Short-term pressure induced suppression of the short-latency response: a new methodology for investigating stretch reflexes

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Leukel C, Lundbye-Jensen J, Gruber M, Zuur AT, Gollhofer A, Taube W. Short-term pressure induced suppression of the short-latency response: a new methodology for investigating stretch reflexes. J Appl Physiol 107: 1051–1058, 2009. First published August 20, 2009; doi:10.1152/japplphysiol.00301.2009.—During experiments involving ischemic nerve block, we noticed that the short-latency response (SLR) of evoked stretches in m. soleus decreased immediately following inflation of a pneumatic cuff surrounding the lower leg. The present study aimed to investigate this short-term effect of pressure application in more detail. Fifty-eight healthy subjects were divided into seven protocols. Unilateral stretches were applied to the calf muscles to elicit a SLR, and bilateral stretches to evoke a subsequent medium-latency response (MLR). Furthermore, H-reflexes and sensory nerve action potentials (SNAPs) were recorded.

Additionally, stretches were applied with different velocities and amplitudes. Finally, the SLR was investigated during hopping and in two protocols that modified the ability of the muscle-tendon complex distal to the cuff to stretch. All measurements were performed with deflated and inflated cuff. Results of the protocols were as follows: 1) inflation of the cuff reduced the SLR but not the MLR; 2) the H-reflex, the M-wave, and, 3) SNAPs of n. tibialis remained unchanged with deflated and inflated cuff; 4) the SLR was dependent on the stretch velocity with deflated and also inflated cuff; 5 and 6) the reduction of the SLR by the cuff was dependent on the elastic properties of the muscle-tendon complex distal to the cuff; and 7) the cuff reduced the SLR during hopping. The present results suggest that the cuff did not affect the reflex arc per se. It is proposed that inflation restricted stretch of the muscles underlying the cuff so that most of the length change occurred in the muscle-tendon complex distal to the cuff. As a consequence, the muscle spindles lying within the muscle may be less excited, resulting in a reduced SLR. Due to its applicability in functional tasks, the introduced method can be a useful tool to study afferent feedback in motor control.

Ia afferents: hopping; ischemia; medium latency response

MOVEMENT IS BROUGHT ABOUT by efferent and afferent neural activity driving the spinal α-motoneurons. The role of afferent feedback in motor control has been studied by using an ischemic nerve blockage (e.g., Refs. 21, 27). With this technique, a pneumatic cuff is encompassed and inflated around a limb to stop blood circulation distal to the cuff. Thicker nerve fibers are more susceptible to ischemia than smaller ones. Therefore, it has been argued that the conductivity of the large-diameter Ia afferent fibers is diminished before that of efferent motoaxons (14, 19). Previously, ischemia has been used to assess the contribution of (Ia) afferent feedback in relation to descending motor commands (5), in motor responses to painful stimuli (27), and in postural tasks, as well as walking (9, 10, 14). However, in functional movements like walking, ischemia is associated with several methodological limitations. First, there is the limited time for investigation. It exists for only a short time window of a few minutes, where solely the (Ia) afferents rather than the motoaxons are thought to be blocked (19). Second, the delayed effect of the Ia afferent ischemic nerve block means that subjects have to wait for ∼15–20 min while held ischemic before the measurement can start. Given the short time window and the delayed effect, repeated measures are very time consuming. Third, ischemia causes pain in the affected limb. It is, therefore, both uncomfortable and demanding for subjects to perform dynamic tasks naturally. Fourth, ischemia increases the risk of vascular diseases (e.g., thromboses) caused by the prolonged blockage of blood flow.

