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Published in:
Developmental Medicine & Child Neurology

DOI:

Published: 2002-01-01

Citation for published version (APA):

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Wartenberg pendulum test: objective quantification of muscle tone in children with spastic diplegia undergoing selective dorsal rhizotomy

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The aim of this study was to investigate the reliability and sensitivity of the Wartenberg pendulum test for quantification of muscle tone in young children with spastic diplegia undergoing selective dorsal rhizotomy (SDR). Fourteen non-disabled children (mean age of 5.5 years, age range 2.3 to 8.8 years, one female and one male in each year) were tested twice. Twenty children with spastic diplegia (12 males, eight females; mean age of 4.3 years, age range 2.5 to 6.3 years) consecutively selected for SDR, were assessed before and 6 months after SDR. Parameters of the pendulum test: R2, R1, maximal velocity, and swing time were correlated with clinical assessments for spasticity (modified Ashworth scale, quadriceps reflex) and measurements of gross motor function: the Gross Motor Function Classification System and the Gross Motor Function Measure. The Wartenberg pendulum test was found to be an objective and sensitive method for quantifying spasticity in knee extensor muscles in children as young as 2.5 years old. The method was responsive to changes after SDR. The only correlation with clinical measurements of spasticity was between the R2 ratio and the quadriceps reflex. Swing time was the most reliable and sensitive variable; it showed a weak correlation with measurements for gross motor function.

Spasticity is a common motor impairment in children with cerebral palsy (CP). It is the result of an insult to the developing brain that produces a disorder of movement and posture that is permanent but not unchanging (Rang et al. 1989). Spasticity is characterized by a velocity-dependent increase in tonic stretch reflexes with exaggerated tendon reflexes resulting from hyperexcitability of the stretch reflex as one component of the upper motor neuron syndrome (Lance 1980). It is a disabling impairment, which interferes with the maintenance of posture and coordinated voluntary movements and may lead to contractions, deformities, and pain. It disrupts activities in daily living and limits the efficacy of physical therapy (Davies 1977). Most knowledge about spasticity is based on studies of adults with stroke, spinal cord injury, and multiple sclerosis (MS). Less is known about spasticity in children with CP.

The measurement of spasticity is a difficult and unresolved problem, partly due to its complex and multifactorial nature (Katz et al. 1992). Clinical, electrophysiological, and biomechanical techniques have been used in its assessment (Sehgal and McGuire 1998). In the clinical setting, spasticity is most often assessed subjectively by quantifying the muscle tendon reflexes and by the original Ashworth scale which grades resistance to passive movement across a relaxed joint on an ordinal scale of 0 to 4 (Ashworth 1964). This scale suffers from a clustering effect with most patients grouped in the middle grades, therefore modifications of the scale have been created by adding an intermediate grade (Katz and Rymer 1989). The modified Ashworth scale (Bohannon and Smith 1987) has been shown to have a high interrater reliability in adult patients with hemiplegia when testing elbow flexors. It is, however, unreliable for measuring tone in the plantar flexors (Lee et al. 1989, Sloan et al. 1992). Another reported disadvantage of the Ashworth scale, original as well as modified, is its inability to differentiate the components of muscle tone (viscoelastic properties versus reflex activation of the contractile elements). In addition, the testing can be performed at different velocities by different investigators which might affect the result (Sehgal and McGuire 1998). Reliability and validity of the Ashworth scale have never been studied in children with CP.

The assessment and management of spasticity in children with CP is a challenging task for clinicians as well as for researchers. New techniques to treat spasticity in children with CP such as selective dorsal rhizotomy (SDR), botulinum toxin injections, intrathecal baclofen infusion, and peroral drug therapy require assessment tools to monitor their effectiveness (Hinderer and Gupta 1996, Forssberg and Tedroff 1997, Hesse and Mauritz 1997). In order to quantify spasticity in children with CP subjective quantification of muscle tendon reflexes and modifications of the Ashworth scale have been used (Peacock and Staudt 1991, Staudt et al. 1995, Steinbok et al. 1997, McLaughlin et al. 1998, Wright et al. 1998). A hand-held force transducer or myometer has been used to quantify resistance to passive motion (Staudt et al. 1995). Biomechanical measurements, such as the spasticity measurement system (SMS; Lehmann et al. 1989) have been used for quantification of the plantar flexors (Price et al. 1991). The Kin-com dynamometer has been used for quantification of spasticity in hamstrings, dorsiflexors, and plantar flexors in children with CP (Engsberg et al. 1996, 1998, 1999). However, the authors commented that children who were not large enough to fit comfortably in the test equipment and who could not presumably cooperate had to be excluded (Engsberg et al. 1998).
Quantification of Spasticity in Cerebral Palsy

