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Title:

Baropodometric quantification and implications of muscle coactivation in the lower limbs caused by head movement: a prospective study

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- 1 Baropodometric quantification and implications of muscle coactivation in the
- 2 lower limbs caused by head movement: a prospective study
- 3
- 4

5 Background: In healthy young adults, muscle coactivation can sometimes be
6 induced by remote voluntary contractions when the motor task is forceful,
7 maximal, tiring, or cyclic and brief.

8 Objectives: To show that a change in plantar pressure is an unequivocal
9 response to backward movement of the head, and to contribute to a better
10 understanding of physiotherapy methods that involve remote muscle
11 activation.

12 Methods: Involuntary coactivation was quantified as a percentage of the
13 anteroposterior plantar pressure distribution, using a baropodometric
14 platform in a population of young adults. The baropodometric data were
15 collected from a 1-second recording after 30 seconds in the reference
16 condition, and from 1-second recordings during the first second and then
17 during the 120th second in the test condition. The results were analyzed with
18 Bayesian statistics (Markov chains and Monte Carlo integration techniques).

19 Results: 90 adults participated in the study (age range: 19-26; 38 males and
20 52 females). The forefoot plantar pressure increased in all cases, by a mean
21 multiplicative factor (on a logit scale) of 1.12 (from 72.24% to 74.45%) when
22 the head was aligned over the trunk.

23 Conclusions: This 90-participant trial confirmed our initial hypothesis: a
24 increase in forefoot plantar pressure is a systematic response to the motor
25 task (head movement), and suggests greater recruitment of the plantar flexor
26 muscles. A spinal reflex and/or a previously unknown form of motor overflow
27 might be involved in this phenomenon. These results support the
28 development of inductive physiotherapy techniques based on remote muscle
29 activation in the treatment of musculoskeletal disorders.

30 ClinicalsTrial.gov identifier: NCT02320097

31

32

33 Keywords:

34 motor irradiation; baropodometry; plantar pressure; inductive physiotherapy

35

36

1. INTRODUCTION

37 Ever since Sherrington's seminal work on spinal reflexes, it has been
38 known that the execution of a coordinated motor task requires the concurrent
39 activation of several muscle groups by the central nervous system (CNS)
40 ([Gelfand et al 1971](#)). Bernstein showed that this grouping strategy simplifies
41 the task's control by the CNS ([Bernstein 1967](#)). These functional synergies
42 between muscles - initiating the movement, counteracting it, and stabilizing
43 the position of the mobilized joints ([Bouisset et al 1977](#)) - also apply to
44 postural muscles involved in the maintenance of balance in upright stance
45 ([Yang et al 2015](#)).

46 However, not all physiological coactivations show synergistic patterns.
47 Some types of coactivation (mainly those due to spinal reflex facilitation) are
48 induced at the same time as a remotely performed motor task ([Zehr & Stein](#)
49 [1999](#)). For example, clenching the jaw and hooking the flexed fingers
50 together while attempting to pull the hands apart (as in the Jendrassik
51 maneuver) is a upper-body task that might facilitate the concurrent activation
52 of lower-body muscles (e.g. the soleus) ([Dowman & Wolpaw 1988](#)). This
53 unintentional coactivation of the soleus can be evidenced by sudden
54 increases in the H-reflex amplitude and in voluntary baseline EMG activity
55 ([Ertuglu et al 2018](#)). When this activation persists over time, it is possible to
56 measure an increase in the force generated by the coactivated muscles by
57 using the concurrent activation potentiation phenomenon ([Ebben 2006](#)).

58 Other involuntary coactivations induced in non-homologous muscles that
59 are ipsilateral or contralateral to the motor task (as in associated movements)
60 ([Abercombie et al 1964](#)) or in contralateral homologous muscles (as in mirror

61 movements) ([Armatas et al 1994](#)) have been ascribed to a motor overflow
62 phenomenon ([Hoy et al 2004a](#)).

63 These coactivations have also been interpreted as a failure to inhibit
64 involuntary muscle activity in the passive limb ([Mayston et al 1999](#)); they
65 appear frequently in children under the age of 10 and in neurologically
66 healthy elderly individuals ([Hoy et al 2004a](#)). In the young adult, muscle
67 coactivation mostly occurs when the motor task recruits the distal muscles of
68 the upper extremities (e.g. finger-pressing tasks) ([Ada & O'Dwyer 2001](#)), is
69 complex, requires maximal force, or produces substantial fatigue ([Hoy et al](#)
70 [2004a](#)).