The present study introduces a new tool to investigate afferent feedback in functional tasks that inherits none of the above-mentioned limitations. This tool was discovered in a recent study involving ischemic nerve blockage. Here we noticed that the earliest peak of the soleus (SOL) stretch reflex in the electromyogram (EMG), termed short-latency response (SLR), was markedly reduced following inflation of a pneumatic cuff surrounding the lower leg. The SLR, which is considered to be mediated by fast-conducting Ia afferent fibers (2, 13, 20), was reduced immediately after inflation. The aim of the present study was twofold: first, to detect the underlying mechanism of the reduction of the SLR by short-term pressure application; and, second, to test the applicability of this method to investigate afferent feedback in functional tasks. To clarify which mechanism was responsible for the reduction of the SLR, we elucidated whether the inflated cuff affects solely the SLR or also other reflex peaks with longer latencies. Therefore, a subsequent reflex peak to the SLR, termed medium-latency response (MLR), was elicited while inflating the cuff. The MLR is attributed to oligosynaptic excitation of spinal motoneurons via group II afferents (3, 8, 14, 22–24) and possibly by group Ib afferents (7). In addition, the afferent and efferent paths of the (Ia afferent) reflex arc were investigated by using H-reflexes and sensory nerve action potentials (SNAPs). This should clarify whether the reduction of the SLR was caused by manipulation of the neurophysiological components of the
reflex arc. Furthermore, it was assessed whether the cuff changed the mechanical characteristics of the initiated stretch.

To investigate the second issue of the present study, the applicability of the introduced method in functional tasks, short-term pressure to the calf muscles was applied by inflating the cuff during hopping. Hopping has previously been shown to comprise a strong SLR (17), and we, therefore, hypothesized that inflation of the cuff would decrease the SLR if the method was applicable in functional tasks.

MATERIALS AND METHODS

A total of 58 subjects, without orthopedic and neurological disorders, were divided into 7 groups with 7 different protocols. Group 1, containing eight subjects (aged 23 ± 3 yr), participated in protocol 1 (effect on the SLR and MLR). Group 2 (10 subjects, aged 27 ± 2 yr) participated in protocol 2 (H-reflex recruitment). Group 3 (six subjects, aged 24 ± 2 yr) participated in protocol 3 (SNAP). Group 4 (eight subjects, aged 25 ± 3 yr) participated in protocol 4 (different stretch velocities and amplitudes). Group 5 (nine subjects, aged 24 ± 4 yr) participated in protocol 5 (high tension). Group 6 (five subjects, aged 24 ± 2 yr) participated in protocol 6 (taping), and group 7 (12 subjects, aged 27 ± 3 yr) participated in protocol 7 (hopping) (see also Table 1). The study was approved by the ethics committee of the Albert-Ludwigs-University in Freiburg, and experimental procedures were performed in accordance with the Declaration of Helsinki. All subjects gave written, informed consent before participation.

EMG Recordings and Kinematics

EMG recordings were obtained from the SOL and tibialis anterior (TA) muscles of the right leg. After preparation, bipolar surface electrodes (Blue sensor P, Ambu, Bad Nauheim, Germany) were attached to the skin (2-cm interelectrode distance). The reference electrode was placed on the tibial plateau. EMG signals were amplified (×1,000), bandpass filtered (10–1,000 Hz), and sampled at 4 kHz. The EMGs were stored for offline analysis with custom-built software (LabView based, National Instruments, Austin, TX).

In protocol 7 (hopping), ankle angles (dorsiflexion and plantarflexion) and knee angles (knee flexion and extension) were recorded (sampling frequency 4 kHz) by custom-built goniometers. The goniometer axis of rotation was aligned with rotational axes of the ankle and knee joint, respectively.

Cuff

A conventional blood pressure cuff (Bosch & Sohn, Jungingen, Germany) was used to compress the right calf muscles. The cuff was placed just above the Achilles tendon. SOL and TA EMG electrodes were placed distal to the cuff (see also Fig. 1). In trials with inflated cuff, pressure was always between 220 and 240 mmHg. In all protocols, the measurements started immediately (5 s) after the cuff was inflated.

H-reflexes

H-reflexes were elicited with an electrical stimulator (constant-current stimulator AS100, Alea Solutions, Zürich, Switzerland) in the right SOL by stimulating the posterior tibial nerve. Stimuli consisted of square-wave pulses of 1-ms duration. The anode, a rubber pad of 10 × 5 cm, was fixed on the anterior aspect of the knee just underneath the patella. During upright stance, the cathode (2 cm in diameter) was placed in the popliteal fossa, moved stepwise until the optimum position for eliciting an H-reflex was found, and then fixed with tape (stimulation intensities in this condition ranged between 5 and 15 mA). Care was taken that the stimulation did not activate TA.