Eva Nordmark and Gert Andersson

The pendulum test was first described by Wartenberg as a simple and reliable clinical test to quantify lower-limb hypertonia in Parkinson disease (Wartenberg 1951). The test was subsequently extended to assess changes in tone in upper motor neuron disorders (Schwab 1964). The extended leg of a supine individual is allowed to fall freely from a fully extended position. Normally the leg swings smoothly with regular, gradually decreasing movements in the vertical plane, like a pendulum. In the spastic limb the swing is dampened by the viscoelastic properties and exaggerated stretch reflexes of the limb. The most commonly measured parameter is the relaxation index or R2 ratio, i.e. the amplitude of the first swing divided by the final angle of the knee (Boezko and Mumenthaler 1958, Bajd and Vodovnik 1984, Katz et al. 1992). In non-disabled elderly persons the R2 ratio is generally more than 1.6 (Brown et al. 1988a, 1988b; Katz et al. 1992). It has been shown to correlate well with the degree of spasticity, as quantified using a clinical assessment such as the Ashworth scale, in adults with MS (Leslie et al. 1992) and hemiparesis (Katz et al. 1992). A significant correlation between changes in the R2 ratio and the Ashworth scores in patients with MS having spasticity-reducing medication has also been shown (Emre et al. 1994).

Very few studies have been published on the Wartenberg pendulum test in children. Lin and collaborators measured the oscillations after eliciting a quadriceps tendon reflex in children with hemiplegia due to CP (Lin et al. 1994). This was, however, not a classical Wartenberg pendulum test. Recently, Fowler and collaborators showed that the test is sensitive in detecting spasticity in patients with CP of between 7 and 50 years old (Fowler et al. 2000). The sitting position was standardized and padded straps were secured around the patient’s waist and distal thigh. They studied a number of parameters and found that the amplitude of the first swing was the best predictor of the degree of spasticity.

In our programme there is a need for a test that is objective and clinically useful in the selection of very young children (as young as 2.5 years of age) for spasticity reducing interventions and in monitoring their effects. The aim of this study was to investigate whether the Wartenberg pendulum test can be used in young children where a standardized sitting position is difficult to obtain. A reliability test was first performed in non-disabled children. Thereafter, children with spastic diplegia were tested before and after SDR. The parameters of the pendulum test were correlated with clinical assessments for spasticity and measurements of motor function.

**Method**

**Participants**

For comparison and test-retest reliability of the method, 14 non-disabled children (mean age of 5.5 years, age range 2.3 to 8.8 years; one female and one male in each year) were assessed. Their weight ranged between 14 and 35 kg, and height ranged between 91 and 139 cm. The interval between the two assessments was 1 to 2 weeks. Only the right leg was tested in the two youngest children as they could not be motivated to cooperate in a longer session. The study group included all children with spastic diplegia who were selected for SDR between March 1996 and September 1999. All 20 patients were evaluated pre- and 6 months postoperatively (Tables I and II). In one patient, only the right leg was tested both times. In a second patient, only the right leg was tested after the SDR, and in a third patient the postoperative data from the right leg could not be used due to an inability to relax. Children and their parents gave their informed consent before participating in the study, which was approved by the research ethics committee at Lund University, Sweden.

