Effects of stretching before and after exercising on muscle soreness and risk of injury: systematic review

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Abstract

Objective To determine the effects of stretching before and after exercising on muscle soreness after exercise, risk of injury, and athletic performance.

Method Systematic review.

Data sources Randomised or quasi-randomised studies identified by searching Medline, Embase, CINAHL, SPORTDiscus, and PEDro, and by recursive checking of bibliographies.

Main outcome measures Muscle soreness, incidence of injury, athletic performance.

Results Five studies, all of moderate quality, reported sufficient data on the effects of stretching on muscle soreness to be included in the analysis. Outcomes seemed homogeneous. Stretching produced small and statistically non-significant reductions in muscle soreness. The pooled estimate of reduction in muscle soreness 24 hours after exercising was only 0.9 mm on a 100 mm scale (95% confidence interval −2.6 mm to 4.4 mm). Data from two studies on army recruits in military training show that muscle stretching before exercising does not produce useful reductions in injury risk (pooled hazard ratio 0.95, 0.78 to 1.16).

Conclusions Stretching before or after exercising does not confer protection from muscle soreness. Stretching before exercising does not seem to confer a practically useful reduction in the risk of injury, but the generality of this finding needs testing. Insufficient research has been done with which to determine the effects of stretching on sporting performance.

Introduction

Many people stretch before or after engaging in athletic activity. Usually the purpose is to reduce muscle soreness after exercising (with delayed onset), to reduce risk of injury, or to improve athletic performance.3,4

This review synthesises research findings of the effects of stretching before and after exercising on delayed onset muscle soreness, risk of injury, and athletic performance. We carried out a systematic review to minimise bias.3

Methods

The protocol was specified before the review was undertaken.

Inclusion and exclusion criteria

The review included randomised or quasi-randomised studies that investigated the effects of any stretching technique, before or after exercising, on delayed onset muscle soreness, risk of injury, or athletic or sporting performance. Studies were included only if stretching was conducted immediately before or after exercising. Studies reported in languages other than English were not included as translations were not available.

Search strategy

Relevant studies were identified by searching Medline (1966 to February 2000), Embase (1988 to February 2000), CINAHL (1982 to January 2000), SPORTDiscus (1949 to December 1999) and PEDro (to February 2000). In Medline, a translation of the optimum OVID search strategy of Dickersin et al was combined with specific search terms for each topic shown in the box.9 The Medline search strategy was translated into comparable search strategies for Embase, CINAHL, and SPORTDiscus. PEDro was searched with the terms “stretch,” “exercise,” “warm-up,” and “cool-down” in the abstract field. Bibliographies of studies identified by electronic searches were then searched recursively until no more studies were identified. MG screened search results for potentially eligible studies, and uncertainties about the eligibility of a particular study were resolved by discussion with RDH.

Assessment of study quality

Methodological quality was assessed with the PEDro scale, which is based on the Delphi list.10 We used this scale because its items were thought to be important by a panel of experts,10 its reliability is supported empirically,11 and we have extensive experience in the use of this scale (http://www.cchss.usyd.edu.au/pedro). A total score out of 10 is derived for each study from the number of criteria that are satisfied (see footnote in table 2 for a brief description of criteria). The quality of included studies was assessed independently by two assessors, and disagreements were resolved by a third independent assessor. Only studies scoring at least 3 were considered in the initial analysis.
Methodological quality of included studies

The reliability of quality ratings was acceptable ($\kappa=0.71$, agreement=87%). The methodological quality of the studies was generally moderate (table 2). The range of quality scores was 2-7 (mean 4.1) out of 10. Not all criteria on the PEDro scale can be satisfied in these studies (for example, blinding of subjects is difficult or impossible). Often a report did not clearly specify that a criterion was met, and consequently we scored the study as not satisfying the criterion. We expect that in several of these studies the criterion was met. For example, two studies of muscle soreness did not clearly report loss to follow up. These studies had very short follow up periods, so loss to follow up was probably low or zero. Two studies did not provide sufficient data to permit inclusion in the meta-analysis.16 20

Data synthesis

Where more than one study was available on a particular outcome, we assessed homogeneity of subjects, interventions, and outcomes. Results of comparable studies were pooled in meta-analyses. Meta-analysis of continuous outcomes (scores for muscle soreness) was performed with a fixed effects model using the inverse of the estimated sampling variances as weights.12 The time to event data were analysed with Cox regression.