71 In routine clinical practice, our observations of the standing position
72 evidenced a recurrent involuntary foot response that appears concurrently
73 with a remote voluntary backward movement of the head.

74 In clinical terms, this response translates into a plantar pressure increase
75 under the forefoot. This is why we used a baropodometric platform to
76 quantify the anteroposterior pressure distribution (as the percentage
77 increase) in a population of young adults.

78 The influence of the measurement time-point, the magnitude of the head
79 displacement in the experimental condition, and the participant's handedness
80 on the anteroposterior pressure distribution were also assessed. The
81 pressure increase was suggestive of involuntary muscle contractions, given
82 that experimental template used with all the participants reduced the level of
83 noise associated with the need to maintain balance in the standing position.
84 Hence, the involuntary lower-body muscle activation induced by remote,
85 voluntary activation of upper-body spinae was indirectly quantified in a novel

86 way by applying a tool generally used to analyze foot problems (pain,
87 postural disorders, deformities, etc.) (Rosario 2014).

88 The objectives of the present 90-participant trial were to demonstrate that an
89 increase in forefoot plantar pressure is a systematic response to backward
90 movement of the head and to contribute to a better understanding of
91 physiotherapy methods that involve remote muscle activation; this may have
92 direct clinical relevance in novel therapeutic strategies (e.g. normo-inductive
93 physiotherapy) based on the use of remote motor irradiation to treat patients
94 suffering from musculoskeletal disorders. This type of therapeutic strategy
95 can be particularly relevant when direct solicitation techniques are ineffective
96 or inapplicable.

97

98

2. METHODS

2.1. Participants

100 This was a prospective, open-label, single-center, single-group study in
101 the Clinical Investigation Centre (INSERM CIC 1434) at Strasbourg
102 University Hospital (Strasbourg, France). All the participants were
103 physiotherapy students recruited from the *Institut de Formation en Masso-*
104 *Kinésithérapie* (Strasbourg, France). The study was approved by the local
105 investigational review board (*CPP Est IV*, Strasbourg, France; reference:
106 14/46), and was performed in accordance with the tenets of the Declaration
107 of Helsinki (1964) and its updates. All participants gave their prior, written,
108 informed consent. None of the participants reported neuromuscular,
109 orthopedic or musculoskeletal disorders, or known pregnancy (Table 1).

110 Bodyweight, height, shoe size, and handedness were documented for each
111 participant.

112 TABLE 1

113 2.2. Procedure

114 To quantify the anteroposterior distribution of the static plantar pressures,
115 following a Win-Pod baropodometry platform was used (Etter et al (2015):
116 sensing area, 400 mm x 400 mm; sampling rate, 200 images per second;
117 pressure range per sensor, 0.4 to 100 N; 2304 sensors; Win-POD software
118 (version 6, Medicauteurs SA, Toulouse, France). An algorithm divided the
119 foot's total surface area into equal anterior and posterior zones. The
120 baropodometric recordings were homogenized by centering the plantar
121 pressures graphs within the same spatial reference frame.

122 To standardize the experimental conditions and thus reduce possible bias
123 related to differences in the participants' standing position, we used a single
124 template for all participants. This comprised a horizontal surface (the force
125 platform) and a vertical surface (a backboard located directly behind the
126 participant's body). The anterior and plantar pressures was recorded (as a
127 percentage of the total pressure) under in two postural conditions (Figs. 1,2):

128 - Reference condition: the heels, buttocks and scapular area were in
129 contact with the backboard, and the head was in a natural position (i.e. not
130 requiring voluntary contractions). The natural head-board distance varied
131 from one participant to another but was always recorded (in mm).

132 - Test condition: the head was no longer in its natural position but was in
133 contact with the backboard. To align the head in the same sagittal plane as
134 the other body masses, the participant had to move it backwards without

135 changing the head's angle with regard to the horizontal plane. The participant
136 had to maintain the aligned head position for 120 s, requiring sustained
137 isometric and symmetric contractions of upper-body spinae muscles.