Experimental Protocols

Protocol 1: Effect on the SLR and MLR. This protocol aimed to elucidate the effect of the inflated cuff on the SLR and MLR. All measurements were conducted in a custom-made ankle ergometer. Subjects stood upright with their feet strapped to the left and right platform of the ergometer. They had the knees extended and the ankles at 90°. Arms had to be held akimbo. The rotation axis of the upper ankle joint coincided with the rotation axis of the torque platform. Torque of the rotation platform was assessed using a torque transducer (Burster, Gernsbach, Germany), and displacement was measured with a goniometer (Megatron, München, Germany). Both devices were mounted between the servomotor of the ankle ergometer and the platform. Unilateral stretches were applied to the right leg plantar flexor muscles by rotating the platform with a maximal

![Fig. 1. Schematic diagram of the placement of the electromyogram (EMG) electrodes and the cuff covering the calf muscles.](http://jap.physiology.org/content/jap/article/107/10/1052.full)
velocity of 250°/s (time from the onset of the stretch to the maximal velocity was set to 10 ms) and a displacement of 10° dorsi-flexion (toe-up rotation). The initiation of the dorsiflexion movement of the platform was defined as the onset of the stretch (time t = 0). Fifteen stretches were evoked with deflated cuff, followed by 15 stretches with inflated cuff. Immediately (5 s) after the cuff was deflated again, 15 stretches were elicited to monitor longer lasting effects on the SLR. The interstimulus interval between the stretches was set to 4 s.

Unilateral stretches evoked solely an SLR. To elicit an additional MLR, the right and left platform of the ergometer were synchronously rotated, while subjects were standing with their eyes closed. Fifteen stretches were applied with the cuff deflated, and 15 with the cuff inflated in a randomized order.

Protocol 2: H-reflex recruitment. This protocol was conducted to investigate whether the Ia afferent pathway proximal to the cuff, the motor axonal properties, and/or the recording conditions were affected by inflation of the cuff. Subjects received unilateral stretches to their right leg plantar flexor muscles as in protocol 1. The stretches were applied to ensure the depressive effect of the cuff on the SLR. The further, H/M recruitment curves were recorded with deflated and inflated cuff, respectively, during quiet upright stance. The interstimulus interval between the electrical stimuli was 4 s. Each H/M recruitment curve contained ~20–30 stimuli, ranging from the intraindividual stimulation intensity to evoke the H-reflex threshold (500 μV peak-to-peak amplitude) to the intensity to evoke the maximum M-wave (Mmax). Stimulation intensity was progressively increased until maximum H-reflex (Hmax) was obtained, and further increased until Mmax was recorded. To exclude that changes in the SOL H-reflex originated from alterations in the excitability of the homonymous (postsynaptic modulation) and antagonistic (reciprocal inhibition) motoneuron pool, the background EMG activity of the rectified SOL and TA were calculated as mean values in a 100-ms time window before the electrical stimulation for all sampled H-reflexes/M-waves. Intraindividual means were calculated for all sampled sweeps.

Protocol 3: SNAP. This protocol was conducted to test whether the afferent fibers of n. tibialis were compressed by the overlying cuff, which could have resulted in an altered conduction velocity of the nerve. Therefore, the size and the latency of SNAPs of n. tibialis, stimulated distal to malleolar medialis and recorded in the popliteal fossa (1), were compared between deflated and inflated cuff. Before starting with the SNAP recordings, the inhibitory effect on the SLR by the inflation of the cuff was tested in the ankle position, while subjects were asked to fixate their ankle joint at 95° plantar flexion. Distal, the tape was fixed at the heel and proximal directly at the insertion of the Achilles tendon. After taping, the cuff was fixed so that its lower border overlaid the proximal end of the tape. With the tape, subjects received 15 unilateral stretches with deflated and inflated cuff in the ankle ergometer as in protocol 1. Then the tape was cut in the middle (but still covered the skin) to regain the natural ability of the muscle-tendon complex distal to the cuff to stretch. Again, 15 stretches were applied with deflated and inflated cuff.