Results

Search results

Only one small and inconclusive study investigated effects of stretching on athletic performance, so these are not discussed further in this review.11 Six studies investigated effects of stretching on delayed onset muscle soreness, and two investigated effects of stretching on the risk of injury (table 1).
threshold quality score and assumptions about correlations between repeated measures had little effect on this result.

**Effect of stretching on risk of injury**
Two studies evaluated the effects of stretching before exercising on the risk of injury in new military recruits undergoing 12 weeks of initial training. The first study investigated effects of supervised stretching of calf muscles before exercising (two stretches of soleus and gastrocnemius muscles for 20 seconds on each limb, total stretch time 160 seconds) on risk of soft tissue injury, bone injury, and all injury. Recruits were considered to have sustained an injury if they were unable to return to full duties without signs or symptoms in three days. In both studies, subjects in both stretch and control groups also performed gentle warm up exercises. The two studies yielded similar estimates of risk reduction (hazard ratios 0.92 (0.52 to 1.61) and 0.95 (0.77 to 1.18); fig 2).

Risks of injury in the two studies differ because injury is defined differently. Time to event data (2630

<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Subjects</th>
<th>Interventions</th>
<th>Outcome measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burk and Schwan</td>
<td>Between subjects</td>
<td>23 volunteers (7 women and 16 men) aged 18-33 years. Exclusion: exercise contraindicated, highly physically trained, extremely active during 6 week period before study</td>
<td>Soreness in leg muscles induced with step test. The stretch group performed post-exercise static stretches immediately after step test, at 2 hour intervals for the first 24 hours after the test, and at 4 hour intervals for the following 48 hours. The left knee extenders and right ankle plantarflexors were stretched for 10 repetitions, each of 30 seconds' duration</td>
<td>Muscle soreness measured 24, 48, and 72 hours after step test on 0-6 scale</td>
</tr>
<tr>
<td>Johansson et al</td>
<td>Within subjects</td>
<td>10 healthy female volunteers with mean (SD) age of 24 (3) years. Exclusion: taking anti-inflammatory drugs, experiencing symptoms of musculo-skeletal injury to leg. Participation in weight training &gt;3 hours/week, experiencing delayed onset muscle soreness at time of testing</td>
<td>Soreness in knee flexor muscles induced with maximal eccentric contractions. Before exercise, four stretches (hurdle position) performed on experimental leg. Each stretch held for 20 seconds</td>
<td>Muscle soreness measured 0, 24, 48, and 96 hours after exercise on 100 mm visual analogue scale</td>
</tr>
<tr>
<td>McIlwain et al</td>
<td>Between subjects</td>
<td>36 male students, aged 18-28 years. Exclusion: engagement in any systematic activity with the non-dominant arm in the 30 days before testing</td>
<td>Soreness of elbow flexor muscles induced with eccentric contractions. After exercise, stretch group performed four stretches of elbow flexor muscles. Each stretch was held for 2 minutes. Participants performed stretching routine at 6, 25, 30, 49, and 54 hours after exercise</td>
<td>Muscle soreness measured 0, 24, 48, and 72 hours after exercise on 0-10 scale</td>
</tr>
<tr>
<td>High et al</td>
<td>Between subjects</td>
<td>62 volunteers (31 women and 31 men), mean age 19.5 years. Exclusion: training in past 6 months involving step climbing</td>
<td>Soreness in leg muscles induced with step test. Before exercise, stretch group performed two quadriceps stretches, each of 50 seconds' duration</td>
<td>Muscle soreness measured 24 hours after the step test on 0-6 scale</td>
</tr>
<tr>
<td>Wessel and Wan</td>
<td>Within subjects</td>
<td>Two samples, each of 10 subjects. Experiment 1 involved two women and eight men, mean age 24.2 years. Experiment 2 involved five women and five men, mean age 25.2 years. Exclusion: history of back or leg injury or disease</td>
<td>Soreness in knee flexor muscles was induced with concentric or eccentric contractions. Knee flexor muscles of experimental leg were stretched before exercise in experiment 1 and after exercise in experiment 2. Ten stretches were performed, each of 60 seconds' duration</td>
<td>Muscle soreness measured 12, 24, 36, 48, 60, and 72 hours after exercise on 100 mm visual analogue scale</td>
</tr>
<tr>
<td>Gulick et al</td>
<td>Between subjects</td>
<td>73 volunteers (38 women and 35 men) aged 21-40 years. Exclusion: pregnant and nursing women, history of liver and kidney dysfunction, peptic ulcer disease, and asthma</td>
<td>Soreness in wrist extensor muscles was induced with eccentric exercise. After exercise, stretch group performed 10 minute stretch of wrist extensor muscles</td>
<td>Muscle soreness measured 24, 48, and 72 hours after step test with 100 mm visual analogue scale</td>
</tr>
<tr>
<td>Pope et al</td>
<td>Cluster randomised</td>
<td>1538 male army recruits (39 platoons), aged 17-35 years. Exclusion: history of any significant injury</td>
<td>Each participant performed physical workout once every second day for 11 weeks (40 sessions). Before exercise, experimental group performed 20 second stretches of gastrocnemius, soleus, hamstrings, quadriceps, hip adductor, and hip flexor muscle groups bilaterally</td>
<td>Participants were observed for duration of 12 week training programme. Leg injuries were recorded if they prevented the subject from returning to activity within 3 days, free of signs and symptoms</td>
</tr>
<tr>
<td>Pope et al</td>
<td>Cluster randomised</td>
<td>1093 male army recruits (36 platoons), aged 17-35 years. Exclusion: significant pre-existing injury</td>
<td>Each participant performed physical workout once every second day for 11 weeks (40 sessions). Before exercising, experimental group performed two 20 second stretches of the soleus and gastrocnemius muscle groups bilaterally. Control group stretched arm muscles instead</td>
<td>Participants were observed for duration of 12 week training programme. Arm injuries, stress fractures of the tibia or foot, periostitis, Achilles tendinitis, and anterior compartment syndrome were recorded if they prevented subject from returning to activity within 3 days, free of signs and symptoms</td>
</tr>
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</table>
subjects, 65 platoons) were combined; 1284 subjects (32 platoons) were allocated to stretch groups and 1346 (35 platoons) to control groups. The discrepancy in sample size occurred because subjects were quasi randomly allocated to an odd number of platoons by military personnel who did not participate in the studies, and then platoons were randomly allocated to groups by the experimenters. A total of 181 injuries occurred in stretch groups and 200 injuries in control groups. Survival curves for stretch and control groups were similar (fig 2). For the meta-analysis the data were analysed with a Cox regression model that incorporated a study factor (study 1 or 2) and a stretch factor (stretch or control). An interaction term was also included in the model initially but was subsequently omitted because it did not contribute significantly (P=0.88). Additional analyses were undertaken to take account of possible clustering of outcomes by platoon, but the results were essentially identical so are not reported here.\(^{25}\) The pooled estimate of the hazard ratio for the stretch factor was 0.95 (0.78 to 1.16, P=0.61).

