



**HAL**  
open science

# A single session of bihemispheric transcranial direct current stimulation does not improve quadriceps muscle spasticity in people with chronic stroke

Thomas Cattagni, Maxime Geiger, Anthony Supiot, Raphael Zory, Didier Pradon, Nicolas Roche

## ► To cite this version:

Thomas Cattagni, Maxime Geiger, Anthony Supiot, Raphael Zory, Didier Pradon, et al.. A single session of bihemispheric transcranial direct current stimulation does not improve quadriceps muscle spasticity in people with chronic stroke. *Brain Stimulation*, 2019, 12 (5), pp.1309-1311. 10.1016/j.brs.2019.06.027 . hal-02528921

**HAL Id: hal-02528921**

<https://univ-cotedazur.hal.science/hal-02528921v1>

Submitted on 25 Apr 2023

**HAL** is a multi-disciplinary open access archive for the deposit and dissemination of scientific research documents, whether they are published or not. The documents may come from teaching and research institutions in France or abroad, or from public or private research centers.

L'archive ouverte pluridisciplinaire **HAL**, est destinée au dépôt et à la diffusion de documents scientifiques de niveau recherche, publiés ou non, émanant des établissements d'enseignement et de recherche français ou étrangers, des laboratoires publics ou privés.

1 **A single session of bihemispheric transcranial direct current stimulation does**  
2 **not improve quadriceps muscle spasticity in people with chronic stroke.**

3 Thomas Cattagni<sup>1,2\*</sup>, Maxime Geiger<sup>1,3,4</sup>, Anthony Supiot<sup>1</sup>, Raphaël Zory<sup>5</sup>, Didier Pradon<sup>1</sup>,  
4 Nicolas Roche<sup>1</sup>

5 \* corresponding author

6  
7 <sup>1</sup> *Inserm Unit 1179, Team 3: Technologies and Innovative Therapies Applied to Neuromuscular diseases, UVSQ,*  
8 *CIC 805, Physiology-Functional Testing Ward, AP-HP, Raymond Poincaré Teaching Hospital, Garches, France.*

9 <sup>2</sup> *Laboratory Movement, Interactions, Performance (EA4334), Faculty of Sport Sciences, University of Nantes,*  
10 *Nantes, France.*

11 <sup>3</sup> *CIAMS, Univ. Paris-Sud, Université Paris-Saclay, 91405 Orsay Cedex, France.*

12 <sup>4</sup> *CIAMS, Université d'Orléans, 45067, Orléans, France.*

13 <sup>5</sup> *Laboratory of Human Motricity, Sport, Education and Health (EA 6312), University of Nice Sophia Antipolis,*  
14 *France.*

15  
16  
17 **Address for correspondence**

18 Thomas Cattagni

19 UFR STAPS, Université de Nantes

20 Laboratoire "Motricité, Interactions, Performance" EA 4334

21 25 bis Boulevard Guy Mollet - BP 72206

22 44 322 Nantes cedex 3, France

23 Email: [thomas.cattagni@univ-nantes.fr](mailto:thomas.cattagni@univ-nantes.fr)

24

25

26 **Word count:** 996 (maximum word count for a letter to the editor: 1000)

27 **Number of figure:** 1 (maximum number of figure/table for a letter to the editor: 1)

28 **Number of reference:** 9 (maximum number of reference for a letter to the editor: 10)

29 Cerebral lesions following stroke cause an interhemispheric competition in the brain  
30 where the excitability of the affected hemisphere decreases and that of the unaffected  
31 hemisphere increases. This leads to a reduction of inhibitory control of spinal networks by the  
32 corticospinal tract of the affected side which in turn lead to the phenomenon of spasticity [1].  
33 It has been found that i) bihemispheric-transcranial direct current stimulation (bi-tDCS) may  
34 reduce the interhemispheric imbalance in chronic stroke people (CSP) [2], and ii) anodal-tDCS  
35 applied over the affected leg motor cortex can alter the excitability of some spinal circuits  
36 involved in spasticity [3]. Although two studies have evaluated the acute effects of tDCS on  
37 spasticity of the upper limb [4,5], the effects of a single session of bi-tDCS on spasticity of  
38 lower limb remain to be clarified. Accordingly, we examined whether a single session of bi-  
39 tDCS could improve quadriceps spasticity in CSP.

