Exercise and Ankle Sprain Injuries: A Comprehensive Review

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Abstract: Ankle sprains are common in team sports and sports played on courts, and often result in structural and functional alterations that lead to a greater reinjury risk. Specific exercises are often used to promote neuromuscular improvements in the prevention and rehabilitation of ankle injuries. This literature review summarizes the neuromuscular characteristics of common ankle sprains and the effectiveness of exercise as an intervention for improving neuromuscular function and preventing reinjury. Our review found that appropriate exercise prescription can increase static and dynamic balance and decrease injury recurrence. In particular, the addition of dynamic activities in the exercise program can be beneficial because of the anticipatory postural adjustments identified as a key factor in the injury mechanism.

Keywords: ankle sprain; neuromuscular training; sensorimotor training; injury prevention; balance training

Introduction

The ankle is the second most commonly injured body part during sports,1 with ankle sprains being the most common ankle injury.1–3 Chronic ankle injuries usually involve some type of long-term alteration in the proprioceptive and neuromuscular function.4 Several researchers have demonstrated deficits of postural control in subjects sustaining an ankle sprain.5–8 Also, deficits have been identified in the injured and uninjured leg, suggesting either the existence of bilateral deterioration or the increased likelihood of ankle sprains among athletes with poorer postural control.5,8

Despite the existence of several investigations, there is still controversy concerning the intrinsic risk factors that lead to ankle sprains6,9 and the classification of functional ankle instability (FAI).10 It is still necessary to define, classify, and clarify the factors leading to chronic ankle instability (CAI).11 Moreover, there is little consensus in the terminology used to refer to preventive or rehabilitative training, and it is also necessary to define, classify, and clarify the factors leading to chronic ankle instability (CAI).11 In addition, the optimal training methods to achieve these objectives remain unclear.

Thus, the aim of this review is to summarize the best evidence with regard to acute lateral ankle sprain, FAI, CAI, and the effectiveness of exercise in the prevention or rehabilitation of these injuries.

Methods

English-language articles on PubMed and the Cochrane Library were searched through October 2012. The search terms (in different combinations) were: neuromuscular; sensorimotor; proprioceptive; balance; training; exercise; program; instability; resistance training; postural control; perturbation; proprioception; coordination,
ankle sprain, and injury prevention. Although a systematic approach was not used, articles were reviewed by 2 of the authors to determine if they were appropriate for inclusion.

Neuromuscular Characteristics of Common Ankle Sprains

Acute Lateral Ankle Sprain and Residual Symptoms

An acute lateral ankle sprain can be defined as a traumatic injury of the ankle joint ligaments, resulting from an excessive inversion of the rear foot or a plantarfexion combined with adduction of the foot.12

Prospective studies found that impaired balance is associated with a greater risk of ankle injuries.8,9,13,14 Other functional intrinsic deficits related to ankle injuries include lower eccentric eversion strength at slower isokinetic speeds, greater concentric strength in plantarfexion at higher isokinetic speed in relation to the dorsiflexion/plantarfexion ratio, and a lower inversion joint position sense in women.14 Despite some authors stating that a reduced dorsiflexion range of motion9,13 and a slower reaction time in the tibialis anterior and gastrocnemius muscles8 are factors that increase ankle injury risk, a recent meta-analysis14 suggested otherwise. Steffen and colleagues15 found that the largest risk factor for ankle sprains is a prior sprain sustained during the previous year. This underscores the importance of prevention in the first place and proper rehabilitation after injury to avoid reinjury.

After experiencing an ankle sprain, it is common for patients to experience residual symptoms.16,17 Recurrent sprains, “giving-way” episodes, pain, swelling, ankle instability, and decreased function are possible residual symptoms12 that may occur in 74% of patients for 1.5 to 4 years after the injury.16

Recurrent Ankle Sprains

Recurrent sprains are defined as > 2 sprains in the same ankle.12 People who have experienced an ankle sprain are up to twice as likely to experience another within the following year.16,19

In a recent review, Hiller et al20 analyzed the characteristics of persons experiencing recurrent sprains, finding that they often exhibit other deficits: increased postural sway while standing on 1 leg with their eyes closed, decreased foot clearance during gait, increased time to stabilization after performing a jump, and a lower concentric invertor strength. However, the cause-effect relationship between recurrent ankle sprains and postural stability is unknown. Interestingly, deficits in ankle range of motion, joint position sense, evetor strength, and peroneal latency were not found.