138 The following time points selected for statistical analysis: a 1-second
139 recording after 30 seconds in the reference condition (providing a "snapshot"
140 of the plantar pressures); a 1-second recording during the first second and a
141 1-second recording of 120th second in the test condition (in order to compare
142 two time points, rather than a mean measurement over the entire 120 s
143 period).

144 FIGURES 1 AND 2

145

146 2.3. Sample size

147 On the basis of a pilot study of a participant whose forefoot plantar
148 pressure increased by 5% following alignment of the head with the
149 backboard, we calculated that a total sample size of 90 participants would
150 yield a power of about 95%. Hence, 10000 data files were simulated using a
151 mean value of 5% for the percentage increase in forefoot plantar pressure
152 and a standard deviation of 2.5% - a rather high but nevertheless acceptable
153 level of variability.

154

155 2.4. Statistical analysis

156 The forefoot plantar pressure distribution was expressed as a percentage
157 (from 0% to 100%); hence, a non-bounded distribution (such as a normal
158 distribution) could not be assumed. Accordingly, we transformed the data into
159 a beta distribution by dividing the percentage by 100 (yielding values of

160 between 0 and 1, corresponding to the support of a beta distribution). We
161 used a Bayesian statistical approach based on Markov chains and Monte
162 Carlo integration techniques (using OpenBUGS software) (Lunn et al 2000).
163 After 5,000 burn-in iterations, the application of three chains with 50,000
164 iterations and a thinning factor of 10 yielded a total of 15,000 iteration
165 samples for *a posteriori* estimates. The model with respect to the study's
166 main objective was a mixed beta regression model with covariates that
167 explained the mean of the beta distribution. More specifically, y_i (the
168 percentage plantar pressure under the forefoot, transformed into a (0-1)
169 range) for participant i in a given motor task was assumed to be beta-
170 distributed with the parameters α_i and β_i . Given that these parameters are
171 not directly understandable, the distribution was reparametrized using the
172 mean μ and the precision φ , where $\mu_i = \frac{\alpha_i}{\alpha_i + \beta_i}$ and $\varphi = \alpha_i + \beta_i$. A vague
173 gamma prior (with the parameters 0.001 and 0.01) was assigned for the
174 common precision. Next, the μ values were additively structured with a logit
175 link. The linear predictor for the subject i was:

$$\mathbf{logit}(\mu_i) = a_0 + a_1 \mathbf{I}(C_i = 1) + a_2 M_i + a_3 D_i + a_4 L_i + b_i$$

176 where:

- 177 • $\mathbf{I}(C)$ stands for the dummy function, whose value is 1 when condition C is
178 fulfilled and 0 when it is not fulfilled;
- 179 • the different conditions were recoded into two modalities: the first for the
180 head held in a natural, neutral position (the reference condition, where
181 $C=0$) and the second for the head aligned with the backboard (the test
182 condition, where $C=1$). A dummy variable was added to take account of an
183 additional condition: M for maintenance of the backwards head position;

- 184 • D is the head-backboard distance in the neutral position;
- 185 • L is an indicator of the participant's handedness (0: left-handed; 1: right-
- 186 handed).
- 187 • b_i is a random participant effect, modelled with a precise, zero-mean
- 188 normal prior.

189

190 With regard to interpretation of the parameters and the logit scale, the a

191 *posteriori* distribution of $\frac{\exp(a_0)}{1+\exp(a_0)}$ (referred to as the expit function) provides

192 an estimate of the forefoot pressure distribution for a left-handed participant

193 in the neutral condition. Next, the a *posteriori* distribution of $\exp(a)$ s provides

194 an estimate of the mean increase in forefoot pressure: $\exp(a_1)$ for alignment

195 of the head with the board, $\exp(a_2)$ for measurement after 120 seconds (if

196 the head is not in the spontaneously chosen position), $\exp(a_3)$ when the

197 distance to the backboard increases by 1 cm, and $\exp(a_4)$ if the participant is

198 right-handed.

199 Lastly, $\frac{\exp(a_0+\dots)}{1+\exp(a_0+\dots)}$ provides an estimate of the resulting forefoot plantar

200 pressure distribution; for example, $\frac{\exp(a_0+a_1)}{1+\exp(a_0+a_1)}$ is the mean forefoot plantar

201 pressure distribution when the head moves back to the backboard.