40

41 Thirteen CSP ( $57\pm 12$  years) were included in this study. Inclusion and exclusion criteria  
42 as well as characteristics of the patients are shown in the Supplemental Material.

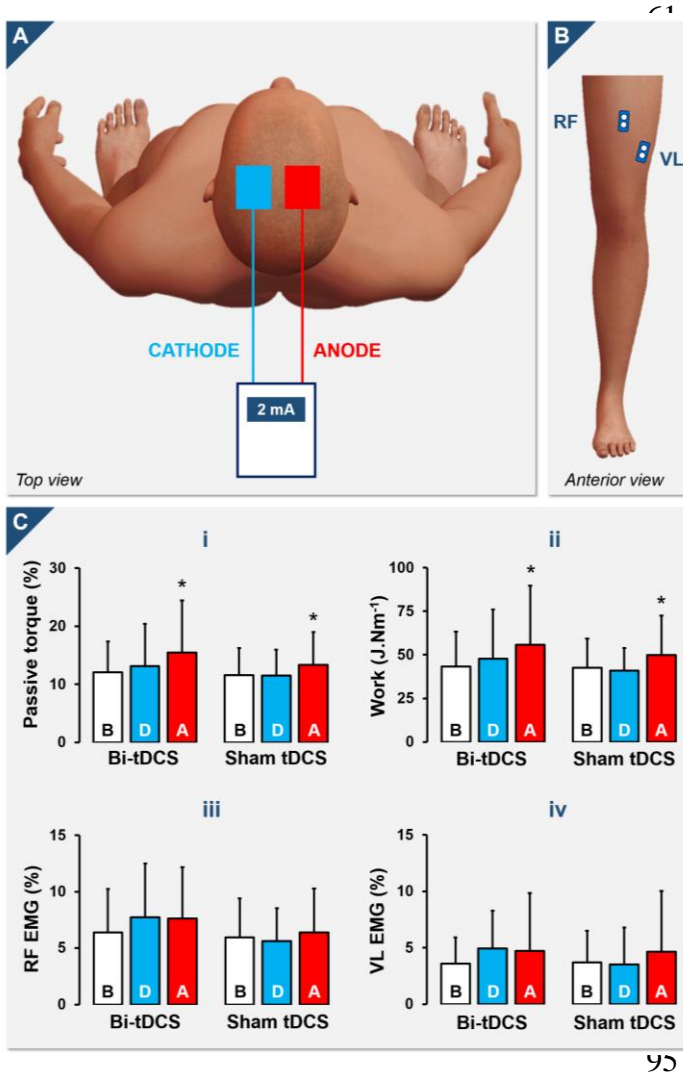
43 This study used a randomized, sham-controlled and double-blind crossover  
44 experimental method. Each participant attended two experimental sessions one week apart: i)  
45 effective bi-tDCS, and ii) sham bi-tDCS. At the beginning of each session, participants  
46 performed 3 maximal isometric voluntary contractions (MVC). Then, an instrumental  
47 assessment of quadriceps spasticity was performed before effective/sham bi-tDCS, 10 minutes  
48 after the beginning of the effective/sham bi-tDCS (During), and immediately after the end of  
49 the effective/sham bi-tDCS.

50 For both bi-tDCS protocols the anode (7x5 cm) was placed over the leg motor cortex of  
51 the affected side with the medial border of the electrode placed laterally to Cz of the  
52 international electroencephalogram 10–20 system [6] (Fig.1A). The cathode was placed in the  
53 same position over the leg motor cortex of the unaffected side. For the effective bi-tDCS,

54 current (intensity: 2 mA) was delivered for 20 minutes using a constant-current electrical  
 55 stimulator (Eldith DC-Stimulator, Germany). For the sham bi-tDCS, the same current was only  
 56 delivered during the first 2 minutes (18 minutes without stimulation).