**Discussion**

This systematic review finds clear evidence from five studies of nominally moderate quality that stretching before or after exercising has no effect on delayed onset muscle soreness. Two further studies on army recruits undergoing military training strongly suggest that muscle stretching before exercising does not produce meaningful reductions in the risk of injury. Not enough research has been done to draw conclusions about the effects of stretching on athletic performance.

**Eliminating potential bias**

These conclusions are consistent with at least one review of the effects of stretching, but not others.\(^{24–26}\) Unlike earlier reviews, we used a systematic review methodology to eliminate potential sources of bias as far as possible, but this does not guarantee the absence of bias. Our review may have been biased by publication bias or by inclusion only of studies reported in English.\(^{27–29}\) Both factors would be expected to inflate estimates of the effects of treatments, yet we found that stretching has no effect on delayed onset muscle soreness or on risk of injury. When we performed a less sensitive search for studies in languages other than English we found no studies that satisfied the inclusion criteria. The PEDro scale, which we used to discriminate between studies of different quality, has not been fully validated. Use of the PEDro scale is, however, unlikely to have biased our conclusions as study findings were consistent (fig 1). Meta-analysis of almost any combination of the included studies is likely to have produced similar findings.

**Effect of stretching on delayed onset muscle soreness**

The results of five studies (77 subjects) imply that stretching reduces soreness in the 72 hours after exercise. The pooled estimate of the hazard ratio for the stretch factor was 0.95 (0.78 to 1.16, P=0.61).

\[ \text{Score on PEDro scale} = \sum \text{score for each criterion} \]

*Column numbers correspond to the following criteria on the PEDro scale:
1—eligibility criteria were specified
2—subjects were randomly allocated to groups (or, in a crossover study, subjects were randomly allocated an order in which treatments were received)
3—allocation was concealed
4—groups were similar at baseline
5—subjects were blinded
6—therapists who administered the treatment were blinded
7—assessors were blinded
8—measures of key outcomes were obtained from more than 85% of subjects
9—data were analysed by intention to treat
10—statistical comparisons between groups were conducted
11—point measures and measures of variability were provided.