202 Given the complexity of this model, we first determined whether the

203 participant's handedness, the distance from the backboard, and the

204 maintenance of a position for 120 seconds were statistically significant by

205 inspecting the parameter's a *posteriori* distribution. If 0 was included in the

206 95% credible interval, the parameter was considered to be non-significant

207 and removed from the model. Once these three parameters had been

208 assessed, the final model was built and the *a posteriori* distributions were
209 estimated.

210

211

3. RESULTS

212 90 individuals volunteered to participate in the study (out of a target
213 population of 134): this number corresponded to the required sample size. 2
214 volunteers could not be included, and so 2 other volunteer participants were
215 selected at random from the target population. The characteristics of the
216 study population are summarized in [Table 2](#).

217 TABLE 2

218 Datasets for 90 participants were analyzed. With a confidence interval of
219 95%, neither the measurement time point (0.0192 [-0.065; 0.103]), the head-
220 backboard distance (0.0342 [-0.092; 0.182]), nor the participant's
221 handedness (-0.032 [-0.409; 0.421]) were significant. Accordingly, these
222 variables were removed from the model. [Table 3](#) summarizes the forefoot
223 pressure (as a percentage) under the various conditions.

224 The *a posteriori* plantar parameters of interest (derived from the reduced
225 model) are summarized in [Table 4](#). In the reference condition, the mean
226 forefoot plantar pressure [95% confidence interval] was 72.44% [69.94-
227 74.79]; the alignment of the head over the trunk increased the forefoot
228 plantar pressure by a multiplicative factor (on a logit scale) of 1.12 [1.05-
229 1.20], yielding a mean value of 74.67% [72.38-76.8].

230 TABLES 3 AND 4

231

4. DISCUSSION

232 In our population sample, the statistically significant increase in forefoot
233 plantar pressure (relative to the reference condition) following the backward
234 alignment of the head over the other body masses was solely dependent on
235 the test condition. The measurement time point (120 seconds), the
236 magnitude of the head displacement (the head-backboard distance) and the
237 participant's handedness (right-handedness for 91% of the participants,
238 much as in the general population ([Coren 1993](#))) did not modulate the
239 pressure distribution. This result agrees with and extends those of our earlier
240 study of 50 healthy young adults (with an identical design: the Win-Pod
241 baropodometry platform and the standardized template); the test condition
242 featured the alignment of the pelvic and thoracic masses with the backboard
243 ([Nisand et al 2016](#)).

244 The hypothesis of a mechanical phenomenon based on a purely gravity-
245 based model can be immediately ruled out. Indeed, according to this model,
246 the resultant of shifts in the center of pressure should act first forwards (due
247 to anticipatory postural adjustments that precede balance perturbations
248 associated with the head movement) and then rearwards (due to the
249 backward movement of the head's mass, which accounts for about 8% of the
250 bodyweight, without any other body masses moving). Hence, for a purely
251 mechanical phenomenon, the increase in plantar pressure should have
252 occurred under the hindfoot ([Vandervael 1966](#); [Massion 1992](#); [Bouisset & Do](#)
253 [2008](#)).

254 An increase in the percentage of forefoot plantar pressure is necessarily
255 an expression of increased plantar flexor muscle activity. This does not rule
256 out (i) a possible coactivation of the dorsal flexor muscles (ii) naturally more

257 powerful plantar flexor muscles; or (iii) naturally less powerful but more
258 intensely activated dorsal flexor muscles. This is why we recorded the
259 surface EMG activity of the gastrocnemius medialis, soleus and tibialis
260 anterior muscles in 6 participants; this evaluation was not initially planned in
261 the study protocol. These recordings confirmed the systematic activation of
262 gastrocnemius medialis and soleus, as well as the almost total absence of
263 anterior tibialis activity. Even though these data cannot evidently be
264 generalized to our whole study population, they argue in favor of a single
265 involuntary motor response: contraction of the plantar flexors. The
266 experimental template (consisting of the force platform and the backboard)
267 removes or at least reduces the noise associated with the need to maintain
268 balance in the standing position. However, one cannot rule out a potential
269 modulation of the motor response by the template. Additional studies in the
270 absence of a template could explore this hypothesis.