Functional Ankle Instability

Ankle instability can be mechanical or functional.12 Mechanical instability refers to a movement that goes beyond its normal range,3,12,20 and may be caused by mechanical deficiencies that alter the ankle joint mechanism, such as pathological laxity, decreased joint mobility, synovial inflammation, and degenerative changes.21

Although the definition of mechanical instability seems widely accepted, there is no universally accepted definition by which to classify functional instability.9 Some authors define FAI as having recurrent sprains or “giving-way” episodes.2,22,23 However, Delahunt et al12 do not associate recurrent sprains with FAI, and they believe that functional instability entails frequent “giving-way” episodes and the feeling of instability in the ankle joint.

Different factors have been suggested as possible causes of the functional instability. Hertel23 suggests that insufficiencies in proprioception, neuromuscular control, postural control, and strength are factors contributing to functional instability. Several authors have reported the presence of an altered postural control and sensorimotor deficits in people with FAI7,4 in both static and dynamic tests.

There is some controversy regarding evertor strength as a factor in FAI.24 The results of a meta-analysis24 suggest that concentric evertor weakness contributes to FAI, whereas other studies have reported that evertor strength deficits are not found in patients with recurrent sprains.20 This discrepancy may be due to different definitions or to the fact that subjects without recurrent sprains but with symptoms of “giving way” or feelings of instability experience evertor strength deficits.20

In addition to muscular strength deficits, muscle activation patterns may be a factor in FAI. It has been suggested that an ankle sprain injury occurs in the initial contact of the foot with the ground25; thus, the majority of ankle injuries do not occur in a static position,15,26 which suggests that dynamic muscle activation may be a factor in injury. Studies have shown that a sudden inversion injury occurs between 40 and 45 ms after foot contact.7,25 A systematic review analyzed several studies that measured the activation of the peroneals and tibialis anterior in response to a postural disturbance in subjects with FAI and concluded that there was no evidence of delayed peroneal reaction times.6 However, 1 study found a delayed tibialis anterior activation in subjects with FAI in response to a perturbation.29

Anderson and Behm30 highlighted the important role of anticipatory postural adjustments in maintaining balance when performing tasks. Some authors have reported that
patients with FAI have deficits in neuromuscular preparatory or anticipatory control (“feed-forward”), where the peroneus longus demonstrates reduced reaction time before the contact with the ground after performing jumps or during walking. Furthermore, Delahunt et al found a statistically significant inverted position of the ankle joint accompanying the lower peroneal activation prior to contact with the ground. Differences in the reaction forces after performing a jump have also been observed, finding an earlier peak ground reaction force in FAI subjects than in healthy controls, which may increase the possibility of experiencing repeated injuries. Moreover, subjects with FAI have been found to exhibit a decrease in vertical foot–floor clearance during the terminal swing phase of the gait cycle and require more time to stabilize after a single-leg jump landing.

Feed-forward deficits may increase injury risk because the ankle joint is less protected by an inadequate ankle joint position. It has been argued that the preparatory activity is more important to maintain the dynamic stability and prevent injuries than reactive activity after foot contact with the ground, because of the short reaction time requirements in functional and dynamic tasks. The importance of preparatory muscle activity for preventing injury during sports has been shown in a prospective study with female team handball and soccer players in relation to anterior cruciate ligament tears, but remains poorly investigated for ankle sprains.

Chronic Ankle Instability

It has been established that CAI affects between 10% and 20% of people who have experienced an acute ankle sprain. A diagnosis of CAI is considered when a patient experiences both types of instabilities (mechanical and functional) with residual symptoms for ≥ 1 year after the initial sprain. This definition of CAI is based on the commonly accepted paradigm proposed by Hertel, which distinguishes between functional and mechanical instability. However, controversy still exists regarding this classification and the terminology and factors that lead to these problems. Recently, Hiller et al proposed an evolution of the paradigm developed by Hertel, where recurrent sprains are separate from the presence of both instability types. Thus, the new model consists of 7 subgroups, and “functional instability” is renamed as “perceived instability.” This is because the authors found patients with both mechanical and functional instability but without recurrent sprains, and, conversely, some patients experience recurrent sprains but do not have any type of instability. This new approach may change future research, rehabilitation, and prevention, although further validation is required.