Protocol 4: Different stretch velocities and amplitudes. Protocol 4 elucidated whether the SLR with inflated cuff was dependent on the velocity of the stretch. Subjects received unilateral stretches to their leg plantar flexor muscles as in protocol 1. The stretches were evoked with three different amplitudes (5°, 10°, 14°) and three different maximal velocities (50°/s, 150°/s, 250°/s). The protocol was executed with deflated and inflated cuff. The time from the onset of the stretch to the maximal velocity was set to 10 ms. The chronological order of the nine conditions was randomized. In total, 15 stretches were recorded for each condition.

Protocol 5: High tension. Protocol 5 elucidated the effect of the inflated cuff when the tension of the muscle-tendon complex was high. Subjects again received unilateral stretches to their right leg plantar flexor muscles as in protocol 1. Thereafter, during upright stance, subjects were asked to lean forward close to the feeling of falling over. This caused a high pretension of the leg plantar flexor muscles. In this posture, subjects received 15 unilateral stretches with deflated and inflated cuff, respectively.

Protocol 6: Taping. In this protocol, the ability of the muscle-tendon unit distal to the cuff to stretch was artificially modulated. This protocol is, in its main aim, analogous to protocol 5, in which the elastic properties were changed by a higher tension of the muscle-tendon unit (leaning forward). In protocol 6, the muscle-tendon complex distal to the cuff was taped longitudinally down the back of the lower leg (Leukotape, BSN Medical, Hamburg, Germany). The rigidity of the tape restricted the tendomuscular system distal to the cuff from moving in response to the stretch. Taping was performed in a supine position, while subjects were asked to fixate their ankle joint at 95° plantar flexion. Distal, the tape was fixed at the heel and proximal directly at the insertion of the Achilles tendon. After taping, the cuff was fixed so that its lower border overlaid the proximal end of the tape. With the tape, subjects received 15 unilateral stretches with deflated and inflated cuff in the ankle ergometer as in protocol 1. Then the tape was cut in the middle (but still covered the skin) to regain the natural ability of the muscle-tendon complex distal to the cuff to stretch. Again, 15 stretches were applied with deflated and inflated cuff.

Protocol 7: Hopping. In this protocol, the cuff was applied during dynamic hopping movements. Subjects performed low-height hopping on a three-dimensional force platform (Kistler, Winterthur, Switzerland) with an individually chosen hopping frequency for 2 min (warm up). The subjects were instructed to hop with “stiff” knees and perform the hops primarily by ankle joint movement. Arms had to be held akimbo. After the warm up, subjects were asked to hop supermaximally at ~60–80% of their maximal individual hopping height with an individually preferred frequency for the rest of the experiment. Twenty hops were performed with deflated cuff, and 20 hops with the cuff inflated. The order of these measurements (hopping with deflated and inflated cuff) was randomized, e.g., some subjects started hopping with the cuff inflated, and others with deflated cuff. After this set, the order was reversed, so that a total number of 40 hops was recorded for each condition (cuff deflated and inflated).

To investigate whether the Ia afferent pathway proximal to the cuff, the motor axonal properties, and/or the recording conditions were affected by inflation of the cuff, H/M recruitment curves were recorded during hopping with deflated and inflated cuff in 10 out of the 12 tested subjects. As in a previous study (18), H-reflexes were elicited to occur at the peak of the SLR during hopping. The peak of the SLR during hopping (first peak in SOL after 35 ms with respect to ground contact) was determined from the rectified and averaged SOL EMG of the 40 jumps of the previous hopping condition in which the cuff was deflated. A light barrier (Optojump, Microjumpt, Bolzano, Italy), mounted 5 cm above the force plate, served as a trigger to elicit the H-reflex (for details, see Ref. 18). Again, the chronological order of the conditions (hopping with deflated and inflated cuff) was randomized. The procedure of the H/M recordings was the same as in protocol 2 (H-reflex recruitment). To avoid fatigue, the interstimulus
interval between the electrical stimuli during hopping was 1 s (e.g., given an average time of the hopping cycle of 300 ms, the subject was stimulated at every third hop).