**Test Procedures**

**Pendulum test**

Children sat comfortably on a couch, with a belt fixed over the thighs and a parent behind them. The lower leg was hanging over the edge of the couch. Knee angle was measured with an electrogoniometer (Biometrics Ltd, Gwent, UK) attached to the lateral side of the knee. EMG was recorded simultaneously from the quadriceps and hamstring muscles. The children were encouraged to relax and close their eyes. The knee was fully extended when the leg was lifted and when no EMG activity could be recorded from the quadriceps and hamstring muscles, the leg was released to swing freely. The EMG and the knee angle were recorded and stored for further analysis with the LabVIEW program (National Instruments Corporation, Austin, Texas, USA). The pendulum test was repeated until at least three successful trials were obtained for each leg. The measurement variables were: (1) R2 ratio – the amplitude (in degrees) of the first swing (A) divided by the amplitude of the final position (C; Fig. 1a); (2) R1 ratio – the amplitude of the first swing (A) divided by the amplitude of the rebound angle (B; Bowman and Bajd 1981); (3) maximal velocity of the first swing (Vmax; °/s), and (4) the time between the peaks, i.e. swing time (s). Swing time is dependent on pendulum length. In non-disabled children, there was a strong correlation between height and swing time (Fig. 2). From these data, the equation \( y = 0.005x + 0.2484 \) was derived where \( y \) indicates expected swing time (s) and \( x \) height (cm). The recorded swing time was divided by the expected swing time and the obtained quotient was defined as relative swing time. Thus, the length dependence was eliminated and the relative swing time could be used for comparison between the two groups of children.

**Clinical Assessments of Spasticity and Gross Motor Function**

Clinical assessment of spastic hypertonia was made when the patient was resting supine. To avoid interexaminer variation, the same experienced physiotherapist examined all participants. The passive muscle tone in quadriceps was assessed by flexing the knee and graded (0 to 5) on a scale for spasticity made by Peacock and Staudt (1991) modified from those of Ashworth (1964) and Bohannon and Smith (1987; Table III). The quadriceps tendon reflex was assessed by an experienced paediatric neurologist and graded on an ordinal scale 0 to 4. Preoperatively, the children were classified according to the Gross Motor Function Classification System (GMFCS; Palisano et al. 1997). This is a five-level classification system based on self-initiated movement for children with CP, with particular emphasis on sitting (truncal control) and walking. Gross motor function was measured with the Gross Motor Function Measure (GMFM; Russell et al. 1989). Correlations between pendulum test parameters and the score for dimension E (walking, running, and jumping), goal score, and total score were tested.
Mean values of the different parameters from the right and left leg were calculated separately as they cannot be considered as independent variables. However, for the correlations with functional tests a mean of the right and left leg was used.

When testing reliability the results of the second test were expressed as percentage of the first test and then the coefficient of variation was calculated. Differences between pre- and postoperative values were calculated with a paired, two-tailed Student t-test. Differences between preoperative values in

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### Table I: Preoperative parameters in children with CP