271 If the mechanical hypothesis is abandoned in favor of a neuromuscular
272 hypothesis, one must consider whether the increase in plantar flexor activity
273 is due to physiological postural instability caused by the change in head
274 position. It is well known that the vestibular, proprioceptive and visual
275 systems are sensitive to the head position and are involved in postural
276 stability. The cerebellum (which is directly related to these systems) and the
277 spinal cord are also involved, however, these were not assessed within the
278 present study ([Nashner & Wolfson 1974](#), [Nashner & McCollum 1985](#),
279 [Deliagina & Orlovsky 2002](#), [Horak & McPherson 1996](#)). Several hypotheses
280 could be therefore considered with regard to this increase: (i) a vestibular
281 sensory disturbance that occurs when the utricle (an otolith organ) is outside

282 its working range (Brandt et al 1981); (ii) an impairment in cervical
283 proprioceptive information that increases the ankle torque and the activity of
284 the soleus muscle (Vuillerme & Rougier 2005), and (iii) a lack of vision, which
285 disrupts the visual inputs in postural control and increases the level of muscle
286 activity at the ankle (Rougier 2003). Similarly, one should also consider a
287 change in postural mechanics due to a displacement of the center of mass
288 away from the ankle joint, changing the ankle moment and thus increasing
289 the muscle activity in lower limbs (Buckley et al 2005). One can also consider
290 postural synergies in which ankle muscles (the soleus, medial
291 gastrocnemius, or anterior tibialis) are coactivated to maintain balance (Yang
292 et al 2015). However, these hypotheses can reasonably be ruled out in our
293 study, for the following reasons: (i) the head moved rearwards, without
294 increasing the degree of lordosis); (ii) the variations in the ankles' flexion-
295 extension angle and thus the noise associated with maintaining balance were
296 neutralized by the use of a standardized template; (iii) the anteroposterior
297 plantar pressure distribution was recorded for 120 s during maintenance of
298 the test condition, i.e. after the disturbance related to the head movement;
299 (iv) even when possible vestibular interference is taken into account, it is likely
300 that maintenance of the position for 120 s will have neutralized this influence;
301 and (v) the reference and test conditions were performed with eyes open.

302 Hence, the facilitation of spinal reflex responses appears to be credible
303 and must be considered in more detail. It has been suggested that
304 hyperexcitability in the spinal cord's alpha motoneuron pool and a
305 subsequent increase in the H reflex amplitude explain involuntary
306 coactivations via activation of the muscle fibers innervated by these neurons

307 ([Schieppati 1987](#)). For example, this type of reflex phenomenon was
308 evidenced (i) in the soleus muscle by remote voluntary contractions of the
309 muscles of the jaws, forearms and hands (the Jendrassik maneuver), and (ii)
310 in the flexor carpi radialis muscles by remote voluntary contractions of the
311 contralateral ankle flexor muscles ([Zehr & Stein 1999](#); [Ertuglu et al 2018](#)).

312 An irradiation process via motor overflow is another plausible, coherent
313 hypothesis - even though the characteristics of our present task contrast with
314 those described in the literature ([Ada & O'Dwyer 2001](#); [Honaga et al 2007](#)).
315 Irradiation by motor overflow is defined as a voluntary movement (the
316 backwards alignment of the head, in our case) that triggers an involuntary
317 motor response of remote muscles (the plantar flexor muscles, in our case)
318 ([Hoy et al 2004a](#)). Indeed, the simple voluntary task studied here
319 (displacement of the head using the template) required very little force and
320 was not tiring. In contrast, this head movement counteracts the participant's
321 forward postural habitus of the head - the most common misalignment
322 relative to an ideal head posture in the sagittal plane. This characteristic
323 seems decisive for triggering an irradiation process, although it would be
324 interesting to establish whether other movements have this particular feature.
325 Most of our study participants were not conscious of the involuntary
326 coactivation. When the participant was conscious of the coactivation, they
327 were unable to inhibit it by voluntary, higher-order cognitive control (i.e.
328 directed attention); this contrasts with the motor overflows described in the
329 literature ([Addamo et al 2010](#)). This particularity suggests that the muscle
330 coactivation observed in our study is of subcortical origin but does not rule
331 the involvement of functional cortical connections (related to the cortical

332 connection theory, the transcallosal facilitation hypothesis, and/or the
333 transcallosal inhibition theory) ([Hoy et al 2004a](#); [Ebben 2006](#); [Addamo et al](#)
334 [2007](#)).