Data Analysis and Statistics

H-reflexes, M-waves, and SNAPs were expressed as peak-to-peak amplitudes. H\(_{\text{max}}\) and M\(_{\text{max}}\) were calculated from peak-to-peak amplitudes of the maximum H-reflexes and the M\(_{\text{max}}\) of the unrectified SOL EMG. M\(_{\text{max}}\) was determined from the largest single response. H\(_{\text{max}}\) was determined from the largest single peak-to-peak response and additionally calculated as the mean of the three largest single responses. The latter accounted for possible outliers of H\(_{\text{max}}\).

The peak of the SLR (peak of the first maximal deflection in the EMG caused by the stretch) was detected from the rectified SOL EMG (see also Figs. 1 and 4). The peak of the MLR was defined as the second maximal deflection in the EMG occurring at least 10 ms after the peak of the SLR. A 20-ms time window was set around the peak of the SLR, and the mean was calculated for each trial. After analyzing each trial, the mean was calculated for all trials. The MLR in SOL was calculated as a mean of the rectified EMG in a 20-ms time window, which followed the time window of the SLR. For instance, when a subject showed a peak of the SLR at 40 ms, the SLR was calculated from 30 to 50 ms. The MLR in this example was calculated from 50 to 70 ms.

In protocol 4 (different stretch velocities and amplitudes), a total of nine conditions with different maximal stretch velocities and amplitudes were tested. The size of the SLR of these conditions was intraindividually normalized to the basic stretching condition of the present study, which is: 10° stretch amplitude and 250°/s maximal stretch velocity.

During hopping, the ankle and knee angles at the SLR were calculated as root-mean-square values in a 20-ms time window around the peak of the SLR. Thereby, 180° knee angle refers to knee extension. An angle of 90° between the fifth metatarsal and the fibula is defined as 90° ankle angle.

To account for changes in the motor axonal properties and/or changes in the recording conditions between deflated vs. inflated cuff, the SLR during stance and the H\(_{\text{max}}\) during stance and hopping were normalized to M\(_{\text{max}}\) (SLR/M\(_{\text{max}}\) × 100 and H\(_{\text{max}}\)/M\(_{\text{max}}\), respectively).

This normalization procedure could only be obtained in protocols 2 (H-reflex recruitment) and 7 (hopping), in which electrical nerve stimulation was applied and thereby M\(_{\text{max}}\) was determined. All values are expressed as group mean ± SD, if not indicated differently.

The SLR obtained with deflated and inflated cuff in protocol 4 (different stretch velocities and amplitudes) was analyzed by means of repeated-measures ANOVA with the within-subject factors amplitude (5°, 10°, 14°) and maximal velocity (50°/s, 150°/s, 250°/s). Paired Student’s T-tests were used for all other statistical analyses.

Differences were regarded significant at P < 0.05 for all tests. SPSS software 15.0 (SPSS, Chicago, IL) was used for the statistical analyses.

RESULTS

Protocol 1: Effect on the SLR and MLR

During unilateral stretches, the SLR was significantly higher with deflated (0.34 ± 0.17 mV) than with inflated cuff (0.17 ± 0.12 mV, P < 0.01), but recovered immediately after the cuff was deflated again (0.34 ± 0.17 mV, P = 0.95). During bilateral stretches while the subjects closed their eyes, the SLR was again higher with deflated (0.30 ± 0.13 mV) than with inflated cuff (0.24 ± 0.13 mV, P < 0.001). However, the MLR, which was observed in all subjects, was not different between deflated and inflated cuff (0.18 ± 0.07 vs. 0.17 ± 0.07 mV, P = 0.53, Fig. 2). The peak of the SLR showed a latency of 42 ± 4 ms, and the peak of the MLR of 61 ± 3 ms.