<table>
<thead>
<tr>
<th>Participant nr</th>
<th>Age (y)</th>
<th>Sex</th>
<th>Height (cm)</th>
<th>GMFCS</th>
<th>GMFM t</th>
<th>GMFM e</th>
<th>Right leg</th>
<th>Quadriceps reflex</th>
<th>Modified Ashworth scale</th>
<th>Right leg</th>
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<tbody>
<tr>
<td>1</td>
<td>2.5</td>
<td>M</td>
<td>85</td>
<td>4</td>
<td>29</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>1.36</td>
<td>0.78</td>
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<tr>
<td>2</td>
<td>2.8</td>
<td>F</td>
<td>97</td>
<td>4</td>
<td>27</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>1.55</td>
<td>1.12</td>
</tr>
<tr>
<td>3</td>
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<td>M</td>
<td>92</td>
<td>4</td>
<td>40</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>1.06</td>
<td>1.49</td>
</tr>
<tr>
<td>4</td>
<td>3.3</td>
<td>F</td>
<td>92</td>
<td>3</td>
<td>51</td>
<td>17</td>
<td>3</td>
<td>1</td>
<td>1.61</td>
<td>1.13</td>
</tr>
<tr>
<td>5</td>
<td>3.3</td>
<td>M</td>
<td>100</td>
<td>3</td>
<td>57</td>
<td>6</td>
<td>2.5</td>
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<td>1.83</td>
<td>0.86</td>
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<tr>
<td>6</td>
<td>3.4</td>
<td>F</td>
<td>92</td>
<td>5</td>
<td>19</td>
<td>0</td>
<td>3</td>
<td>4</td>
<td>1.34</td>
<td>1.22</td>
</tr>
<tr>
<td>7</td>
<td>3.4</td>
<td>M</td>
<td>104</td>
<td>4</td>
<td>42</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>1.27</td>
<td>1.05</td>
</tr>
<tr>
<td>8</td>
<td>3.5</td>
<td>F</td>
<td>98</td>
<td>1</td>
<td>80</td>
<td>65</td>
<td>3</td>
<td>1</td>
<td>1.53</td>
<td>1.19</td>
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<tr>
<td>9</td>
<td>3.8</td>
<td>M</td>
<td>92</td>
<td>4</td>
<td>36</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1.32</td>
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<td>10</td>
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<td>M</td>
<td>93</td>
<td>4</td>
<td>36</td>
<td>4</td>
<td>3.5</td>
<td>2</td>
<td>1.43</td>
<td>0.66</td>
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<tr>
<td>11</td>
<td>4</td>
<td>M</td>
<td>100</td>
<td>4</td>
<td>20</td>
<td>0</td>
<td>3</td>
<td>4</td>
<td>1.88</td>
<td>1.14</td>
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<tr>
<td>12</td>
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<td>M</td>
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<td>4</td>
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<td>0.75</td>
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<td>4</td>
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<td>1</td>
<td>3.5</td>
<td>2</td>
<td>1.28</td>
<td>0.71</td>
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<tr>
<td>15</td>
<td>5.2</td>
<td>F</td>
<td>103</td>
<td>3</td>
<td>68</td>
<td>18</td>
<td>3.5</td>
<td>2</td>
<td>1.26</td>
<td>0.78</td>
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<tr>
<td>16</td>
<td>5.2</td>
<td>M</td>
<td>102</td>
<td>2</td>
<td>76</td>
<td>38</td>
<td>3</td>
<td>1</td>
<td>1.28</td>
<td>0.94</td>
</tr>
<tr>
<td>17</td>
<td>5.3</td>
<td>M</td>
<td>104</td>
<td>3</td>
<td>65</td>
<td>14</td>
<td>3</td>
<td>2</td>
<td>1.66</td>
<td>1.15</td>
</tr>
<tr>
<td>18</td>
<td>5.6</td>
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<td>113</td>
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<td>20</td>
<td>6.5</td>
<td>M</td>
<td>104</td>
<td>2</td>
<td>84</td>
<td>57</td>
<td>3</td>
<td>2</td>
<td>1.94</td>
<td>1.52</td>
</tr>
<tr>
<td>Mean</td>
<td>4.3</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>SD</td>
<td>1.1</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Median</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>4.7</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>1.54</td>
<td>1.09</td>
</tr>
</tbody>
</table>

In participant 8, left leg was not investigated. GMFCS, Gross Motor Function Classification System; GMFM t, Gross Motor Function Measure total score; GMFM e, Gross Motor Function Measure, dimension E (walking, running, and jumping); R1, amplitude of first swing divided by amplitude of rebound angle; R2, amplitude of first swing divided by final angle of knee; Vmax, maximal velocity.

### Table II: Measurements at first test for control children, and pre- and postoperatively for children with CP

<table>
<thead>
<tr>
<th>Variables</th>
<th>Control children (n=14)</th>
<th>CP preop (n=20)</th>
<th>CP preop–control</th>
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<tbody>
<tr>
<td></td>
<td>n Mean SD Range</td>
<td>n Mean SD Range</td>
<td>% p a</td>
</tr>
<tr>
<td>R2 ratio Right</td>
<td>14 1.86 0.26 (1.37–2.24)</td>
<td>20 1.03 0.25 (0.66–1.49)</td>
<td>55 &lt;0.001</td>
</tr>
<tr>
<td>Left</td>
<td>12 1.82 0.22 (1.35–2.13)</td>
<td>19 1.10 0.26 (0.72–1.54)</td>
<td>60 &lt;0.001</td>
</tr>
<tr>
<td>R1 ratio Right</td>
<td>14 4.01 1.40 (1.83–6.95)</td>
<td>20 1.51 0.24 (1.06–1.94)</td>
<td>38 &lt;0.001</td>
</tr>
<tr>
<td>Left</td>
<td>12 3.78 1.24 (1.93–6.11)</td>
<td>19 1.88 0.50 (1.15–3.17)</td>
<td>50 &lt;0.001</td>
</tr>
<tr>
<td>Vmax (˚/s) Right</td>
<td>14 388 77.5 (277–492)</td>
<td>20 244 58.0 (92–325)</td>
<td>63 &lt;0.001</td>
</tr>
<tr>
<td>Left</td>
<td>12 392 59.8 (329–459)</td>
<td>19 260 60.0 (142–366)</td>
<td>66 &lt;0.001</td>
</tr>
<tr>
<td>Relative swing time (s) Right</td>
<td>14 1.00 0.05 (0.96–1.07)</td>
<td>20 0.50 0.16 (0.20–0.79)</td>
<td>50 &lt;0.001</td>
</tr>
<tr>
<td>Left</td>
<td>12 1.00 0.05 (0.90–1.06)</td>
<td>19 0.59 0.17 (0.30–0.85)</td>
<td>59 &lt;0.001</td>
</tr>
</tbody>
</table>