Hiller et al reported that patients without recurrent sprains but with other CAI symptoms exhibit evertor strength deficits. Conversely, a review concluded that patients with CAI do not experience impaired evertor strength or activation deficits during a stimulus reaction, although lowered invertor muscle strength may be present. Patients with CAI present with impaired ankle joint positional sense in the frontal plane and impaired dynamic postural control. This review highlights again the greater importance of the anticipatory adjustments for injury prevention. A recent study of patients with CAI found a lower co-contraction of the tibialis anterior and peroneus during the pre-landing after performing a jump, which may result in poor ankle stabilization and possibly increase the risk of injury. However, the effects of training in the preparatory action require further investigation.

Exercise for Ankle Injuries

One of the limiting factors in reviewing the literature on ankle exercise is the lack of consistent terminology. Although the term proprioception training is widely used, by definition it refers only to the afferent input, whereas the exercises described in the literature primarily involve motor tasks. Terms used in the literature to describe afferent and efferent aspects of ankle exercise are neuromuscular training, sensorimotor training, and neuromotor training. Recently, an American College of Sports Medicine position stand defined neuromotor training as a type of training that includes motor skills such as balance, coordination, agility, proprioception, and gait; however, the article used the term neuromotor training interchangeably with neuromuscular training.

Neuromuscular training programs incorporate different exercise components. For example, Paterno et al include balance training, strengthening exercises, and plyometrics in their neuromuscular training program. More recently, Janssen et al consider neuromuscular training to include sensorimotor exercises, proprioception, and balance training. O’Driscoll and Delahunt consider neuromuscular exercise to include proprioception tasks, strength, or both; however, in a recent intervention by the same authors, their neuromuscular training program incorporated postural stability, strengthening exercises, plyometrics, and speed/agility. Furthermore, Zech et al consider neuromuscular and proprioceptive training to include balance exercises, plyometrics, and postural disturbances. Thus, a need exists for a consensus on the terminology used in the ankle rehabilitation literature,
as this will facilitate the search for information and future research in this area. Based on the present literature review, we suggest using neuromuscular training as a general term for any type of training that involves neuromuscular stress in response to multiple tasks. However, a concise description of the exercise program is also essential.

Effectiveness of Exercise in Prevention and Rehabilitation

Several reviews and meta-analyses have examined the effects of neuromuscular training. It has been established that balance training is effective in improving postural and neuromuscular control in healthy and physically active participants, as well as in prevention and rehabilitation. Balance training may increase static and dynamic balance in athletes and nonathletes and may also have a positive effect on agility and jumping. Wikstrom et al also recommend balance and coordination exercises as a tool to improve postural control in patients with acute lateral ankle sprains. Moreover, neuromuscular training is effective in decreasing “giving-way” episodes after acute ankle sprains, increasing joint functionality and improving postural control.

Anderson and Behm recommended the combination of balance and strength training for people with somatosensory deficits. The application of instability resistance training using unstable devices is an interesting element to reach greater muscle activation with lower load, and a method to perform both strength training and balance training. In fact, Behm and Anderson stated that the main objective of performing training with unstable devices is to improve balance, stability, and proprioceptive capabilities. Furthermore, they highlight the role of the trunk/core stabilization as an essential element in maintaining both static and dynamic balance, especially when trying to exert forces on external objects. According to these authors, the integration of strength and balance training can improve motor control by increasing muscle activation, strength, and stiffness. Balance training provokes unexpected postural disturbances, eliciting a stabilization reflex through co-contraction mechanisms with shorter reaction times. The reflex activation of the muscles around the ankle contributes significantly to the joint stabilization.

