Iyengar Yoga for Treating Symptoms of Osteoarthritis of the Knees: A Pilot Study

SHARON L. KOLASINSKI, M.D.,1 MARIAN GARFINKEL, Ed.D.,2 ADAM GILDEN TSAI, M.D.,1 WHITNEY MATZ, B.A.,1 ALISON VAN DYKE, B.A.,1 and H. RALPH SCHUMACHER, Jr., M.D.1,3

ABSTRACT

Objectives: The American College of Rheumatology (ACR) Guidelines for the medical management of osteoarthritis (OA) emphasize the use of nonpharmacologic interventions including exercise. Implementation of an exercise program can be difficult for patients, and little is known about the benefits of alternative therapies such as yoga. The aim of this pilot study was to assess the feasibility of using yoga in the tradition of B.K.S. Iyengar to treat the symptoms of osteoarthritis of the knee.

Design: Participants were instructed in modified Iyengar yoga postures during 90-minute classes once weekly for 8 weeks.

Subjects: Participants met ACR criteria for osteoarthritis of the knee and completed a medical history and physical examination, Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC), Arthritis Impact Measurement Scale 2 (AIMS2), Patient Global Assessment (GA) by Visual Analog Scale (VAS), Physician GA by VAS, and 50-foot Walk Time before and following an 8-week course of yoga instruction. Eleven (11) subjects enrolled, nine completed at least one session and seven (six of whom were obese) had data from pre- and post-course time points available for analysis.

Results: Statistically significant reductions in WOMAC Pain, WOMAC Physical Function, and AIMS2 Affect were observed when participants’ status were compared to their pre-course status. WOMAC Stiffness, AIMS2 Symptoms, Social and Role, Physician GA, and Patient GA measured trends in improvement of symptoms. No adverse events from treatment were reported.

Conclusions: This pilot study suggests that yoga may provide a feasible treatment option for previously yoga-naive, obese patients >50 years of age and offers potential reductions in pain and disability caused by knee OA. Future studies should compare yoga to other nonpharmacologic interventions for knee OA, such as patient education or quadriceps-strengthening exercises.

INTRODUCTION

Osteoarthritis (OA) is the most common form of arthritis and a leading cause of disability in the United States.1 The incidence of OA increases with age and will represent an increasingly significant problem for the aging U.S. population.1 Symptoms of osteoarthritis of the knees include morning stiffness, gelling after periods of inactivity, and pain. As the disease progresses, cartilage is lost and joints may become enlarged and more limited in their range of motion. Limitations in motion may be caused by cartilage destruction, as well as spasm of surrounding muscles and loss of flexibility of surrounding soft tissues such as those of tendons and ligaments. As there are no disease-modifying agents available for OA, the standard care of patients with osteoarthritis of the knees is aimed at reducing...
pain and improving the functioning of the knees by focusing on the surrounding tissues through exercise or external support.

Although management of osteoarthritis typically includes the use of medications, pharmacologic agents can be associated with numerous potential side effects and variable efficacy. Emphasis has been placed on measures that can be used along with or in place of prescription medications. Recent practice guidelines have reflected recognition that exercise, including both aerobic and strengthening, as well as range of motion, are essential elements of any treatment program for osteoarthritis of the knees. Physicians and other health care professionals treating individuals with osteoarthritis need to provide these patients with viable options to accomplish their exercise goals. This can include exploration of alternative therapies for the management of chronic pain. Although significant attention has focused on stretching and strengthening the quadriceps muscles for reducing symptoms of knee OA, yoga is one of several practices that have the potential to be effective in OA as well. Al though yogic philosophy addresses numerous aspects of well-being that might have an effect on health and disease, the use of the physical postures, or asanas, can be used as a form of exercise. Yoga improves both flexibility and strength and could theoretically be beneficial to some musculoskeletal problems. The use of the Iyengar approach to hatha yoga emphasizes strength, flexibility, and relaxation, with particular attention to alignment of body structures (e.g., the relationship of the distal to the proximal extremities and the extremities to the spine and torso). Iyengar yoga is distinguished from the many forms of yoga currently advocated by its focus that it can be practiced by all; that part of the way in which it is accessible to all is through the use of props that help the practitioner to achieve appropriate and precise positioning; and that it emphasizes the importance of the proper sequence of postures as important to their successful completion. This study assessed the feasibility and safety of using yoga as a treatment for the symptoms and disability resulting from osteoarthritis of the knee.