%, mean preoperative values as a percentage of control group; ns = p > 0.1.

a Differences between values of CP group preoperatively and control group, calculated with unpaired Student t-test, two-tailed p value.

b Differences between pre- and postoperative values calculated with paired Student t-test, two-tailed p value. R2, amplitude of first swing divided by final angle of knee; R1 ratio, amplitude of first swing divided by amplitude of rebound angle; Vmax, maximal velocity.
those with CP and unaffected children were calculated with unpaired, two-tailed Student t-test. The results from the pendulum test were compared with the clinical assessments for spasticity and function using non-parametric statistics, Spearman’s rank correlation coefficient ($r_s$). The results from the pendulum test were correlated with age using parametric statistics, Pearson’s correlation coefficient ($r_p$). Statistical significance was set at $p<0.01$

Results

PENDULUM TEST IN NON-DISABLED CHILDREN

An example of a typical pendulum test response in a non-disabled 5-year-old female is illustrated in Fig. 1a. The leg movement was characterized by a smooth swing with a low damping factor. The amplitude of the first swing ($A$) was much larger than that of the final position ($C$). The $R_2$ ratio was 1.71, $R_1$ 3.11, $V_{max}$ 381˚/s, and swing time 0.88 seconds. The expected swing time was 0.84 seconds. Hence the relative swing time was 1.04. The mean values of $A$ right and left legs in the non-disabled children are illustrated in Figures 3a to 3d and Table II. The two lowest $R_2$ values were obtained in two of the youngest children. However, for the whole group, there was no correlation between $R_2$ and age. Neither did $R_1$ or maximal velocity show any correlation with age. The swing time, on the other hand, showed a strong correlation with age and height (see Fig. 2), which is to be expected as it is dependent on pendulum length. When corrected for this, by calculating the relative swing time, the age dependence was eliminated in order to facilitate the comparison between groups.

TEST–RETEST RELIABILITY IN NON-DISABLED CHILDREN

In order to test the reliability of the pendulum test, the mean values of the four parameters for each leg were calculated. The results from the second test were expressed as a percentage of the results from the first test and plotted against age in Figures 4a to 4d. No correlation with age was found. The reliability was expressed as the coefficient of variation (CV), i.e. the standard deviation as a percentage of the mean. The relative swing time displayed the lowest CV (4% and 3% in the right and left legs, respectively).

PENDULUM TEST IN CHILDREN WITH CP

A typical pendulum test in a 5-year-old female with spastic diplegia before SDR is illustrated in Fig 1b. EMG recordings from the quadriceps and hamstring muscles are also presented. The diagram differs from that for a normally developing child in a number of aspects. First, when the leg was

<table>
<thead>
<tr>
<th>Score</th>
<th>Definition</th>
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<tbody>
<tr>
<td>0</td>
<td>Hypotonic: less than normal muscle tone, floppy</td>
</tr>
<tr>
<td>1</td>
<td>Normal: no increase in muscle tone</td>
</tr>
<tr>
<td>2</td>
<td>Mild: slight increase in tone, ‘catch’ in limb movement or minimal resistance to movement through less than half of the range</td>
</tr>
<tr>
<td>3</td>
<td>Moderate: more marked increase in tone through most of the range of the motion but affected part is easily moved</td>
</tr>
<tr>
<td>4</td>
<td>Severe: considerable increase in tone, passive movement difficult</td>
</tr>
<tr>
<td>5</td>
<td>Extreme: affected part rigid in flexion or extension</td>
</tr>
</tbody>
</table>