335 In patients with plantar flexor disorders, targeting these muscles by remote
336 activation may be a relevant therapeutic strategy whenever direct solicitation
337 techniques are ineffective or inapplicable (e.g. due to the presence of acute
338 pain, bone and joint trauma, or peripheric paralysis in the affected area). A
339 remote muscle activation strategy can be used to strengthen the target
340 muscles, increase their endurance, enhance joint flexibility or improve
341 postural stability ([Ebben 2006](#), [Vicky et al 1993](#)). A remote muscle activation
342 strategy can also be used for normalizing excessive residual muscle tension
343 and thus relieving harmful mechanical stress on bone and joint structures.
344 The latter option is the basis of normo-inductive physiotherapy techniques:
345 the inductive movement (the voluntary motor task) is carried out continuously
346 until the remote involuntary motor response is extinguished. Certain clinical
347 outcomes (such as reduced pain levels and improvements in dysfunction and
348 acquired deformities of the musculoskeletal system) seem to be correlated
349 with this extinction. The observed extinction of the remote involuntary motor
350 response suggest the induced “normalizing” muscle activity has a positive
351 effect ([Destieux et al 2013](#); [Nisand et al 2015](#); [Nisand et al 2016](#); [Callens et](#)
352 [al 2017](#)).

LIMITATIONS

The present study had several limitations. Firstly, the baropodometry data could not tell us (i) which plantar flexors were activated, (ii) whether one

plantar flexor was activated more than the others, or (iii) whether or not dorsal flexors were coactivated. These questions could have been addressed by using EMG to identify and characterize activations and coactivations. Nevertheless, the baropodometry platform enables us to quantify induced muscle activity.

Secondly, the age range of the study population (healthy young adults aged 19 to 26) was quite narrow; hence, our results cannot be extrapolated to older adults.

5. CONCLUSION

The results of this 90-participant trial tended to confirm our initial hypothesis: the involuntary, systematic coactivations that appeared simultaneously in both lower limbs (as evidenced by an increase in forefoot plantar pressure) were triggered by remote voluntary muscle contractions – a motor task that was neither complex, demanding, tiring, cyclic nor brief. This finding is suggestive of a spinal reflex or (more plausibly) a previously unknown form of motor overflow. Further research will be needed to (i) define the electrical characteristics of this coactivation (using EMG recordings), (ii) investigate the neural networks involved in this phenomenon (using imaging or transcranial magnetic stimulation), and (iii) determine the therapeutic effects of the remote voluntary contractions triggered by applying normo-inductive physiotherapy techniques.

Clinical Relevance

- In patients with plantar flexor disorders, targeting the latter muscles via remote activation might be a relevant therapeutic strategy whenever direct solicitation techniques are ineffective or inapplicable.
- Typically, indirect solicitation techniques are intended to strengthen the target muscles, increase their endurance, enhance joint flexibility, and improve postural stability.
- In normo-inductive physiotherapy, indirect solicitation techniques seek to normalize excessive residual tension in the target muscles and thus relieve the associated symptoms.

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Declaration of interest

The authors declare that they have no competing interests.

Authors' contributions

MN, CC, CM and ES designed and led the study; J-BC, CC and CD collected the data. ES analyzed the data, and all authors interpreted the data. MN, CC and CD drafted the manuscript, and all co-authors revised it critically for important intellectual content. All authors have read and approved the final manuscript.

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Figure legends:

Figure 1: The experimental conditions.

a) The template comprised a horizontal surface (materialized by the force platform) and a vertical surface (materialized by a backboard located directly behind the body).

b) The participant stands on the baropodometric platform with his/her arms by the side of the trunk, barefoot, and wearing close-fitting underwear and a shower cap. He/she looks straight ahead, with a horizontal gaze and the eyes open. The heels (with the feet together), buttocks and scapular area are in contact with the backboard. No specific instructions are given concerning the position of the head: it is held in a spontaneously chosen, natural position that does not require any muscle contraction.

c) In the reference condition, the head is held at a certain, spontaneously chosen distance from the backboard. This distance was measured in mm. A vertical slot in the board increased the accuracy of this measurement.

d) After a voluntary backward movement of the head (so that the head was in contact with the backboard), the participant maintained this position for 120 seconds.