PATIENTS AND METHODS

Patients were recruited from the community by advertisements placed around the campus of the University of Pennsylvania and in the outpatient medical and rheumatology practices at the University of Pennsylvania Medical Center. The presence of osteoarthritis of the knee was diagnosed using the Clinical Criteria for the Classification of Idiopathic Osteoarthritis (OA) of the Knee developed by the American College of Rheumatology. These criteria do not require radiographic confirmation. Qualified participants were ≥50 years of age with symptomatic osteoarthritis in at least one knee for at least 6 months before study entry and were not currently participating in an exercise program. In addition, they had at least two of the following: stiffness <30 minutes; crepitus; bony tenderness; bony enlargement; or absence of palpable warmth. Subjects were excluded who had any of the following: symptoms of locking or instability; a corticosteroid injection in the symptomatic knee within 3 months of study entry; a hyaluronic acid injection in the symptomatic knee within 6 months of study entry; a history of knee surgery within the last 2 years or a joint replacement at any point; chronic use of a knee brace, cane, or walker; or a prior diagnosis of inflammatory arthritis. Patients were excluded who had significant medical comorbidities that might preclude participation. No changes in medication for arthritis symptoms were permitted during the trial. Patients signed an informed consent form before participation. The study was approved by the University of Pennsylvania Institutional Review Board.

Baseline data collection included medical history and a general and rheumatologic physical examination. Outcome measures were assessed for all subjects at study entry and after the 8-week yoga intervention. Outcome measures chosen were those recommended to be of value by the Osteoarthritis Research Society for interventions in OA. These included the Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC), the Arthritis Impact Measurement Scale 2 (AIMS2) social and psychological subsets (Affect, Symptom, Social Interaction, Role), the Patient Global Assessment (GA) by a 100-mm visual analog scale (VAS), and the Physician Global Assessment by a 100-mm visual analog scale. The 50-foot walk time was also assessed.

The yoga intervention consisted of 15 postures taken from Light on Yoga and taught by a certified senior Iyengar yoga teacher (M.G.) over 8 weeks during weekly 1 and 1.5-hour sessions. Patients were required to attend five of the eight sessions as well as the preintervention and postintervention assessment visits to be included in the analysis. Patients were asked not to start other physical therapy interventions during the time that they participated in the study.

The sequence and adaptation of classical yoga postures (asanas) were designed by the instructor, based on the Iyengar method of hatha yoga. The Iyengar method takes into account both underlying anatomical structure and body alignment. Iyengar yoga allows for individual variation in the ability of participants and specifically includes the use of assistive devices such as blocks, belts, and blankets to support parts of the body while performing the asanas. Postures were performed in standing, sitting, and supine positions on standard yoga mats. The asanas are listed below, along with a brief description and the most commonly used props where applicable. All participants were encouraged to stretch as fully as possible while not exceeding the limits of their comfort and were encouraged to use props as needed.

The postures used included Tadasana (Mountain Pose; basic standing pose), Uttitha Trikonasana (Standing Extended Triangle Pose; stretch to the sides with arms and legs...
YOGA FOR KNEE OA

RESULTS

Eleven subjects enrolled and nine attended at least one session. Seven attended at least five classes and had data from pre- and postcourse time points available for analysis. Because of an unrelated illness (pneumonia), one subject withdrew; another was unable to accommodate the class into her work schedule. No participant had previously practiced yoga. The seven women who completed the trial had a mean change from baseline to a hypothesized percent change of 100% (null hypothesis). For all significantly non-normal distributions, a nonparametric, signed rank test was performed. The following measures had significantly non-normal distributions: WOMAC Pain, WOMAC Physical Function, and Patient GA.

