson, NV)

Riverside Rehabilitation – Office Manager  Aug 2009 – Jan 2010
(Rexburg, ID)

(Rexburg, ID)
Lindsay C. Martin

EDUCATION:

University of Nevada at Las Vegas, Las Vegas, Nevada
Doctor of Physical Therapy May 2010 – May 2013

Creighton University, Omaha, Nebraska
Bachelor of Science – Exercise Science August 2007 – May 2010

CAREER-RELATED EXPERIENCE:

The Keith Kleven Institute, Las Vegas, NV
Outpatient Clinical Affiliation January 2013 – April 2013

Summerlin Hospital, Las Vegas, NV
Rehabilitation Clinical Affiliation October 2012 – December 2012

Sunrise Hospital, Las Vegas, NV
Acute Clinical Affiliation July 2012 – September 2012

- Attended a body mechanics course to assure both patient and therapist safety during transfers

Barton Memorial Hospital, South Lake Tahoe, CA
Rural Clinical Affiliation June 2011 – July 2011

- Examined and evaluated numerous patients with musculoskeletal and neurologic pathologies in the acute and outpatient settings

Omaha Sports Physical Therapy, Omaha, Nebraska
Physical Therapy Intern August 2009 – December 2009

RESEARCH EXPERIENCE:

Mentored Group Research Project
Student Investigator February 2011 – May 2013

- Co-authored a $30,000 Arthritis Foundation Quality of Life Grant Application involving self-management of knee osteoarthritis in post-menopausal women
- Received a $30,000 grant from UNLV School of Nursing to conduct a study to assess two different approaches to treating knee osteoarthritis
- Conducted a systematic review investigating land-based exercise and its effect on quality of life outcomes in patients with knee osteoarthritis

PROFESSIONAL MEMBERSHIPS/CERTIFICATIONS:

American Physical Therapy Association
Member since 2010

American Heart Association
Healthcare Provider – CPR and AED Certified since 2006

CONTINUING EDUCATION:

American Physical Therapy Association
Combined Sections Meeting – Chicago, Illinois February 2012

Explain the Pain Seminar
Presented by Dr. Adrian Louw – Las Vegas, Nevada February 2012
Michael Soukup

Education:
- Doctor of Physical Therapy  Anticipated graduation date: May 2013
  - University of Nevada, Las Vegas
  - Cumulative GPA: 3.73
  - WICHE scholarship recipient
  - Differential Tuition Scholarship recipient
  - UNLV Access grant recipient
  - American Indian Graduate College fellowship recipient
- Bachelor of Science in Health Ecology  2009
  - University of Nevada, Reno
  - Cumulative GPA: 3.6
  - Millennium Scholarship recipient
  - Harriet Wolf scholarship recipient

Relevant Experience
- VA Southern Nevada Healthcare System
  - Outpatient PT clinical affiliation  Jan 2013-April 2013
    - Participated in specialty clinics to address specific issues such as falls, prosthetics, and motorized mobility.
- Complex Care Hospital at Tenaya
  - LTACH PT clinical affiliation  Oct 2012-Dec 2012
- Spring Valley Hospital Medical Center
  - Acute PT clinical affiliation  June 2012-Sept 2012
- Body Wise Physical Therapy
  - Orthopaedic outpatient clinical affiliation  June 2011-Aug 2011
    - Evaluated and treated patients with various orthopaedic problems in several rural northern Nevada clinics.
- Body Wisdom Physical Therapy
  - Physical therapy tech  April 2009-May 2010
- Reno Orthopaedic Clinic
  - Physical therapy tech  Jan 2008-Aug 2008

Mentored Student Research
- Grant co-author: Study design comparing effects of two exercise treatments and effects on quality of life in women with knee osteoarthritis
- Awarded $30,000 internal grant from UNLV to conduct study

Memberships/Certifications
- Nevada PT license pending
- APTA since 2010