Figure 2: An example of the pressure distribution on the force platform.

For this participant, in the reference condition, the forefoot pressure (measured as a percentage of the total) is 43% for the left forefoot and 42% for the right forefoot. In the test condition, these values were respectively 81% and 73%.



C0: The reference condition

C1: The test condition

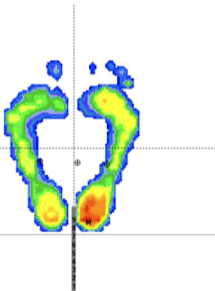
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Correspondant :
Age : 20 ans
Poids : 54 Kg
Taille : 166 cm
Pointure : 39,
Date : 11/02/2015
Pathologie :

065
H
Correspondant :
Age : 20 ans
Poids : 54 Kg
Taille : 166 cm
Pointure : 39,
Date : 11/02/2015
Pathologie :

Surface : 44 cm²
Poussée : 19 %
Répartition : 43 %

Analyse statique
Toile
Droite

Surface : 46 cm²
Poussée : 24 %
Répartition : 42 %



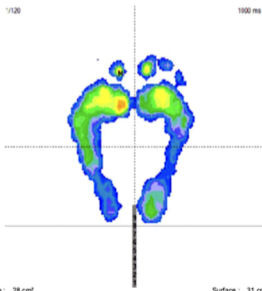
Surface : 40 cm²
Poussée : 25 %
Répartition : 57 %

Surface : 40 cm²
Poussée : 33 %
Répartition : 58 %

Surface : 54 cm²
Poussée : 44 %
Répartition : 81 %

Analyse posturologique
Tête mur

Surface : 56 cm²
Poussée : 33 %
Répartition : 73 %



Surface : 28 cm²
Poussée : 10 %
Répartition : 19 %

Surface : 31 cm²
Poussée : 12 %
Répartition : 27 %

Table 1: Eligibility criteria applied to the study population

Inclusion criteria	<ul style="list-style-type: none">• Age between 18 and 30• Social security coverage• Ability to understand the study's objectives, procedures and risks, and to provide written, informed consent
Exclusion criteria	<ul style="list-style-type: none">• Past or concomitant infectious or cancerous diseases of the spine• Vertebral osteosynthesis• Acute neck or arm pain• Limb trauma in the previous 12 months• Acute leg pain• Neuropathic disease or the sequelae of neuropathic disease of the legs• Myasthenia gravis• Central nervous system disorders• Inner ear problems• Subjects under legal guardianship• Known pregnancy• Simultaneous participation in another biomedical research study of a drug or medical device

Table 2: Characteristics of the study population (90 healthy young adults)

Gender	Males: 38	Females: 52
Handedness	Left-handed: 8	Right-handed: 82
Age	20.6 ± 1.3 (19-26)	
Bodyweight	65.7 ± 11.0 kg (44.6-113.5)	
Height	171.2 ± 8.8 cm (152-201)	
Shoe size	40.6 ± 2.8 (36-48)	
Head-backboard distance (in C0)	36.3 ± 17.4 mm (0-84)	

Quantitative variables are quoted as the mean ± standard deviation (range).

Table 3: Summary of forefoot plantar pressure (as a percentage) under the experimental conditions

	Reference condition	Test condition	
		0 s	120 s
Mean (SD)	71.2 (11.0)	73.8 (10.8)	72.9 (11.3)
Quartile 1	63.7	66.0	65.0
Quartile 2	71.0	74.0	72.0
Quartile 3	79.0	82.0	81.0

SD: standard deviation

Table 4: The parameters' *a posteriori* distributions in the reduced model

	mean (SD)	median	95% confidence interval
<hr/>			
Forefoot plantar pressure			
reference condition (%)	72.44 (1.229)	72.50	[69.94; 74.79]
test condition (%)	74.67 (1.111)	74.68	[72.38; 76.80]
Multiplicative factor	1.122 (0.0382)	1.122	[1.049; 1.2]
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Model parameters			
Intercept	0.9672 (0.06157)	0.9692	[0.8443; 1.087]
Backward head effect	0.1148 (0.03403)	0.1153	[0.04786; 0.1822]
<hr/>			

SD: standard deviation