Table I continued

<table>
<thead>
<tr>
<th>Left leg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quadriceps reflex</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>3</td>
</tr>
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<td>3.5</td>
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<td>3.5</td>
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<td>2</td>
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<td>3</td>
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<tr>
<td>–</td>
</tr>
<tr>
<td>3</td>
</tr>
</tbody>
</table>

Table II continued

<table>
<thead>
<tr>
<th>CP postop (n=20)</th>
<th>CP post–pre</th>
<th>CP postop-ND</th>
</tr>
</thead>
<tbody>
<tr>
<td>$n$ Mean SD Range</td>
<td>$p^b$</td>
<td>$p^a$</td>
</tr>
<tr>
<td>19</td>
<td>1.76</td>
<td>0.24</td>
</tr>
<tr>
<td>18</td>
<td>1.85</td>
<td>0.24</td>
</tr>
<tr>
<td>19</td>
<td>3.35</td>
<td>1.27</td>
</tr>
<tr>
<td>18</td>
<td>4.00</td>
<td>1.78</td>
</tr>
<tr>
<td>19</td>
<td>364</td>
<td>65.0</td>
</tr>
<tr>
<td>18</td>
<td>385</td>
<td>84.0</td>
</tr>
<tr>
<td>19</td>
<td>0.93</td>
<td>0.07</td>
</tr>
<tr>
<td>18</td>
<td>0.95</td>
<td>0.07</td>
</tr>
</tbody>
</table>

Table III: Scale for grading spasticity modified from those of Ashworth (1964) and Bohannon and Smith (1987) by Peacock and Staudt (1991)

<table>
<thead>
<tr>
<th>Score</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Hypotonic: less than normal muscle tone, floppy</td>
</tr>
<tr>
<td>1</td>
<td>Normal: no increase in muscle tone</td>
</tr>
<tr>
<td>2</td>
<td>Mild: slight increase in tone, ‘catch’ in limb movement or minimal resistance to movement through less than half of the range</td>
</tr>
<tr>
<td>3</td>
<td>Moderate: more marked increase in tone through most of the range of the motion but affected part is easily moved</td>
</tr>
<tr>
<td>4</td>
<td>Severe: considerable increase in tone, passive movement difficult</td>
</tr>
<tr>
<td>5</td>
<td>Extreme: affected part rigid in flexion or extension</td>
</tr>
</tbody>
</table>
stretched, there was an extension deficit of 20 degrees, and a tonic stretch reflex was observed in the hamstrings. Second, when the leg was released the amplitude of the first swing was only 40 degrees, i.e. less than the final (vertical) position. As seen in the EMG recording, the quadriceps muscle was activated during flexion. This stretch reflex was strong enough to produce an extension before the lower leg had reached a vertical position, explaining the low R2 ratio (0.74). Also, during the second and third flexion movements, stretch reflexes were elicited in the quadriceps. At the end of the pendular movement when the knee was flexed, a tonic stretch reflex was observed in the quadriceps. Third, the peak velocity and swing time were low. In this leg the mean R1 ratio was 1.46, Vmax 270°/s, and swing time 0.40 s. The expected swing time was 0.85 s. Hence, the relative swing time was 0.46 s. This low value can be explained by the stretch reflexes in both quadriceps and hamstring muscles. All these values were considerably lower than in the control participant (see Fig. 1a). As seen in Figures 3a to 3d and Table II, there was a highly significant difference ($p<0.001$) between the group of normally developing children and those with spasticity, preoperatively. Mean values in the patient group were between 38 and 66% of those of the control group.

RESPONSIVENESS TO CHANGE
Six months after SDR, all parameters of the pendulum test were significantly improved ($p<0.001$) compared with preoperative values (Figs 1c and 3a to 3d). They were now similar to those of the control children. Only the relative swing time was still significantly lower (right leg, $p=0.001$ and left leg, $p=0.01$). EMG recordings revealed no reflexes postoperatively (not shown in Fig. 1c as in this patient, there was a large movement artifact during the initial part of the pendulum test).