Some researchers have demonstrated the effectiveness of balance training to improve reaction time in the tibialis anterior muscle and the peroneus longus in subjects with a history of ankle sprains, and to improve synchronized activation of these muscles in patients with CAI. Interestingly, Clark and Burden note that it was unlikely that subjects have sufficient strength torque to prevent an ankle inversion injury; however, the authors suggest that balance training helps to reduce the risk of recurrent injuries by increasing joint stiffness. Other authors have agreed that improving reaction time does not prevent inversion ankle injuries, because it is improbable that peroneal reaction alone is enough to avoid injury. Decreasing the recurrence of ankle sprains is one of the most frequently demonstrated effects of exercise training in reviews that focus on exercise and ankle injuries. Van der Wees et al published a review that analyzed the effectiveness of exercise therapy in patients with acute ankle sprains and FAI. The authors concluded that exercise (i.e., proprioceptive training, coordination training, strength training, or functional exercises) is effective in the prevention of recurrent sprains for both types of patients. Similarly, Zech et al confirm that proprioceptive/neuromuscular training could be effective in preventing recurrent sprains in patients with CAI or those experiencing an acute ankle sprain. Proprioceptive exercises, balance training, and strengthening improve postural control, increase muscle strength, reduce muscle reaction time, and are effective for patients with recurrent “giving-way” episodes. Verhagen and Bay evaluated the effectiveness of different measures to prevent ankle sprains. After analyzing 24 studies, the authors noted that neuromuscular exercise is effective to prevent recurrent sprains, reducing them by approximately 50%. However, several authors have found no effect in the prevention of a first-time ankle sprain.

Although the effectiveness of exercise in preventing recurrent ankle sprains has been demonstrated, the pathways through which exercise reduces risk remain unclear. According to Hupperets et al, sensorimotor training provides neurophysiological and morphological changes, such as increased strength or improved muscle reaction time, that lead to functional improvements, which in turn reduce the risk of recurrent sprains. Previously, Karlsson and Lansinger found that neuromuscular training accelerates the healing process by restoring and strengthening the ligaments, muscles, and reflexes that protect the ankle. In addition, Taube et al found that balance training adaptations occur in all sensory systems that facilitate postural control.

Balance training is also used to improve postural control of patients with CAI. Webster and Gribble conducted a systematic review to test the effectiveness of neuromuscular rehabilitation in patients with CAI. The authors confirmed the effectiveness of functional closed-kinetic chain exercises, especially in subjects using unstable devices such as a wobble board to improve dynamic postural control and self-reported outcomes, including reductions in recurrent injuries.
and colleagues analyzed other CAI reviews and concluded that neuromuscular training is effective in the treatment of subjects with this injury. O’Driscoll and Delahunt recently conducted a systematic review of neuromuscular training (proprioception, strength, or both) in patients with CAI. Their review found moderate evidence of neuromuscular training effects on static and dynamic balance, joint position sense, isometric strength, muscle onset latencies, injury recurrence, and Shank–rear-foot coupling. Table 1 summarizes the most demonstrated benefits of exercise on ankle sprain injuries.

Table 1. Effects of Neuromuscular/Neuromotor/Sensorimotor Training in Ankle Sprain Injuries

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Neuromuscular/Neuromotor/Sensorimotor Training (Balance, Proprioception, Plyometrics, Strength, Speed/Agility)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute ankle sprain</td>
<td>Improve postural control46, Decrease “giving-way” episodes45, Decrease recurrent ankle sprains44, Improve muscle reaction time45, Improve joint position test44, Improve muscle reaction time46, Improve Shank–rear-foot coupling46</td>
</tr>
<tr>
<td>Functional ankle instability</td>
<td>Decrease “giving-way” episodes, Decrease recurrent ankle sprains, Increase muscle strength, Improve muscle reaction time, Improve joint position test, Improve Shank–rear-foot coupling</td>
</tr>
<tr>
<td>Chronic ankle instability</td>
<td>Decrease recurrent ankle sprains, Increase muscle strength, Improve muscle reaction time, Improve Shank–rear-foot coupling</td>
</tr>
</tbody>
</table>

**Conflict of Interest Statement**

Joaquin Calatayud, MSc, Sebastien Borreani, MSc, Juan Carlos Colado, PhD, Jorge Flandez, MSc, Phil Page, PhD, and Lars L. Andersen, PhD, have no conflicts of interest to declare.

**References**

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