57 As recommended, spasticity was assessed using an “objective” instrumental evaluation  
 58 [7,8]. Each set of instrumental evaluations of spasticity consisted of 5 fast passive quadriceps  
 59 stretches at an acceleration of  $\sim 500^{\circ} \cdot s^{-2}$  (maximum speed of  $240^{\circ} \cdot s^{-2}$ ).

60



**Figure 1.** A. Schematic view of electrode placement for effective and sham bihemispheric-transcranial direct current stimulation (bi-tDCS). The right brain hemisphere and the left leg represent the affected sides while the left brain hemisphere and the right leg represent the unaffected sides. B. Schematic view of electrode placement for rectus femoris (RF) and vastus lateralis (VL) EMG recordings. C. Mean and standard deviation of the normalized torque (i), normalized work (ii), and normalized EMG of RF (iii) and VL (iv) signals during fast passive quadriceps stretches before ('B', white histograms), during ('D', blue histograms), and after ('A', red histograms) effective bi-tDCS ('bi-tDCS') and sham bi-tDCS ('sham tDCS'). \* indicates significant difference with baseline assessment (before effective or sham bi-tDCS measurements).

96

97

98 An isokinetic dynamometer (Biodex, Shirley Corporation, USA) was used to generate  
 99 quadriceps stretches and to measure quadriceps torque of the affected limb. Participants were  
 100 seated in the dynamometer chair with an 85° hip angle and the lower legs hanging over the edge

101 of the seat. The knee angle was set at 90° for the MVCs. Passive pain-free range of motion was  
102 determined for each participant at the beginning of the first session and was used to set the  
103 limits of motion for both sessions. EMG activity of the rectus femoris (RF) and the vastus  
104 lateralis (VL) of the affected limb was recorded during both MVCs and quadriceps stretches.  
105 Bipolar surface electrodes linked to their amplifier (Bagnoli-4, Delsys Inc., USA) were placed  
106 on the skin, according to the SENIAM recommendations [9] (Fig.1B).

107 For each quadriceps stretching test, maximum resistive peak torque (MRPT, Nm)  
108 produced was recorded, and work (J) was calculated by summing the area under the torque  
109 curve (torque multiplied by angular displacement in radians). Then, the MRPT was expressed  
110 as a percentage of the MVC torque to obtain the relative MRPT (rMRPT, %). The work (J.Nm<sup>-1</sup>)  
111 was normalized by the MVC torque to obtain the relative work (a.u.). For each quadriceps  
112 stretching test and muscle a RMS for the entire EMG signal during the stretching phase was  
113 calculated and normalized to the RMS value obtained over a 0.5-s window around the MVC  
114 peak torque (relative EMG, %). For each spasticity parameter (rMRPT, relative work, and RF  
115 and VL relative EMG) and assessment (before, during and after effective/sham bi-tDCS), a  
116 mean of the 5 quadriceps stretching tests was used in the analysis.

117 To verify the effect of bi-tDCS on spasticity parameters, separate ANOVAs with factors  
118 of time (×3: before/during/after) and stimulation (×2: effective/sham bi-tDCS) were used. *Post-*  
119 *hoc* analyses were performed using the Tukey-HSD comparisons.

120

121 Statistical analysis revealed no main effect of “stimulation” on any spasticity parameter  
122 but a main effect of “time” for rMRPT ( $F_{(2,24)}=4.7$ ;  $P<0.05$ ; Fig.1Ci) and relative work  
123 ( $F_{(2,24)}=4.4$ ;  $P<0.05$ ; Fig.1Cii). No significant “time” effect was found for the RF ( $F_{(2,24)}=2.5$ ;  
124  $P=0.14$ ; Fig.1Ciii) and VL ( $F_{(2,24)}=1.2$ ;  $P=0.31$ , Fig.1Civ) relative EMG. The lack of interaction

125 between the factors “stimulation” and “time” (All  $P$ -value $>0.35$ ) showed that the time effects  
126 were not attributed to the effective bi-tDCS.

127

## 128 **Discussion**

129 The results showed that a single session of bi-tDCS does not alter quadriceps spasticity  
130 either during or immediately after application.