CORRELATION WITH CLINICAL TESTS
For the children with diplegia, the preoperative R2 ratio showed a statistically significant correlation with the quadriceps reflex for the right leg, $r_s=-0.626$ ($p=0.003$) and nearly significant for the left leg, $r_s=-0.566$ ($p=0.014$). There was no significant correlation between the R2 ratio and Ashworth scale for either leg. For the variables R1, Vmax, and relative swing time there was no significant correlation with either of the clinical tests for spasticity.

No significant correlations were found between the R2, R1, and Vmax and the GMFCS and GMFM. However, statistically significant correlations were found between the relative swing time and these tests. The correlation between the relative swing time and the GMFCS was ($r_s=-0.584$ ($p=0.007$). The correlation between the relative swing time and the GMFM dimension E, was ($r_s=0.614$ ($p=0.004$).

Discussion
In the present study, the pendulum test variables could differentiate between the unaffected group and the group with spasticity and they responded to the decreased spasticity after SDR. The relative swing time was the most reliable parameter.

The pendulum test has been evaluated in non-disabled adults, and adults with either rigidity or spasticity. It has been demonstrated to be a practical and reproducible measure of spastic tone (Wartenberg 1951; Bozko and Mumenthaler 1958; Schwab 1964; Bajd and Bowman 1982; Brown et al. 1988a, b; Jamshidi and Smith 1996). There is only one report...
Figure 3: Comparison of individual values and mean of right (■) and left (▲) legs in non-disabled children (14 right and 12 left legs), with children before (20 right and 19 left legs) and after SDR 9 right and 18 left legs). ns = p>0.1, *p<0.001. (a) R2 ratio, (b) R1 ratio, (c) Maximal velocity (°/s), (d) Relative swing time (s).

Figure 4: Reliability of pendulum test parameters in control group. Results from second test are expressed as a percentage of those from first test and plotted versus age for right (■) and left (▲) legs. CV, coefficient of variation, expressed as standard deviation in percentage of mean. (a) R2 ratio, CV right leg 17% and left leg 13%; (b) R1 ratio, CV right leg 37% and left leg 47%; (c) Maximal velocity, Vmax (°/s), CV right leg 18% and left leg 14%; (d) Swing time (s), CV right leg 4%, and left leg 3%.
on the sensitivity of the pendulum test in children with CP
(Fowler et al. 2000). The authors concluded that it is a valid
tool for assessing spasticity in persons with CP. However, the
youngest children were 7 years old and the material includes
patients up to 50 years old. The purpose of the present study
was to determine if the Wartenberg pendulum test was
applicable and useful in quantifying spasticity in children as
young as 2.5 years.

In order to avoid the lower leg hitting the couch, the children
had to sit so far forward that the distal part of the thigh
had no support. As a consequence, the thigh was leaning
down during the test and in the final position of the lower
leg, the knee flexion was less than 90° (approximately 70°,
see Fig. 1). This explains how the R2 ratio could attain values
of 2 or more, which is impossible with a horizontal thigh and
a final vertical position of 90°.

Our goal was to perform repeated measurements on all
children, even the very young ones and children with
impaired cognitive function. As the test relies on the partici-
pants being relaxed and not assisting or resisting the pendular
movements, we chose a test position where the child was sit-
ting relaxed and safely with one parent close behind. The
advantage of this test position was that the children were com-
fortable and tolerated the test very well. The disadvantage
was that the position was not quite standardized. This could have
affected the results. However, in the choice between a stan-
dardized position and a relaxed child, we preferred the latter.
It is most likely that the test results would have been more
affected by inability to relax than by rather small differences in
the sitting position. In addition, it would not have been possi-
able to perform repeated measurements if the patients had felt
uncomfortable. To minimize the error from voluntary activa-
tion of the investigated muscle we used EMG recordings to
ensure that the children were relaxed when the test started.