Protocol 2: H-reflex Recruitment

Normalized to M\(_{\text{max}}\), the SLR with unilateral stretches was significantly different between deflated (6.0 ± 4.9%) and inflated cuff (4.1 ± 4.6%, P < 0.05), but recovered immediately after the cuff was deflated again (6.3 ± 4.5%, P = 0.71). The peak of the SLR showed a latency of 43 ± 3 ms.

With respect to the normalized H\(_{\text{max}}\), there was no difference between deflated and inflated cuff, neither when the largest single response was compared (0.42 ± 0.21 vs. 0.43 ± 0.2, P = 0.71), nor the mean calculated out of the three largest single responses (0.39 ± 0.21 vs. 0.40 ± 0.19, P = 0.93). The H-reflex latency (peak) during stance was 39 ± 3 ms. M\(_{\text{max}}\) amplitude was 9.1 ± 2.6 mV with deflated cuff. This was not statistically different from M\(_{\text{max}}\) with inflated cuff (8.4 ± 2.4 mV, P = 0.10, Fig. 3). The background EMG activity of SOL and TA was not different between deflated (SOL: 38 ± 2 μV; TA: 18 ± 5 μV) and inflated cuff (SOL: 36 ± 3 μV, P = 0.37; TA: 17 ± 5 μV, P = 0.18), indicating that the excitability of the homonymous and antagonistic motoneuron pool was unaltered between the conditions.

Protocol 3: SNAP

To investigate whether inflation of the cuff affected (compressed) the underlying afferent fibers of n. tibialis, the amplitude and the latency (peak) of SNAPs were compared between deflated and inflated cuff. There was no change in the SNAP amplitude between deflated (9.3 ± 0.2 μV) and inflated cuff (10.4 ± 0.2 μV, P = 0.10). The latency of the SNAPs was the same between deflated and inflated cuff (9 ± 1 vs. 9 ± 1 ms, P = 0.89).

Protocol 4: Different Stretch Velocities and Amplitudes

With deflated cuff, the maximal stretch velocity, but not the stretch amplitude, showed a significant effect on the size of the SLR [stretch velocity: F(2,14) = 34.06; P < 0.001; stretch amplitude: F(2,14) = 2.03; P = 0.17, Fig. 4]. This
indicates that, with deflated cuff, the size of the SLR was dependent on the stretch velocity, but not on the amplitude of the stretch. This was also true for the SLR with inflated cuff: the stretch velocity, but not the stretch amplitude had a significant effect on the size of the SLR \[\text{stretch velocity: } F(2,14) = 14.26; P = 0.01; \text{ stretch amplitude: } F(2,14) = 0.12; P = 0.89, \text{ Fig. 4}.\] The peak of the SLR showed a latency of 40 ms.

**Protocol 5: High Tension**

During quiet upright stance, subjects again showed a significantly higher SLR with deflated cuff \((0.27 \pm 0.16 \text{ mV})\) than with inflated cuff \((0.16 \pm 0.13 \text{ mV}, P < 0.01)\). However, when subjects were instructed to lean forward to pretense their leg plantar flexors, the SLR was no longer decreased with inflated compared with deflated cuff \((0.27 \pm 0.11 \text{ vs. } 0.27 \pm 0.13 \text{ mV}, P = 0.95, \text{ Fig. 5}).\) The SLR with deflated cuff showed no difference when posture was altered, e.g., subjects standing relaxed vs. leaning forward \((P = 0.94).\) The latency of the peak of the SLR in this protocol was \(41 \pm 3 \text{ ms}\).

**Protocol 6: Taping**

In the conditions without tape, subjects again showed a significantly higher SLR with deflated cuff \((0.30 \pm 0.08 \text{ mV})\) than with inflated cuff \((0.16 \pm 0.09 \text{ mV}, P < 0.001)\). Based on the mean values, this represented a reduction of the SLR of 46%. In the conditions with tape, there was no longer a significant reduction of the SLR between deflated \((0.28 \pm 0.11 \text{ mV})\) and inflated cuff \((0.23 \pm 0.09 \text{ mV}, P = 0.10)\). Based on the mean values, the reduction of the SLR in the taping condition was only \(18\%.\) The peak of the SLR in protocol 6 showed a latency of \(40 \pm 2 \text{ ms}\).
Protocol 7: Hopping