The total score is determined by counting the number of criteria that are satisfied, except that scale item 1 is not used to generate the total score, so total scores are out of 10.

+ Indicates the criterion was clearly satisfied, - indicates that it was not, ? indicates that it is not clear if the criterion was satisfied.

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**Table 2 Quality scores of studies in systematic review**

<table>
<thead>
<tr>
<th>Study</th>
<th>Outcome</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Total score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buroker and Schwane(^{15})</td>
<td>Soreness</td>
<td>-</td>
<td>+</td>
<td>?</td>
<td>?</td>
<td>-</td>
<td>-</td>
<td>+</td>
<td>?</td>
<td>+</td>
<td>+</td>
<td>4/10</td>
</tr>
<tr>
<td>Johansson et al(^{16})</td>
<td>Soreness</td>
<td>+</td>
<td>+</td>
<td>?</td>
<td>?</td>
<td>-</td>
<td>-</td>
<td>+</td>
<td>?</td>
<td>+</td>
<td>+</td>
<td>5/10</td>
</tr>
<tr>
<td>McLayn et al(^{17})</td>
<td>Soreness</td>
<td>-</td>
<td>+</td>
<td>?</td>
<td>?</td>
<td>-</td>
<td>-</td>
<td>+</td>
<td>?</td>
<td>+</td>
<td>+</td>
<td>5/10</td>
</tr>
<tr>
<td>Wessel and Wan(^{19})</td>
<td>Soreness</td>
<td>-</td>
<td>+</td>
<td>?</td>
<td>?</td>
<td>-</td>
<td>-</td>
<td>+</td>
<td>?</td>
<td>+</td>
<td>+</td>
<td>5/10</td>
</tr>
<tr>
<td>Pope et al(^{21})</td>
<td>Injury</td>
<td>+</td>
<td>+</td>
<td>?</td>
<td>?</td>
<td>-</td>
<td>-</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>7/10</td>
</tr>
<tr>
<td>Pope et al(^{22})</td>
<td>Injury</td>
<td>+</td>
<td>+</td>
<td>?</td>
<td>?</td>
<td>-</td>
<td>-</td>
<td>+</td>
<td>?</td>
<td>+</td>
<td>+</td>
<td>3/10</td>
</tr>
</tbody>
</table>

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**Fig 2 Survival curves from studies of Pope et al 1998 and Pope et al 2000, showing risk of injury in army recruits undergoing training**\(^{21, 22}\)
What is already known on this topic

Reviews of the effects of stretching before exercising have drawn conflicting conclusions. The literature on effects of stretching before and after exercising on muscle soreness and risk of injury has not been systematically reviewed.

What this study adds

Stretching before and after exercising does not confer protection from muscle soreness and stretching before exercise does not seem to confer a practically useful reduction in the risk of injury.

Effects of stretching on risk of injury

The pooled estimate from two studies was that stretching decreased the risk of injury by 5%. This effect was statistically non-significant. Even if this effect was not simply a sampling error it would not be large enough to be of practical significance. In army recruits, whose risk of injury in the control condition is high (approximately 20% over the training period of 12 weeks), a 5% reduction in relative risk implies a reduction in absolute risk of about 1%. Thus, on average, about 100 people stretch for 12 weeks to prevent one injury and (if the hazard reduction was constant) the average subject would need to stretch for 23 years to prevent one injury. Most athletes are exposed to lower risks of injury so the absolute risk reduction for most athletes is likely to be smaller still.

Although these data imply that the muscle stretching protocol used in these studies does not appreciably reduce risk of injury in army recruits undergoing military training, it is not possible to rule out with certainty a clinically worthwhile effect of other stretch protocols on risk of injury in other populations. It would be particularly interesting to determine if more prolonged stretching carried out by recreational athletes over many months or years can produce meaningful reductions in risk of injury.

We thank Rodney Pope for allowing us to use raw data from his studies and for performing the analysis of clustering.

Contributors: RDH and MG designed, analysed, and wrote up the review. MG conducted the search and extracted data with assistance from RDH. Both authors are guarantors for the paper.

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12 NHS Centre for Reviews and Dissemination. Undertaking systematic reviews of research on effectiveness—CRD guidelines for those carrying out or commissioning reviews. York: University of York, 1996.

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