Different test positions have been studied in adults: lying
supine (Jamshidi and Smith 1996), semi-supine (Vodovnik et
Brown and collaborators studied the importance of the test
position in non-disabled elderly individuals and found that
the position contributed very little to the total variability
(Brown et al. 1988a). In a small group of non-disabled young
adults this contribution was even smaller. In a recent study
on non-disabled elderly individuals and those with hemiple-
gia, Fowler and collaborators (1998) tested the influence of
quadriceps muscle length on the pendulum test. They
reported that the angle of reversal was influenced by muscle
length such that there was no difference between patients
and non-disabled individuals when the difference in muscle
length was taken into account. However, the peak velocity
was much lower in the patients and this could not be
explained by muscle-length difference. In the present study,
all parameters were reduced to about the same extent in the
patients (see Table II). Thus, variation in muscle length does
not seem to have influenced the results. However, as there is
no study on the influence of sitting position in children with
CP, we cannot entirely exclude the possibility that some vari-
ation is due to this.

CORRELATION WITH CLINICAL TESTS OF SPASTICITY AND MOTOR
FUNCTION MEASUREMENTS
Preoperatively, there was a negative correlation between the
R2 ratio and the quadriceps reflex. As seen in Figure 1b, a
stretch reflex was elicited in the quadriceps muscle during
the flexion of the knee reducing the amplitude of the first
swing, which leads to a low R2 ratio. Thus, such a correlation
is expected to occur.

The lack of correlation between any of the pendulum test
parameters and the modified Ashworth scale (Peacock and
Staudt 1991) is not in accordance with previous studies that
have shown a significant correlation between R2 and the
Ashworth scale in adult patients (Katz et al. 1992, Leslie et al.
1992). This might be explained partly by the clustering effect
on the 6-point ordinal scale, with 14 of 20 patients grouped
in grades 2 to 3 (see Table I). Other reasons that might have
influenced our results could be the small sample size and the
fact that the tests were performed in different positions and
at different times on a given day. It should also be kept in
mind that the validity and reliability of the Ashworth scale
have not been tested in children with CP. Therefore, a lack of
correlation between the pendulum test parameters and this
method is rather non-informative.

There are few reports concerning the relation between
spasticity and motor function. In the present study, swing
time was the only variable which showed a significant corre-
lation with GMFCS and the GGMFM. The correlation was
weak, which is to be expected as motor function is depend-
ent on many factors of which spasticity is only one. It must
also be kept in mind that the pendulum test can only mea-
sure the properties of one muscle group (i.e. the quadriceps)
under passive conditions. Nevertheless, it has been shown
that gross motor function is also improved after SDR and
physical therapy (Steinbok et al. 1997, McLaughlin et al.

The finding that the different pendulum parameters cor-
relate with different tests suggest that they reflect different
aspects of the spastic muscle’s resistance to passive move-
ments. Further studies to elucidate the mechanisms affecting
different variables will be necessary. Little attention has been
paid, for example, to the potential effect of viscoelastic prop-
erties of the knee extensor muscles on the result of the pen-
dulum test. The present observation that relative swing time
was different between the non-disabled and the postopera-
tive group, in whom there was no residual spasticity in the
quadriceps, indicates that this parameter could also be sen-
titive to differences in viscoelastic properties.

New treatments of spasticity have been introduced in phys-
iotherapy, pharmacology, and surgery. For future research it
will be important to identify the mechanisms behind the
motor impairment in patients with CP, such as spasticity,
cocontraction, and weakness. To this end, there is need for
reliable and sensitive tests to be developed that can deter-
mine the relative importance of these mechanisms in any
patient. Only then can the optimal therapeutic intervention
be chosen and its effects be assessed.

Conclusions
The Wartenberg pendulum test combined with EMG is an
objective and sensitive method for quantifying spasticity in
knee extensor muscles in children as young as 2.5 years. The
method is responsive to changes after SDR. The only correla-
tion with clinical measurements of spasticity was between the
R2 ratio and the quadriceps reflex. Swing time was the most
reliable and sensitive variable, which showed a weak correla-
tion with measurements for gross motor function. Limitations
of the test are mainly that it can be used only for one muscle group (quadriceps) and that it measures the properties under passive conditions.

Accepted for publication 26th June 2001.

Acknowledgement
This work was in part financially supported by the Swedish National Health Board, Josef and Linnea Carlssons Foundation, the Lekande Barnen Foundation, and the Folke Bernadotte Foundation. The authors thank the children and families who participated in the study and Dr Jan Lagergren who took part in the clinical assessments. The authors thank Dr Gösta Blennow and Professor Ulrich Moritz for support and useful discussions.

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