Compared with their status before taking the yoga classes, participants had statistically significant improvements in their levels of pain and disability measured by the WOMACs Pain and Physical Function Subscales (Table 1). WOMAC Pain declined 46.7% (p = 0.04) and WOMAC Physical Function fell 39.1% (p = 0.04). WOMAC Stiffness declined 39.0%, but this was not statistically significant (p = 0.06). Only one participant had an increase in WOMAC Pain or WOMAC Stiffness. This subject experienced a personal tragedy between the last yoga class and the follow-up assessment, and it is likely that her mental distress under these circumstances may have had a significant bearing on her outcome measures. The AIMS2 showed fewer changes over this time period for this intervention (Table 2). Only the AIMS2 Affect Component showed a statistically significant improvement at 23.2% (p = 0.002). A large but nonsignificant improvement in AIMS2 Symptoms (36.5% improvement; p = 0.1) was noted. Improvements in Physician Global Assessment (29.5% improvement; p = 0.2) and in Patient GA (24.1% improvement; p = 0.2) were observed but did not reach statistical significance (Table 3). The 50-foot walk time was unchanged. No participant reported experiencing an adverse event.

DISCUSSION

In this study, a sequence of asanas based on the teachings of B.K.S. Iyengar was used specifically as an intervention to treat knee OA symptoms. The results presented suggest that a supervised 8-week course of yoga can be beneficial in reducing pain and disability and improving affect in symptomatic knee OA patients. Stiffness was less clearly affected. There were also significant improvements in the AIMS2 psychologic subscale. Psychologic factors have been previously demonstrated to have an impact on pain perception in OA.16,17

Percent change from baseline

\[
\text{Percent change} = \frac{\text{Final value} - \text{Baseline value}}{\text{Baseline Value}} \times 100\%
\]

A negative percent change from baseline represented an improvement in OA symptoms. A Shapiro-Wilkins Goodness of Fit Test was performed for each distribution. Absolute changes in outcomes measured were also calculated and gave similar results. A paired t test was performed for each measure comparing the absolute change/percent change from baseline to a hypothesized percent change of zero (null hypothesis).

<table>
<thead>
<tr>
<th>WOMAC subscale</th>
<th>% Change</th>
<th>% Change SD</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td>−46.7</td>
<td>±53.2</td>
<td>0.04(^a)</td>
</tr>
<tr>
<td>Physical function</td>
<td>−39.1</td>
<td>±44.0</td>
<td>0.04(^b)</td>
</tr>
<tr>
<td>Stiffness</td>
<td>−39.0</td>
<td>±55.4</td>
<td>0.06(^b)</td>
</tr>
</tbody>
</table>

SD, standard deviation.

\(^a\)Signed rank test.

\(^b\)Student’s t Test.

Note: Bolded items show statistically significant results.
A third study used a group of participants who may be more comparable to the subjects in our study. Second, the sample size was small. The study was not powered to assess adequately the magnitude of the effect of yoga on OA. However, the aim of this study was to test the feasibility and safety of using yoga to treat OA in a sample of the affected population who may have had difficulty committing to an exercise program in the past. These subjects were middle aged, obese, did not regularly exercise, and had not performed yoga asanas before. However, they were able to participate in the class and to show improvements in different body parts and therefore the levels of pain experienced.

There are several limitations of this uncontrolled pilot study. First, the sample size was small. The study was not powered to assess adequately the magnitude of the effect of yoga on OA. However, the aim of this study was to test the feasibility and safety of using yoga to treat OA in a sample of the affected population who may have had difficulty committing to an exercise program in the past. These subjects were middle aged, obese, did not regularly exercise, and had not performed yoga asanas before. However, they were able to participate in the class and to show improvements in different body parts and therefore the levels of pain experienced.

CONCLUSIONS

In summary, ACR management guidelines emphasize the importance of nonpharmacologic therapy of OA, and recent evidence supports exercise as a beneficial intervention. This pilot study suggests that yoga provides a safe and feasible
exercise option for previously yoga-naive, obese patients over \( \geq 50 \) years of age and offers potential reductions in pain and disability caused by knee OA.

**ACKNOWLEDGMENT**

This study was partially supported by the American College of Rheumatology Clinical Summer Preceptorship Program (W.M.).

**REFERENCES**


Address reprint requests to:

Sharon L. Kolasinski, M.D.
Division of Rheumatology
University of Pennsylvania School of Medicine
504 Maloney Building
36th and Spruce Streets
Philadelphia, PA 19104

E-mail: sharonk@mail.med.upenn.edu