131 Other than one case study [4], only Bradnam et al. [5] investigated the effects of a single  
132 session of tDCS on upper limb spasticity. They found a reduction in spasticity according to the  
133 modified Ashworth scale. Although their tDCS protocol (cathodal-tDCS over the unaffected  
134 hemisphere) differed from the present study, our stimulation set-up also included the  
135 application of a cathodal current over the unaffected hemisphere, thus should have had similar  
136 effects to that of Bradnam et al. [5]. The differences in results suggest that neural structures  
137 involved in lower limb spasticity do not respond to tDCS in the same way as those involved in  
138 upper limb spasticity. Further studies are required to determine whether i) a single session of  
139 bi-tDCS can modulate spinal networks excitability in spastic CSP, and ii) the lack of acute  
140 effect of bi-tDCS on the spasticity of CSP is specific to the quadriceps or consistent for other  
141 leg muscles (e.g. triceps surae). In addition, in contrast with studies reporting spasticity  
142 improvement in CSP following a tDCS session and using a subjective spasticity assessment  
143 (manual testing) [4,5], we used an objective instrumental spasticity assessment, which is more  
144 sensitive to the degree of spasticity and is not operator-dependent [7,8].

145 The results of this study do not support the use of a single session of bi-tDCS to improve  
146 quadriceps spasticity in CSP.

147

## 148 **Conflict/declaration of interest**

149 None

150 **Acknowledgements**

151 This work was supported by the « Fondation Garches ». The authors would like to thank the «  
152 Centre d'Investigation Clinique et Technologique 805 » for its monitoring of the study.

153

154 **References**

- 155 [1] Li S, Francisco GE. New insights into the pathophysiology of post-stroke spasticity.  
156 *Front Hum Neurosci* 2015;9:192. doi:10.3389/fnhum.2015.00192.
- 157 [2] Nowak DA, Grefkes C, Ameli M, Fink GR. Interhemispheric competition after stroke:  
158 Brain stimulation to enhance recovery of function of the affected hand. *Neurorehabil  
159 Neural Repair* 2009. doi:10.1177/1545968309336661.
- 160 [3] Roche N, Lackmy A, Achache V, Bussel B, Katz R. Effects of anodal transcranial  
161 direct current stimulation over the leg motor area on lumbar spinal network excitability  
162 in healthy subjects. *J Physiol* 2011;589:2813–26. doi:10.1113/jphysiol.2011.205161.
- 163 [4] Vandermeeren Y, Lefebvre S, Desfontaines P, Laloux P. Could dual-hemisphere  
164 transcranial direct current stimulation (tDCS) reduce spasticity after stroke? *Acta  
165 Neurol Belg* 2013;113:87–9. doi:10.1007/s13760-012-0163-5.
- 166 [5] Bradnam L V., Stinear CM, Barber PA, Byblow WD. Contralesional Hemisphere  
167 Control of the Proximal Paretic Upper Limb following Stroke. *Cereb Cortex*  
168 2012;22:2662–71. doi:10.1093/cercor/bhr344.
- 169 [6] Klem GH, Lüders HO, Jasper HH, Elger C. The ten-twenty electrode system of the  
170 International Federation. *The International Federation of Clinical Neurophysiology.*  
171 *Electroencephalogr Clin Neurophysiol Suppl* 1999;52:3–6.
- 172 [7] Kim DY, Park C, Chon JS, Ohn SH, Park TH, Bang IK. Biomechanical assessment  
173 with electromyography of post-stroke ankle plantar flexor spasticity. *Yonsei Med J*  
174 2005;46:546–54. doi:10.3349/ymj.2005.46.4.546.
- 175 [8] Fleuren JFM, Voerman GE, Erren-Wolters C V, Snoek GJ, Rietman JS, Hermens HJ,  
176 et al. Stop using the Ashworth Scale for the assessment of spasticity. *J Neurol  
177 Neurosurg Psychiatry* 2010;81:46–52. doi:10.1136/jnnp.2009.177071.
- 178 [9] Hermens HJ, Freriks B, Disselhorst-Klug C, Rau G. Development of recommendations  
179 for SEMG sensors and sensor placement procedures. *J Electromyogr Kinesiol*  
180 2000;10:361–74.