During hopping, we observed a significantly reduced SLR with inflated cuff compared with deflated cuff (protocol 1). The MLR is ascribed to group II (3, 8, 22–24) and possibly Ib afferents (7), whereas the SLR is attributed to the activation of fast-conducting Ia afferent fibers (2, 4, 6, 11, 13, 16, 20). In the present study, it might have been possible that the inflation of the cuff changed the excitability of the Ia afferent pathway proximal to the cuff and thereby reduced the SLR. Therefore, we conducted protocol 2 in which H-reflexes were elicited. The H-reflex is mainly transmitted via Ia afferent fibers (26). The comparability of Hmax between deflated and inflated cuff indicates that the motor axonal properties were not significantly altered by the cuff and that the recording conditions did not change. Based on these observations, there remain two components of the reflex arc that could have been influenced by the inflated cuff: the afferent nerve fibers underneath the cuff might have been compressed, and/or the muscle spindles receiving the stretch could have been affected. The results of protocol 3 make it unlikely that the transmission of afferents was altered by the cuff. In this protocol, SNAPs, which are propagated mainly via large (Ia) afferent fibers, were elicited distal to the cuff and recorded in the popliteal fossa (1). The amplitude and the latency of the SNAPs were the same between deflated and inflated cuff. Therefore, as the conductivity of afferent nerve fibers underlying the cuff was not altered by inflation of the cuff, the decrement of the SLR seems to be associated with the muscle spindles. The results of protocol 4 support this assumption. Here, different stretch velocities and amplitudes were applied. The modulation of the size of the SLR with deflated and also inflated cuff was related to the stretch velocity but not the amplitude of the stretch. Primary spindle endings of Ia afferent fibers, which are thought to be responsible for eliciting at least the first part of the SLR, were argued to signal the very initiation of a length change of a muscle (25). The strength of the initial length change of a muscle can be modulated by the stretch velocity. The dependency of the SLR on the stretch velocity but not the stretch amplitude was shown in previous protocols.
Application in Functional Tasks

The introduced method can be of functional significance. An immediate, completely reversible, and easily repeatable depression of the SLR by short-term inflation of a cuff surrounding the muscle can be used to gain a deeper understanding of afferent feedback mechanisms in motor control. In the present study, the new technique was used to investigate afferent feedback during hopping (protocol 7). With ischemia, a selective blockage of the SLR during hopping is difficult, because of the limited time window allowed for testing, the associated pain, and, therefore, the restricted movement behavior. During hopping, short-term inflation of the cuff was able to reduce the SLR. However, it has to be noted that, although the group mean values were significantly different, there remained a few subjects showing no changes of the SLR between deflated and inflated cuff during hopping. Interestingly, in these subjects, it was possible to reduce the SLR by cuff inflation during upright stance in the ankle ergometer. There are at least two implications associated with this finding: one is that there is no SLR during hopping (in these subjects), and the other is that the cuff did not work in these subjects. Since other studies provided evidence that the SLR plays a role during hopping (17), it is argued that, based on the above-mentioned explanatory model of the mechanism of the cuff, the failure to reduce the SLR in these subjects may be due to a high tension of the muscle-tendon unit during ground contact (when the stretch occurred). Therefore, caution may be advised when interpreting effects of the introduced methodology, e.g., in conditions in which excessive tendomuscular tension is produced.

Besides this methodological constraint, it is concluded that, due to its immediate, reversible, and easily repeatable effect, accompanied with a lower risk of vascular diseases (e.g., thromboses) than ischemia, and its applicability in functional tasks, the introduced method bears the potential to investigate stretch reflex contributions in highly dynamic tasks. In this context, it is important to note that changes in the movement execution (e.g., the mechanics) cannot be attributed to the depression of the SLR. This is not possible, as the mechanics between deflated and inflated cuff differ fundamentally and not just because of the depressive effect on the SLR. Finally, it is important to note that the results of all protocols do not restrict the effect of the cuff to a selective blockage of Ia afferents. The cuff may affect other afferents as well.

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